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- 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.

SAMPLE

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.

SAMPLE

Additional Coverage Features

A. Guarantee Purchase Option

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**.

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.

SAMPLE

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 *Severe 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 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 you if:

- 1) The Non-Forfeiture Benefit Rider is not part of your Policy, or
- 2) You have purchased the Non-Forfeiture Benefit Rider, but your *Coverage* ends before its third year anniversary and the Non-Forfeiture Benefit Rider is not yet in effect or unless you have experienced a *Substantial Premium Increase* prior to the third year anniversary.

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.

SAMPLE

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) Reduced benefit options at the same premium, without undergoing medical underwriting. 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 greater 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.

SAMPLE

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) You have not made an election.
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Coverage Exclusions

Limitations and Exclusions

- 1) Treatment provided in a government facility, unless a charge is made and the insured is legally obligated to pay; services for which benefits are available under *Medicare* or other governmental program, except *Medicaid*; any state or Federal workers' compensation, employer's liability or occupational disease law; or a motor vehicle no-fault law.
 - 2) Illness, treatment, or medical condition arising out of War or Acts of War or your participation in a Felony, Riot or Insurrection.
 - 3) Self-inflicted Injury or Suicide. Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or insane.
 - 4) Services and Supplies Outside the United States. Charges for services or supplies outside of the United States and its possessions.
 - 5) Treatment for Alcoholism or Drug Addiction. Charges in connection with the treatment of alcoholism or drug addiction.
 - 6) First Party Benefits under Pennsylvania's Motor Vehicle Liability Insurance Law. Charges for services and supplies for which benefits are payable as first party benefits under Pennsylvania's Motor Vehicle Liability Insurance Law.
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SAMPLE

Claim Rules

We encourage you and your provider to send timely proof of loss to *Prudential*. This is important to you because the benefits *Prudential* pays under the Group Contract are charged against your *Lifetime Maximum*. This means that if claim submission is delayed, you may not know how much *Coverage* remains in your *Long Term Care* plan. Your receipt of benefits also affects your premium waiver. Premiums may become due and payable if *Prudential* is unaware of your claim status. If we do not receive timely proof of loss, premiums may be due even if you would have been eligible for the **Waiver of Premium** benefit.

Benefits are paid when *Prudential* receives satisfactory proof of loss. An explanation of benefits notice, which explains the determination of your claim, will be sent to you within 15 days from the date *Prudential* receives proof of your loss. You can choose whether you want to receive the *Coverage* payments or have them paid directly to the service provider. *Prudential* will need copies of your *Plan of Care* and the provider's bill indicating that you have received the services, as well as the Claim Form stated below. The bill must show the date, the name of the person who received the service, each type of service received and the charge for that service. 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. Details of the specific claim processes are stated fully in the provisions below.

A. Notice of Claim

Written notice of claim must be given to *Prudential* within 20 days after the occurrence or commencement of any loss covered by the *Group Contract*, or as soon thereafter as is reasonably possible.

Notice given by or on behalf of the insured to The Prudential Insurance Company of America, at P. O. Box 8526, Philadelphia, PA 19176, or to its authorized agent, with information sufficient to identify the insured, shall be deemed notice to *Prudential*.

B. Claim Forms

Upon receipt of a notice of claim, *Prudential* will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the *Group Contract* as to proof of loss upon submitting, within the time fixed in the Certificate for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

SAMPLE

C. Proof of Loss

Written proof of loss must be furnished to *Prudential* at its office in case of claim for loss for which the *Group Contract* provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which *Prudential* is liable and, in case of claim for any other loss, within 90 days after the date of such loss.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

D. Time of Payment of Claims

Benefits payable under the *Group Contract* for any loss other than loss for which the *Group Contract* provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the *Group Contract* provides periodic payment will be paid monthly. Any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

E. Payment of Claims

Any accrued indemnities unpaid at the Insured's death may, at *Prudential's* option, be paid to the Insured's estate. All other indemnities will be payable to the Insured.

If any indemnity of the *Group Contract* shall be payable to the estate of the Insured, or to an Insured who is a minor or otherwise not competent to give a valid release, *Prudential* may pay such indemnity, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of the Insured who is deemed by the *Prudential* to be equitably entitled thereto. Any payment made by *Prudential* in good faith pursuant to this provision shall fully discharge *Prudential* to the extent of such payment.

Subject to any written direction of the Insured in the Enrollment Form or otherwise, all or a portion of any indemnities provided by the *Group Contract* on account of nursing services may, at *Prudential's* option and, unless the Insured requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the entity or person rendering such services; but it is not required that the service be rendered by a particular entity or person.

SAMPLE

F. Physical Examination

Prudential, at its own expense, has the right to examine you. *Prudential* may do this when and as often as is reasonable while your claim is pending. However, a physical examination will not be required more than once in any 90 day period.

G. 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 (five years in Kansas; six years in South Carolina) after the charges are incurred. 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. For Missouri residents, no such action shall be brought more than three years after the expiration of the period within which proof of loss must be furnished.

H. 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 denial. You will have 60 calendar days from the date you receive the denial to submit a written appeal to *Prudential* at the address specified on the notice.

Prudential will send you a written acknowledgment of your letter within 10 days of its receipt. If no additional information is required and the appeal is denied, the acknowledgment will include a detailed explanation of the reasons for the denial, including reference to the *Group Contract* provision on which the denial is based.

If additional information is required, the acknowledgment will request the specific information needed.

Within 15 days of the receipt of the additional information, *Prudential* will notify you in writing of the decision concerning your claim. If the decision cannot be made within 15 working days from the date it receives all requested data, *Prudential* will notify you, giving the reasons more time is required. If the decision is not made within an additional 30 days, *Prudential* will notify you, at that time, and every 45 days thereafter, the reasons why additional time is needed for investigation of your claim. This notice will also state when a decision on the claim may be expected.

If you 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, but not later than 15 days from the date all necessary information is received, the Committee will send you written notice of its decision.

SAMPLE

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.

Acute Care Facility - An institution that meets either of these two tests:

- 1) It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations.
- 2) It is legally operated, has 24-hour-a-day supervision by a staff of *Physicians*, has 24 hour a day nursing service by *Registered Nurses*, and complies with (a) or (b):
 - (a) It mainly provides general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic and major surgical facilities. All such facilities are in it or under its control.
 - (b) It mainly provides specialized inpatient medical care and treatment of sick or injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All such facilities are in it, under its control, or available to it under a written agreement with a hospital or with a specialized provider of those facilities.

SAMPLE

But, Acute Care Facility does not include a *Nursing Home*. Neither does it include an institution, or part of one, which: (i) is used mainly as a place for convalescence, rest, nursing care or for the aged; or (ii) furnishes mainly homelike or custodial care, or training in the routines of daily living; or (iii) is mainly a school.

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 - An organization that provides a program of *Adult Day Care* and that meets all of the following requirements.

- 1) It is established and operated as an Adult Day Care Facility in accordance with any applicable state or local laws including the laws requiring Adult Day Care Facilities to be licensed.
- 2) Its staff includes
 - a) A full-time director; and
 - b) one or more *Registered Nurses* in attendance for at least four hours during operating hours; and
 - c) Not less than two full-time staff members.
- 3) It operates at least five days a week for a minimum of six hours per day, but is not an overnight facility.
- 4) It maintains a written record of medical services given to each client.
- 5) It has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assisted Living Facility - A facility that is primarily engaged in providing ongoing care and related services to at least five inpatients in one location and meets all of the following criteria.

- 1) It is licensed by the appropriate licensing agency, if the state in which it operates licenses such facilities.
- 2) It provides 24-hour-a-day care and services sufficient to support the needs of persons who have a *Chronic Illness or Disability*.

SAMPLE

- 3) It has trained and ready to respond employees on duty at all times to provide care.
- 4) It provides three meals a day and accommodates special dietary needs.
- 5) It has formal arrangements with a *Physician* or *Registered Nurse* to furnish medical care in care of an emergency.
- 6) It has appropriate methods and procedures for handling and administering drugs and biologicals.

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. This 90 day period is not an additional waiting period. *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.

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* 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.

SAMPLE

- 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 person who is actively at work and works for Commonwealth of Pennsylvania as an active permanent full-time Employee or an active permanent part-time Employee who is working greater than 50% of regular full-time hours.

Group Contract - Group Contract No. LT-91475-PA between *Prudential* and Commonwealth of Pennsylvania 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 agency or organization which:

- 1) Specializes in giving nursing care or therapeutic services in the home; and
- 2) Is licensed to provide such care by the appropriate state licensing agency or authority where the services are performed or is *Medicare* certified as a home health Care Agency; and
- 3) Maintains a complete medical record and *Plan of Care* for each patient; and

SAMPLE

4) Is operating within the scope of its license or certification.

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.

SAMPLE

Medicare – The program under The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 or Health Insurance for the Aged Act (42 U.S.C.A. s s 1495-1495 ccc).

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 – The provision of supervisory or hands-on services 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.

SAMPLE

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.

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

Qualified Adult - A person of the same or opposite sex of an *Employee* or *Retiree*, who

- 1) is over the age of 18.
- 2) has lived with the *Employee* or *Retiree* for at least six months.
- 3) has a serious and committed relationship with the *Employee* or *Retiree*.
- 4) is not legally married nor a *Domestic Partner* to anyone else.
- 5) is not otherwise eligible for this *Coverage*.
- 6) is financially interdependent with the *Employee* or *Retiree*. Financially interdependent means that the *Qualified Adult* and the *Employee* or *Retiree* are jointly responsible for the cost of food and housing.

Qualified Long Term Care Services – Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or *Personal Care* services which are required by an individual with a *Chronic illness* or *Disability* and are provided pursuant to a *Plan of Care*.

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*.

SAMPLE

Severe Cognitive Impairment – A severe 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
 - i) short-term or long-term memory,
 - ii) orientation as to people, places or time, and
 - iii) deductive or abstract reasoning.

Substantial Assistance -

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

SAMPLE

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 your premium is not paid within the time allowed, your *Coverage* will lapse. If *Prudential* later accepts the past due and unpaid premium, without an enrollment form for reinstatement, your *Coverage* will be reinstated.

If *Prudential* requires an enrollment form for reinstatement, you will be given a conditional receipt for the premium. If such enrollment form is approved, your *Coverage* will be reinstated as of the approval date. Lacking such approval, the *Coverage* will be reinstated on the 45th day after the date of the conditional receipt unless *Prudential* has previously written you of its disapproval. The reinstated *Coverage* will cover only loss that results from:

- 1) an injury sustained after the date of reinstatement; or
- 2) a sickness that starts more than 10 days after the date of reinstatement.

In all other respects, your rights and *Prudential's* rights under your *Coverage* will remain the same, subject to any provisions noted on or attached to the reinstated Certificate.

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 C 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.

SAMPLE

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.

SAMPLE

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.

SAMPLE

NON-FORFEITURE BENEFIT RIDER – Shortened Benefit Period

If you elected the Non-Forfeiture Benefit Rider and pay the additional premium, these provisions change your *Long Term Care Coverage*. This rider provides for additional benefits if your insurance ends due to non-payment of premium.

Changes Made in the Coverage

The following benefit replaces the Contingent Non-Forfeiture Provisions in your *Long Term Care Coverage*.

Non-Forfeiture Benefit

This rider provides a non-forfeiture benefit in the form of a shortened benefit period. This rider will pay benefits according to the conditions in effect at the time insurance ended, up to the benefit limits you have chosen. However, you will have a reduced *Lifetime Maximum*.

If your insurance ended due to non-payment of premium on or after the third anniversary of your Effective Date, you may be entitled to receive benefits under this provision.

No benefits will be paid if either of the following apply.

- 1) Your insurance ended prior to your third anniversary.
- 2) You have already received benefits equal to the *Lifetime Maximum* benefit available under your *Coverage*.

If you are entitled to a benefit, this benefit will be equal to the greater of the following.

- 1) 30 times the *Daily Maximum* for *Nursing Home Care* at the time of lapse, up to your remaining *Lifetime Maximum*.
- 2) The total amount of premiums paid for your *Coverage*.

This benefit can be used at any time during your lifetime. To use it, you must request benefits and *Prudential* must determine your eligibility. Your benefits will be based on the benefit limits in effect when your insurance ended. The inflation protection provisions end when premiums are no longer paid. No inflation increases will occur for benefits amounts under the Non-Forfeiture Benefit provisions.

The Prudential Insurance Company of America



Secretary

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

SAMPLE

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.

SAMPLE

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.

SAMPLE

**This Claims and Appeals Section
is not part of the
Group Insurance Certificate.**

SAMPLE

Claims and Appeals Section

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. 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.

SAMPLE

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.

SAMPLE

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.

SAMPLE

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.

SAMPLE

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 CareSM is a service mark of The Prudential Insurance Company of America.



COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S OFFICE OF ADMINISTRATION
207 FINANCE BUILDING
HARRISBURG, PENNSYLVANIA 17120

Via email (John.Hafner@prudential.com) and First Class Mail

August 13, 2007

Mr. John Hafner
Account Executive
The Prudential Insurance Company of America
290 West Mount Pleasant Avenue
Livingston, NJ 07039

RE: RFP # CN00023197 Voluntary Benefits

Dear Mr. Hafner:

I have replaced Matthew Bembenick as the project officer on RFP # CN00023197 Voluntary Benefits. I may be contacted at the address listed above and via phone at 717-705-0951 or via email at vikapoor@state.pa.us.

The Governor's Office of Administration ("OA") has evaluated the proposal that your company submitted in response to RFP Number CN00023197, Voluntary Benefits. Based on that evaluation, I would like to take this opportunity to relay several pieces of information to you. First, OA has determined, in accordance with Section III-3 of the RFP, that it is not interested in the Accidental Death and Dismemberment ("AD&D") policy proposed by your firm, at this time. The remaining benefits proposed by your firm will continue to receive consideration by OA.

Second, OA has selected Prudential as one of the offerors to proceed to the "Best and Final Offers" phase of the evaluation process.

Therefore, in accordance with Sections I-20, II-9, II-10 and III-3 of the RFP, OA invites you to submit a Best and Final Offer ("BAFO") for the Technical, Disadvantaged Business, and Cost submittal portions of your proposal for following benefits only:

- Term Life Insurance (Group)
- Long Term Disability (Group)
- Long Term Care (Group)

In addition, please provide a response to the questions referenced in Attachment 1 -- Best and Final Offer Questions -- Prudential.

The BAFO and responses should be submitted as a replacement to and in accordance with the requirements of the original proposal you submitted, and is due via email and hard copy to Mr. Emanuel Williams, DGS Bid Room, 555 Walnut Street, 6th Floor Forum Place, Harrisburg, PA 17101 on or before Tuesday, August 21, 2007 at 1:00 p.m. in order to be considered. Mr. Williams' email is emwilliams@state.pa.us. If there is a change in Cost that affects the

Page 2

Disadvantaged Business portion of your proposal, then you are required to resubmit the Disadvantaged Business portion.

This letter is to be considered only an invitation to participate further in this RFP process, and is not binding in any way. Neither OA nor the Commonwealth will be bound until a formal written contract has been negotiated and executed by all necessary Commonwealth officials. Accordingly, all activities in furtherance of this process, including your compliance with the conditions set forth in this letter, are considered to be at your sole cost and risk.

Sincerely,

A large black rectangular redaction box covering the signature of the Project Officer.

Vijay Kapoor
Project Officer

DGS RFP# CN00023197 Voluntary Benefits

Attachment 1 - Best and Final Offer Questions – Prudential

1. On page 28 of your proposal, you note that you expect to eliminate a number of legacy systems over the next two years. Are any of the major systems, such as eligibility or claims affected by this change? Please provide specifics.
2. Do you remain open to negotiations regarding the performance criteria and standards?
3. Where is your alternative hardware for system back-up located?
4. Please provide details on how silent call monitoring is used to enhance performance in the various administrative units. Is there a standard process by which calls are selected for monitoring?
5. For how long do you maintain records of enrollment, premiums, claims, etc.? How and where is that data stored?
6. Please provide a copy of each policy proposed that exactly matches the benefits quoted in your proposal.