GENWORTH LIFE INSURANCE COMPANY

A Stock Life Insurance Company (herein called We, Us and Our)
[Administrative Office: P. O. Box 947500, Maitland, FL 32794-7500
Phone Number 800-416-3624]

GROUP COMPREHENSIVE LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

Group Policy No.: Series 7046 Certificate Form No.: 7046CERT

The Group Policy is an approved Long Term Care Insurance Policy under California law and regulations. However, the benefits payable by the Group Policy will not qualify for Medi-Cal asset protection under the California Partnership for Long Term Care. For information about policies and certificates qualifying under the California Partnership for Long Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number, 1 (800) 434-0222.

The group contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify You for federal and state tax benefits.

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. You are advised to review carefully all limitations.

CAUTION: The issuance of this long term care insurance coverage is based upon the responses to questions on your application. A copy of your application will be provided to you. If your answers are incorrect or untrue, We have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Us at this address: General Electric Capital Assurance Company, [Administrative Office, P. O. Box 947500, Maitland, FL 32794-7500].

1. POLICY DESIGNATION

The policy is a Group Policy issued in the [state of INSERT STATE].

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the Group Policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the group policy and certificate contain governing contractual provisions. This means that the group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR CERTIFICATE CAREFULLY!**

3. TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED

You may return your Certificate for any reason within 30 days after you receive it. To do so, mail or deliver it to Our Administrative Office at the above address. We will refund the full amount of any premium paid within 30 days of such a return; and the Certificate will be considered never to have been issued.

[There is a Return of Premium on Death Benefit that provides for a refund of premiums paid for coverage upon your death. In order for it to be payable, you must die while insured before the age of 75. The amount returned is equal to a portion of the premiums paid less any claim payments made.] [The Group Policy does not include a benefit that returns premiums to you upon cancellation or to your heirs or estate upon your death.]

[However,] We will return unearned premium in the event your coverage terminates due to death, surrender or cancellation.

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither We, nor our agents represent Medicare, the federal government, or any state government.

5. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home, in the community, or in the Home.

This coverage reimburses you for covered long term care expenses you incur. It is subject to limitations, Elimination Period and other requirements.

6. BENEFITS PROVIDED BY THE POLICY – BENEFIT ELIGIBILITY

BENEFITS

Benefits are available up to the daily, monthly, annual, and lifetime maximums until applicable maximum lifetime benefits you selected are exhausted. You must meet the Eligibility for the Payment of Benefits requirements in order to receive benefits.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

For you to be eligible for benefits provided by your coverage, We must have both:

- A Current Eligibility Certification; and
- Ongoing proof which demonstrates that the Covered Care you receive is needed due to your continually being a Chronically Ill Individual. The proof can be based on information from care providers, personal physicians and other Licensed Health Care Practitioners.

Activities of Daily Living means the following self-care functions: bathing (washing oneself); dressing (putting on and taking off clothes and assistive devices); toileting (including performing associated personal hygiene tasks); transferring (moving in and out of a bed, chair or wheelchair); continence (control of bowel and bladder functions); and eating (taking nourishment).

Chronically Ill Individual means a person who has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- Requiring Substantial Supervision to protect the person from threats to health and safety due to a Severe Cognitive Impairment.

Current Eligibility Certification means a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that you meet the requirements for being a Chronically Ill Individual.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that: is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in your: short-term or long term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

Substantial Assistance means either Hands-on Assistance or Standby Assistance.
Hands-on Assistance is the physical assistance (minimal, moderate or maximal) of another person without which you would be unable to perform the Activity of Daily Living.
Standby Assistance means the presence of another person, within arm's reach of you, that is necessary to prevent, by physical intervention, your injury while you are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired person from threats to his health or safety (such threats as may result from wandering.)

CONDITIONS
Benefits will be paid as reimbursement for Covered Expenses incurred for Covered Care services that meet all of the following additional conditions:
- Your coverage provides benefits for such Covered Care;
- The Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- Except as stated in the Extension of Benefits provision of the Certificate you will receive if you become insured, your coverage is in force on the date(s) the Covered Care is received;
- You have not exhausted any daily, monthly, annual or lifetime limits on the specific benefits claimed;
- You meet all additional requirements for the benefits you claim;
- The service, cost or item for which benefits are payable constitutes Qualified Long Term Care Services; and
- You satisfy the Elimination Period.

Right To A Second Assessment
If a Licensed Health Care Practitioner assesses your condition and decides not to certify you as a Chronically Ill Individual, We will inform you of this. If the Licensed Health Care Practitioner made that determination without a personal examination of you, a second assessment will be allowed.

Benefit payments cease when your Policy Lifetime Maximum is exhausted and are subject to: the Elimination Period; the Facility Care Maximum; and all other limits determined from the specific benefits.

Those limits are based on your plan selection as shown on the enrollment material and stated in the Certificate you will receive if you become insured.

Covered Care means only those Qualified Long Term Care Services for which your coverage pays benefits or would pay benefits in the absence of an Elimination Period.

Covered Expenses means costs you incur for which a benefit may be payable under this coverage up to the applicable coverage maximums. Each benefit section defines the Covered Expenses under that benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

[*Elimination Period* means the total number of days that you remain a Chronically Ill Individual and incur Covered Expenses before benefits are payable. The Elimination Period begins on the first day that you are both a Chronically Ill Individual and incur Covered Expenses. Each day on which you remain a Chronically Ill Individual and incur Covered Expenses that are subject to the Elimination Period will count toward the Elimination Period. The days do not have to be consecutive. Each benefit states how its payment is affected by the Elimination Period. The number of days may be accumulated before the filing of a claim if We can establish that you met these Elimination Period requirements before the filing of a claim. The Elimination Period need only be met once during your lifetime.]

[OR]

[*Elimination Period* means the total number of days that you remain a Chronically Ill Individual before benefits are payable. Each benefit states how its payment is affected by the Elimination Period. The Elimination Period begins on the first day that you are both a Chronically Ill Individual and incur Covered Expenses. However, you are not required to continue to incur Covered Expenses to satisfy the Elimination Period. You must remain a Chronically Ill Individual for each consecutive day following the first day of the Elimination Period in order to satisfy the Elimination Period. Elimination Period days may be accumulated before the filing of a claim if We can establish that you met these Elimination Period requirements before the filing of a claim. The Elimination Period need only be met once during your lifetime.]

Facility Care Maximum means the maximum amount We will pay [daily/monthly] when you are Confined in a Nursing Facility, Residential Care Facility or Hospice Care Facility. This amount is also used to determine other benefit maximums.

Licensed Health Care Practitioner means any of the following who is not a family member: a Physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional Nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is practicing within the scope of that license.

Plan of Care means a written individualized plan for care and support services for you that: has been developed as a result of an assessment and incorporates any information provided by your personal physician; has been prescribed by a Licensed Health Care Practitioner; fairly, accurately and appropriately addresses your long term care and support service needs. It specifies: the type, frequency and duration of all formal and informal services required to meet those needs; the kinds of providers appropriate to furnish those services; and an estimate of the appropriate cost of such services.

Policy Lifetime Maximum means the maximum amount of benefits payable to you. The Policy Lifetime Maximum is exhausted only when the total of all benefits paid equals the applicable Policy Lifetime Maximum. Covered Expenses We incur for Care Coordination Services do not count against your Policy Lifetime Maximum. The Policy Lifetime Maximum will increase in accordance with the terms of any inflation protection in force. The Policy Lifetime Maximum will increase or decrease in accordance with any increase or decrease you elect.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are: required by a Chronically Ill Individual; and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. ***Maintenance or Personal Care Services*** means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which you are a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

CARE COORDINATION SERVICES

These services are intended to help identify care needs and community resources available to deliver care when you are a Chronically Ill Individual. These services are furnished by a team of Covered Care Coordinators provided by Us at no cost to you. We will pay for these services when you receive them while your coverage is in effect. These payments will be at our expense; and will NOT count against any payment maximum.

Care Coordination Services will provide you with a team of Covered Care Coordinators who will review your specific situation and develop Plans of Care to meet your needs. Covered Care Coordinators will: assess your functional, cognitive and personal needs for care and services on an ongoing basis; work with you to identify the specific services and care providers you require; develop and suggest initial and subsequent Plans of Care to assist you in meeting your needs; provide the initial and ongoing Current Eligibility Certifications; and monitor your care needs on an ongoing basis to help you receive appropriate care.

You or your family should contact Us immediately when you choose to use the services of a Covered Care Coordinator. We will then make arrangements for a Covered Care Coordinator to contact you and begin providing you with this assistance. You are not required to use these Care Coordination Services. However, you may, at your own expense, use a Licensed Health Care Practitioner who is not a Covered Care Coordinator to provide a Plan of Care, Current Eligibility Certification, or assist in coordinating services.
Care Coordination Services will not be provided in connection with the International Coverage Benefit. Payment for these services is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period. Care Coordination Services are not subject to the Policy Lifetime Maximum.

NURSING FACILITY BENEFIT

You are eligible to receive benefits during your Confinement in a Nursing Facility. Covered Expenses for Nursing Facility care means expenses you incur for care and support services (including room and board) provided by the Nursing Facility. Covered Expenses do not include expenses you incur for prescription medications or any charges for your comfort and convenience such as transportation, televisions, telephones, beauty care, guest meals and entertainment. We will pay up to the Facility Care Maximum for Covered Expenses you incur during your Confinement. The Nursing Facility Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

Confinement or Confined means you are a resident in a facility during a period for which room and board charges are Covered Expenses.

Nursing Facility means a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse; the facility must employ at least one full-time (at least 30 or more hours per week) Nurse; and a Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing, or unit thereof can qualify as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.
Excluded Places: A Nursing Facility does NOT include any of the following: a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness; a Residential Care Facility; your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); a substantially similar adult residence establishment or environment.

RESIDENTIAL CARE FACILITY BENEFIT

You are eligible to receive benefits during your Confinement in a Residential Care Facility. Covered Expenses for care in a Residential Care Facility means expenses you incur for care and support services (including room and board) provided by the Residential Care Facility. Covered Expenses do not include expenses you incur for prescription medications or any charges for your comfort and convenience such as transportation, televisions, telephones, beauty care, guest meals and entertainment. We will pay up to the

Facility Care Maximum for Covered Expenses you incur during your Confinement. The Residential Care Facility Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

Residential Care Facility means a facility licensed as a Residential Care Facility for the elderly or a residential care facility as defined in the California Health and Safety Code. Outside California, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impairment in cognitive ability and which also: provide care and services on a 24-hour basis; have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services; provide three (3) meals a day and accommodate special dietary needs; have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency; and have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.
Excluded Places: A Residential Care Facility is NOT any of the following: a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness; a Nursing Facility; your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); or a substantially similar adult residence establishment or environment.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as a Residential Care Facility only if it is engaged primarily in providing care that satisfies the above definition.

BED RESERVATION BENEFIT

You are eligible to receive benefits to reserve your accommodations in a Nursing Facility or Residential Care Facility during your temporary absence (for any reason) from that facility. Covered Expenses for Bed Reservation Benefits means the same as Covered Expenses for reserving your room and board accommodations in the Nursing Facility or Residential Care Facility. We will pay up to the Facility Care Maximum for Covered Expenses you incur while you are temporarily absent from the Nursing Facility or Residential Care Facility. This benefit is payable for a maximum of 60 days per calendar year. The Bed Reservation Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

HOME AND COMMUNITY CARE BENEFIT

You are eligible to receive benefits for Covered Expenses you incur for Home and Community Care. Covered Expenses for Home and Community Care means expenses you incur for the following services: Adult Day Care; Nurse and Therapist Services; Home Health Services; Personal Care Services; and Homemaker Services. Based on your plan selection (choices shown in your enrollment materials), We will pay up to the Home and Community Care Maximum for Covered Expenses you incur. Your Home and Community Care Maximum is a percentage of your Facility Care Maximum. The Home and Community Care Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

Home means the place where you maintain independent residence. This could be a house, condominium, apartment, unit in a congregate care community or similar residential environment. Home does not mean: a hospital; a Nursing Facility; a Residential Care Facility; or a Hospice Care Facility.

Adult Day Care means medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside the Home, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, transferring, toileting and taking medications.

Nurse and Therapist Services means health care services provided in your Home by a Nurse, or a licensed physical, occupational, respiratory or speech therapist.

Home Health Services means assistance you receive in your Home from a Home Health Agency or Independent Provider with: simple health care tasks; personal hygiene; managing medications; performing Activities of Daily Living; and supervision needed when you have Severe Cognitive Impairment.
Homemaker Services means assistance with activities necessary to or consistent with your ability to remain in your residence, that is provided by a skilled or unskilled person under a Plan of Care developed by a physician or a multidisciplinary team under medical direction.

Home Health Agency means an entity that is regularly engaged in providing Home Health Services or Personal Care Services for compensation and employs staff who are qualified by education, training or experience to provide such care. The entity must: be supervised by a qualified professional such as a Nurse, a licensed social worker, or a Physician; keep clinical records or care plans on all patients; provide ongoing supervision and training to its staff appropriate to the services to be provided; and have the appropriate state licensure or certification, where required.

Independent Provider means a person who is not affiliated with a Home Health Agency and is licensed or certified in the state where the care will be provided, to provide assistance in performing Activities of Daily Living or supervision for someone who has Severe Cognitive Impairment. If the state in which you live does not require licensure or certification for Independent Providers, We may approve benefits for an Independent Provider if We can determine, using Our sole discretion, that the individual is qualified by education, training and experience to provide Home Health Services or Personal Care Services. The education must include training in safely assisting Chronically Ill Individuals. We will require written proof of licensure or certification, and will accept inclusion in a state sponsored nurse aide registry, if the state in which you live maintains such a registry.

Personal Care Services means assistance with the Activities of Daily Living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a Licensed Health Care Practitioner. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

HOME ASSISTANCE BENEFIT

You are eligible to receive benefits for Covered Expenses you incur for Home Assistance. Covered Expenses for Home Assistance means expenses you incur (including tax, installation and labor costs) for the following services or items: Home Modifications, Assistive Devices and Supportive Equipment; Emergency Medical Response Systems; and Caregiver Training. Covered Expenses must be: intended to enable you to remain independent in your Home; and stated in, and furnished in accordance with your Plan of Care. We will pay up to the Home Assistance Lifetime Maximum of [50] [2 (two)] times your Facility Care Maximum for Covered Expenses you incur for Home Assistance Services. Payment under the terms of this benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

Home Modifications, Assistive Devices and Supportive Equipment means items such as the following that are intended to relieve your need for direct physical assistance; and (as stated in your Plan of Care) are expected to enable you to remain at Home for at least 90 days after the date of purchase or first rental: ramps to permit movement from one level of your Home to another; grab bars to assist in toileting, bathing or showering; hospital-style beds, wheelchairs or crutches; adaptive equipment to enable independent feeding and dressing (specialized utensils and fasteners); and pumps and other devices for intravenous injection. This does NOT include: Home repair, remodeling, or installation of an elevator, escalator, hot tub, swimming pool, or Jacuzzi or other similar items or services; items that will, other than incidentally, increase the value of your Home; and artificial limbs, teeth, corrective lenses, hearing aids, or equipment placed in your body, temporarily or permanently.

Emergency Medical Response Systems means the installation and any ongoing fees for any type of medical alert system.

Caregiver Training means the training of a family member, friend or other person to provide care for you in your Home. Caregiver Training must be included in your Plan of Care. Covered Expenses for Caregiver Training means expenses incurred for training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for you. The training cannot be received when you are Confined in a hospital, Residential Care Facility or Nursing Facility, unless it is reasonably expected that the training will make it possible for you to return to your Home, where you can be cared for by the person receiving the training.

[INFORMAL CARE BENEFIT

You are eligible to receive benefits for Covered Expenses you incur for Informal Care. Covered Expenses for Informal Care means expenses you incur for Informal Care that is: intended to enable you to remain independent in your Home; and stated in, and furnished in accordance with your Plan of Care. We will pay for Covered Expenses you incur for Informal Care up to [25%] [1%] of the Facility Care Maximum per calendar day for no more than 30 days per year. Payment under the terms of this benefit is subject to the Elimination Period. Days of Covered Care under this Benefit cannot be used to satisfy the Elimination Period. The Informal Care Benefit is also subject to the Policy Lifetime Maximum.

Informal Care means Maintenance or Personal Care Services another person (which may include a member of your Immediate Family) provides to you, in your Home, because you are a Chronically Ill Individual. In all instances the person providing the assistance and supervision must be someone who did not normally reside with you in your Home at the time you became eligible for benefits and is neither from a Home Health Agency nor an Independent Provider. The assistance may be in the form of help with: simple health care tasks; personal hygiene; managing medications; or performing Activities of Daily Living. Supervision is applicable when you have Severe Cognitive Impairment. Your Plan of Care must specify the type, frequency and duration of Informal Care required.]

HOSPICE CARE BENEFIT

You are eligible to receive Hospice Care Benefits when We determine that you are a Chronically Ill Individual, you are Terminally Ill, and you are not receiving preventive or curative treatment for that illness. Covered Expenses for Hospice Services means expenses you incur for care and support services (including room and board) in a Hospice Care Facility, Nursing Facility or Residential Care Facility. Covered Expenses for Hospice Services also means Covered Expenses for Home Health Services, Personal Care Services, and Homemaker Services. Covered Expenses do not include expenses you incur for medications, supplies, equipment or Physician visits. We will not pay for any charges for your convenience such as transportation, televisions, telephones, beauty care, guest meals or entertainment. We will pay up to the Facility Care Maximum for Covered Expenses you incur during your Confinement in a Hospice Care Facility, Nursing Facility or Residential Care Facility. We will pay up to the Home and Community Care Maximum for all other Covered Expenses you incur for Hospice Services. Payment under the terms of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period. The Hospice Care Benefit is also subject to the Policy Lifetime Maximum.

Hospice Services means outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is Terminally Ill, and to provide supportive care to the primary caregiver and the family. Care may be provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner..

Hospice Care Facility means a facility which provides a formal Hospice Services program directed by a Physician on an inpatient basis. A Hospice Care Facility must be licensed or certified by the state in which it is located, if such license or certification is required. A Hospice Care Facility may be licensed or certified as

a Nursing Facility, Residential Care Facility, or other type of health care facility. Hospice Care Facility does not mean: a hospital, a clinic; a community living center; or a place that provides residential or retirement care only.

Terminally Ill means having six months or less to live, as determined by a physician.

RESPITE CARE BENEFIT

You are eligible to receive Respite Care Benefits, prior to your meeting the Elimination Period, when it provides temporary, short-term relief for those persons who normally and primarily care for you in your Home on a regular, unpaid basis. Covered Expenses for Respite Care means: care in a Nursing Facility; care in a Residential Care Facility; and Home and Community Care. We will pay up to the Facility Care Maximum for Covered Expenses you incur for Respite Care. This maximum applies to all such expenses you incur. We will pay this Benefit until the Respite Care Benefit Annual Maximum of [30] [21] times the Facility Care Maximum per calendar year is reached. Days on which you receive Respite Care do not need to be consecutive. Payment under the terms of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period. The Respite Care Benefit is also subject to the Policy Lifetime Maximum.

Respite Care means temporary care you receive in order to relieve the unpaid person who normally and primarily provides you with care in your Home. Your Plan of Care must state: the name of the unpaid caregiver for whom the respite is being provided; the period of respite; and the Covered Care you will require to replace that normally provided by that unpaid caregiver.

BENEFITS NOT LISTED

Subject to our approval, you will be eligible to receive payment for Covered Expenses you incur for services, devices or treatments not otherwise payable under your coverage, or benefits payable in a different manner than specified. Covered Expenses for the Benefits Not Listed means fees charged for care, services, devices or treatments approved by Us after We determine that they: are cost-effective; are appropriate to your needs; are consistent with general standards of care; provide you with an equal or greater quality of care than otherwise provided by your coverage; are Qualified Long Term Care Services; and are clearly specified in your Plan of Care and in a separate written mutual agreement between Us, you (or your representative) and, if appropriate, your Physician. The written mutual agreement will state how the Elimination Period affects payment. It will also state any time and payment maximums. The Benefits Not Listed is also subject to the Policy Lifetime Maximum.

INTERNATIONAL COVERAGE BENEFIT

You are eligible to receive benefits during your Confinement in an Out-of-Country Nursing Facility. Covered Expenses for International Coverage means expenses you incur for care and support services (including room and board) provided by the Out-of-Country Nursing Facility (as defined in the Certificate you will receive if you become covered). We will pay up to 75% of the Facility Care Maximum per calendar [day/month] for not more than 1,460 days per lifetime. [If the Facility Care Maximum applies to a calendar period, payment under this Benefit for periods of less than a full month will be pro-rated based on a 30-day month and the number of days for which payment is being made.] This Benefit will not qualify for waiver of premium; and is in lieu of all other Benefits and reimbursements otherwise provided by the policy for expenses incurred during the same period. The International Coverage Benefit is subject to the Elimination Period and the Policy Lifetime Maximum.

CONTINGENT NONFORFEITURE BENEFIT

You will receive coverage under this benefit if you are not covered by the Nonforfeiture Benefit. If there is a substantial increase in premium rates, you will be given the right to reduce coverage or convert to a paid-up status with a reduced Policy Lifetime Maximum equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) the maximum

amount in effect at the time of lapse applicable to 90 days of Nursing Facility Confinement. In no event will this amount exceed the Policy Lifetime Maximum at the time of conversion.

[[OPTIONAL] NONFORFEITURE BENEFIT

If you are covered by the Nonforfeiture Benefit Rider, it will provide a continuation of your coverage up to a specified dollar amount, called the Nonforfeiture Benefit Allowance, if your coverage terminates due to non-payment of premium before your Policy Lifetime Maximum has been paid. If your coverage terminates due to non-payment of premium on or after it has been in force for ten years, We will continue to pay benefits, subject to all of the terms and conditions of your coverage, until the Nonforfeiture Benefit Allowance has been reached or when you no longer meet the Eligibility for the Payment of Benefits requirements of the Group Policy, whichever occurs first. The Nonforfeiture Benefit Allowance We will pay will be the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) the maximum amount in effect at the time of lapse applicable to 90 days of Nursing Facility Confinement. In no event will this amount exceed the Policy Lifetime Maximum at the time of lapse.]

7. EXCLUSIONS AND LIMITATIONS

There are no pre-existing conditions exclusions or limitations.

Non-eligible Facilities/Providers: A Nursing Facility, Residential Care Facility or Hospice Care Facility is not covered unless it meets the applicable definition for such a facility. Your "***Home"*** means the place where you maintain independent residence. This could be a house, condominium, apartment, unit in a congregate care community or similar residential environment. Your Home does not mean: a hospital; a Nursing Facility; a Residential Care Facility; or a Hospice Care Facility.

Non-eligible Levels of Care*:* Coverage is not based on the specific level of care; but is for care furnished, for a specific covered reason, by or through the covered facilities and providers. Care from family members is covered only when specifically indicated.

Exclusions/Exceptions and Limitations: We will not pay benefits for any expenses incurred for any room and board, care, treatment, services, equipment, or other items:

- For which no charge is normally made in the absence of insurance;
- Provided outside the United States of America, its territories and possessions, except as described in the International Coverage Benefit;
- Provided by a family member, unless a benefit specifically states that a family member can provide Covered Care. We will not consider care to have been provided by a family member when:
  - He or she is a regular employee of the organization that is providing the services; and
  - Such organization receives payment for the services; and
  - He or she receives no compensation other than the normal compensation for employees in his or her job category.
- Provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to you or your estate;
- Resulting from war or any act of war, whether declared or not;
- Resulting from attempted suicide or an intentionally self-inflicted injury;
- Resulting from participation in a felony, riot or, insurrection;
- Resulting from your alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician);
- For which you receive, or are eligible to receive, workers' compensation benefits, occupational disease act benefits, or similar benefits.

Non-Duplication: Benefits will be paid only for Covered Care expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other federal, state or other governmental health care program or law except Medi-Cal or Medicaid.
- However, the Non-Duplication provision will not disqualify a Covered Care expense from being used to satisfy the Elimination Period.

Coordination With Other Coverage: We will reduce the amount We will pay for Covered Care when the total amount payable under this and all other Long Term Care Coverage is greater than the actual expense you incur for that Covered Care. We consider ***Long Term Care Coverage*** to be coverage, whether group or individual, that provides nursing facility, residential care facility or home health care benefits. This applies whether those benefits are payable on an expense reimbursement, indemnity, cash payment or other basis.

When benefits are reduced, the amount We will pay will be the lesser of:
- The amount We would pay in the absence of this provision; or
- The difference between the actual expense incurred and the amount payable under all other Long Term Care Coverages whose benefits are payable before those of your coverage. In making this determination We will use the order of benefit payments stated below.

Any Long Term Care Coverage without a coordination of coverage provision will pay first without any reduction in its benefits. For this and all other Long Term Care Coverage, the coverage with the earliest effective date will be deemed to be first to pay, and the later coverage(s) secondary, in order of effective date, from the earliest to the latest.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [You may elect one of the inflation protection options to increase your coverage.] Only increases taken in accordance with one of the inflation protection options do not require proof of insurability.

[AUTOMATIC INFLATION PROTECTION – 5% COMPOUND ANNUAL INCREASES RIDER

If you have this option, We will increase by 5%: the prior year's Facility Care Maximum; the prior year's Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage even if you are receiving benefits. The increased amounts will be rounded to the nearest whole dollar. These increases are not reduced by benefit payments.]

[AUTOMATIC INFLATION PROTECTION – 5% COMPOUND ANNUAL INCREASES TO AGE 70 RIDER

If you have this option, We will increase by 5%: the prior year's Facility Care Maximum; the prior year's Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage, even if you are receiving benefits. No increase will occur after you have reached 70 years of age. The increased amounts will be rounded to the nearest whole dollar. These increases are not reduced by benefit payments..**]**

[AUTOMATIC INFLATION PROTECTION – 5% SIMPLE INCREASES RIDER

If you have this option, We will increase by 5%: your original Facility Care Maximum; your original Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage even if you are receiving benefits. The increased amounts will be rounded to the nearest whole dollar. These increases are not reduced by benefit payments.]

[AUTOMATIC BENEFIT INCREASE RIDER: AGE-ADJUSTED: COMPOUND TO 65, SIMPLE THEREAFTER.
If you have this option, We will increase: your Facility Care Maximum; your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage even if you are receiving benefits. The increase amounts will be: (a) prior to age 66 on a Compound Basis; (b) after age 66, on a Simple Basis; and (c) rounded to the nearest whole dollar.

"Compound Basis" means that the benefit amounts in effect on the date of the increase will be multiplied by 5% to determine the current benefit amounts. "Simple Basis" means, with respect to the Facility Care Maximum and benefit maximums other than the Policy Lifetime Maximum, that the amount of the increase will be determined by multiplying 5% times the Facility Care Maximum in effect on the anniversary date of your Coverage Effective Date next following your 66th birthday. This amount will be the amount of the increase that occurs on each anniversary thereafter while your coverage is in force. With respect to the Policy Lifetime Maximum, Simple Basis means that the amount of the increase will be determined by multiplying 5% times the Policy Lifetime Maximum in effect on the effective date of the increase. In calculating the amount of the increase, benefit payments will not be deducted. For additions to your benefit amounts that are not the result of this Rider, the amount of the increase will be determined separately.]

[AUTOMATIC BENEFIT INCREASE RIDER: AGE ADJUSTED COMPOUND PROTECTION : AGES 61 [AND 76] – [5%, 3%] TO AGE 61 / 3% [TO AGE [76] [2%, 3%][THEREAFTER].
If you have this option, We will increase: your Facility Care Maximum; your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage, even if you are receiving benefits. The increase amounts will be on a Compound Basis and rounded to the nearest whole dollar.

"Compound Basis" means that the benefit amounts in effect on the date of the increase will be multiplied by by the appropriate percentage based on Your age to determine the current benefit amounts: when younger than age 61, [3%, 5%]; after age 61, [but younger than age 76,] 3%[; and after age 76, [2%, 3%]].

[AUTOMATIC BENEFIT INCREASE RIDER –[3%, 4%, 5%] COMPOUND ANNUAL INCREASES TO AGE 76]
If you have this option, We will increase by [3%] [4%] [5%]: your Facility Care Maximum; your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage, even if you are receiving benefits. No increase will occur after you have reached 75 years of age. The increased amounts will be rounded to the nearest whole dollar.

"Compound Basis" means that the benefit amounts in effect on the date of the increase will be multiplied by the appropriate percentage to determine the current benefit amounts."**]**

[AUTOMATIC BENEFIT INCREASE RIDER: AGE ADJUSTED PROTECTION—AGE[S] 61 [AND 76] – 5% COMPOUND TO AGE 61 / 5% SIMPLE [TO AGE [76; [2%, 5%] SIMPLE] THEREAFTER].
If you have this option, We will increase: your Facility Care Maximum; your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the Your Coverage Effective Date, even if you are receiving benefits. The increase amounts will be: (a) prior to age 61 on a Compound Basis; [(b) after age 61, on a Simple Basis;] [(b) from age 61 [to age 76,][and thereafter]on a Simple Basis;] [(c) from age 61 to age [76 and thereafter] on a Simple Basis;] and [(c)(d)] rounded to the nearest whole dollar.

"Compound Basis" means that the benefit amounts in effect on the date of the increase will be multiplied by [5%] to determine the current benefit amounts.

"Simple Basis" means, with respect to the Facility Care Maximum and benefit maximums other than the Policy Lifetime Maximum, that the amount of the increase will be determined by multiplying the appropriate percentage based on your age times the Facility Care Maximum in effect on the anniversary date of your Coverage Effective Date following your [61st and 76th] birthdays respectively. "Simple Basis" means that, with respect to an increase to your Policy Lifetime Maximum that occurs[: (a)]on the anniversary of Your Coverage Effective Date next following Your 61st birthday and [on each such anniversary until you are age 76/thereafter], the amount of the increase will be determined by multiplying 5% times the Policy Lifetime Maximum in effect on the anniversary of Your Coverage Effective Date next following your 61st birthday; [and (b) [On the anniversary of Your Coverage Effective Date next following Your 76th birthday and each such anniversary thereafter, the amount of the increase will be determined by multiplying [2%, 5%] times the Policy Lifetime Maximum in effect on the Anniversary Date next following your 76th birthday. In calculating the amount of the increase on a Simple Basis, benefit payments will not be deducted.]

With respect to an addition to your benefit amounts that is not the result of the Rider, the amount of the increase will be determined separately.

[FUTURE PURCHASE OPTIONS

If you have this option, you will be offered on every third anniversary of the Group Policy Effective Date, while your coverage is in force, the option to increase by 5% compounded annually: your Facility Care Maximum; your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. You will receive these offers provided: your coverage remains in force; you are not currently receiving benefits; you have not filed a claim which is pending; you have not been determined to be currently eligible for benefits; and you are not currently satisfying the Elimination Period. The additional premium required for each increase will be based on your age and premium rate as of the effective date of the offer. Once you have refused [two consecutive] offers, future offers will cease; and you must submit proof of insurability satisfactory to Us if you want to increase coverage.]

Inflation Protection – Graphic Comparisons

The charts below compare the benefit levels and costs of coverage over time (and at ages 75 and 85) with and without inflation protection. **Chart I** compares benefits with the different types of inflation coverage available under the Group Policy, as well as no protection at all. **Chart II** compares the premiums for coverage with and without these same inflation options. These charts use the following plan design for a person aged 45 when coverage is issued: $150 per day Facility Care Maximum, 5 Year Benefit Duration, 75% Home and Community Care Benefit, 90-DAY (SERVICE DAYS) Elimination Period, and an Informal Care benefit. For the Future Purchase Option, the chart indicates that all offers under the Option were accepted. It is assumed that premiums did not change over the time span. (This is not a rate guarantee. The company reserves the right to change premiums rates as noted in the paragraph " TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.")

CHART I

Lifetime Maximum for Issue Age 45, 5 Year Plan, 75% Home Care, 90 Service Day Elimination Period

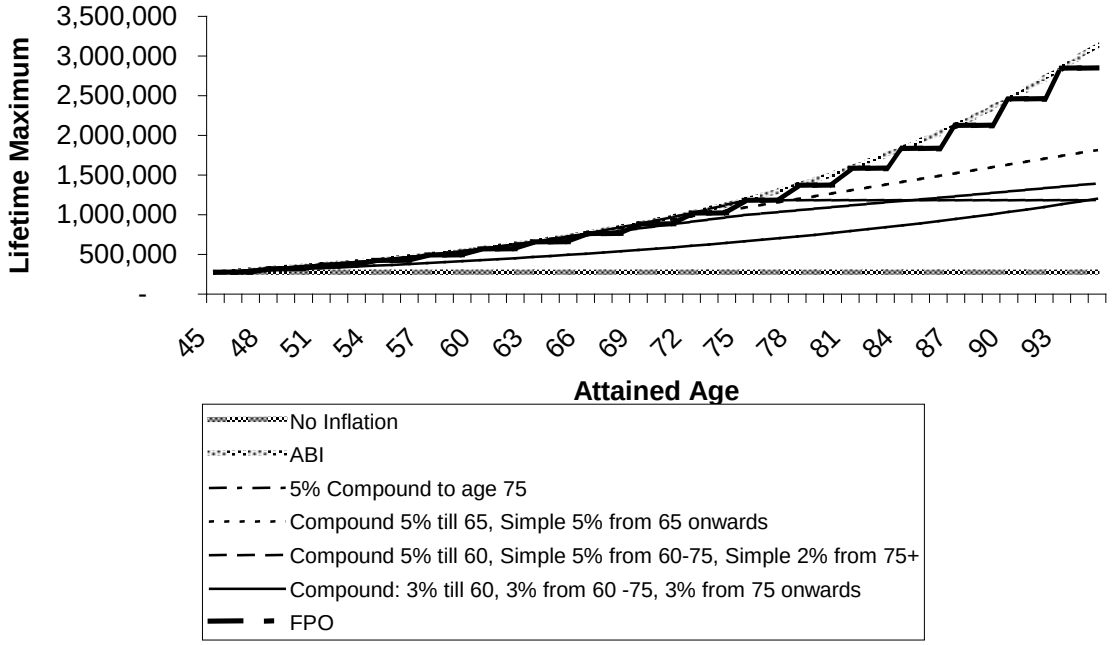
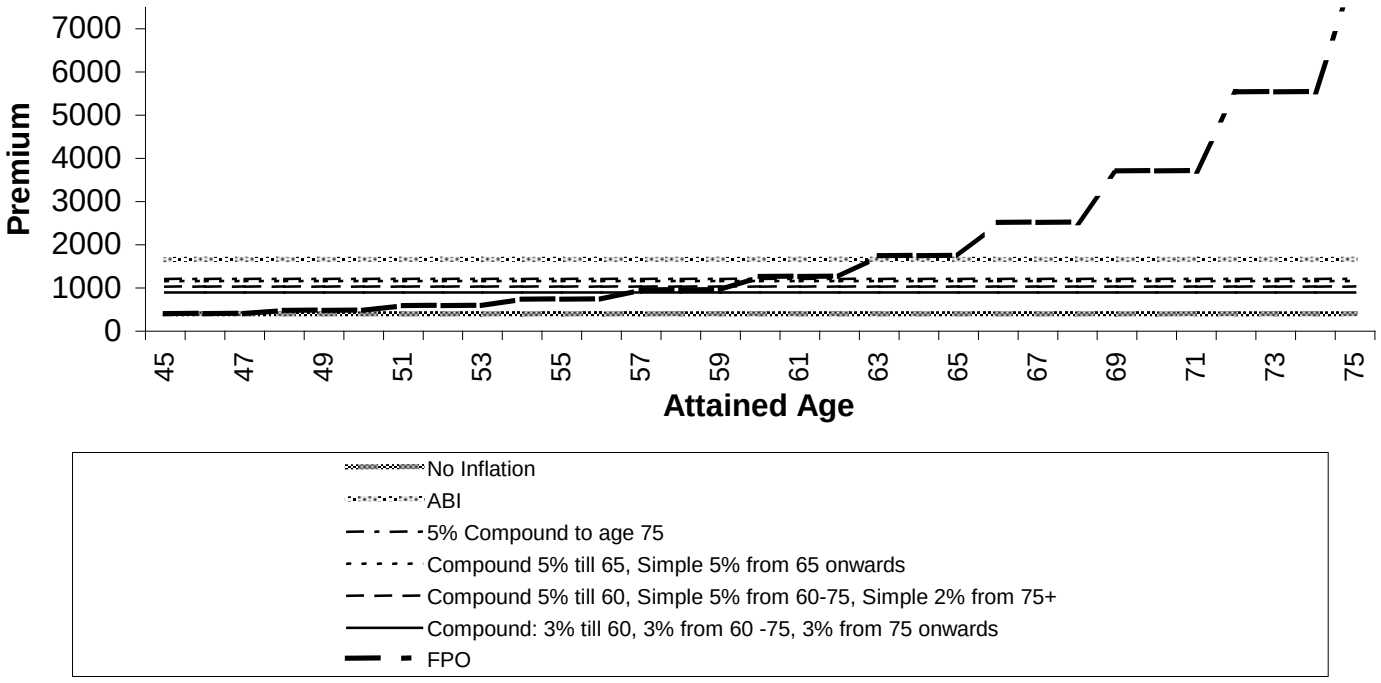


CHART II

Premium For Issue Age 45, 5 Year Plan, 75% Home Care, 90 Service Day Elimination Period



9. TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED

Renewability: THIS COVERAGE IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your Certificate, to continue your coverage as long as premiums for your coverage are paid on time. We cannot change any of the terms of the Group Policy on our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Continuation Coverage: If the Group Policy is terminated, We will continue your coverage as stated in the Certificate you will receive if you become insured.

Waiver of Premium Benefit: We will waive your premium payments that become due when benefits are payable under: the Nursing Facility Benefit; the Residential Care Facility Benefit; the Home and Community Care Benefit; the Bed Reservation Benefit; or the Hospice Care Benefit.

Terms Under Which The Company May Change Premiums: We have a limited right to change the premium rates for your coverage. The premium rates for your coverage will not increase due to a change in your age or health. Premium rates may increase on a group or eligible class basis, subject to the approval of the California Department of Insurance. We will give you and/or the policyholder at least 60 days notice before We change the premiums for your coverage.

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your application for coverage under the Group Policy is approved, the Group Policy provides coverage for treatment of Alzheimer's disease, Parkinson's disease, senile dementia, and all other forms of organic brain disease.

11. PREMIUM

The initial premium for your coverage will be determined from the premium rate schedule contained in your enrollment material based on the option selected and your issue age.

12. ADDITIONAL FEATURES

Underwriting

We will underwrite your application by reviewing one or more of the following: the information submitted on your application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Continuation for Lapse Due to Cognitive or Functional Impairment

If your coverage terminates due to non-payment of premiums, We will provide a retroactive continuation of coverage if within seven (7) months of the termination date you provide Us with proof that you were a Chronically Ill Individual, beginning on or before the expiration date of the grace period. All past due premiums for your coverage that was in force immediately prior to the date of lapse must be paid. In that event, any benefits for which you qualified during the continuation period will be paid to the same extent they would have been paid if your coverage had remained in force from the date of termination.

13. INFORMATION AND COUNSELING.

The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.