The University of Arizona

Group Contract LT-45727-AZ

Prudential Long Term Care℠ Coverage

The Prudential Insurance Company of America

751 Broad Street,
Newark, New Jersey 07102-3777

83500
BCOV 1004 (S-5)

Foreword

The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102-3777

IMPORTANT: Within 30 days of receipt, if you decide you do not want this Long Term Care Coverage, you may return this Certificate, along with a written request to cancel the Coverage, to: The Prudential Insurance Company of America, Long Term Care Customer Service Center, P. O. Box 8526, Philadelphia, PA 19176. Your Coverage will be canceled as of the Effective Date and any premium paid will be returned to you within 10 days of receiving your cancellation request. If premiums are not returned within 30 days, Prudential will pay you interest on any premiums paid from the date Prudential receives notice of your cancellation.

RENEWABILITY. The Long Term Care Coverage described in this Certificate is guaranteed renewable. This means you have the right to continue this Coverage as long as you pay your premiums on time and have not exhausted your Lifetime Maximum. Please read the **Keeping Your Coverage** provision for more information. Prudential cannot change the terms of your Coverage on its own, except as described in this paragraph. It may increase the premiums you pay. It may change the provisions of the Coverage to conform with changes in any state or Federal law or regulation that applies to this Coverage. This change can be made upon agreement by the Group Contract Holder.

NOTICE TO BUYER: This plan may not cover all of the costs associated with *Long Term Care* incurred by you during the period of *Coverage*. You are advised to carefully review all *Coverage* limitations.

CAUTION. This Certificate may not apply when you have a claim! Please read! The issuance of this *Long Term Care Coverage* is based upon your responses to the questions on your Enrollment Form. If you provided evidence of insurability, a copy of your Enrollment Form is attached. If your answers are misstated or untrue, or you fail to include all material medical information requested*, Prudential* may have the right to deny benefits or rescind your *Coverage,* subject to the Incontestability provision. 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 *Prudential* at this address: The Prudential Insurance Company of America, Long Term Care Customer Service Center, P. O. Box 8526, Philadelphia, PA 19176, or call 1-800-732-0416.

THIS CERTIFICATE IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for *Medicare*, review the *Guide to Health Insurance for People with Medicare* available from *Prudential* by calling the Long Term Care Customer Service Center at 1-800-732-0416.

Tax Status of Premiums and Benefits

The *Long Term Care Coverage* described in this Certificate is intended to be Qualified Long Term Care Insurance as defined by the Internal Revenue Code Section 7702B(b), as amended. As such, the benefits you may receive under this Certificate should not be considered taxable income. In addition, some or all of the premiums you pay towards this *Coverage* may be tax deductible as a medical expense subject to certain limitations. Consult a tax advisor for more information concerning this deduction. Public guidance issued by the Internal Revenue Service or Treasury Department may provide that a provision of this *Coverage* does not comply with the requirements of Code Section 7702B. If the *Group Contract Holder* wishes the *Long Term Care Coverage* to maintain tax qualified status, a change in the *Group Contract* will be made in an amendment to it that is signed by an officer of *Prudential* and the *Group Contract Holder*.

State Disclosures

For residents of *the State of California*.

California law requires that health insurers treat California Registered Domestic Partners as spouses under any insurance contract issued in that state. In that instance, they will be afforded the same rights and responsibilities as spouses, and all references to "spouse" in this coverage will include California Registered Domestic Partners.

For residents of the State of California.

THIS INSURANCE IS APPROVED LONG TERM CARE INSURANCE UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS INSURANCE WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES 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.

This 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.

For residents of the State of Georgia.

The Georgia Insurance Department does not in anyway warrant that this *Coverage* meets the requirements of Internal Revenue Code Section 7702 B(b).

For residents of the State of Illinois.

THIS CERTIFICATE IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED LONG TERM CARE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR MORE INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS LONG TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELP LINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.

For residents of the State of Iowa.

THIS CERTIFICATE DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED LONG TERM CARE INSURANCE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-800-281-5705.

For residents of the State of Maine.

If you have a Medicare Supplement Policy or Major Medical Policy, this Coverage may be more than you need. For information call the Maine Bureau of Insurance at 1-800-300-5000.

For residents of the State of Maryland.

This Certificate has not been approved under the Maryland Partnership for Long Term Care Program under Title 15, Subtitle 4 of the Health - General Article.

For residents of the State of Wisconsin.

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG TERM CARE INSURANCE. THIS CERTIFICATE MEETS THOSE STANDARDS.

THIS CERTIFICATE COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES.

THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ YOUR CERTIFICATE CAREFULLY.

FOR MORE INFORMATION ON LONG TERM CARE SEE THE GUIDE TO LONG TERM CARE GIVEN TO YOU WHEN YOU APPLIED FOR THIS COVERAGE. THIS CERTIFICATE'S BENEFITS ARE NOT RELATED TO MEDICARE.

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEM WITH YOUR INSURANCE? -- If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

The Prudential Insurance Company of America, Long Term Care Customer Service Center, P.O. Box 8526, Philadelphia, PA 19176. (800) 732-0416

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by contacting:

OFFICE OF THE COMMISSIONER OF INSURANCE

Complaints Department, P.O. Box 7873, Madison, WI 53707-7873

1-800-236-8517 or 608-266-0103.

Thank you for choosing this *Prudential Long Term Care Coverage*.

This *Coverage* is intended to provide coverage for many of the services you will need if you require *Long Term Care* subject to the terms, conditions, exclusions and limitations set forth in the *Group Contract*. This may be necessary if you have a condition that affects your ability to perform everyday activities such as *Bathing* or *Dressing*. If you have a *Cognitive Impairment* that affects your ability to take care of yourself safely, you may require *Long Term Care*. Services included in this *Coverage* are those which may be provided in your home or community or in a setting such as a *Nursing Home*. This *Coverage* is not intended to cover services provided in an acute care hospital. See the following pages for details about the benefits available under this *Coverage* and how you will be eligible to receive them.

If you are insured, this document is your Group Insurance Certificate. The Prudential Insurance Company of America certifies that insurance is provided according to the *Group Contract* for you. All benefits are subject in every way to the entire *Group Contract* which includes the Group Insurance Certificate. All the terms, conditions, exclusions and limitations shall be read together as a whole to determine eligibility for *Coverage* and whether and to what extent any benefits are payable. The *Group Contract* alone forms the agreement under which payment of the insurance is made. This Certificate replaces any older Certificates previously issued to you for the *Long Term Care Coverage.*

Certain terms used in this Certificate, indicated in italics, have been defined to make it easier for you to understand your *Coverage*. Please refer to the **Definitions** section.

If you have questions or would like more information about your *Long Term Care Coverage*, please call Prudential's Long Term Care Customer Service Center toll free at 1-800-732-0416, between 8:00 AM and 8:00 PM Eastern Time, Monday through Friday. A representative will be happy to assist you.

***Prudential* reserves the right to determine whether benefits being sought meet the definitions and intent of this *Coverage*.**

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Schedule of Benefits

Your Confirmation Statement will indicate your Plan selection.

INSTITUTIONAL CARE BENEFITS					
NURSING HOME CARE Up to the *Daily Maximum* for *Nursing Home* Care	$100	$150	$200	$250	$300
ASSISTED LIVING FACILITY CARE Up to the *Daily Maximum* for *Assisted Living Facility* Care	$100	$150	$200	$250	$300
BED RESERVATION Up to the *Daily Maximum* for *Bed Reservation*	$100	$150	$200	$250	$300
21 Day Benefit Limit per *Calendar Year*	$2,100	$3,150	$4,200	$5,250	$6,300
HOME & COMMUNITY-BASED CARE BENEFITS*					
HOME HEALTH CARE Up to the *Daily Maximum* for *Home Health Care*	$60	$90	$120	$150	$180
CASH ALTERNATIVE DAILY BENEFIT	$30	$45	$60	$75	$90
ADULT DAY CARE Up to the *Daily Maximum* for *Adult Day Care*	$60	$90	$120	$150	$180
ADDITIONAL BENEFITS					
HOSPICE CARE Up to the *Daily Maximum* for *Hospice Care*	$100	$150	$200	$250	$300
RESPITE CARE Up to the *Daily Maximum* for *Respite Care*	$100	$150	$200	$250	$300
21 Day *Calendar Year* Benefit Limit	$2,100	$3,150	$4,200	$5,250	$6,300
100 Day Lifetime Benefit Limit	$10,000	$15,000	$20,000	$25,000	$30,000
INTERNATIONAL COVERAGE					
Daily Maximum for Nursing Home Care	$75	$113	$150	$188	$225
Daily Maximum for Home Health Care	$45	$68	$90	$113	$135
365 Day Lifetime Benefit Limit					

INDEPENDENCE SUPPORT					
Independence Support Lifetime Benefit Limit	$5,000	$7,500	$10,000	$12,500	$15,000
CAREGIVER TRAINING					
Caregiver Training Lifetime Benefit Limit	$500	$500	$500	$500	$500
INFORMATION AND REFERRAL SERVICES					
Information and Referral by *Prudential*	No limit	No limit	No limit	No limit	No limit
PRIVATE CARE MANAGEMENT					
Private Care Management Calendar Year Benefit Limit	$1,200	$1,800	$2,400	$3,000	$3,600
ALTERNATE PLAN OF CARE	Paid at the discretion of Prudential				
LIFETIME MAXIMUM**					
OPTION 1	$109,500	$164,250	$219,000	$273,750	$328,500
OPTION 2	$182,500	$273,750	$365,000	$456,250	$547,500
OPTION 3	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* The benefits paid for all covered *Home & Community-Based Care* services received on any given day will not exceed the *Daily Maximum* benefit for *Home Health Care*.

** Option 1 - The Lifetime Maximum is equal to the *Daily Maximum* for care in a *Nursing Home* you choose, times 365 days, times 3 years. For example, electing the $100 *Daily Maximum* for care in a *Nursing Home* provides a *Lifetime Maximum* of $109,500 ($100 x 365 x 3).

Option 2 - The Lifetime Maximum is equal to the *Daily Maximum* for care in a *Nursing Home* you choose, times 365 days, times 5 years. For example, electing the $100 *Daily Maximum* for care in a *Nursing Home* provides a *Lifetime Maximum* of $182,500 ($100 x 365 x 5).

Option 3 - The Lifetime Maximum is unlimited.

Optional or Additional Benefits available to Eligible Persons

This *Long Term Care Coverage* includes the following additional and/or optional benefits.

- When you enrolled, you had the option of choosing automatic, annual inflation increases. This benefit is described in the section entitled **Automatic Compound Inflation Increase Rider**. Your Confirmation Statement will indicate if you have elected this Rider.

- This coverage includes premium refund upon death benefit. This benefit is described in the section entitled **Premium Refund Available at Death**.

This Certificate describes The University of Arizona's *Long Term Care Coverage* as of April 1, 2008. Your Effective Date of *Coverage* and the Plan you have chosen are shown in the Confirmation Statement.

Who is Eligible

You are eligible for this group *Coverage* while you are

1) A Benefits-eligible *Employee* of The University of Arizona, who is actively-at-work and is employed at a .50 FTE (20 hours per week) or greater and in a position that is at least six (6) months or more in duration.

2) Related to an *Employee* in one of the following ways:

    a) You are the spouse or *Domestic Partner* of the *Employee*.

    b) You are the sibling of the Employee.

    b) You are the parent or grandparent of the *Employee* or the *Employee's* spouse.

    c) You are the spouse of the parent or grandparent.

    d) You are the adult child of an *Employee* or the adult child's spouse or Domestic Partner.

    e) You are the surviving spouse of a deceased *Employee*.

3) A Retiree of The University of Arizona.

4) Related to a Retiree in one of the following ways:

    a) You are the spouse or *Domestic Partner* of a Retiree.

    b) You are the surviving spouse of a deceased Retiree.

You must be at least 18 but less than age 85 when your Enrollment Form is completed.

When You Become Insured

Prudential will determine if you are accepted for *Coverage* based upon your responses to the questions on your Enrollment Form and any other evidence of insurability that *Prudential* may require. If you are accepted, the Effective Date of your *Coverage* and the Plan you have chosen will be shown in the Confirmation Statement included with this Certificate.

Delay of Effective Date

If you are an *Employee*, your *Coverage* will be delayed if you are not actively at work on the day your insurance would otherwise begin. Instead, it will begin on the first day of the month following the date you return to work as an active *Employee*.

If you are eligible for this *Coverage* other than as an *Employee*, your *Coverage* will be delayed if, on the day your insurance would otherwise begin, you are confined in a health care institution or are receiving *Home and Community-Based Care* or *Hospice Care*. Instead it will begin on the first day of the month following the date you are discharged from such confinement and are not receiving such care.

Keeping Your Coverage

If any of the following situations occur, you may keep your *Coverage* in effect.

1) The person through whom you have your *Coverage* leaves the *Group Contract Holder*.

2) You become divorced from your spouse.

3) Your relationship with your *Domestic Partner* is terminated.

4) Your spouse or *Domestic Partner* dies.

5) The *Group Contract Holder* withdraws sponsorship.

- If the person through whom you have your *Coverage* leaves the *Group Contract Holder*,

  You must notify *Prudential* in writing within 60 days of this change in status.

- If you become divorced, or your *Domestic Partner* relationship is terminated or your spouse dies,

  You must notify *Prudential* in writing within 60 days of the final judgment of divorce, of the date of termination of the relationship, or the death that you want to continue your *Coverage*. *Prudential* will then adjust the billing, if necessary, to reflect your change in status.

- If the *Group Contract Holder* withdraws sponsorship of the *Group Contract* and does not replace it within 31 days of the date *Coverage* would otherwise end,

  Prudential will send you a written notice within this 31 days. To continue your *Coverage*, you must return the notice within 60 days along with any premium payments that are indicated.

- If your premiums are being waived when any of the above events occur,

  You must still notify *Prudential* in writing as described above. You will not have to send premiums as long as your premium payments were current before the waiver period.

Notice should be sent to: The Prudential Insurance Company of America, Long Term Care Customer Service Center, P. O. Box 8526, Philadelphia, PA 19176.

Premiums

A. Paying Premiums

You are responsible for the entire cost of this *Coverage* and your premium payments. The University of Arizona does not contribute to the cost of this *Coverage*. Your premium contribution is shown on your Confirmation Statement.

B. Amount of Premiums

Premiums for this *Coverage* are based on your age as of the date you enroll for Coverage and the *Coverage* option(s) you have chosen.

- Premiums will not automatically increase as you become older.
- Premiums will not automatically increase because you use benefits.

As long as you continue to pay the required premium for this *Coverage*, have not reached your *Lifetime Maximum*, and have answered the questions on the Enrollment Form truthfully, you can keep this *Coverage* in effect.

C. Increases In Premiums

You will be charged an additional separate premium if you choose to increase your benefits. The premium for your original *Coverage* will remain the same. Your age as of the date you enroll for the additional *Coverage* will be used to determine the additional separate premium.

Prudential also reserves the right to change premium rates. Any change will apply on a class basis to all insureds. Class, for purposes of this section, means a grouping of insured risks that exhibit a trait requiring a separate premium rate due to risk characteristics.

You will be given 60 days advance written notice of any such change.

D. Correcting Premiums

If the age used to determine your premium is found to be in error, the premium charge will be adjusted to reflect your correct age. If this adjustment results in a change in the amount of such premium, any difference between the premium paid and the premium required on the basis of the correct age will be satisfied as follows.

1) If the adjustment results in an increased premium, Prudential will notify you and the Group Contract Holder, if necessary, and request payment of the additional premium required for your Coverage, with the next premium due after the date on which the error was identified.

2) If the adjustment results in a decreased premium, the difference will be refunded by *Prudential.* You may ask *Prudential* to send you a refund or apply the overpayment towards future premiums.

If your *Coverage* would have been denied had your age not been misstated, or if you would have been subject to additional medical evidence requirements, *Prudential's* liability will be limited to a refund of all premiums you have paid for this *Coverage*.

E. Grace Period

If you are being billed directly by *Prudential*, the due date will be indicated on your bill. If premium is not received within 31 days of the date due, you and your designee (if applicable) will be mailed a notice requesting payment within 31 days. The notice will be deemed to have been given as of five days after the date of mailing. Your 31 day grace period starts as of this fifth day following the date of mailing. The Certificate remains in force during the grace period. If *Prudential* does not receive payment within this time, your *Coverage* will be terminated.

If your premiums are being paid through payroll or pension deduction and the premiums are not remitted to *Prudential* within the period agreed to by The University of Arizona and *Prudential* in the Group Contract, you will be automatically billed by *Prudential.* In that case, you will be subject to the grace period previously described.

F. Waiver of Premium

After you meet the **Benefit Eligibility Criteria** and satisfy the required **Benefit Waiting/Elimination Period,** the premiums for your *Coverage* will be waived. Premiums will be waived beginning the first day of the month following the date you satisfy the **Benefit Waiting/Elimination Period.** Premiums will again become due as of the first day of the month following the month in which you no longer meet the **Benefit Eligibility Criteria**.

G. Premium Refund Upon Cancellation of Insurance

Upon proper notification of the cancellation of this *Coverage* at a time occurring after the free look period described in the **Foreword** section, *Prudential* will refund on a pro-rata basis any part of the periodic premium contribution for you which applies to the period after cancellation.

H. Premium Refund Upon Your Death

Upon proper notification of the death of the insured, *Prudential* will refund on a pro-rata basis any part of the periodic premium contribution for that insured which applies to the period of time after death.

Long Term Care Coverage

A. Covered Services

Certain terms used in this section have been defined to make it easier to understand and use your *Coverage*. See the **Definitions** section.

This *Coverage* pays benefits for *Eligible Charges* incurred by you for *Institutional Care* which includes care in a *Nursing Home, Assisted Living Facility* care and *Bed Reservation*; *Home and Community-Based Care,* which includes *Home Health Care* and *Adult Day Care*; and Additional Benefits which include *Hospice Care*, *Respite Care*, *Independence Support*, *Caregiver Training*, *Information and Referral Services*, *Private Care Management* and *Alternate Plan of Care*. Benefits paid for *Eligible Charges* count towards fulfillment of your *Lifetime Maximum*.

Benefits for *Eligible Charges* for the following services are provided once the **Benefit Waiting/Elimination Period** described below has been satisfied. Not all charges are covered (see **Coverage Exclusions** section). The actual amount paid depends on the Plan you have chosen. The benefits paid for all covered *Long Term Care* services (with the exception of *Independence Support*, *Caregiver Training* and *Information and Referral Services*) received on any given day will not exceed the *Daily Maximum* benefit for *Nursing Home* Care. The benefits paid under this *Coverage* will not exceed the *Lifetime Maximum*. All applicable maximums and limits are described in this Certificate and are outlined on the **Schedule of Benefits** page.

INSTITUTIONAL CARE BENEFITS

Nursing Home Care - This Certificate provides *Coverage* for care provided by a *Nursing Home* while you are a resident. Benefits for *Eligible Charges* will be paid up to your *Daily Maximum* for *Nursing Home* Care as shown in the **Schedule of Benefits**.

Assisted Living Facility Care- This Certificate provides *Coverage* for care provided by an *Assisted Living Facility* while you are a resident. Benefits for *Eligible Charges* will be paid up to your *Daily Maximum* for *Assisted Living Facility* Care as shown in the **Schedule of Benefits**.

Bed Reservation – While you are receiving *Long Term Care* services in a *Nursing Home* or an *Assisted Living Facility*, you may incur charges for *Bed Reservation* by that institution to retain your bed while you are confined in an acute care facility for 24 hours or more. This Certificate provides *Coverage* for such charges if

1) The *Bed Reservation* occurs while you are receiving benefits under this Certificate for care in a *Nursing Home* or an *Assisted Living Facility*. And
2) The charge for *Bed Reservation* is a customary facility charge that would be made in the absence of insurance.

Benefits for *Eligible Charges* will be paid up to your *Daily Maximum* for *Bed Reservation* as shown in the **Schedule of Benefits**. See the **Schedule of Benefits** for specific limits on the *Bed Reservation* benefit.

HOME & COMMUNITY-BASED CARE BENEFITS

Home Health Care - This Certificate provides Coverage for each day you receive Home Health Care or Personal Care from a Home Health Care Agency, Referral Agency, Nurse Registry or provided by an Independent Health Care Professional. Eligible Charges will be paid up to your Daily Maximum for Home Health Care.

Benefits under this provision will not be paid in addition to benefits paid for Long Term Care services received in an Assisted Living Facility.

Adult Day Care – This Certificate provides Coverage for each day you receive Adult Day Care from an Adult Day Care Facility. Benefits for Eligible Charges will be paid up to your Daily Maximum for Adult Day Care as shown in the **Schedule of Benefits**.

The benefits paid for all covered Home & Community-Based Care services received on any given day will not exceed the Daily Maximum benefit for Home Health Care.

ADDITIONAL BENEFITS

Hospice Care - This Certificate provides *Coverage* for *Hospice Care*. Benefits for *Eligible Charges* will be paid up to your *Daily Maximum* for *Hospice Care* as shown in the **Schedule of Benefits**. The **Benefit Waiting/Elimination Period** does not apply to *Hospice Care* benefits.

Respite Care - This Certificate provides *Coverage* for short-term care provided for limited periods of time in an *Institutional Care* setting or for *Home and Community-Based Care* to relieve your *Informal Caregiver*. Benefits for *Eligible Charges* will be paid up to the *Daily Maximum* for *Respite Care,* as shown in the **Schedule of Benefits**. See the **Schedule of Benefits** for specific limits on the *Respite Care* benefit.

Independence Support - This Certificate provides *Coverage* for a personal emergency response system or for home modifications related to your *Long Term Care* needs aimed at allowing you to stay at home. Benefits for *Eligible Charges* will be paid up to the Independence Support Lifetime Benefit limit as shown in the **Schedule of Benefits**. No **Benefit Waiting/Elimination Period** applies to Independence Support benefits.

Caregiver Training - This Certificate provides *Coverage* for *Caregiver Training* for an *Informal Caregiver*. Benefits for *Eligible Charges* will be paid up to the *Caregiver Training* Lifetime Benefit Limit as shown in the **Schedule of Benefits**. No **Benefit Waiting/Elimination Period** applies to *Caregiver Training* benefits.

Information and Referral Services – If you would like information regarding community resources or your benefits, *Prudential's* Long Term Care Customer Service Center is available to help. You do not have to be eligible for benefits. No **Benefit Waiting/Elimination Period** applies to Information and Referral Services benefits. Call 1-800-732-0416 for assistance.

Private Care Management - This Certificate provides *Coverage* for a *Private Care Manager* to provide information, resources or to coordinate your *Long Term Care*. You must first meet the **Benefit Eligibility Criteria** in order to use this benefit. Benefits for *Eligible Charges* will be paid up to the Private Care Management *Calendar Year* Benefit Limit as shown in the **Schedule of Benefits**. No **Benefit Waiting/Elimination Period** applies to Private Care Management benefits.

Alternate Plan of Care - *Prudential* recognizes there are emerging trends in the delivery of *Long Term Care*. We have attempted to describe the types of care, services and settings that are covered under this Certificate. However, we will consider a claim for benefits for care received in an alternate setting or for non-institutional services designed to help eligible individuals remain independent in their homes. Determination of your eligibility for this benefit and the benefit amount will be made on an individual basis at the sole discretion of *Prudential.* To qualify, such care must be a Qualified Long Term Care Service within the meaning of Internal Revenue Code 7702B.

B. Obtaining Benefits

Limitations or Conditions on Eligibility for Benefits

Eligibility for the Payment of Benefits - Benefit Eligibility Criteria - Submitting a claim form and a bill is not enough to assure that benefits will be paid. In order to receive benefits, you must FIRST be assessed by an *Assessor* and be confirmed as having a *Chronic Illness or Disability*. A *Chronic Illness or Disability* is one in which there is:

1) A loss of the ability to perform, without *Substantial Assistance*, at least two *Activities of Daily Living.* This loss must be expected to continue for 90 days. *Activities of Daily Living* are *Bathing*, *Continence*, *Dressing*, *Eating*, *Toileting* and *Transferring*. Or
2) A severe *Cognitive Impairment* which requires *Substantial Supervision* to protect you from threats to health or safety.

Using Your Coverage

It is important that you start the process of using your *Coverage* by calling the Long Term Care Customer Service Center at 1-800-732-0416. You are encouraged to call *Prudential* before you begin using *Long Term Care* services so that you know in advance whether your benefits will be available. Either you or your authorized or legal representative may call.

Prudential will arrange for a trained *Assessor* to assess you or you may select your own *Assessor.* As part of the assessment process, you and your caregiver may be interviewed. If *Prudential* arranges the assessment, the interview may be by telephone or in-person depending on your condition. The assessment will be based on objective standards of measurement.

If you wish to select your own *Assessor*, you must notify *Prudential* when you call our Long Term Care Customer Service Center. *Prudential* will send you an assessment form that your *Assessor* must complete and return to *Prudential*.

Based on the information obtained during the assessment, your eligibility will be confirmed or denied based on *Prudential's* use of objective standards of measurement. These may include the "Katz Index of ADL's," "Folstein's Mini-Mental Examination," or any other equivalent objective standard of measurement currently in use at the time of assessment and acceptable to *Prudential*, subject to the terms and conditions of the Certificate. You will be sent a written notice to confirm your eligibility. If you are not eligible, you will be sent a written notice explaining the reasons you were not eligible.

If you are eligible, you will need a *Plan of Care*. Your *Plan of Care* will be used to determine benefits based on the Plan you have chosen.

You will be reassessed periodically to determine if you are still eligible for benefits. To comply with federal income tax requirements, you must be assessed at least once each year.

Appealing Decisions about Eligibility

You have the right to appeal decisions made about your eligibility for benefits. When you are determined to be ineligible for benefits, you will be sent a notice that explains why you are not eligible. This notice will also explain the procedure you should follow if you choose to appeal the decision.

Prudential will send you a written acknowledgment of your appeal. If no additional information is required and the appeal is denied, the acknowledgment will include a detailed explanation of the reason(s) for the denial. If additional information is required, *Prudential* will explain what information is needed. Upon receipt and review of the additional information, *Prudential* will notify you in writing of the results of the review.

If you still disagree with the appeal decision, you can request in writing within 60 days of the decision that the matter be submitted to the Benefit Appeal Committee. This Committee includes, but is not limited to, clinical consultants, legal consultants, and product management staff. After a thorough review, the Committee will send you written notification of its decision.

C. Benefit Waiting/Elimination Period Before Payment Begins

A **Benefit Waiting/Elimination Period** must be met once during your lifetime before benefits are payable. This Certificate has one combined **Benefit Waiting/Elimination Period** for all covered services to which it applies. This is a period, counted in calendar days, which begins on the date you are assessed, if that assessment results in eligibility for benefits, and continues as long as you have a *Chronic Illness or Disability*. You do not need to incur charges to satisfy the **Benefit Waiting/Elimination Period**. The **Benefit Waiting/Elimination Period** can be satisfied over multiple periods of *Chronic Illness or Disability*.

No benefits are payable during the **Benefit Waiting/Elimination Period** for charges for which the **Benefit Waiting/Elimination Period** applies.

Your **Benefit Waiting/Elimination Period** is shown on your Confirmation Statement.

Premium Refund Available at Death

If you die before age 74, *Prudential* may refund a percentage of the premiums paid. This refund will be based on a percentage of the premiums you have paid minus the benefits *Prudential* has paid. This benefit will be paid even if, at the time of your death, you are receiving benefits and premiums have been waived. Waived premiums are not considered paid premiums and will not be returned under this provision. In the event of your death, *Prudential* will pay the refund to your spouse, if living, otherwise to your estate. The amount of the refund will be determined as follows:

Age	**Amount of Refund**
under 65	100% of Premiums you Paid minus Benefits *Prudential* Paid
65	90% of Premiums you Paid minus Benefits *Prudential* Paid
66	80% of Premiums you Paid minus Benefits *Prudential* Paid
67	70% of Premiums you Paid minus Benefits *Prudential* Paid
68	60% of Premiums you Paid minus Benefits *Prudential* Paid
69	50% of Premiums you Paid minus Benefits *Prudential* Paid
70	40% of Premiums you Paid minus Benefits *Prudential* Paid
71	30% of Premiums you Paid minus Benefits *Prudential* Paid
72	20% of Premiums you Paid minus Benefits *Prudential* Paid
73	10% of Premiums you Paid minus Benefits *Prudential* Paid
74 or older	0% of Premiums you Paid minus Benefits *Prudential* Paid

CASH ALTERNATIVE BENEFIT

The following benefit is added to your *Long Term Care Coverage*.

Cash Alternative Benefit

Under this provision, at your option, your *Coverage* will pay a monthly fixed benefit to you in lieu of reimbursement for *Eligible Charges* for *Home and Community-Based Care* as stated above.

The Cash Alternative Daily Benefit is payable for each day in the month in which you have a *Chronic Illness or Disability*, after you satisfy the **Benefit Waiting/ Elimination Period**. The Cash Alternative Daily Benefit is equal to 50% of your *Daily Maximum* for *Home Health Care*.

The Cash Alternative Daily Benefit is subject to the following:

1) You must meet the Benefit Eligibility Criteria.
2) You can only elect this benefit on a monthly basis. This election is made on the claim form.
3) It is in lieu of any other *Institutional Care* or *Home and Community-Based Care* benefits payable for that month.

These benefits are subject to the **Benefit Waiting/Elimination Period** and reduce your *Lifetime Maximum*.

NOTICE: Since the Cash Alternative Benefit is made without regard to costs incurred by you, part of the benefits could be considered taxable income. If the benefits paid under this provision are in excess of the per diem limit as prescribed by law, they could be considered taxable income. This per diem limit is indexed for inflation. You should consult with a tax advisor for more information concerning the tax implications.

INTERNATIONAL COVERAGE BENEFIT

The following benefit is added to your *Long Term Care Coverage*.

International Coverage Benefit

Your *Coverage* provides benefits for *Long Term Care* services you receive outside the United States as:

1) A resident in an Out-of-Country Nursing Home;
2) Home Health Care services or Personal Care services.

Benefits for these *Eligible Charges* for care you receive outside the United States will be paid up to 75% of your *Daily Maximum* for *Nursing Home Care* or *Daily Maximum* for *Home Health Care*, as shown in the **Schedule of Benefits**, according to the services you use.

Payment of International Coverage benefits is limited to 365 days during which *Eligible Charges* are incurred over the lifetime of the *Coverage*. When the International Coverage benefits are exhausted, any *Eligible Charges* incurred for *Long Term Care* services received inside the United States will be considered under your *Coverage*.

These benefits are subject to the **Benefit Waiting/Elimination Period** and reduce your *Lifetime Maximum*.

There is no International Coverage benefit for Bed Reservation, Hospice Care, Respite Care, Independence Support, Caregiver Training or Alternate Plan of Care when provided or charges are incurred outside of the United States.

The following terms are added to the **Definitions** section.

Out-of-Country Nursing Home - An institution, not excluded below, that meets the following criteria.

1) It is located outside the United States, its territories and possessions.
2) It is a legally operated facility that is engaged primarily in providing skilled, intermediate or custodial nursing care for at least 10 people.
3) It provides such care in accordance with the authority granted by a license or similar accreditation, acceptable to *Prudential*, that has been issued by the national or requisite political subdivision of the country in which it is located to provide the levels of care for which benefits would be payable under the Certificate's **Institutional Care Benefits**.
4) It provides continuous room and board accommodations for all of its residents.
5) It employs at least one full-time *Graduate Nurse*, with a *Graduate Nurse* on duty or on call in the facility at all times.
6) It has an awake employee on duty in the facility who is trained and ready to provide residents with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform *Activities of Daily Living* or *Severe Cognitive Impairment* and who is aware of the whereabouts of the residents.
7) It provides three meals a day and accommodates special dietary needs.
8) It has arrangements with a duly licensed *Physician* or *Graduate Nurse* to furnish medical care and services in case of an emergency.
9) It has methods and procedures to provide necessary assistance to residents in managing prescribed medications.

The following facilities are excluded.

1) A facility whose primary function is not to provide *Long Term Care* services.
2) A hospital or clinic, sub-acute care or rehabilitation hospital or unit.
3) A place that operates primarily for the treatment of alcoholism, drug addiction or mental illness.
4) Your home or place of residence in an area used principally for independent residential living, including hotels, motels, spas, retirement homes, boarding homes and adult foster care facilities.
5) A substantially similar adult residence establishment or environment.

Graduate Nurse - A person who has completed a post-secondary nursing care training program and has a current license to provide skilled nursing care to sick or infirm individuals under the direction of a licensed *Physician*.

The following paragraph is added to the **Proof of Loss** subsection of the **Claim Rules** section.

At your own expense, you must obtain and submit all required documentation to us in English. If you are submitting Proof of Loss for the International Coverage Benefit, you must also submit a copy of your passport, airline ticket or other proof acceptable to *Prudential* that you are outside the United States.

The following paragraph is added to the **Coverage Exclusions** section.

The Exclusion for “Services and Supplies Outside the United States” does not apply to the International Coverage Benefit.

Additional Coverage Features

A. Periodic Offers for Inflation Increase Protection

Every three years you will be offered the opportunity to increase your benefits to keep up with inflation. If you accept the offer, the amount of the additional benefit shall be the difference between your existing benefits and those benefits compounded annually at a rate of five percent for the period beginning with the purchase of your existing benefits and extending until the year in which the offer is made. Benefits will be rounded to the nearest dollar.

Your *Lifetime Maximum* will also increase accordingly. Your remaining *Lifetime Maximum* is equal to your increased *Lifetime Maximum* less the sum of all benefits paid on your behalf during the period your *Coverage* was in effect.

Your age on the Effective Date of the increase will be used to determine the additional separate premium for the increased *Coverage*. Therefore, your premium will increase each time you accept an inflation protection offer.

You do not have to provide evidence of insurability to take inflation increases. However, if you decline the previous two offerings made to you, and then want to increase *Coverage*, you will be required to submit satisfactory evidence of insurability the next time you accept an offer.

You will be offered the increase in *Coverage* even if you meet the **Benefit Eligibility Criteria**. However, the increased *Coverage* will not take effect until you no longer meet the **Benefit Eligibility Criteria**.

An example of the increasing benefit, based upon an initial $100 Daily Maximum for Nursing Home Care, a Lifetime Maximum of $109,500 and a 5% annually compounded increase is shown below. The amounts shown assume each offer has been accepted.

Long Term Care Coverage Anniversary	Multiplicative Factor	Daily Maximum for Nursing Home Care	Lifetime Maximum
Year 3	1.1576	$116	$127,020
Year 6	1.3401	$134	$146,730
Year 9	1.5513	$155	$169,725
Year 12	1.7959	$180	$197,100
Year 15	2.0789	$208	$227,760
Year 18	2.4066	$241	$263,895
Year 21	2.7860	$279	$305,505

Shown for illustration purposes only.

B. Restoration of Benefits

All benefits paid under this *Coverage* are deducted from your *Lifetime Maximum* (unless otherwise indicated). However, your *Lifetime Maximum* benefit may be restored. If as a result of a reassessment, you have no limitations performing an *Activity of Daily Living* or a *Cognitive Impairment*, and you do not attempt to access benefits, submit a claim, or incur *Eligible Charges* for a period of six months from the date of reassessment, your *Lifetime Maximum* benefit will be restored. Your *Lifetime Maximum* benefit will be restored to the level then in effect as if you had never made a claim or received benefits under this *Coverage*.

C. Changing Plans

You may make a written request to change your Plan while it is in force.

If you choose a higher Plan, you must complete another Enrollment Form. This form can be obtained by calling the Long Term Care Customer Service Center at 1-800-732-0416. *Prudential* will review your request and determine whether you are accepted for the higher Plan. If your request is denied, you will be sent a written notice that explains why you were not accepted.

You may make a request to reduce your coverage to lower your premium while your Plan is in force. You may choose at least one of the following options:

1) Reducing the Lifetime Maximum.

2) Reducting the Daily Maximum.

Prudential may limit any reduction in coverage to options available for this Plan and to those for which benefits will be available after consideration of claims paid or payable. The age to determine the premium for reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

To make a request, you may write to us at The Prudential Insurance Company of America, Long Term Care Customer Service Center, P.O. Box 8526, Philadelphia, PA 19176. You may call 1-800-732-0416 for additional assistance. You are not required to provide evidence of insurability if you are decreasing your Plan.

If you change your Plan, your premium will be adjusted. You will be sent a notice confirming the Effective Date of the new Plan.

D. Contingent Non-Forfeiture Provisions

The following Contingent Non-Forfeiture provisions apply to your *Coverage*. These provisions change your *Long Term Care Coverage* to provide options to you in the event your *Coverage* ends following a *Substantial Premium Increase*.

A *Substantial Premium Increase* is one that results in a cumulative increase to your initial annual premium that is equal to or exceeds a certain percentage of that premium. It does not include premium increases which result from a voluntary purchase of additional *Coverage*. The percentage is based on your Age as of the Effective Date stated in your Confirmation Statement and is shown in the table below.

SUBSTANTIAL PREMIUM INCREASE TABLE			
AGE AS OF EFFECTIVE DATE	**PERCENT OF INCREASE**	**AGE AS OF EFFECTIVE DATE**	**PERCENT OF INCREASE**
Less than 30	200%	72	36%
30 - 34	190%	73	34%
35 - 39	170%	74	32%
40 - 44	150%	75	30%
45 - 49	130%	76	28%
50 - 54	110%	77	26%
55 - 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

Contingency Options -- You will be notified of any *Substantial Premium Increase* at least 60 days prior to such change. The notice will include the amount of the premium and its due date, and the following contingency options in the event of lapse.

1) Alternative *Coverage* options at a lower premium. Or

2) A lesser *Lifetime Maximum*, with no further premium payment required. You will have 120 days following the premium due date to elect this option. Under this option, the same *Daily Maximum* benefits in effect at the time of lapse will be payable, but the *Lifetime Maximum* will be equal to the lesser of:

   (a) The total amount of premiums paid for your *Coverage.* Or

   (b) 30 times the *Daily Maximum* for *Nursing Home* Care at the time of lapse.

The total of all benefits paid while your *Coverage* is in premium paying status and in the paid up status will not exceed the *Lifetime Maximum* which would have been payable if your *Coverage* did not lapse.

Option 2 will automatically take effect if:

1) Your Coverage lapses within 120 days of the due date of the *Substantially Increased Premium*; and

2) Your Policy has been in force for at least three years; and

3) You have not made an election.

Coverage Exclusions

Charges Not Covered

1) Work-connected Conditions Charge. A charge covered by a workers' compensation law, occupational disease law or similar law.

2) Government Plan Charge: A charge for a service or supply:

   a) furnished by or for the United States government or any other government, unless payment of the charge is required by law. Or

   b) to the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered. This (b) does not apply to a state plan under *Medicaid* or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. When this (b) applies to *Medicare*, the benefits provided by *Medicare* will be deemed to include any amount that would have been payable by *Medicare* in the absence of a deductible or coinsurance requirement under that program.

3) War, Felony, Riot or Insurrection. Charges for a condition due to war or any act of war while you are insured or due to your participation in an act of felony, riot or insurrection. "War" means declared or undeclared war and includes resistance to armed aggression. "Riot" means a wild, violent, public disturbance of the peace.

4) Self-inflicted Injury or Suicide. Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or suffering from inorganic based insanity.

5) Services and Supplies Outside the United States. Charges for services or supplies outside of the United States and its possessions.

6) Treatment for Chronic Alcoholism or Chemical Dependency. Charges in connection with the treatment of chronic alcoholism or chemical dependency.

Coordination of Benefits With Other Coverages

A. What Coordination of Benefits Means

The purpose of this *Long Term Care Coverage* is to help you pay for covered expenses, but not to pay for more than you actually incur. To do this, *Prudential* coordinates its payments with certain other coverages you may have that provide benefits for the same services covered by this *Long Term Care Coverage*. Coordinating with other coverages helps your benefits under this *Long Term Care Coverage* last longer and helps maintain the premium rates for this insurance.

Other coverages with which this insurance coordinates include:

1) Other group *Long Term Care* coverages (insured or uninsured).

2) The following coverages, to the extent they cover the same types of expenses (e.g. *Nursing Home*, *Home Health Care*) that this insurance covers:

    a) Coverage (other than *Medicare* or *Medicaid*) under a governmental program provided or required by statute, if coordination is allowed by law. This can include coverage under the no fault or medical payment provisions of an automobile insurance contract.

    b) Coverage under group medical coverages (insured or uninsured).

B. How Coordination of Benefits Works

One of the coverages will pay benefits first. The *Long Term Care* coverage which pays first is the primary plan. The other coverage(s) will pay next and are the secondary coverages.

1) If this *Long Term Care Coverage* is primary, it will pay its benefits first, as it would in the absence of another coverage. The secondary coverages then pay benefits according to their rules.

2) If this *Long Term Care Coverage* is the secondary coverage, we will pay benefits as follows:

    a) The amount paid for your expenses by the primary coverage and the amount this *Long Term Care Coverage* would have paid for your expenses will be added.

    b) If the total is greater than the actual charges, this *Long Term Care Coverage* will reduce its payment and pay up to the actual charges.

c) If the total is less than the actual charges, this *Long Term Care Coverage* will pay its full benefits for those charges. In this situation, the total paid by both coverages might be less than the actual charges.

C. Which Coverage is Primary

The following rules determine which coverage is primary.

1) A coverage which does not have a coordination of benefits provision with rules that are similar to those in this *Coverage* is the primary coverage.

2) A coverage which covers you as an *Employee* or retiree is primary to a coverage which covers you as a relative (e.g. by blood or marriage) of the *Employee* or retiree. If you are also covered by *Medicare*, this rule may be reversed depending on *Medicare's* rules regarding its payments for your expenses.

3) A coverage which covers you as an "active" *Employee* or as the relative (e.g. by blood or marriage) of such an *Employee* is primary to a coverage which covers you as a laid off or retired employee or as the relative (e.g. by blood or marriage) of such an *Employee*. But if the other coverage does not have this rule, it is ignored.

4) If the above rules do not apply, then the coverage which has covered you the longest will be primary.

When you apply for benefits under this *Coverage*, you will have to provide information about your other coverages. *Prudential* has the right to request and obtain the information it needs to apply the rules in this provision.

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Claim Rules

A. Notice of Claim

When *Prudential* is notified of your claim, you will be sent a claim form. It will be sent no later than 10 business days following receipt of your notice. If you do not receive the claim form within this specified time, you may send *Prudential* written documentation to confirm your *Chronic Illness or Disability*, your *Plan of Care* and the *Provider's* bill as written proof of loss.

B. Proof of Loss

Prudential must receive copies of your *Plan of Care* and the *Provider's* bill with the claim form as written proof of loss that you have received the services. The bill must show the date, each type of service received, and the charge for that service. This proof of loss should be sent within 90 days of the date your loss begins. Failure to furnish such proof within the time required will not invalidate or reduce any claim if

1) It was not reasonably possible to furnish the proof within that time. And

2) Proof is furnished as soon as reasonably possible.

In no event shall proof be furnished later than one year from the time proof is otherwise required, except in the absence of your legal capacity.

C. Timely Submission

We encourage you and your *Provider* to send monthly proof of loss to *Prudential*. Timely submission is important to you because the benefits *Prudential* pays under this Certificate are charged against your *Lifetime Maximum*. This means that if claim submission is delayed, you may not know how much *Coverage* remains.

The address to which you submit the bills is on the claim form. If you have any questions about the address or would like additional claim forms, you can call 1-800-732-0416.

D. When Benefits are Paid

You can choose whether you want to receive the *Coverage* payments or have them paid directly to the service *Provider*. Benefits are paid when *Prudential* receives satisfactory proof of loss. A benefit unpaid at your death will be paid to your estate except as otherwise required or authorized by law or judicial decree to be paid to another person or entity. Any payment made in good faith will fully release *Prudential* of its responsibility to the extent of the payment. If benefits are not paid in a timely fashion, *Prudential* will pay interest on any such late claim payments, in accordance with the laws then in effect.

E. Physical Exam

Prudential, at its own expense, has the right to have you examined. *Prudential* may do this when and as often as is reasonable while your claim is pending.

F. Legal Action

No action at law or in equity shall be brought to recover on the *Group Contract* until 60 days after the proof described above is furnished. No such action shall be brought more than three years after the expiration of the period within which proof of loss must be furnished (five years in Kansas; six years in South Carolina).

For Florida residents, no such action shall be brought after the end of the applicable Florida statute of limitations from the time within which proof of loss is required.

G. Appeals

You have the right to appeal decisions made about your claims. The explanation of benefits notice will explain the procedure you should follow if you choose to appeal a claim decision.

Prudential will send you a written acknowledgment of your appeal. If no additional information is required and the appeal is denied, the acknowledgment will include a detailed explanation of the reasons for the denial. If additional information is required, *Prudential* will explain what information is needed. Upon receipt and review of the additional information, *Prudential* will notify you in writing of the results of the review.

If you still disagree with the appeal decision, you can request in writing within 60 days of the decision that the matter be submitted to the Claim Appeal Committee. This Committee includes, but is not limited to, clinical consultants, legal consultants and product management staff. After a thorough review, the Committee will send you written notification of its decision.

General Information

A. Definitions

Activities of Daily Living

Bathing - Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence - The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

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

Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

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

Transferring - Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either by walking, using a wheelchair or by other means.

Adult Day Care - A day program for three or more individuals in a community group setting which

1) is provided in an *Adult Day Care Facility*.

2) provides social and health-related services.

3) supports frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Facility - A facility that is licensed or certified as an *Adult Day Care Facility* by the state in which services are rendered. If a state does not license or certify an *Adult Day Care Facility*, the *Adult Day Care* program must be licensed or certified by the state in which services are rendered.

Assessor - A *Licensed Health Care Practitioner* who is qualified to evaluate conditions relevant to your functional or cognitive ability. Qualifications are based on training and experience, and may include health care industry, state or national standards.

Assisted Living Facility - For an *Assisted Living Facility* that is located in a state that licenses or certifies such a facility, an *Assisted Living Facility* is one which is licensed or certified by the state in which the facility is located.

For facilities located in states that do not license or certify *Assisted Living Facilities*, an *Assisted Living Facility* is one that meets, in *Prudential's* judgment, the following minimum criteria.

1) It is a group residence that maintains records for services to each resident.

2) It provides services and oversight on a 24 hour a day basis which support a resident in a manner that promotes dignity, independence and privacy.

3) It provides a combination of housing, supportive services, and personal assistance designed to respond to the resident's need for help with *Activities of Daily Living* and instrumental activities of daily living.

4) It provides, at a minimum, assistance with *Bathing, Dressing*, and help with medications.

5) It is NOT licensed as a *Nursing Home*.

The criteria is based on established, national industry standards such as those developed by The Assisted Living Quality Coalition; The Assisted Living Federation of America; The American Association of Homes and Services for the Aging; and The Joint Commission on the Accreditation of Health Organizations.

Bed Reservation - The retention of your bed by a *Nursing Home* or an *Assisted Living Facility* that occurs if you are a resident in such a facility and you are absent from the facility for 24 hours or more.

Calendar Year - A year starting January 1.

Caregiver Training – Training provided by a *Home Health Care Agency*, *Nursing Home*, hospital or other similar facility acceptable to *Prudential* and received by your Informal Caregiver to care for you in your residence.

Chronic Illness Or Disability - An illness or disability certified by a *Licensed Health Care Practitioner* in which there is

1) A loss of the ability to perform, without *Substantial Assistance*, at least two *Activities of Daily Living*. This loss must be expected to continue for 90 days. *Activities of Daily Living* are: *Bathing*, *Continence*, *Dressing*, *Eating*, *Toileting*, and *Transferring*. Or

2) A severe *Cognitive Impairment* which requires *Substantial Supervision* to protect you from threats to health or safety.

Cognitive Impairment - A loss or deterioration in intellectual capacity that is

1) comparable to and includes Alzheimer's disease and similar forms of irreversible dementia.

2) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long term memory; orientation as to people, places, or time; and deductive or abstract reasoning.

Coverage – The *Long Term Care Insurance* on any person described in the **Who is Eligible** section.

Daily Maximum – The maximum daily benefit payable for *Eligible Charges* according to the Plan you have chosen as shown in the **Schedule of Benefits** and your Confirmation Statement.

Domestic Partner – A person of the same or opposite sex of an *Employee* or *Retiree*, who

1) is someone other than your spouse.

2) has lived with you for at least six months and intends to remain a member of your household for the period of *Coverage.*

3) has a serious and committed relationship with you.

4) is financially interdependent with you.

5) is not related to you in a way that would prohibit legal marriage or legally married or a *Domestic Partner* to anyone else.

Eligible Charges - The charges for your *Long Term Care* that may be used as the basis for a claim. These charges must be incurred

1) for services and supplies described in the **Covered Services** section.

2) while you are insured for the *Long Term Care Coverage*.

3) after the **Benefit Waiting/Elimination Period**, if any, is satisfied.

A charge is considered incurred on the date you receive the service or supply. A charge is not an *Eligible Charge* if it is described in the **Coverage Exclusions** section.

Employee - A Benefits-eligible *Employee* of The University of Arizona, who is actively-at-work and is employed at a .50 FTE (20 hours per week) or greater and in a position that is at least six (6) months or more in duration.

Group Contract - *Group Contract* No. LT-45727-AZ between *Prudential* and The University of Arizona which includes this Group Insurance Certificate.

Group Contract Holder - The entity to whom this *Group Contract* was issued.

Home and Community-Based Care - *Home Health Care* or *Personal Care* received from a *Home Health Care Agency,* a licensed *Referral Agency,* a licensed *Nurse Registry* or provided by an *Independent Health Care Professional* and *Adult Day Care* received from an *Adult Day Care Facility*.

Home Health Aide - A person whose function is to provide *Personal Care* services. If state and local licensing or certification is required, the person must be licensed or certified as a *Home Health Aide* where the service is performed. If licensing or certification is not required, any person who meets the minimum training qualifications recognized by the Foundation for Hospice & Home Care, the National League of Nursing or the Health Care Financing Administration will be considered a *Home Health Aide*, provided they are employed through an eligible *Home Health Care Agency*.

Home Health Care Agency - An organization that provides *Home Health Care* and is licensed or certified as a *Home Health Care Agency* by the state in which services are rendered.

Home Health Care - Services provided to ill, disabled or infirm persons in their residences. Such services may include assistance with *Activities of Daily Living,* homemaker services and *Respite Care* services.

Hospice - A licensed or certified facility or community-based program designed to provide services to *Terminally Ill* individuals.

Hospice Care - Services and supplies provided through a *Hospice* to *Terminally Ill* individuals.

Independent Health Care Professional - A full-time, professional, licensed or certified *Home Health Aide*, *Registered Nurse*, *Licensed Practical Nurse* or *Therapist* independently providing *Home Health Care* services within the scope of his or her license.

Informal Caregiver - An unpaid person, typically a family member or friend, who regularly provides *Home Health Care* or *Personal Care* to you in your home. This would include assistance with *Activities of Daily Living*.

Institutional Care - Care provided by a *Nursing Home* or *Assisted Living Facility* while you are a resident.

Licensed Health Care Practitioner - A *Physician*, a professional *Registered Nurse*, a licensed social worker, or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.

Licensed Practical Nurse - A professional nurse legally designated "LPN" who, where licensing is required, holds a valid license from the state in which the nursing services is performed. The term *Licensed Practical Nurse* (LPN) shall include a licensed vocational nurse (LVN) and any other similarly designated nurse in those jurisdictions in which a professional nurse is designated as other than an LPN and for whom licensing is required.

Lifetime Maximum - The maximum lifetime benefit payable for *Eligible Charges* for the Plan you have chosen as shown in the **Schedule of Benefits** and your Confirmation Statement.

Long Term Care - Medical, social and/or *Personal Care* services required over a long period of time by a person with a *Chronic Illness or Disability. Long Term Care* can include care in an *Assisted Living Facility* or *Nursing Home, Adult Day Care, Home and Community-Based Care, Hospice Care,* or *Respite Care.*

Medicaid - Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.

Medicare - Title XVIII, Health Insurance for the Aged and Disabled, of the United States Social Security Act, as amended from time to time.

Nurse Registry - An organization that meets the following requirements.

1) Its main function is to provide a referral service for *Registered Nurses* or *Licensed Practical Nurses* specialized in providing *Home Health Care* services.

2) It is appropriately licensed by the state in which the services are provided, if the state in which the *Nurse Registry* is located requires licensure.

Nursing Home - A facility that provides skilled, intermediate, or custodial care and meets at least one of the following criteria.

1) It is *Medicare*-approved as a *Provider* of skilled nursing care services.

2) It is licensed by the state in which it is located as a skilled nursing facility, an intermediate care facility, or a custodial care facility.

3) It meets all the following criteria.

    a) Its main function is to provide skilled, intermediate or custodial nursing care.

    b) It is engaged in providing continuous room and board accommodations for three or more persons.

    c) It has a *Physician* on staff or available to it under contract.

    d) It is under the supervision of a *Registered Nurse* or *Licensed Practical Nurse*.

e) It maintains medical records for each patient.

f) It maintains control of and records of all medications dispensed.

Personal Care - Services provided to help a person perform *Activities of Daily Living*, (also known as custodial care).

Physician - A licensed practitioner of the healing arts acting within the scope of the license.

Plan of Care - A written plan that

1) has been developed for you.

2) describes the type, the frequency, and the duration of the *Long Term Care.*

3) describes the types of *Providers* that are needed.

4) is signed by the *Licensed Health Care Practitioner* responsible for your care.

Private Care Manager - A private *Licensed Health Care Practitioner*, not associated with *Prudential*, who is qualified to coordinate your necessary *Long Term Care*, medical care, *Personal Care* and social services. Qualifications are based on training and experience and can include health care industry, state or national standards.

Provider - A licensed or certified professional or entity that provides *Long Term Care* services.

Prudential - The Prudential Insurance Company of America, 751 Broad Street, Newark, New Jersey 07102-3777.

Referral Agency - An agency that meets the following requirements.

1) Its main function is to provide a referral service for *Registered Nurses*, *Licensed Practical Nurses*, *Therapists* or licensed *Home Health Aides* providing *Home Health Care*.

2) It is licensed by the state in which the *Home Health Care* is delivered, to provide such services. If licensing is not required, the agency must be accredited by the Joint Commission on Accreditation of Health Care Organizations, the National Care Organizations, the Community Health Accreditation Program, the Foundation for Hospice and Home Care or the National League of Nurses.

Registered Nurse - A professional nurse legally designated “RN” who, where licensing is required, holds a valid license from the state in which the nursing service is performed.

Respite Care - Short-term care provided for limited periods of time in certain settings to relieve your *Informal Caregiver*.

Substantial Assistance -

1) The physical assistance of another person without which you would not be able to perform an *Activity of Daily Living*. Or

2) The constant presence of another person within arm's reach which is necessary to prevent, by physical intervention, injury to you while you are performing an *Activity of Daily Living*.

Substantial Supervision - Continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect you from threats to your health or safety.

Terminally Ill – When a *Physician* certifies that an individual has no reasonable prospect of cure and has a life expectancy of less than 6 months.

Therapist - A physical therapist, occupational therapist, respiratory therapist, speech pathologist or audiologist who is licensed as such where the services are performed.

When Your Insurance Ends

Your Insurance will end when the first of these occurs:

1) You fail to pay, when due, or within the **Grace Period**, any premium required for the *Coverage*. This will not apply if the premium is being waived in accordance with the **Waiver of Premium** provision.

2) You have exhausted your *Lifetime Maximum*.

A. Reinstating Coverage

If you fail to pay your premium and your *Coverage* ends for this reason, you may be eligible to reinstate your *Coverage*. You may make a request for reinstatement within 60 days of the date premiums were due.

In addition, if due to your *Chronic Illness or Disability*, you fail to pay your premium and your *Coverage* ends for this reason, you may be eligible to reinstate your *Coverage*. You or your representative may make a request for reinstatement within five months of the date premiums were due. Your *Chronic Illness or Disability* must be confirmed by *Prudential*. See the **Benefit Eligibility Criteria** under Section B of the **Long Term Care Coverage** provisions for details.

Call the Long Term Care Customer Service Center at 1-800-732-0416 to determine if your *Coverage* can be reinstated.

If your *Coverage* can be reinstated, you must pay the past due premiums. Upon reinstatement, you will have the same level of *Coverage* you had before your *Coverage* ended.

B. Extension of Benefits

If your *Coverage* ends while you are confined in a *Nursing Home* or an *Assisted Living Facility,* using your *Bed Reservation* benefits, or confined in a *Hospice,* benefits will continue for the duration of that uninterrupted stay*.* Your confinement must have started while this *Long Term Care Coverage* was in effect. Benefits will be extended until the earlier of:

1) The date on which you no longer incur *Eligible Charges* for *Nursing Home* care or care in an *Assisted Living Facility*, *Bed Reservation,* or inpatient *Hospice Care*.

2) The date you reach the *Lifetime Maximum*.

During this extension of benefits period, you will be considered covered under this Certificate for purposes of the **Waiver of Premium** provision.

C. Rescinding Your Coverage - Incontestability

Your acceptance for this *Long Term Care Coverage* is based on information furnished on your Enrollment Form. All statements made by you shall be deemed representations and not warranties. These statements will not be used in a contest to avoid this *Coverage* or reduce benefits unless

1) It is in a written statement signed by you.

2) A copy of that statement is or has been furnished to you.

If this information misrepresented you or your health status, and as a result, *Prudential* offered you *Coverage* which you otherwise would not have been offered, *Prudential* can rescind your *Coverage*, or deny an otherwise valid claim. Your *Coverage* can be rescinded in this situation within six months of your Effective Date.

If your *Coverage* has been in effect at least six months, but less than two years, *Prudential* can also rescind your *Coverage* or deny an otherwise valid claim. This can be done if all the following apply.

1) Information on your Enrollment Form misrepresented you.

2) As a result, *Prudential* offered you *Coverage* which you otherwise would not have been offered.

3) The misrepresentation pertains to the condition for which benefits are claimed.

After two years, your *Coverage* can be rescinded if *Prudential* can show that relevant facts relating to your health were knowingly and intentionally misrepresented.

These provisions also apply whenever you purchase additional *Coverage* and provide additional evidence of insurability. For example, if you choose a higher Plan, that portion of your *Coverage* could be rescinded. If your additional *Coverage* is rescinded, benefits will be paid according to the *Daily Maximums* in effect before the increase.

If you realize there is an inaccuracy in your Enrollment Form, you should notify *Prudential* before the end of the two-year period. This will help to assure you have the *Coverage* when you need it.

AUTOMATIC COMPOUND INFLATION INCREASE RIDER

If you elected the Automatic Compound Inflation Increase Rider and pay the additional premium, these provisions change your *Long Term Care Coverage* to provide for automatic compound inflation increases.

Changes Made in the Coverage

The following benefit is added to your *Long Term Care Coverage*.

Inflation Protection

Your benefits will automatically increase on the anniversary of the Effective Date of your *Coverage*. These increases will occur even if you are receiving benefits. Each year, all benefits increase by 5% compounded annually, rounded to the nearest dollar. Your *Lifetime Maximum* will also increase accordingly. Your remaining *Lifetime Maximum* is equal to your increased *Lifetime Maximum* less the sum of all benefits paid on your behalf during the period your *Coverage* was in effect.

If your *Coverage* ends and is later reinstated as described in the Certificate, benefits will be increased as if *Coverage* had remained in effect.

An example of the increasing benefit, based upon an initial $100 *Daily Maximum* for *Nursing Home* Care and a Lifetime Maximum of $109,500 is shown below.

Long Term Care Coverage Anniversary	Multiplicative Factor	Daily Maximum for Nursing Home Care	Lifetime Maximum
Year 1	1.0500	$105	$114,975
Year 2	1.1025	$110	$120,450
Year 3	1.1576	$116	$127,020
Year 4	1.2155	$122	$133,590
Year 5	1.2763	$128	$140,160
Year 10	1.6289	$163	$178,485
Year 15	2.0789	$208	$227,760
Year 20	2.6533	$265	$290,175

Shown for illustration purposes only.

Your Confirmation Statement will indicate if you have selected this Rider.

Canceling this Rider

If you want to cancel this rider, you must send a written request to the Long Term Care Customer Service Center. The address is shown in your Certificate. If you cancel this Rider, your benefits will revert to the Benefit Option you choose when you enrolled. Also, the premium charged will be based on your age when you enrolled for *Coverage*.

The Prudential Insurance Company of America

Secretary

Your Confirmation Statement will indicate if you have selected this Rider.

This Claims and Appeals Procedures section is not part of the Group Insurance Certificate.

CLAIMS AND APPEALS PROCEDURES

Plan Benefits Provided by

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer's plan(s). For all purposes of this Group Contract, the Employer/Policyholder acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such written execution.

The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious.

Claim Procedures

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a description of Prudential's appeals procedures and applicable time limits, and

(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

2. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

(a) the specific reason(s) for the adverse determination,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the plan.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Long Term Care Coverage is underwritten by The Prudential Insurance Company of America.

Coverage under Prudential's Long Term Care Coverage is subject to all applicable laws and regulations.

Prudential Long Term Care[SM] is a service mark of The Prudential Insurance Company of America.