The State of Michigan

Certificate of Insurance under

Group Contract LT-51131-MI

Prudential Long-Term Care Solid Solutions℠

The Prudential Insurance Company of America

751 Broad Street,
Newark, New Jersey 07102-3777

Prudential

83500
BCOV 1004

FOREWORD

CORPORATE ADDRESS: The Prudential Insurance Company of America
751 Broad Street, Newark NJ 07102-3777

CONTACT ADDRESS: Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176
1-800-732-0416

The Prudential Insurance Company of America (Prudential) certifies that the benefits described in this Certificate of Insurance (Certificate) are provided under and are subject to the terms and conditions of the Group Insurance Contract (Contract) issued to the Group Insurance Contract Holder (Contract Holder) shown on the cover. This Certificate and the Schedule of Benefits is your evidence of Coverage under the Contract. Your Original Effective Date and your benefit amounts are shown on the Schedule of Benefits. All benefits are subject in every way to the entire Group Insurance Contract, which includes this Certificate.

In your Certificate, The Prudential Insurance Company of America is referred to as Prudential, we, our, or us. The insured is referred to as you, your, or yours. Please see the Definitions section of this Certificate for additional defined terms.

TAX STATUS: The Group Insurance Contract, including this Certificate of Insurance is intended to be a Qualified Long-Term Care Insurance Contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

RENEWABILITY: Your Coverage is guaranteed renewable. It begins on the Original Effective Date shown in the Schedule of Benefits. You can continue your Coverage as long as the full modal premium is paid on time and the Lifetime Maximum has not been exhausted. Prudential cannot change the terms of your Coverage on its own, except it may change the premiums. (See “Premiums” provisions.) Certain provisions of your Coverage may be changed to conform with changes in state or federal law or regulation that apply to your Coverage.

IMPORTANT 30-DAY REVIEW: You have 30 days from receipt of your Certificate to review it. If you decide you do not want it, you may return the Certificate during these 30 days, to Prudential at the Contact Address shown above. Your Coverage will be deemed void from its Original Effective Date and any premium paid will be returned to you.

CAUTION: The issuance of this Long-Term Care Insurance Certificate is based upon your responses to the questions on your Enrollment Form, if applicable, and any Evidence of Insurability Forms. A copy of your Enrollment Form and, if applicable, any Evidence of Insurability Forms are enclosed. If your answers are incorrect or untrue, Prudential may have the right to deny benefits or rescind your Certificate or both. 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 the Contact Address shown above.

NOTICE TO BUYER: This Certificate 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.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Guide to Health insurance for People with Medicare* available from Prudential.

STATE NOTICES

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 HELPLINE 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 1-800-351-4664.

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 North Carolina.

PRE-EXISTING CONDITIONS EXCLUSION. Please read your Certificate carefully. This Coverage does not contain a Pre-existing Conditions Exclusion. The Coverage Exclusions section describes how this exclusion works.

For Residents of the State of Wisconsin

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. THIS COVERAGE 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 THIS 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.

This Certificate does not include a *Pre-existing Condition* Limitation.

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.

Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176
1-800-732-0416

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

800-236-8517 or 608-266-0103

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WHO IS ELIGIBLE

WHO IS ELIGIBLE

Persons eligible under this Contract include the following:

1) Employees: A person who is actively at work and works for the Contract Holder on a full-time or part-time basis at least 32 hours bi-weekly or a career employee who works less than 32 hours bi-weekly. Employees working at least 32 hours bi-weekly may enroll on a guarantee issue basis within 90 days of their date of eligibility. Career Employees who work less than 32 hours bi-weekly or Employees working at least 32 hours bi-weekly that are outside of their new entrant period can enroll at any time and will be required to complete a medical history statement, which is subject to approval.

2) Retired Employees: A person who has retired by the terms of the Contract Holder's retirement plan.

3) Family Members:

   a) Spouse: The legal Spouse of an Employee or Retired Employee.

   b) Surviving Spouse: The legal Spouse of a deceased Employee or Retired Employee.

   c) Parent: The parent, parent-in-law, stepparent or step-parent-in-law of an Employee, Retired Employee, Spouse or Surviving Spouse.

   d) Grandparent: The grandparent, grandparent-in-law, step-grandparent or step-grandparent-in-law of an Employee, Retired Employee, Spouse or Surviving Spouse.

   e) Adult Child: A person who is at least 18 years old and who is a natural child, adopted child or stepchild of an Employee or Retired Employee, Spouse or Surviving Spouse or the legal Spouse of such person.

   f) Sibling: A person who is the brother or sister or stepbrother or stepsister of an Employee or Retired Employee, Spouse or Surviving Spouse.

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

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 Forms that Prudential may require. If you are accepted, the Effective Date of your Coverage and the benefits you have chosen will be shown in the Schedule of Benefits included with this Certificate. The applicable full modal premium must be paid for Coverage to take effect.

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 facility or are receiving Home Care or Hospice Care. Instead it will begin on the first day of the month following the date you are discharged from such confinement or are not receiving such care.

KEEPING YOUR COVERAGE

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

1) If the person through whom you have your Coverage leaves the Contract Holder, you must notify Prudential in writing within 60 days of this change in status if such change requires an adjustment to your billing method.
2) If you become divorced or your Spouse dies, you must notify Prudential in writing within 60 days of the final judgment of divorce or the death that you want to continue your Coverage. Prudential will then adjust the billing method and/or amount, if necessary, to reflect your change in status.
3) If the Contract Holder withdraws sponsorship of the Contract and does not replace it within 31 days of the date Coverage would otherwise end, Prudential will send you a written notice within these 31 days. To continue your Coverage, you must return the notice within 60 days of receipt along with any premium payments that are indicated.
4) 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 Prudential at the Contact Address shown above.

PREMIUMS

PREMIUM PAYMENT OPTIONS

The Premium Payment Option that applies to your Coverage is shown in your Schedule of Benefits. This option determines the length of time you will pay premiums. These options are described below.

LIFETIME PREMIUM PAYMENT OPTION: If you have the Lifetime Premium Payment Option, your premiums are payable when due while your Coverage is in force.

PAYING PREMIUMS

Your original premium is based on your age and the rates in effect on the Effective Date of your insurance. Your premiums are due and payable in accordance with the premium payment option you choose. Your premium contribution is shown on your Schedule of Benefits. Your premiums must be paid in U.S. currency.

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

AMOUNT OF PREMIUM

Your age at the time you purchase a benefit is used to rate that benefit. The amount of your premium is calculated using the rate for the combination of benefits you have chosen. Premiums will not automatically increase as you become older. Premiums will not automatically increase because benefits are paid.

INCREASES IN PREMIUM

Prudential has the right to change your premium. Any change will apply on a class basis to all insureds in your class. 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.

Any change in rates may be subject to review by the appropriate state regulatory agency. We will not change premiums rates more frequently than once a year. We will notify you at least 60 days before a change in the premium rates.

INCREASES IN BENEFITS

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 at the time you purchase additional benefits is used to rate that benefit. The amount of your additional premium is calculated using the rate then in effect for the additional benefits you have chosen.

MISSTATEMENT OF AGE

The age shown on your Application is used to determine your eligibility for Coverage and to calculate your premium. If that age is in error, Prudential may adjust premiums to reflect your correct age, reduce your benefits or rescind your Coverage, as stated below.

If we need to rescind your Coverage, Prudential's liability will be limited to a refund of the premiums paid for this Coverage.

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

MISSTATEMENT OF INFORMATION

If Prudential relied on information provided by you to apply a discount to your Coverage premium and it is later discovered that you were not eligible for the discount, then the premium rate will be adjusted prospectively with the next premium due.

WAIVER OF PREMIUMS

After you meet the Benefit Eligibility Criteria and satisfy any applicable Elimination Period, the premiums for your Coverage will be waived according to the following rules:

1) Waiver begins on the first day of the month following the date you satisfy your Elimination Period.
2) Waiver ends on the last day of the month in which your Chronic Illness or Disability ends. Premiums will again become due as of the first day of the month after the date your Chronic Illness or Disability ends.

Premiums will not be waived if you are only receiving Hospice Care, Respite Care, Home Support Services or Information Services.

GRACE PERIOD

Your first full modal premium must be paid for your Coverage to take effect. A grace period does not apply to the first premium. Your renewal premium is due on or before the premium due date.

Your Coverage provides a 31-day grace period for your renewal premiums. This means that if a renewal premium is not paid on or before the due date, it may be paid during the grace period. During the grace period, your Coverage will stay in effect. If the full modal premium is not received within the grace period, Prudential will mail a late payment notice to request payment within 31 days to you and your designee (if applicable). The notice will be deemed to have been given 5 days after the date mailed.

If we do not receive payment within 31 days of the date the late payment notice is given, your Coverage will lapse as of the premium due date.

PROTECTION AGAINST UNINTENTIONAL LAPSE

You have the right to name a person, in addition to yourself, to receive notice that your Coverage will lapse because your full modal premium was not received. You may exercise or waive this right at the time you enroll for your Coverage or any time thereafter. At least every two years, Prudential will notify you of your right to name a person for this purpose or to change the person currently named.

REFUND OF UNEARNED PREMIUM

Unless satisfactory proof is provided to Prudential to indicate a third party has the legal right to a refund of premiums made in connection with this Coverage, all premium refunds shall be made to the insured or the insured's estate.

Upon proper notice of the cancellation of your Coverage after the 30-day period described on page one, Prudential will refund on a pro-rata basis any part of the premium paid in advance that applies to the period after cancellation.

Upon receipt of proper notice of your death, Prudential will refund to your estate on a pro-rata basis any part of the premium paid in advance that applies to the period of time after death.

LONG-TERM CARE BENEFIT DESCRIPTIONS

This Coverage provides benefits for Qualified Long-Term Care Services. Benefit Descriptions are stated below. Not all charges are covered. Please refer to the Coverage Exclusions section for a list of exclusions applicable to your Coverage.

The actual amount payable depends on the benefits you have chosen. Daily benefits, calendar year limits, lifetime benefits and the Lifetime Maximum are shown in the Schedule of Benefits. These benefits are subject to change if you have elected Inflation Protection. Prudential will pay benefits for Eligible Charges up to the stated daily, monthly, calendar year and/or lifetime benefit that applies for the charges incurred, after all terms and conditions of coverage have been met. Limits on specific benefits are stated in the Benefit Descriptions section.

Please refer to The Claims Process provisions. Prudential will pay benefits if the conditions described in these provisions are met. Benefits for Eligible Charges are provided once the Elimination Period, if any, has been satisfied. All benefits are subject to the Elimination Period unless the Benefit Descriptions section states otherwise. Only services included in the Plan of Care will be considered Eligible Charges.

FACILITY CARE

NURSING HOME

Your Coverage provides benefits for Eligible Charges you receive per day as a resident of a Nursing Home up to the Facility Daily Benefit.

Benefits for these Eligible Charges will be paid up to your Facility Daily Benefit for each day you are a resident in Nursing Home.

These benefits are subject to the Elimination Period and reduce your Lifetime Maximum.

Benefits will not be paid for Facility Care and Home Care incurred on the same day. Either the Facility Daily Benefit or the Assisted Living Facility Daily Benefit is payable for the same day.

ASSISTED LIVING FACILITY, RESIDENTIAL HEALTH CARE FACILITY, ADULT FOSTER HOME OR BOARD AND CARE FACILITY

Your Coverage provides benefits for Eligible Charges you receive as a resident of an Assisted Living Facility, Residential Health Care Facility, an Adult Foster Home or Board and Care Facility, up to the Assisted Living Facility Daily Benefit selected.

Benefits for these Eligible Charges will be paid up to your Assisted Living Facility Daily Benefit for each day you are a resident in one of the above listed facilities.

These benefits are subject to the Elimination Period and reduce your Lifetime Maximum.

Benefits will not be paid for Facility Care and Home Care incurred on the same day. Either the Facility Daily Benefit or the Assisted Living Facility Daily Benefit is payable for the same day.

BED RESERVATION

While you are receiving Long-Term Care services in a Nursing Home, you may incur charges for Bed Reservation by that facility to retain your bed while you are absent from the facility for any reason. Charges for Bed Reservation are Eligible Charges if:

1) The charge for Bed Reservation is a separate, customary facility charge that would be made in the absence of insurance.
2) You would be required to pay such charge in the absence of insurance.
3) The charge is incurred while you are receiving benefits under this Certificate for care in a Nursing Home.

Benefits for these Eligible Charges will be paid up to the Facility Daily Benefit. This benefit is subject to a Bed Reservation Calendar Year limit of 60 days.

Benefits will not be paid for Home Care for the same day on which a Bed Reservation benefit is paid.

Bed Reservation benefits are subject to the Elimination Period and reduce your Lifetime Maximum.

HOSPICE CARE

Your Coverage provides benefits for Eligible Charges for Hospice Care. Benefits for these Eligible Charges will be paid up to the Facility Daily Benefit for each day you receive Hospice Care as a resident in a facility or in your Home.

Hospice Care benefits will reduce your Lifetime Maximum, but are not subject to the Elimination Period. Since Hospice Care is not subject to the Elimination Period, days in which those covered services are received do not count toward meeting your Elimination Period.

RESPITE CARE

Your Coverage provides benefits for Eligible Charges for Respite Care. Respite Care can include short-term care you receive as a resident of a Nursing Home, an Assisted Living Facility, a Residential Health Care Facility, an Adult Foster Home or Board and Care Facility or Home Health Care, Homemaker Services or Personal Care Services received for limited periods of time.

Benefits for these Eligible Charges will be paid up to the Facility Daily Benefit for each day you receive Respite Care. This benefit is subject to a Respite Care Calendar Year limit of 30 days.

Respite Care benefits reduce your Lifetime Maximum but are not subject to the Elimination Period. Since Respite Care is not subject to the Elimination Period, days in which those covered services are received do not count toward meeting your Elimination Period.

HOME CARE

ADULT DAY CARE, HOME HEALTH CARE HOMEMAKER SERVICES AND PERSONAL CARE SERVICES

Your Coverage provides benefits for Eligible Charges you receive as Home Health Care, Homemaker Services or Personal Care Services, up to the Home Care Daily Benefit. Such services must be received from a Home Health Care Agency, Referral Agency, Nurse Registry, or provided by an Independent Health Care Professional. Your Coverage also provides benefits for Eligible Charges when you receive Adult Day Care.

These benefits are subject to the Elimination Period and reduce your Lifetime Maximum.

Benefits will not be paid for Facility Care and Home Care, including the Cash Alternative Benefit, incurred on the same day.

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 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 Elimination Period. Therefore, the monthly fixed benefit is equal to the number of the days in the month in which you have a Chronic Illness or Disability times the Cash Alternative Daily Benefit.

The Cash Alternative 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 must be made on the claim form.
3) It is in lieu of any other Facility Care, Home Care or International Coverage benefits payable for that month.

Charges for Qualified Long-Term Care services do NOT need to be incurred and any Coverage Exclusions related to incurring charges shall not apply to the Cash Alternative Benefit.

These benefits are subject to the 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.

ADDITIONAL BENEFIT DESCRIPTIONS

HOME SUPPORT SERVICES

Your Coverage provides benefits for goods or services that help you remain independent in your Home and relate to your Qualified Long-Term Care Service needs. These goods or services must be ordered by a Licensed Health Care Practitioner and be part of your Plan of Care. Eligible Charges are listed below.

Assistive Devices or Technology means adaptive tools, devices or technology that helps you function independently in your Home. Examples of such items include but are not limited to, specially adaptive eating and dressing utensils, a “Health Buddy” prompting device, “smart shoes” with GPS (global positioning system), or “Wander Mats.”

Caregiver Training means a training program provided by a Home Health Care Agency, Nursing Home, hospital or other similarly licensed medical facility acceptable to Prudential which provides instruction to Primary Informal Caregivers in basic care giving techniques which will allow you to remain in your Home. Such training is to help your Primary Informal Caregiver tend to your specific Long-Term Care needs. The Primary Informal Caregiver may be a relative or someone chosen by you, but in no event will we pay for training provided to someone who will be paid to care for you.

Durable Medical Equipment means reusable equipment you rent or purchase that is designed to be used in your Home to assist you in performing Activities of Daily Living. Examples include walkers, hospital-style beds, crutches and wheelchairs and those items routinely considered Durable Medical Equipment under the Medicare Program. Durable Medical Equipment does not include prescription drugs, athletic equipment, equipment placed in your body or items commonly found in a household.

Emergency Medical Response System means a communication system that is installed in your Home and used to call for assistance in the event of a medical emergency. It does not include a home security system or normal telephonic equipment or service.

Home Modifications means modifications to your Home that are primarily being made to improve your ability to perform Activities of Daily Living and to allow you to live safely and independently in your Home. Examples of Home Modifications include the following.

1) Installation of ramps for wheelchair access.
2) Installation of grab bars.
3) Widening doorways.
4) Other similar accessibility modifications.

Home Modifications do not include hot tubs, swimming pools, home repair or maintenance or other similar modifications. This benefit will not cover normal home modification that would only provide an incidental benefit to your Chronic Illness or Disability.

Transportation Services means transportation provided by a licensed transportation carrier, which carries passengers for a fare, from your Home directly to and/or from a Provider solely for the purpose of receiving Qualified Long-Term Care Services, if the services are included in your Plan of Care.

Benefits for Home Support Services are subject to the Home Support Services Lifetime Benefit. These benefits reduce your Lifetime Maximum but are not subject to the Elimination Period.

ALTERNATE PLAN OF CARE

Your Coverage provides benefits for a broad range of services including Facility and Home Care. Because there are new emerging trends in the delivery of Long-Term Care services, Prudential will consider a claim for services designed to help you function independently in your home or for stays in facilities not otherwise covered. Determination of Eligible Charges and your benefits will be based on the type of services received. Depending upon the nature of the services, either the Facility or Home Care Daily Benefit shall apply.

Eligible Charges must be for a service that meets the following requirements.

1) It must be considered a Qualified Long-Term Care Service within the terms of Internal Revenue Code Section 7702B(b).
2) It must be clearly specified in your Plan of Care.
3) It must be agreed to by you, your Licensed Health Care Practitioner and Prudential as an appropriate alternative to services covered in your Certificate. However, you may choose to stop the covered alternative services at any time and use other services covered in your Certificate.

Alternate Plan of Care benefits are subject to the Elimination Period and reduce your Lifetime Maximum.

INFORMATION AND REFERRAL SERVICES

Prudential Benefit & Resource Information Service - Your Coverage gives you access to information on Long-Term Care resources in your community. Prudential's Long-Term Care Customer Service Center can help provide this information. You do not need to meet the Benefit Eligibility Criteria in order to use this service. Call 1-800-732-0416 for assistance.

Prudential Benefit & Resource Information Services are not subject to the Elimination Period and do not reduce your Lifetime Maximum.

Private Care Consultant – Your Coverage provides benefits when you use a Private Care Consultant. Eligible Charges can include, but are not limited to, charges by a Private Care Consultant for the following types of services.

1) Advocacy for your care with respect to appropriate use of your own as well as community resources.
2) Development of your Plan of Care.
3) Arrangement for delivery of Qualified Long-Term Care Services appropriate to your needs.
4) Counseling, support and education with respect to your Long-Term Care needs and resources.

Benefits for these Eligible Charges will be paid up to the Private Care Consultant Calendar Year Benefit.

Private Care Consultant benefits are not subject to the Elimination Period and will not reduce your Lifetime Maximum.

INTERNATIONAL COVERAGE

Your Coverage provides benefits for Qualified 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, Homemaker Services or Personal Care Services.

Benefits for these Eligible Charges for care you receive outside the United States will be paid up to your International Coverage Facility Daily Benefit or International Coverage Home Care Daily Benefit, according to the services you use.

Payment of International Coverage benefits is limited to 365 days during which Eligible Charges are incurred over the duration of the Coverage.

These benefits are subject to the Elimination Period and reduce your Lifetime Maximum.

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

GUARANTEED PURCHASE OPTION

Please refer to the Definitions section in your Certificate for defined terms.

This benefit allows you to increase your benefit levels as described below, by 5% compounded annually without proof of good health.

GUARANTEED PURCHASE OPTION

Every three years on the Anniversary Date of the Effective Date of your Coverage, while your coverage is in effect, Prudential will increase your benefits. You will be notified of this increase at least 60 days prior to the Anniversary Date. You will not have to provide proof of good health to receive this increase.

All increases will occur even if you meet the Benefit Eligibility Criteria at the time of the increase.

These increases will occur without taking any action. If you want to decline any increase, you must notify Prudential in writing, within 30 days of receipt of the notification.

Increases To Your Benefits

With each increase, your benefits that provide coverage for Eligible Charges up to a specified dollar amount per day, per Calendar Year or per lifetime will be increased by 5% compounded annually over the three-year period. Amounts are rounded. The number of days during a Calendar Year for which benefits are payable for Bed Reservation and Respite Care shall remain the same. The number of days during a lifetime for which benefits are payable for International Coverage shall remain the same.

You will receive a new Schedule of Benefits following each increase, listing your increased benefits.

Increases To Your Lifetime Maximum

The increase to your Lifetime Maximum will be the increase to your Facility Daily Benefit times the benefit period multiplier, where the benefit period multiplier is the Lifetime Maximum at issue divided by the Facility Daily Benefit at issue.

Conversion To Automatic Inflation Protection

You have a right to convert to Automatic Inflation protection if available under the Group Contract. You may elect to convert to Automatic Inflation one time only on an Anniversary Date, without having to provide additional evidence of insurability. The premium for the Automatic Inflation protection will be based on your age at the time you elect to convert. If you wish to exercise this option, you should contact Prudential at the Contact Address or phone number.

Termination Of Guaranteed Purchase Option

This benefit will terminate if any of the following events occur.

1) This benefit will terminate if your Coverage lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision.
2) You elect to convert to Automatic Inflation protection.

Effect Of Lapse And Termination Of Guaranteed Purchase Option

If your Coverage ends and is later reinstated, increases will be made as if your Coverage had remained in effect.

If your Coverage lapses for non-payment of premium and coverage continues under the Non-Forfeiture Benefit, no increases will be made after the due date of the unpaid premium.

If you elect a lesser Lifetime Maximum under the Contingent Non-Forfeiture Provisions, no additional increases will be made.

RETURN OF PREMIUM UPON DEATH BENEFIT

Only for those who were enrolled for Long Term Care Coverage and covered on January 31, 2012 under a group insurance contract issued by another insurance carrier.

Please refer to the Definitions section in your Certificate for defined terms.

This benefit may provide for a return of premium upon your death as described below. Your Coverage and this benefit must have the same Effective Date.

RETURN OF PREMIUM UPON DEATH BENEFIT

Upon your death, Prudential may return a percentage of the premium paid for your Coverage. 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. Prudential will pay the refund to your estate upon receipt of a copy of the death certificate and a written request for such benefits.

If your Coverage also includes a Return of Premium (upon lapse) benefit, and Coverage ends because of your death, return of premium benefits will be determined under this benefit, not that Return of Premium Benefit.

The amount returned will be determined as follows.

Age at Death	Amount of Refund
Under 65	100% of Premiums paid less benefits paid or payable
65	90% of Premiums paid less benefits paid or payable
66	80% of Premiums paid less benefits paid or payable
67	70% of Premiums paid less benefits paid or payable
68	60% of Premiums paid less benefits paid or payable
69	50% of Premiums paid less benefits paid or payable
70	40% of Premiums paid less benefits paid or payable
71	30% of Premiums paid less benefits paid or payable
72	20% of Premiums paid less benefits paid or payable
73	10% of Premiums paid less benefits paid or payable
74	0% of Premiums paid less benefits paid or payable

Termination of Return of Premium Upon Death Benefit

This benefit will terminate if your Coverage lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision.

NON-FORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD

Only for those who were enrolled for Long Term Care Coverage and covered on January 31, 2012 under a group insurance contract issued by another insurance carrier.

Please refer to the Definitions section in your Certificate for defined terms.

This benefit adds a provision that extends Coverage as described below, for a shortened benefit period if your Coverage ends due to non-payment of premium. Your Coverage and this benefit must have the same Effective Date.

The **Contingent Non-Forfeiture Provisions** in the **Additional Coverage Features** section of your Coverage is replaced by the following.

NON-FORFEITURE BENEFIT

If your Coverage ends due to non-payment of premium, your Coverage will be extended as a Non-Forfeiture Benefit unless either of the following occurs.

1) Your Coverage ends before its third anniversary.
2) You have already received benefits that equal or exceed the total amount of premiums paid for your Coverage.

Shortened Benefit Period

Under the Non-Forfeiture Benefit, benefits will be payable based on the Facility, Assisted Living Facility and Home Care Daily Benefits in effect on the date your Coverage would otherwise have ended. However, there will be a reduced Lifetime Maximum. A reduced Lifetime Maximum means that your benefits will be payable for a shorter length of time. The reduced Lifetime Maximum will be equal to the greater of items 1) or 2).

1) 30 times the Facility Care Daily Benefit in effect at the time your Coverage ends, up to the Lifetime Maximum in effect on the date your Coverage would otherwise have ended.
2) The total amount of premiums paid for your Coverage, and any options, less the sum of all benefits paid on your behalf, while your Coverage is in effect.

Termination of Non-Forfeiture Benefit

This benefit will terminate if any of the following events occur.

1) Before your third anniversary, your Coverage lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision.
2) Your Coverage becomes paid up under the Premium Payment Option you have selected.
3) You send a written request to terminate this benefit. This benefit will end as of the date the request is received, unless a later date is specified in the written request.

ADDITIONAL COVERAGE FEATURES

TAX STATUS OF PREMIUMS AND BENEFITS

The Group Insurance Contract, including this Certificate of Insurance is intended to be a Qualified Long-Term Care Insurance Contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. The benefits you may receive should not be considered taxable income. In addition, some or all of the premiums you pay 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 your Coverage does not comply with the requirements of Code Section 7702B. In this event, this provision will be automatically nullified without any further action by Prudential or the Group Insurance Contract Holder.

OTHER GOODS AND SERVICES

From time to time, Prudential may offer or provide certain goods and services to you in addition to the insurance coverage. Prudential also may arrange for third party vendors to provide goods and services at a discount (including without limitation beneficiary financial counseling services, estate guidance and employee assistance programs) to you. Though Prudential may make the arrangements, the third party vendors are solely liable for providing the goods and services. Prudential shall not be responsible for providing or failing to provide the goods and services to you. Further, Prudential shall not be liable to you for the negligent provision of the goods and services by third party vendors.

COMMUNICATION THROUGH ELECTRONIC MEANS

Prudential reserves the right to designate the form and means for all communications or notices required by your Coverage.

With our prior consent, communications made by you or your representative pursuant to or in connection with your Coverage, using electronic means or technologies, may be made to us.

With your prior consent, communications made by Prudential pursuant to or in connection with your Coverage, using electronic means or technologies, may be made to you.

The transmittal of information, that is authorized or not otherwise prohibited by state or federal law, by electronic means or technology, is intended to have the same legal effect, validity, and enforceability as it would if the information were provided in other than an electronic form.

RESTORATION OF BENEFITS

Your Lifetime Maximum will be restored to the amount that would be in effect if no claims had been paid under your Coverage. All conditions stated below must be met.

1) You must be reassessed by a Licensed Health Care Practitioner so Prudential can verify you no longer have a Chronic Illness or Disability.
2) That status must be continuous for at least six consecutive months from the date of the reassessment and confirmed by Prudential through the results of a subsequent assessment within this time period.
3) You do not receive nor claim benefits under your Coverage for six consecutive months, beginning with the date of Assessment.
4) Your Lifetime Maximum has not been exhausted.
5) If you claim benefits at any time for the above six-month period, any amount of your Lifetime Maximum that has been restored will be null and void.

This benefit is not applicable if you have elected an unlimited (lifetime) Lifetime Maximum.

CHANGING YOUR COVERAGE

You may make a written request to change your Coverage while it is in force. If you choose to add additional benefits, you must complete another Enrollment Form and any applicable Evidence of Insurability Form. These forms 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 additional benefits. 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 Coverage.

If you change your Coverage, your premium will be adjusted. You will be sent a new Schedule of Benefits confirming the Effective Date of the new Coverage.

CONTINGENT NON-FORFEITURE PROVISIONS

If the Non-Forfeiture Benefit is not a part of your Coverage, these Contingent Non-Forfeiture provisions apply. These provisions change your Long-Term Care Coverage to provide options to you in the event your Coverage ends due to non-payment of premium after a Substantial Premium Increase.

A Substantial Premium Increase is one that results in a cumulative increase to your Annual Premium that is equal to or exceeds a certain percentage of that premium. It does not include premium increases that result from a voluntary purchase of additional benefits.

The limits of cumulative increase as a percentage of your annual premium are based on your age as of the Effective Date shown in your Schedule of Benefits. The table below shows the cumulative increase that will trigger the Contingent Non-Forfeiture Provision.

SUBSTANTIAL PREMIUM INCREASE TABLE

PREMIUM AGE	PERCENT OF INCREASE	PREMIUM AGE	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 the change to your premium. 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 benefits at the premium in effect prior to the increase, without undergoing medical underwriting.
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 Benefit amounts in effect at the time of lapse will be payable, but the Lifetime Maximum will be equal to the greater of the following items.
   a) The total amount of premiums paid for your Coverage.
   b) 30 times the Facility Daily Benefit at the time of lapse.

The total of all benefits paid under your Coverage will not exceed the Lifetime Maximum that would have been payable if your Coverage did not lapse.

Option 2 will automatically take effect if both of the following apply.

1) Your Coverage lapses within 120 days of the premium due date for the Substantially Increased Premium.
2) You have not made an election.

THE CLAIMS PROCESS

In accordance with the provisions below, this section describes what Prudential needs to determine if benefits are payable under your Coverage. You must have a Chronic Illness or Disability while your Coverage is in force. You must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Licensed Health Care Practitioner must then develop a Plan of Care, consistent with the certification. Prudential must be provided with satisfactory proof of loss, including a completed claim form and other documentation. Once these requirements are met, Prudential will review your claim and determine whether benefits are payable.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR PAYMENT OF BENEFITS

BENEFIT ELIGIBILITY CRITERIA

Before incurring Eligible Charges and submitting a claim, you must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Chronic Illness or Disability is one that meets either definition below.

1) A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting period. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.

2) A Severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health and safety.

A Licensed Health Care Practitioner must then develop a Plan of Care.

NOTICE OF CLAIM

If you think you have a Chronic Illness or Disability that is expected to last at least 90 days, you should call the Prudential Customer Service Center at, 1-800-732-0416. Either you or your representative may call. This notice should be given to Prudential within 20 days of the onset of a potential Chronic Illness or Disability, or as soon as reasonably possible.

Notice may be given to The Prudential Insurance Company of America at our Long-Term Care Customer Service Center. The notice should include your name and Certificate number. The address for the Customer Service Center appears on the first page of your Coverage.

CERTIFICATION PROCESS

Prudential will arrange for an Assessment to determine if you have a Chronic Illness or Disability. As part of the Assessment process, you will be interviewed. The Assessment will be based on objective standards of measurement. The Assessment must be made at a time when the chronic nature of the condition can be determined.

A Licensed Health Care Practitioner must certify your Chronic Illness or Disability. After your Chronic Illness or Disability is certified, a Plan of Care, acceptable to Prudential, must be developed consistent with your needs. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied and determine if you are eligible for benefits. You will be sent a written notice to confirm the date you become eligible. If you are not eligible, you will be sent a written notice explaining the reasons you are not eligible.

You can select your own Licensed Health Care Practitioner to certify your Chronic Illness or Disability. If you wish to do so, you should notify us when you call our Long-Term Care Customer Service Center. Prudential will send you an Assessment form that your Licensed Health Care Practitioner must complete and return together with an acceptable Plan of Care to us prior to submitting proof of loss. Prudential must receive proof that a Licensed Health Care Practitioner has certified, in writing, that you have a Chronic Illness or Disability. Prudential must receive such proof within 12 months of the certification date. The certification must occur on or after your Effective Date. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied to determine if you are eligible for benefits.

CLAIM FORMS

When Prudential is notified, you will be sent a claim form. It will be sent no later than 10 working days following the date of your notice. If you do not receive the claim form within this time, you may send us the documentation identified in the Proof of Loss section of your Coverage.

PROOF OF LOSS For reimbursement of Eligible Charges, your Proof of Loss must include the Provider's bill, together with the completed claim form. Any bill must include all of the following.

1) The name of the person who received the service.
2) The name and address of the Provider who rendered the service.
3) The date(s) of service.
4) Each type of service rendered.
5) The charge for that service.

At your own expense, you must obtain and submit all required documentation to us in English.

If you are submitting Proof of Loss for charges for Qualified Long-Term Care Services rendered by a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility, or by a vendor providing such services on behalf of the facility, you must submit a written bill that itemizes and separately details each service, cost and expense that you sustained. This bill must include an itemized listing of all services, costs and expenses, including type and date of each, hours of services per day and cost per hour for each date services are provided to you. Charges for room and board or comparable expenses for residence in the facility must be listed separately from any other costs. Prudential reserves the right to require that facility bills be sufficiently itemized to allow us to determine which charges, if any, from a facility may be Eligible Charges under your Coverage. You are responsible for obtaining a sufficiently itemized bill from the facility you use.

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.

A Provider's bill does not need to be submitted for a claim under the Cash Alternative Benefit.

The proof of loss should be sent within 90 days of the date loss begins. Failure to furnish such proof within the time required will not invalidate or reduce any claim if both of the following apply.

1) It was not reasonably possible to furnish the proof within that time; and
2) Proof is furnished as soon as reasonably possible.

Except in the absence of legal capacity, the required proof must be given no later than one year (Fifteen months for residents of Hawaii) from the time specified.

PHYSICAL EXAMINATION

You may be required to have a physical examination to be eligible for benefits. Prudential may do this when and as often as is reasonable, while your claim is pending, at its own expense.

TIME OF CLAIM PAYMENT

Benefits are payable when Prudential receives satisfactory proof of loss. An explanation of benefits notice that explains the resolution of your claim will be sent to you within 30 days from the date Prudential receives satisfactory proof of loss.

Benefits due and unpaid at your death will be paid to your estate.

At your request, all or a portion of any benefits payable under your Coverage may be paid directly to the eligible Provider if located in the United States. Benefits not assigned will be paid directly to you.

Benefits will be calculated and paid in United States currency. If applicable, any foreign exchange rate will be as determined by Prudential.

FACILITY OF PAYMENT

Prudential may pay benefits to a person whom we deem entitled to the benefits if they would otherwise be paid to your estate, or to a person who is a minor or to a person otherwise not competent to give a valid release.

We may pay up to $1,000 under this provision. Any payment made by us, in good faith pursuant to this provision, shall fully discharge Prudential to the extent of such payment.

LATE PAYMENTS

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.

REASSESSMENT

You will be reassessed periodically to determine if you are still eligible for benefits. To comply with federal income tax requirements, you must be certified as having a Chronic Illness or Disability at least once in a 12-month period. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied to determine if you continue to be eligible for benefits.

APPEALS

You have the right to appeal decisions made about your eligibility for benefits or a claim.

If your claim or benefit is denied, Prudential will explain the procedure you must follow if you choose to appeal a claim decision.

Prudential will send you a written acknowledgement of your appeal within 10 days of receipt. If no additional information is required and the appeal is denied, the acknowledgment will include an explanation of the reasons for the denial. If additional information is required, we will explain what information is needed. If we do not receive the requested data within 21 days, we will notify you in writing. Within 30 days of the receipt of the required information, Prudential will notify you in writing of the decision concerning your claim.

The Appeals process does not in any way negate or reduce your rights under the Legal Actions provision.

LEGAL ACTIONS

No action at law or in equity can be brought against Prudential to recover benefits from this Coverage until 60 days after the required proof of loss is furnished to Prudential. No such action shall be brought more than three years (five years in Kansas; six years in South Carolina) after you incur Eligible Charges.

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 and Texas 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.

ELIMINATION PERIOD

The Elimination Period must be satisfied once during your lifetime before benefits are paid. The number of calendar days for your Elimination Period is stated in your Schedule of Benefits.

Prudential will begin to count days to satisfy your Elimination Period with the date you are certified by a Licensed Health Care Practitioner, within the last 12 months, as having a Chronic Illness or Disability. Each day your Chronic Illness or Disability continues counts in satisfaction of this Elimination Period.

If your Chronic Illness or Disability ends before the Elimination Period is satisfied, the number of days that elapsed during that Chronic Illness or Disability will be applied towards satisfaction of Elimination Period.

Since Hospice Care and Respite Care are not subject to the Elimination Period, days in which those covered services are received do not count toward meeting your Elimination Period.

No benefits are payable during the Elimination Period for charges to which the Elimination Period applies.

COORDINATION OF BENEFITS WITH OTHER COVERAGES

WHAT IT MEANS

Long-Term Care insurance helps you pay for the cost of any Long-Term Care expenses described in this Certificate. It is not meant for you to receive benefits that are greater than the actual costs you incurred. Therefore, Prudential coordinates its benefit payments with other types of coverage that might pay you benefits for the same Long-Term Care expenses. In doing so, the benefits under this Coverage can last longer and it helps premium rates for this insurance to remain reasonable.

This Coordination of Benefits provision follows the guidelines set by the National Association of Insurance Commissioners.

OTHER COVERAGES

The other coverage(s) we look at include government programs (other than Medicaid), group medical benefits, no-fault or medical payment provisions of an automobile insurance contract and other employer-sponsored Long-Term Care insurance. We do not look at Medicaid or individual insurance policies.

HOW IT WORKS

One coverage will pay benefits first and is called the primary coverage.

Other coverage(s) that pay next are called the secondary coverage(s).

If Prudential's Long-Term Care Insurance Coverage is primary, we will pay benefits without coordinating with other coverage(s). That means that we will pay benefits to the maximum extent permitted by your Coverage.

If another plan is primary, then it will pay first. In that case, we will pay no more than the difference between the amount payable by your other coverage(s) and your actual expenses.

WHICH COVERAGE IS PRIMARY

The following rules determine which coverage is primary.

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

A coverage that 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 Medicare also covers you, this rule may be reversed depending on Medicare's rules regarding its payments for your expenses.

A coverage that 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.

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

INFORMATION

Certain information is needed to apply the above Coordination of Benefits rules. We have the right to decide which information we need to provide benefits and to collect the information from or given that information to any other organization, person or entity, if needed to provide benefits. We need not notify the insured of the receipt or disbursement of information. Each person claiming benefits under the coverage must provide us with any facts we need to pay the claim.

RIGHT OF RECOVERY

A payment made under another coverage may include an amount that should have been paid under this Coverage. If it does, we may pay that amount to the organization or entity that made that payment. That amount will be treated as though it was a benefit paid under this Coverage. We will not have to pay that amount again.

If we pay more than we should have paid under this provision, we may recover the excess from one or more of the following.

1) The persons we have paid or the person for whom we have paid.
2) Insurance companies.
3) Other entities or organizations.

COVERAGE EXCLUSIONS

Your Coverage is designed to provide benefits to pay for your Qualified Long-Term Care Services. Your Coverage does not provide benefits for any of the following.

1) Work-connected Conditions Charge. A charge covered by a worker's compensation law, occupational disease law or similar law.
2) Illness, treatment or medical conditions arising out of
   a) War or an act of war, whether declared or undeclared, while you are insured; or
   b) Your participation in a felony, riot or insurrection; or
   c) Alcoholism and drug addiction.
3) Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This 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.
4) Charges for services or supplies for which no charge would be made in the absence of insurance.
5) Charges for care or treatment provided outside the United States except as described in the International Coverage benefit.
6) Charges arising from intentionally self-inflicted injury or attempted suicide.

NON-DUPLICATION OF MEDICARE BENEFITS

Benefits under your Coverage are not payable for expenses for Qualified Long-Term Care Services to the extent that:

1) Such expenses are reimbursable under Medicare; or
2) Such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

This provision does not apply if following situations apply.

1) Such expenses are reimbursable by Medicare as a secondary payer.
2) Claim is under the Cash Alternative Benefit, Cash Benefit or Flexible Cash Benefit, if any.

DEFINITIONS

This section defines certain terms used in your Certificate. These definitions apply to the terms used in your Certificate, Outline of Coverage and the Contract, and any other attached forms.

ACTIVELY AT WORK

A requirement that you be performing the regular duties of your job, working on a full or part-time basis, at your employer's place of business, or at any other place that your employer's business requires you to go, without absence for reasons other than cold, influenza, or vacation within 30 days prior to enrollment.

ACTIVITIES OF DAILY LIVING (ADLs)

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 - Moving into or out of a bed, chair or wheelchair.

ADULT DAY CARE

A formal community based program for six (6) or more persons, providing social and health related services during the day, to functionally and/or cognitively impaired adults. It must be licensed and/or certified as Adult Day Care according to the laws of the jurisdiction in which it is located. If licensure and/or certification is not required, then the Adult Day Care must satisfy all of the following requirements:

1) It must have a structured program that includes a variety of health, social and other related support services in a protective setting during daytime hours, but less than 24-hour care.

2) It must have established procedures for obtaining emergency medical services for clients.

3) It must maintain a written record of services provided to each client.

4) It must provide personal assistance with meals, toileting, continence and transferring.

ADULT FOSTER HOME OR BOARD AND CARE FACILITY

A family home or other facility in which residential care is provided to five or fewer adults in a home-like environment for compensation. Residents must be unrelated to the Provider by blood or marriage and be elderly or functionally and/or cognitively impaired. It must be licensed and/or certified as an Adult Foster Home or Board and Care Facility according to the laws of the jurisdiction in which it is located.

Adult Foster Home does not include any house, institution, hotel or other similar living arrangement that supplies room or board only, if you do not receive any Qualified Long-Term Care Services as a resident of the facility.

ASSESSMENT

An evaluation performed by a Licensed Health Care Practitioner to determine or verify that you have a Chronic Illness or Disability. The Assessment will be based on objective standards of measurement using generally accepted tests to produce verifiable results. The Assessment must be made at a time when the chronic nature of the condition can be determined.

ASSISTED LIVING FACILITY OR RESIDENTIAL HEALTH CARE FACILITY

It must be licensed and/or certified as an Assisted Living Facility or Residential Health Care Facility according to the laws of the jurisdiction in which it is located. For facilities located in a jurisdiction that does not license or certify Assisted Living Facilities or Residential Health Care Facilities, it is a facility that provides ongoing services to a minimum of three residents in one location and is determined by Prudential to meet 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.

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 above criteria are 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 that occurs if you are a resident in such a facility and you are absent from that facility for 24 hours or more for any reason.

CALENDAR YEAR

During the first year your Coverage is in force, the Calendar Year begins with your Original Effective Date and ends December 31 of the same year. Each Calendar Year thereafter, starts with January 1 and ends December 31 of the same year.

CHRONIC ILLNESS OR DISABILITY

An illness or disability certified by a Licensed Health Care Practitioner in which there is at least one of the following.

1) The loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting period. The Activities of Daily Living are defined and listed above.

2) A Severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health or safety.

COVERAGE

The Prudential Long-Term Care Insurance coverage provided to an eligible insured, as described in this Certificate of Insurance, and issued in consideration of the statements made in the Group Insurance Contract and any other required evidence of insurability and the payment of premium.

DAILY BENEFIT

The maximum amount payable per day for Eligible Charges according to the benefits you have chosen.

ELIGIBLE CHARGES

The charges for your Qualified Long-Term Care Services that are used as the basis for a claim determination by Prudential. Such Qualified Long-Term Care Services must be included in your Plan of Care in order for the charges to be considered Eligible Charges. These charges must be incurred

1) while your Coverage is in force.
2) after the Elimination Period, if any, is satisfied.
3) after the date you are certified as having a Chronic Illness or Disability.

Eligible Charges must be incurred for services and supplies described in Your Long-Term Care Insurance Benefit Descriptions section. Eligible Charges must be incurred from Providers who meet the criteria defined by your Coverage. A charge is considered incurred on the date you receive the service or supply.

Room and board charges and comparable expenses for residence in a facility shall not be Eligible Charges unless a Licensed Health Care Practitioner certifies in a Plan of Care both of the following.

1) The primary reason for your residence in a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility is your need to receive Qualified Long-Term Care Services in connection with your Chronic Illness or Disability on a 24-hour per day basis.
2) Such services are available at that Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility.

A charge is not an Eligible Charge if it is described in the Coverage Exclusions section. Eligible Charges do not include charges incurred during the Elimination Period even after it is satisfied.

Eligible Charges also do not include charges for ancillary or miscellaneous items or services, provided in or by a facility or as part of a Home Health Care provided to you which are not directly related to providing Qualified Long-Term Care Services in connection with your Chronic Illness or Disability. Examples include, but are not limited to, charges for utilities, hair care, newspapers, routine over-the-counter medical supplies, guest charges and convenience items.

ELIMINATION PERIOD	The number of calendar days that you have a Chronic Illness or Disability that must elapse before benefits may be payable. The Elimination Period applies to all benefits unless the Benefit Description states otherwise. The Elimination Period is shown in the Schedule of Benefits. Prudential will begin to count days to satisfy your Elimination Period with the date you are certified by a Licensed Health Care Practitioner, within the last 12 months, as having a Chronic Illness or Disability. Each day your Chronic Illness or Disability continues counts in satisfaction of this Elimination Period.
EMPLOYEE	A person who is actively at work and works for the Contract Holder on a full-time or part-time basis at least 32 hours bi-weekly or a career employee who works less than 32 hours bi-weekly. Employees working at least 32 hours bi-weekly may enroll on a guarantee issue basis within 90 days of their date of eligibility. Career Employees who work less than 32 hours bi-weekly or Employees working at least 32 hours bi-weekly that are outside of their new entrant period can enroll at any time and will be required to complete a medical history statement, which is subject to approval.
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 persons under the direction of a licensed Physician.
GROUP INSURANCE CONTRACT	Group Insurance Contract No. LT-51131-MI between Prudential and The State of Michigan, including this Certificate of Insurance.
GROUP INSURANCE CONTRACT HOLDER	The entity to which this Group Insurance Contract was issued.
HOME	Your primary place of residence, which may include your independent living quarters in a continuing care retirement community or similar entity. Home does not include a Nursing Home, an Assisted Living Facility, a Residential Health Care Facility, an Adult Foster Home or Board and Care Facility, a rest home, a hospital or rehabilitation facility, or a facility for the treatment of alcoholism, chemical dependency or mental illness.

HOME HEALTH AIDE

A person whose function is to provide Personal Care Services or Homemaker Services. A Home Health Aide must be licensed or certified according to the laws of the jurisdiction in which care is rendered.

When licensing or certification is not required, a person will be deemed a Home Health Aide if he or she meets both of the following criteria.

1) He or she meets the minimum training qualifications recognized by the Foundation for Hospice & Home Care, National League of Nursing or Centers for Medicare and Medicaid Services.
2) He or she is employed through an eligible Home Health Care Agency, or is an Independent Health Care Professional.

HOME HEALTH CARE AGENCY

An organization that meets at least one of these three tests.

1) It is an agency licensed as a home health care agency in the jurisdiction in which the Home Health Care is delivered.
2) It is a home health care agency as defined by Medicare.
3) It is an agency or organization that provides a program of Home Health Care that meets all these tests.
   a) It is licensed to provide the services for Home Health Care in the Plan of Care.
   b) It maintains written records of services provided to patients.
   c) Its staff includes at least one Registered Nurse or nursing care by a Registered Nurse is available to it.

HOME HEALTH CARE

Medical and non-medical services, provided to ill, disabled or infirm persons in their Home.

HOMEMAKER SERVICES

Services that are designed to maintain your ability to function independently in your Home. Homemaker Services include but are not limited to the following.

1) Shopping.
2) Planning menus, preparing meals, and delivering meals to your Home.
3) Laundry and light house cleaning and maintenance. Light house cleaning includes vacuuming, dusting, dry mopping, dishwashing, cleaning the kitchen and bathroom and changing beds.

HOSPICE A public agency or private organization providing palliative medical care (care which seeks to reduce pain and provide comfort, rather than provide a cure) to Terminally Ill persons. The agency or organization must meet federal certification requirements as a Hospice, or be licensed according to the laws of the jurisdiction in which it is located.

HOSPICE CARE Services and supplies provided through a Hospice to meet the special physical, psychological, spiritual and social needs for a Terminally Ill person and his or her immediate family. Hospice Care provides palliative and supportive medical, nursing and other health services through home and inpatient care during the illness to one or both of the following.

1) A Terminally Ill person who has no reasonable prospect of cure as estimated by a Physician.
2) The immediate family or Primary Informal Caregiver of the person described in 1) above.

Hospice Care includes the following.

1) Part-time nursing care by or supervised by a Registered Nurse.
2) Counseling, including dietary counseling, for the Terminally Ill person.
3) Family counseling for the immediate family and the Primary Informal Caregiver before the death of the Terminally Ill person.
4) Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill person.

INDEPENDENT HEALTH CARE PROFESSIONAL A Home Health Aide, Registered Nurse, Licensed Practical Nurse or Therapist independently providing Home Health Care services within the scope of his or her license.

LICENSED HEALTH CARE PRACTITIONER A Physician, a 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 according to the laws of the jurisdiction in which the nursing service 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.

LICENSED SOCIAL WORKER

A person who has a Baccalaureate, Master's or Doctoral degree in Social Work from a program accredited by the Council on Social Work Education and is appropriately licensed or certified, if licensing and certification is required, in the United States' jurisdiction where the social work is performed.

LIFETIME MAXIMUM

The maximum lifetime benefit payable for Eligible Charges according to the benefits you have chosen for this Coverage. Your initial Lifetime Maximum is the amount available for all benefits payable under your Coverage as of the Original Effective Date. Benefits paid are deducted from the Lifetime Maximum, unless the benefit description states otherwise. If Eligible Charges are less than your Daily Benefit, only the amount of the benefit payment for the Eligible Charge is deducted from your Lifetime Maximum.

MEDICAID

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

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. §1495- 1495ccc).

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 according to the laws of the jurisdiction in which the services are provided, if the jurisdiction in which the Nurse Registry is located requires licensure.

NURSING HOME

A facility that provides skilled, intermediate or custodial care and meets one of the following criteria.

1) It is Medicare-approved as a Provider of skilled nursing care services.
2) It is licensed and operated according to the laws of the jurisdiction in which it is located as a skilled nursing home, 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.

   A nursing home shall not include a facility or part thereof that is primarily a facility for the treatment of alcoholism, chemical dependency or mental illness.

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 Coverage's Facility 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 Qualified Long-Term Care Services.

2) A hospital or clinic, sub-acute care or rehabilitation hospital or unit.

3) A facility or part thereof that operates primarily for the treatment of alcoholism, chemical dependency 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.

PERSONAL CARE SERVICES

The provision of hands-on services needed to assist a person with a Chronic Illness or Disability. Such care can provide assistance with simple health care tasks, personal hygiene, and other supportive tasks, including use of the telephone, managing medications, moving about outside, preparing meals, shopping for essentials, and transportation to and from health care Providers. Personal Care Services can be provided by a skilled or unskilled person.

PHYSICIAN Any person licensed by a United States jurisdiction as a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) practicing within the scope of his or her license.

PLAN OF CARE A written plan that has been developed to meet your Long-Term Care needs. The Plan of Care must meet the following requirements.

1) It is developed and approved by a Licensed Health Care Practitioner based on review of your health status, medical records and information from the Licensed Health Care Practitioner responsible for your care.
2) It names the type, frequency and duration of services you need.
3) It names the types of Providers that are needed.
4) It is in accordance with accepted medical and nursing standards of practice in the United States.

Your Plan of Care must be updated as your condition and care needs change. We must be provided with a revised Plan of Care if it is updated by your Licensed Health Care Practitioner.

PRIMARY INFORMAL CAREGIVER An unpaid person who regularly provides one of the following.

1) Substantial Assistance when you are unable to perform at least two of the Activities of Daily Living.
2) Substantial Supervision when you have Severe Cognitive Impairment.

PRIVATE CARE CONSULTANT A Licensed Health Care Practitioner not associated with Prudential, who is qualified to coordinate your necessary medical care, Long-Term 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 Qualified Long-Term Care Services.

QUALIFIED LONG-TERM CARE SERVICES Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or Personal Care Services, provided in a setting other than an acute care unit at a hospital which began while your Coverage is in-force.

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 according to the laws of the jurisdiction in which it is located 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 according to the laws of the United States jurisdiction in which the nursing service is performed.

RESPITE CARE

Short-term care provided by a third party to relieve your Primary Informal Caregiver from care giving responsibilities.

SEVERE 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, and
2) Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's
   a) Short-term or long-term memory,
   b) Orientation as to people, places, or time and
   c) Deductive or abstract reasoning.

SPOUSE

The person to whom you are legally married.

SUBSTANTIAL ASSISTANCE

Hands-on assistance or stand-by assistance.

1) Hands-on assistance is the physical assistance of another person without which an individual would be unable to perform an Activity of Daily Living.
2) Stand-by assistance is the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to an individual while the individual is 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 that is necessary to protect you from threats to your health or safety.
TERMINALLY ILL	A medical prognosis given by a Physician that your life expectancy is six months or less.
THERAPIST	A physical therapist, occupational therapist, respiratory therapist, speech pathologist or audiologist who is licensed according to the laws of the jurisdiction in where the services are performed.
UNITED STATES	The United States of America, its territories and possessions.

WHEN YOUR COVERAGE ENDS

TERMINATION OF YOUR COVERAGE

Your Coverage and any optional benefits will end at 12:01 A. M. on the earliest of the following dates.

1) The premium due date if you fail to pay the full modal premium required for your Coverage when due or in accordance with the Grace Period provision. This will not apply if the premium is being waived under the Waiver of Premiums provision.
2) The date you have exhausted your Lifetime Maximum.
3) The date of your death.
4) The date we receive written notice requesting cancellation of your Coverage or the date requested in such notice, if later.

EXTENSION OF BENEFITS

Termination of your Coverage will be without prejudice to benefits payable for your care in a Nursing Home, an Assisted Living Facility, a Residential Health Care Facility, an Adult Foster Home or Board and Care Facility if such care began while your Coverage was in force and continues without interruption after your Coverage ends. Benefits will be extended until the earlier of the following.

1) The date on which you no longer incur Eligible Charges for such care.
2) The date your Lifetime Maximum has been exhausted.

If you are receiving benefits when the Coverage terminated, you will be considered covered under your Coverage for purposes of the Waiver of Premiums provision.

REINSTATEMENT

If your full modal premium is not paid within the time required, your Coverage will lapse. To reinstate your Coverage, all of the following must occur.

1) You must request reinstatement within 90 days from the date the last notice of unpaid premium is given by Prudential.
2) You must complete a reinstatement application.
3) Prudential must approve the reinstatement application.
4) You must pay all past due premium as of the date of reinstatement.

If your Coverage lapsed due to your Chronic Illness or Disability, you or your representative may request reinstatement, without a reinstatement application, if both of the following items apply.

1) The request is made within five months of the premium due date.
2) Your Chronic Illness or Disability is certified by a Licensed Health Care Practitioner and existed on the premium due date.

Your Coverage will be reinstated as of the premium due date provided all past due premium has been received.

In all other respects, your rights and Prudential's rights will remain the same. You will have the same level of Coverage you had before your Coverage lapsed. All benefits paid before the reinstatement count towards your Lifetime Maximum under the reinstated Coverage.

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

RESCINDING YOUR COVERAGE - INCONTESTABILITY

Your Coverage was issued based on information given in your Enrollment Form and any applicable Evidence of Insurability Forms. All statements made by you are considered to be to the best of your knowledge and belief. Such statements will be deemed representations and not warranties. A statement will not be used in a contest to avoid this insurance or reduce benefits unless both of the following apply.

1) It is a written statement signed by you.
2) A copy of that statement is or has been furnished to you or your representative.

During the first six months your Coverage is in force, if:

1) Information on your Enrollment Form and any applicable Evidence of Insurability Forms misrepresented any information about you or your health or medical history; and
2) As a result, we offered you insurance that you otherwise would not have been offered,

Prudential can rescind your Coverage or deny an otherwise valid claim.

After your Coverage has been in effect for six months, but less than two years, if:

1) Information on your Enrollment Form and any applicable Evidence of Insurability Forms misrepresented any information about you or your health or medical history; and
2) As a result, we offered you insurance that you otherwise would not have been offered; and
3) The misrepresentation pertains to the condition for which benefits are claimed,

Prudential can rescind your Coverage or deny an otherwise valid claim.

After your Coverage has been in effect for two years, if:

1) Relevant facts relating to your health were knowingly and intentionally misrepresented on your Enrollment Form and any applicable Evidence of Insurability Forms; and
2) As a result, we offered you insurance that you otherwise would not have been offered,

Prudential can rescind your Coverage or deny an otherwise valid claim.

These provisions also apply if you provide additional evidence of insurability to purchase additional coverage after your Effective Date.

AUTOMATIC COMPOUND INFLATION INCREASE BENEFIT – NO MAXIMUM

Your Schedule of Benefits will indicate if you selected this option. If you did not elect this option, then the Automatic Compound Inflation Benefit – No Maximum is not part of your Coverage.

Please refer to the Definitions section in your Certificate for defined terms.

This benefit increases the benefit levels as described below, by 5% compounded annually.

AUTOMATIC COMPOUND INCREASES

Your benefits will automatically increase on the Anniversary Date of the Effective Date of your Coverage. The first increase will take effect on the Anniversary Date that follows the Effective Date of this benefit. The increase will occur even if you are receiving benefits.

If you have purchased additional benefits after the Effective Date of this benefit, increases will also occur for those benefits, in accordance with the terms and conditions described herein.

Your premium will not increase solely due to increases under this benefit.

Increases to your Benefits

With each increase, your benefits that provide coverage for Eligible Charges up to a specified dollar amount per day, per Calendar Year or per lifetime will be increased each year by 5%. The number of days during a Calendar Year for which benefits are payable for Bed Reservation and Respite Care shall remain the same. The number of days during a lifetime for which benefits are payable for International Coverage shall remain the same.

Increases to your Lifetime Maximum

The increase to your Lifetime Maximum will be the increase to your Facility Daily Benefit times the benefit period multiplier, where the benefit period multiplier is the Lifetime Maximum at issue of this benefit divided by the Facility Daily Benefit at issue of this benefit.

Termination of Automatic Compound Inflation – No Maximum

This benefit will terminate if any of the following events occur.

1) Your Coverage lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision.
2) You send a written request to terminate this benefit. This benefit will end as of the date the request is received, unless a later date is specified.

Effect of Lapse and Termination of Automatic Compound Inflation – No Maximum

If your Coverage ends and is later reinstated, automatic inflation increases will be made as if your Coverage had remained in effect.

If your Coverage lapses for non-payment of premium and Coverage continues under the Non-Forfeiture Benefit, no increase will be made after the due date of the unpaid premium.

If you elect a lesser Lifetime Maximum under the Contingent Non-Forfeiture Provisions, no additional increases will be made.

The Claims and Appeals section

is not part of the

Group Insurance Certificate.

CLAIMS AND APPEALS

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.

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 Solid Solutions^{SM} is a service mark of The Prudential Insurance Company of America.