CareScout Insurance Company
Administrative Office
3100 Albert Lankford Dr.
Lynchburg, Virginia 24501-4948

Long-Term Care Insurance Outline of Coverage

from CareScout Insurance Company

Policy form series ICC25-1111

NOTICE TO BUYER

This Policy may not cover all of the costs associated with long-term care incurred by the buyer (You, and Your) during the period of coverage. The buyer is advised to review carefully all Policy limitations.

CAUTION

The issuance of this long-term care insurance Policy is based upon Your responses to the questions on Your Application. A copy of Your Application will be attached to any issued Policy. If Your answers are incorrect or untrue, CareScout Insurance Company (called We, Us and Our in this Outline of Coverage) has the right to deny Benefits or rescind the Your Policy. 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: the Administrative Office address shown above.

1. POLICY DESIGNATION

The Policy is an individual policy of insurance.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This Outline of Coverage provides a very brief description of the important features of the 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 individual Policy, and not this Outline of Coverage, contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and Us. Therefore, if You purchase this coverage, or any other coverage, it is important that You **READ YOUR POLICY CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

The Policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of the Policy, to continue the Policy as long as You pay Your Premium on time. We cannot change any of the terms of Your Policy on Our own, except that, in the future, **WE MAY INCREASE THE PREMIUM YOU PAY**.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

WE HAVE THE RIGHT TO INCREASE OR OTHERWISE CHANGE PREMIUM BECOMING DUE IN THE FUTURE. We will not single You out for an increase or other change to Your Premium, even as Your age changes, Your health changes, or You use Policy Benefits. Generally, any increase or other change to Your Premium will apply equally to policies like Yours, such as policies issued in the same state, on the same forms, and with the same Coverage, Rating, age at Policy issue, date of Policy issue, and Policy change history. When determining whether to increase or otherwise change Premium, We may consider information from Your Policy along with information from policies like Yours. We may also consider information from other policies and from other sources. We will not change Premium more frequently than once in any 12-month period, except for changes to Premium due to changes You make to the Policy or due to changes to Your Premium Payment Mode. We will give You at least 60 days' written notice before We change Premium.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

30-Day Free Look Period: You have 30 days from the day You receive the Policy to review and return it to Us at Our Administrative Office if You are not satisfied with it for any reason or believe there are any mistakes. All Premium paid will be refunded within 30 days after: (a) return of the Policy during this 30-Day Free Look Period; or (b) Our denial of Your Application.

Unearned Premium Refunds: Unearned Premium will be refunded if the Policy ends due to death, surrender or cancellation.

7. 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/producers represent Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more 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.

The Policy reimburses You for covered long-term care expenses You incur. It is subject to a Deductible Period, a Coverage Maximum, a Daily Benefit Maximum, and all other limitations, exclusions, and conditions of the Policy.

9. BENEFITS PROVIDED BY THIS POLICY

(a) Covered Services: Payment of institutional and non-institutional Benefits described below is subject to the provisions, conditions, limitations and exclusions set forth in the Policy. Once the Deductible Period has been satisfied, Benefits are available up to the Daily Benefit Maximum and the Coverage Maximum until the applicable Benefits are exhausted. Benefits are paid, up to the applicable limits, for Your Covered Expenses. You will be responsible for the payment of any expenses not covered by the Policy. A summary of the limits and features chosen for Your Policy are shown at the end of this Outline of Coverage.

(b) Institutional Benefits: These pay for Covered Expenses incurred while confined in a Nursing Facility, Assisted Living Facility, or Hospice Care Facility. Bed Reservation coverage is available for temporary absences (up to the Daily Benefit Maximum, 90 days per calendar year) from one of these facilities.

(c) Non-Institutional Benefits: These include the following:

Privileged Care© Coordination Services are offered to assist in identifying care needs and community resources available to deliver care while You are Chronically Ill. When You choose to use these services, they will be furnished by a Privileged Care Coordination team provided by Us at no cost to You.

The ***Home and Community Care Benefit*** pays Covered Expenses, consistent with the needs addressed in Your Plan of Care, for services received at home and in the community for:

- *Adult Day Care*; and
- The following services provided by a Home Health Agency or an Independent Provider:
    - *Nurse and Therapist Services*
    - *Home Health or Personal Care Services*; and
    - *Incidental Homemaker and Chore Care*;

Adult Day Care or Home Health Agency providers are paid up to the Daily Benefit Maximum per calendar day while Independent Providers are paid up to 50% of the Daily Benefit Maximum per calendar day.

The ***Home Assistance Benefit*** pays Covered Expenses for the following services or items intended to enable You to remain safely in Your Home: home modifications; assistive devices; supportive equipment; emergency medical response systems; and caregiver training. It pays up to a lifetime limit equal to 90 times the Daily Benefit Maximum.

The ***Hospice Care Benefit*** pays Covered Expenses for services designed to provide palliative care and alleviate Your discomforts when You are both Chronically Ill and Terminally Ill. Benefits are payable up to the Daily Benefit Maximum per calendar day for care received either in a covered facility or while You are living at home.

The ***Respite Care Benefit*** pays Covered Expenses for short-term care to relieve the person who normally and primarily provides You with care in Your home on a regular, unpaid basis. It pays for up to the Daily Benefit Maximum per calendar day, 90 days per calendar year.

The ***Contingent Nonforfeiture Benefit*** gives You the right to reduce coverage or convert to limited paid-up Benefits in the event of a cumulative Premium increase that is considered to be substantial as determined under the Policy.

(d) Eligibility For The Payment Of Benefits: For You to be eligible for the payment of Benefits under the Policy:
- You must be Chronically Ill;
- We must receive a Current Eligibility Certification for You; and
- We must receive ongoing proof which verifies that the Covered Care You receive is needed due to You continually being Chronically Ill.

Conditions: Benefits will only be paid as reimbursement for expenses paid bv You or on Your behalf only if all of the following conditions have been satisfied:
- You must meet the above Eligibility For The Payment Of Benefits requirements.
- The expenses must qualify as Covered Expenses under the Policy.
- The Covered Care and related Covered Expenses must be consistent with and received pursuant to Your Plan of Care as prescribed by a Licensed Health Care Practitioner.
- Except as stated in the Extension of Benefits provision, the Policy must not have ended on or before the date(s) the Covered Care is received.
- Any applicable Deductible Period has been satisfied.
- You must not have exhausted the Coverage Maximum or any daily, annual or lifetime limits applicable to the Coverage provided for the Benefits being claimed.
- The care, service, cost or item for which Benefits are payable must meet the definition of Qualified Long-Term Care Services.
- Expenses must not be excluded from coverage under the Exclusions and Limitations section of the Policy.

Meaning Of Terms: The following definitions are being provided to assist You in understanding certain terms used in this Outline of Coverage. The Policy contains additional definitions not provided for in this Outline of Coverage. The definition of any capitalized term in this Outline of Coverage is provided for in the General Definitions section of the Policy.

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

Chronically Ill or *Chronically Ill Individual* refers to a person who has been certified by a Licensed Health Care Practitioner as:
- Being unable to perform, without Substantial 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 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.

Plan of Care is a written, individualized plan for care and support services specific to You that:
- has been developed as a result of an assessment of You and incorporates any information provided by Your personal Physician; and
- has been provided by a Licensed Health Care Practitioner who is not a member of Your Immediate Family; and
- fairly, accurately and appropriately addresses Your long-term care and support service needs; and
- specifies: the type, frequency and duration of all services required to meet those needs; and the types of providers to furnish those services.

Severe Cognitive Impairment is 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 the person's: 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 is either:

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

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

Coverage Maximum means the maximum amount of Benefits under the Policy as determined from the Schedule. The Coverage Maximum will change as described in the Schedule and when You elect changes.

Covered Care means those Qualified Long-Term Care Services for which the Benefits are payable or would be payable in the absence of a Deductible Period or Benefit limits.

Covered Expenses means costs You incur for Covered Care. Each Benefit 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 by You.

A *Current Eligibility Certification* is a written certification by a Licensed Health Care Practitioner, who is not a member of Your Immediate Family, certifying that You meet the above requirements for being Chronically Ill. The certification must be renewed and received by Us at least every 12 months.

Deductible Period means the length of time, as stated in the Schedule, before You are entitled to Benefits under the Policy. The Schedule describes how the Deductible Period is satisfied. Each Benefit states the extent to which Coverage is subject to the Deductible Period. Days used to satisfy the Deductible Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Deductible Period for Your Coverage, unless, subsequent to satisfying the Deductible Period, You add additional days to Your Deductible Period which have not previously been satisfied. Calendar days You received Covered Care and related Covered Expense that are otherwise excluded from Coverage because of the Non-Duplication provision may be used to satisfy the Deductible Period.

Daily Benefit Maximum means the maximum amount We will pay per calendar day when you are Confined in a Nursing Facility or Assisted Living Facility, receiving Hospice Care, or are receiving Home and Community Care provided by a Home Health Agency as stated in the Policy Schedule. This amount is also used to determine other Benefit maximums.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance or personal care services which: (1) are required by a Chronically Ill Individual; and (2) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

OTHER FEATURES AND OPTIONS

(Options are available for an additional Premium)

Optional Nonforfeiture Benefit: This Benefit provides for the continuation of the Policy if the Policy ends due to non-payment of Premium after it has been in force for at least three years. Any Benefit Increases will cease; and the Coverage Maximum will be reduced to the greater of: (a) the sum of all Premium paid for the Policy; or (b) the amount equal to the 30 times the Daily Benefit Maximum in effect at the time the Policy ends. In no event will this amount exceed the unused Coverage Maximum at the time the Policy ends.

[Optional Waiver of Home and Community Care Deductible Period: This provides that there is no Deductible Period for the Home and Community Care Benefit; and each day of Covered Care under that Benefit will count towards satisfying the Deductible Period applicable for other Benefits.]

10. EXCLUSIONS AND LIMITATIONS

There are no exclusions or limitations for pre-existing conditions disclosed on Your Application. Any incorrect or omitted material information in Your Application for the Policy, or any increase in Coverage, may cause the Coverage that became effective as a result of Your Application to be rescinded (voided) or a Claim to be denied, as stated in the Misstatements/Incontestability provision of the Policy.

Non-eligible Facilities/Providers: A Nursing Facility, Assisted Living Facility or Hospice Care Facility must meet the applicable definition stated in the Policy in order to qualify for coverage.

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 Immediate Family members is covered only when specifically provided for in the Policy.

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, its territories, and possessions;
- Provided by Your Immediate Family, unless a Benefit specifically states that a member of Your Immediate Family can provide Covered Care. We will not consider care to have been provided by a member of Your Immediate Family when: he or she is a regular employee of the Home Health Agency, Adult Day Care provider, Hospice Care Facility, Assisted Living Facility or Nursing Facility that is providing the services; and such Home Health Agency, Adult Day Care provider, Hospice Care Facility, Assisted Living Facility or Nursing Facility receives payment for the services; and he or she receives no compensation other than the normal compensation for employees in her or his 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 illness, treatment or medical condition arising out of any of the following:
  - War or any act of war, whether declared or not;
  - Attempted suicide or an intentionally self-inflicted injury;
- Resulting from Your alcoholism or drug addiction (except for an addiction directly resulting from a valid controlled-substance prescription from a provider and when the prescription medication is taken exactly as prescribed). Alcoholism includes alcohol use disorder, alcohol abuse and alcohol dependency.

Non-Duplication: Benefits will be paid only for Covered 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 government health, or law except Medicaid.

This Non-Duplication provision will not disqualify a Covered Expense from being used to satisfy any Deductible Period requirement.

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

11. 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 the Policy may be adjusted. Benefit levels will not increase over time unless the plan You purchase provides Benefit Increases. Unless otherwise described, these increases: will be automatic; will not require proof of good health; will be made without a corresponding increase in Premium; will continue without regard to Your age, claim status or claim history, or length of time You have been insured under the Policy: and is subject to the We have a Limited Right to Change Premium provision of the Policy.

Benefit Increases cease when*:* (a) the date the Policy ends; (b) the Policy is continued under any Nonforfeiture Benefit, if applicable; or (c) they are terminated by You.

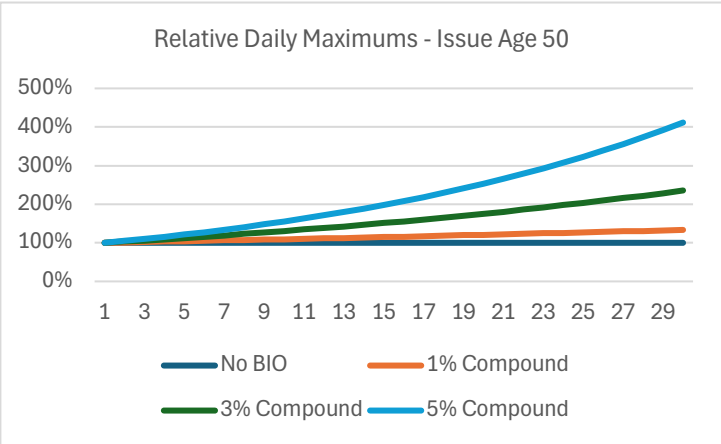
You will not be able to purchase a Benefit Increases option after the time the Policy is issued.

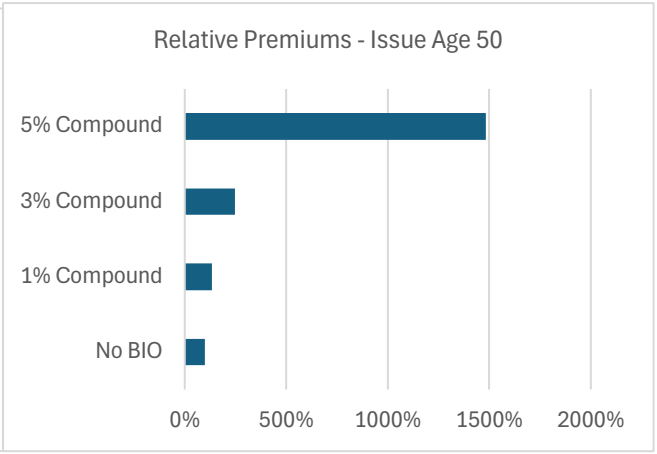
Available increase options are described below. They are followed by a graphic comparison of the Benefit levels of coverage that increase Benefits over time with coverage that does not increase Benefits. A similar graphic comparison illustrates Premium for those coverages at a given issue age.

AVAILABLE BENEFIT INCREASES OPTIONS

5%/3%/1% Automatic Compound Benefit Increases: On each anniversary of the Policy Effective Date, Your then current: Daily Benefit Maximum; and Coverage Maximum will each increase by 5%, 3%, 1%, as described in Your Policy Schedule.

INFLATION PROTECTION – GRAPHIC COMPARISONS





12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Coverage is provided for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses subject to the same exclusions, limitations and provisions applicable to other Covered Care.

13. PREMIUM

Options and Premium	Annual Premium for Selected Option
Plan Selected	Plan A
Policy without any Benefit Increases	$_____
O Waiver of Home and Community Care Deductible Period Rider	$_____
O Nonforfeiture Benefit	$_____
O 5%, 3%, 1% Compound Benefit Increases	$_____
Total if paid annually	$_____
Modal Payment Factor*	__.___
Modal Premium (After Factor)	$_____
Annual Total Modal Premium	$_____
Premium Payment Period:	Lifetime

* You may have the right to choose one of the following Premium Payment Modes: annual in one payment; semi-annual in two payments; quarterly in four payments; or monthly in twelve payments. If You elect a Premium Payment Mode other than annual, You will pay additional charges for electing that Premium Payment Mode. The additional charges associated with paying more frequently than once a year are calculated by multiplying the Annual Modal Premium by the applicable modal premium factor. The modal premium factors are: 1.00 for annual; .51 for semi-annual; .26 for quarterly; and .09 for monthly.

14. ADDITIONAL FEATURES AND REMINDERS

Underwriting: We will underwrite Your Application by reviewing the information submitted on Your application and any other information You authorize Us to obtain.

Continuation for Lapse Due to Cognitive or Functional Impairment: If the Policy terminates due to non-payment of Premium, We will provide a retroactive continuation if, within seven (7) months of the termination date, You provide Us with proof that You were Chronically Ill, beginning on or before the end of the Grace Period. No continuation of coverage

will be implemented under this provision unless all past due Premium is paid within such seven (7) month period. 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 the Policy had not ended so long as the requirements for continuation have been satisfied.

Reminder: This Outline of Coverage is not a contract; and the only contract under which Coverage will be provided is the Policy issued when Your Application is approved. The Policy will set forth in detail the Benefits and Services provided and the Premium and conditions required to continue the Policy until it ends.

15. ANSWERS TO QUESTIONS

CONTACT THE STATE AGENCY LISTED IN THE NAIC'S *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY.

SCHEDULE	*(Complete to show coverage selected)*
Daily Maximum - per Calendar Day	$_____
Coverage Maximum	$_____
Benefit Increases The Coverage Maximum is: first reduced on a dollar for dollar basis as payments are made for Covered Expenses; then if not exhausted, increased together with the Daily Benefit Maximum and other amounts based on the Daily Benefit Maximum, when Benefit Increases apply; and exhausted when reduced to zero.	**O** 5% Compound **O** 3%, Compound **O 1**% Compound **O** None

Benefits And Services Provided	**We pay the lesser of Your Covered Expenses or the applicable limit listed below, except where otherwise noted**
Privileged Care Coordination Services:	Not subject to coverage limits
Nursing Facility Benefit:	Daily Benefit Maximum per calendar day
Assisted Living Facility Benefit: (Includes room charges in an Assisted Living Facility)	Daily Benefit Maximum per calendar day
Bed Reservation Benefit:	90 times the Daily Benefit Maximum per calendar year
Home and Community Care Benefit:	
Adult Day Care or Home Health Agency	Daily Benefit Maximum per calendar day
Independent Provider	50% of Daily Benefit Maximum per calendar day
Home Assistance Benefit: (Covers equipment, modifications & training)	A Policy total payment maximum equal to 90 times the Daily Benefit Maximum.
Hospice Care Benefit:	Daily Benefit Maximum per calendar day
Respite Care Benefit	Up to 90 days per calendar year
Alternate Care Benefit:	Payment subject to mutual agreement

Coverage includes a Contingent Nonforfeiture Benefit and any applicable Features and Optional Benefits.
The maximum total amount payable for all Covered Expenses incurred on a day is limited to the Daily Benefit Maximum. This does not apply to the Home Assistance Benefit and Alternate Care Benefit.