
Summary of Coverage

Employer: Army and Air Force Exchange Service (AAFES)

Group Policy: GLTC-750573

SOC: 1A

Issue Date: April 1, 2005

Effective Date: April 1, 2005

The benefits shown in this Summary of Coverage are available for:

- Employees;
- Retirees; and
- their eligible dependents.

Eligible Classes

Active employees (Employees)

All active full-time and part-time employees and active military personnel assigned to AAFES are in an Eligible Class.

An Employee who retires after the effective date of this Plan will remain in an Eligible Class, but only if the Employee retires while covered under this Plan. Long Term Care coverage will be provided in accordance with the terms of the group contract which apply to Employees.

Retired employees (Retirees)

All employees who retired under the Member Employer's IRS Qualified Retirement Plan and received a pension consideration (except a deferred vested pension) under that plan are in an Eligible Class.

Eligibility Date

Employees

The Eligibility Date is the Effective Date of this Plan for Employees then in an Eligible Class. Otherwise, it is the date the Employee commences active work for the Employer or, if later, the date the Employee enters an Eligible Class.

Retirees

The Eligibility Date is the Effective Date of this Plan.

Schedule of Long Term Care Coverage

Deductible Period

90 days As shown on the Covered Family Member's Insert A

Daily Benefit Amount (DBA)

Nursing Care Facility DBA

An amount equal to any whole multiple of \$1, as shown on the Covered Family Member's Insert A

Minimum: \$ 50

Maximum: \$ 350*

Community Based Services DBA

60% of the Nursing Care Facility DBA

Informal Care DBA

25% of the Nursing Care Facility DBA

As shown on the Covered Family Member's Insert A.

Maximum Daily Benefit Amount

An amount equal to the Nursing Care Facility Daily Benefit

As shown on the Covered Family Member's Insert A.

Lifetime Maximum Benefit

An amount equal to 1,825 times the Covered Family Member's Nursing Care Facility DBA.

As shown on the Covered Family Member's Insert A.

**The Daily Benefit Amounts and the Lifetime Maximum Benefit, shown above, are subject to change in accordance with the provisions of the Changes Section of the Booklet-Certificate.*

Premium Contributions

The premium contributions of an Employee toward the cost of his or her coverage and the coverage, if any, of his or her dependent spouse will be deducted from the Employee's pay. They are subject to change. In some instances, an Employee may be a Direct Pay Insured.

If both an Employee and his or her dependent spouse make written request for coverage, a 10% discount may be applied to the coverage of the Employee and his or her spouse. However:

- The discount will not be applied and will not take effect until the date that coverage is in force for both the Employee and his or her spouse.
- The discount will cease to apply on the date that either the Employee or his or her spouse ceases to be a Covered Family Member; except that: in the event of the death of the Employee or his or her spouse, the discount will continue to apply to the survivor.

The premium contributions of a Retiree toward the cost of his or her coverage and the coverage, if any, of his or her dependent spouse may be deducted from the Retiree's monthly pension. They are subject to change. In some instances, a Retiree may be a Direct Pay Insured.

If both an Retiree and his or her dependent spouse make written request for coverage, a 10% discount may be applied to the coverage of the Retiree and his or her spouse. However:

- The discount will not be applied and will not take effect until the date that coverage is in force for both the Retiree and his or her spouse.
- The discount will cease to apply on the date that either the Retiree or his or her spouse ceases to be a Covered Family Member; except that: in the event of the death of the Retiree or his or her spouse, the discount will continue to apply to the survivor.

The parents and parents-in-law of Employees are Direct Pay Insureds.

The premium contributions toward the cost of the coverage for the surviving spouse of a Retiree will be deducted from the deceased Retiree's pension. They are subject to change. In some instances, the surviving spouse of a Retiree may be a Direct Pay Insured.

The premium contributions of a Portable Insured or a Direct Pay Insured toward the cost of his or her coverage and the coverage, if any, of his or her dependents, must be paid directly to Aetna.

Premium contributions are subject to change by Aetna due to: actual or expected group experience; a change in factors bearing on the risk assumed; or Aetna's estimates for future cost factors. A change in one's premium contributions due to group experience may occur only once during any policy year. However, if one's benefits are modified at any time, his or her premium contributions may, at such time, be changed to reflect the change in benefits. Premium contributions will not be changed solely due to one's age or one's use of the Long Term Care coverage; any change will be made on a class basis.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group policy. Requests for amounts of coverage other than those to which one is entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company's policy form GR-700-W.

THE FOLLOWING NOTICE APPLIES ONLY TO COVERED FAMILY MEMBERS WHO HAVE BEEN REQUIRED TO PROVIDE EVIDENCE OF GOOD HEALTH.

CAUTION: THE ISSUANCE OF THIS LONG TERM CARE INSURANCE CERTIFICATE IS BASED UPON RESPONSES TO THE QUESTIONS ON THE MEDICAL QUESTIONNAIRE. A COPY OF THE ENROLLMENT FORM CONTAINING THE QUESTIONNAIRE WAS FURNISHED EACH APPLICANT AT THE TIME OF APPLICATION. IF THE ANSWERS ARE INCORRECT OR UNTRUE, AETNA HAS THE RIGHT TO DENY BENEFITS OR TO RESCIND YOUR COVERAGE. THE BEST TIME TO CLEAR UP ANY QUESTIONS IS

NOW BEFORE A CLAIM ARISES! IF, FOR ANY REASON, ANY OF YOUR ANSWERS ARE INCORRECT, CONTACT AETNA AT THIS ADDRESS:

**AETNA LIFE INSURANCE COMPANY
LONG TERM CARE UNIT
151 FARMINGTON AVENUE, RT52
HARTFORD, CONNECTICUT 06156**

**KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET-CERTIFICATE**

THE FOLLOWING NOTICE APPLIES ONLY TO COVERED FAMILY MEMBERS WHO RESIDE IN ARIZONA:

NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.

Group Long Term Care Insurance

FOR EMPLOYEES OF ARMY AND AIR FORCE EXCHANGE SERVICE (AAFES)

This Plan is provided under a policy intended to be a qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

RENEWABILITY: Subject to any maximum benefits herein, this certificate is guaranteed renewable to each Covered Family Member, except for nonpayment of any required premium. Refer to the "Portability" section for details.

NOTICE TO BUYER:

This Booklet-Certificate may be returned within 30 days of its delivery for a full refund of premiums paid.

This Plan may not cover all of the costs associated with Long Term Care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Plan limitations.

THE FOLLOWING NOTICE APPLIES ONLY TO COVERED FAMILY MEMBERS WHO HAVE BEEN REQUIRED TO PROVIDE EVIDENCE OF GOOD HEALTH.

CAUTION: THE ISSUANCE OF THIS LONG TERM CARE INSURANCE CERTIFICATE IS BASED UPON RESPONSES TO THE QUESTIONS ON THE MEDICAL QUESTIONNAIRE. A COPY OF THE ENROLLMENT FORM CONTAINING THE QUESTIONNAIRE WAS FURNISHED EACH APPLICANT AT THE TIME OF APPLICATION. IF THE ANSWERS ARE INCORRECT OR UNTRUE, AETNA MAY HAVE THE RIGHT TO DENY BENEFITS OR TO RESCIND YOUR COVERAGE. THE BEST TIME TO CLEAR UP ANY QUESTIONS IS NOW BEFORE A CLAIM ARISES! IF, FOR ANY REASON, ANY OF YOUR ANSWERS ARE INCORRECT, CONTACT AETNA AT THIS ADDRESS:

AETNA LIFE INSURANCE COMPANY
LONG TERM CARE UNIT RT52
151 FARMINGTON AVENUE
HARTFORD, CONNECTICUT 06156

Aetna Life Insurance Company

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Aetna's toll-free telephone number for information or to make a complaint at:

1-800-537-8521

You may write to Aetna at:

Aetna Life Insurance Company
Long Term Care Unit, SH41
151 Farmington Avenue
Hartford, Connecticut 06156

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

Premium or Claim Disputes:

Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

Notice:

This notice is for information only and does not become a part or condition of your Certificate.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al siguiente número de teléfono gratuito de Aetna para obtener información o para presentar una queja:

1-800-537-8521

Usted puede escribir a Aetna:

Aetna Life Insurance Company
Long Term Care Unit, SH41
151 Farmington Avenue
Hartford, Connecticut 06156

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771

Disputas Sobre Primas o Reclamaciones:

Si surge una disputa concerniente a su prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

Aviso:

Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Folleto.

Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while a person is covered under the group contract.

Aetna will issue an Insert A to each person who becomes covered. If a person becomes covered, this Booklet, with the Insert A, will become the Certificate of Coverage. It replaces and supersedes any and all Certificates of Coverage issued to the person by Aetna under the group contract shown on the Insert A.



President
Aetna Life Insurance Company

Cert. Base-1.
Effective Date: April 1, 2005
Issue Date: April 1, 2005

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Eligibility

Eligibility for coverage under this Plan is limited to those listed below.

Employees and Retirees

Employees and Retirees in an Eligible Class shown in the Summary of Coverage are eligible for coverage.

An Employee or Retiree becomes eligible for coverage on the Eligibility Date described in the Summary of Coverage.

Dependents

The following are eligible dependents:

An Employee's or a Retiree's spouse. However, any such spouse who is insured under this Plan (or eligible for benefits because of prior insurance under this Plan) as an Employee or Retiree is not a dependent.

The parents of an Employee or Retiree and the parents of an Employee's or Retiree's spouse.

The term "parents" is limited to two persons with respect to the Employee or Retiree and two persons with respect to the Employee's or Retiree's spouse. Such person must be named by the Employee or Retiree and must be: the natural parent of the Employee or Retiree or the Employee's or Retiree's spouse; a person who legally adopted the Employee or Retiree or the Employee's or Retiree's spouse; or any other person who at one time was married to the natural or adoptive parent of the Employee or Retiree or the Employee's or Retiree's spouse.

An Employee or Retiree is eligible for any applicable dependent coverage on the date he or she becomes eligible for Employee or Retiree coverage.

No person may be covered both as a dependent and an Employee or Retiree; and no person may be covered as a dependent of more than one Employee or Retiree.

Surviving Spouses of Employees

A person who is a surviving spouse of a deceased Employee on the effective date of this Plan is eligible; provided such employee was a regular full-time employee of an employer participating in this Plan at the time of his or her death.

A surviving spouse becomes eligible for coverage on the effective date of this Plan.

A surviving spouse is not eligible for any dependent coverage.

Surviving Spouses of Retirees

A person who is a surviving spouse of a deceased Retiree on the effective date of this Plan is eligible.

A surviving spouse becomes eligible for coverage on the effective date of this Plan.

A surviving spouse is not eligible for any dependent coverage.

Effective Dates

Written Consent

In any instance in this Effective Dates Section where Aetna's written consent is required, Aetna will not give such consent unless each of the questions on the health statement is answered. Answering each question does not obligate Aetna to give its consent and does not guarantee coverage.

Employees

If an Employee makes written request for coverage during the initial enrollment period designated by the Employer, coverage becomes effective on April 1, 2005, provided the Employee is in an Eligible Class. If a newly hired Employee makes written request for coverage within 31 days of his or her Eligibility Date, coverage will become effective on the first of the month following the date Aetna processes such written request, provided the Employee is in an Eligible Class. Otherwise, coverage takes effect on the first of the month following the date Aetna gives its written consent provided that:

- the Employee is in an Eligible Class; and
- the Employee has made written request for coverage.

The coverage of an Employee is fully contributory and contributions will be deducted from the Employee's pay.

If an Employee happens to be ill, injured or on medical leave of absence and away from work on the date coverage would become effective, the coverage will not go into effect until the first day of the month following the date he or she returns to work for at least 5 consecutive working days.

An Employee will be considered to be active at work on any of the Employer's scheduled work days if, on that day, the Employee:

- is performing all the usual and customary duties of his or her occupation on a regular basis; and
- is reporting for work at his or her usual place of employment or other location to which the Employer's business requires the Employee to travel.

In addition, an Employee will be considered to be active at work on the following days:

-
- Any day which is not one of the Employer's scheduled work days if the Employee were active at work on the preceding scheduled work day.
 - An Employee's normal vacation day.

This "active at work" requirement also applies to any increase in an Employee's Daily Benefit Amount for which an Employee makes written request. Any such increase in Daily Benefit Amount will be subject to all other terms of the "Increases With Aetna's Written Consent" section of this Certificate, except that for an Employee who is active at work such increase may be allowed during a special enrollment period without Aetna's written consent but only by agreement between Aetna and the Employer.

Retirees

Coverage takes effect on the first of the month following the date Aetna gives its written consent, but not before April 1, 2005, provided that:

- the Retiree is in an Eligible Class; and
- the Retiree makes written request for coverage.

The coverage of a Retiree is fully contributory and contributions will be deducted from the Retiree's pension.

Dependent Spouses

Coverage takes effect on the first of the month following the date Aetna gives its written consent, but not before April 1, 2005, provided that:

- written request for coverage is made; and
- the Employee or Retiree is in an Eligible Class.

The coverage of the dependent spouse of an Employee is fully contributory and contributions will be deducted from the Employee's pay.

The coverage of the dependent spouse of a Retiree is fully contributory and contributions will be deducted from the Retiree's pension.

Dependent Parents

Coverage takes effect on the first of the month following the date Aetna gives its written consent, but not before April 1, 2005, provided that:

- written request for coverage is made; and
- the Employee or Retiree is in an Eligible Class.

The coverage of a dependent parent is fully contributory and contributions must be paid directly to Aetna.

Newly Acquired Dependent Spouses

If an Employee or Retiree does not have a spouse on the date he or she becomes eligible under this Plan or his or her spouse is no longer an eligible dependent because of death or divorce, he or she will be eligible for dependent coverage for a spouse on the date he or she acquires a spouse.

Coverage takes effect on the first of the month following the date Aetna gives its written consent, but not before April 1, 2005, provided that:

- written request for coverage is made; and
- the Employee or Retiree is in an Eligible Class.

The coverage of a newly acquired dependent spouse of an Employee is fully contributory and contributions will be deducted from the Employee's pay.

The coverage of the newly acquired dependent spouse of a Retiree is fully contributory and contributions will be deducted from the Retiree's pension.

Surviving Spouses of Retirees

Coverage takes effect on the first of the month following the date Aetna gives its written consent, but not before April 1, 2005, provided that written request for coverage is made.

The coverage of a surviving spouse is fully contributory and contributions will be deducted from the surviving spouse's pension.

Changes in Coverage Amounts

Increases with Aetna's Written Consent

A Covered Family Member may elect to increase his or her Daily Benefit Amount anytime. Aetna must give its written consent before such an increase may take effect. Coverage may be increased up to:

- the maximum Daily Benefit Amount in force; or
- the Modified Maximum Daily Benefit Amount in force, if any.

An increase of less than \$ 1 in a Covered Family Member's Daily Benefit Amount may not be chosen. The increased Daily Benefit Amount will take effect on the date agreed to by Aetna and the Employer. In no event will such an increase become effective without Aetna's written consent.

Increases with Aetna's written consent will not always be available. A Covered Family Member may not purchase added coverage:

- when he or she is in a Benefit Period;
- if contributions have not been made or premiums have not been paid on his or her behalf for any reason.

The premium rate for increased coverage amounts with Aetna's written consent will be based on the Covered Family Member's age as of the effective date of the increased coverage amount.

Inflation Protection Increases

Every three years, starting three years after the group policy becomes effective, a Covered Family Member will be able to buy added coverage to help protect against the effects of inflation. There will be a special enrollment period. This period will be determined by the Employer and agreed to by Aetna. During this period only, a Covered Family Member may buy added amounts of coverage without Aetna's written consent. A special enrollment period is the only time an increase in coverage will be allowed without such consent. The amount available during the first special enrollment period will equal any amount from a minimum of \$1 up to 5% of a Covered Family Member's most recent Daily Benefit Amount, compounded each year for each of the preceding three years. This amount, plus the Covered Family Member's previous Daily Benefit Amount, will become his or her Modified Daily Benefit Amount.

The inflation protection amounts offered at future special enrollment periods will equal any amount from a minimum of \$1 up to 5% of a Covered Family Member's most recent Modified Daily Benefit Amount, compounded each year for each of the preceding three years. During each such period, the inflation protection amount offered to a Covered Family Member will be added to his or her most recent Daily Benefit Amount to become the new Modified Daily Benefit Amount.

During the first special enrollment period, the Maximum Daily Benefit Amount will be increased to become the Modified Maximum Daily Benefit Amount. The amount of the increase will equal 5% of the Maximum Daily Benefit Amount available on the effective date of the group policy, compounded each year for each of the preceding three years. During each subsequent special enrollment period, the Modified Maximum Daily Benefit will be increased. The amount of the increase will equal 5% of the most recent Modified Maximum Daily Benefit Amount, compounded each year for each of the preceding three years.

A Covered Family Member may not purchase inflation protection increases if:

- he or she has previously declined the increases offered during two consecutive special enrollment periods; or
- if any required contributions have not been made or any required premiums have not been paid on his or her behalf for any reason.

The premium rate for inflation protection amounts purchased will be based on a Covered Family Member's age at the time the increased coverage takes effect.

Decreases in Coverage Amounts

A Covered Family Member may elect to decrease his or her Daily Benefit Amount anytime. Aetna must be given written notice. A Covered Family Member may not decrease his or her Daily Benefit Amount:

- by less than \$ 1; or
- to an amount less than the plan minimum.

The decreased Daily Benefit Amount will become effective on the date agreed to by Aetna and the Employer; but in no event later than 90 days after the date the Covered Family Member notifies Aetna. Any decrease in Daily Benefit Amount will result in eligibility for the benefits described in the "Nonforfeiture Benefits" section of this certificate, if any, for the amount of coverage decreased.

Long Term Care Coverage

Definitions

Some words and terms used in this Plan are defined below.

Adult Day Care

A program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center

As to a facility located in Texas: a provider of Adult Day Care services operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality of care requirements in the provision of adult day care).

As to a facility located in a jurisdiction other than Texas: a provider of Adult Day Care services for at least six (6) or more persons.

Alternate Plan of Care

A written plan developed by or with a Licensed Health Care Practitioner to specify care, services or devices that will meet a Covered Family Member's care and treatment needs as an alternative to confinement in a hospital, nursing care facility or other institution.

It must be agreed to by:

- Aetna;
- the Covered Family Member; and
- his or her attending Physician.

An Alternate Plan of Care, for example, might include durable medical equipment, such as a wheelchair or grab bars, that allows a Covered Family Member to stay in his or her home.

Assisted Living Facility

A facility that meets any applicable licensing requirements of the jurisdiction in which it located and that is operated pursuant to state and federal law.

It is not:

- a hospital, a nursing care facility or similar establishment; or
- a place for drug addicts, alcoholics, mental retardates, educational care or care of mental disorders.

Covered Family Member

A person for whom coverage under this Plan is in force.

Daily Benefit Amount

The amount of daily benefit chosen by a Covered Family Member under this Plan as shown in the Covered Family Member's Insert A.

Direct Pay Insured

Any person who is not a Portable Insured, but who is required to make premium payments directly to Aetna.

Hospice Care

Care given by or under arrangement with a Hospice Care Agency or Hospice Facility to a Covered Family Member who is Terminally Ill.

Hospice Care Agency

An agency or organization which:

- Has Hospice Care available 24 hours a day.
 - Meets any applicable licensing requirements.
 - Provides:
 - skilled nursing services;
 - medical social services; and
 - psychological and dietary counseling.
 - Provides or arranges for other services which will include:
 - services of a Physician;
 - physical and occupational therapy;
 - part-time home health aide services which mainly consist of caring for Terminally Ill persons; and
 - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
 - Has personnel which include at least:
 - one Physician;
 - one R.N.; and
 - one licensed or certified social worker employed by the Agency.
 - Establishes policies governing the provision of Hospice Care.
 - Assesses the patient's medical and social needs.
 - Develops a hospice care program to meet those needs.
 - Provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the Agency.
 - Permits all area medical personnel to utilize its services for their patients.
 - Keeps a medical record on each patient.
 - Has a full-time administrator.
-

Hospice Facility

A facility, or distinct part of one, which:

- Mainly provides inpatient Hospice Care to Terminally Ill persons.
- Provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.

-
- Keeps a medical record on each patient.
 - Utilizes volunteers trained in providing services for non-medical needs.
 - Has a full-time administrator.
-

Home Health Care Services

Medical or nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services.

Home Health Care Agency

As to an agency located in Texas, one which provides Home Health Care Services and is licensed by the Texas Department of Health under Texas Civil Statutes, Article 4447u.

As to an agency located in a jurisdiction other than Texas, one which provides Home Health Care Services and meets licensing standards of the jurisdiction in which it is located.

Hospital

An institution which:

- Mainly provides inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons.
 - Charges its patients for the services it provides.
 - Is supervised by a staff of physicians.
 - Provides R.N. services 24 hours a day.
 - Is not mainly a nursing home or a place for: rest; the aged; drug addicts; or alcoholics.
-

Informal Caregiver

A person who has responsibility for caring for or providing assistance to a Covered Family Member in his or her home. A person who makes charges for any services provided may be considered an Informal Caregiver, but only if no benefits are payable for such charges under any benefit provision of this Plan except the Informal Care Benefit.

Licensed Health Care Practitioner

Any Physician (as defined in section 1861(r)(1) of the Social Security Act) and any Registered Nurse (R. N.), licensed social worker or other individual who meets such requirement as may be prescribed by the Secretary of the Treasury. A licensed social worker includes any social worker who has been issued a license, certificate, or similar authorization by a State or jurisdiction or a body authorized by a State or jurisdiction to issue such authorization.

L. P. N.

A Licensed Practical Nurse.

L. V. N.

A Licensed Vocational Nurse.

Loss of Functional Capacity

This means that a Covered Family Member on a given day meets either of the following requirements:

- Due to a physical incapacity resulting from disease or injury or the effects of aging, the Covered Family Member has been certified by a Licensed Health Care Practitioner as having a functional loss in accomplishing at least two of the following activities of daily living for a period of at least 90 days:

Bathing:	Washing oneself by a sponge bath; or washing oneself in either a tub or shower, including the task of getting into and out of the tub or shower.
Transferring:	Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.
Dressing:	Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Toileting:	Getting to and from the toilet, getting on and off the toilet and associated personal hygiene.
Continence:	The ability to maintain control of bowel and bladder functions; and when unable to maintain control of bowel and bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
Eating:	Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), or by a feeding tube or intravenously. "Eating" does not include shopping for food or preparing food for consumption.

A "functional loss," means the Covered Family Member is unable to perform the activity without the substantial assistance (i.e., hands-on assistance and standby assistance) of another person each time the activity is performed.

- Due to the Impairment of Cognitive Ability, as established by the clinical diagnosis of a Licensed Health Care Practitioner authorized to make such a diagnosis. Such diagnosis shall include the Covered Family Member's history and neurological, psychological and/or psychiatric evaluations, and laboratory findings. "Impairment of Cognitive Ability" means the deterioration or loss in intellectual capacity requiring substantial supervision by another person for protection of the Covered Family Member and others.

Aetna will verify that a Covered Family Member has met all the necessary requirements to be determined to have suffered a Loss of Functional Capacity. Aetna will take into account, as appropriate: evidence furnished by the Covered Family Member; and written documentation furnished by the family member's attending Physician and other Licensed Health Care Practitioners. A Covered Family Member who otherwise meets either of the requirements described above, will not be determined to have suffered a Loss of Functional Capacity unless, within the preceding 12 month period, a Licensed Health Care Practitioner has certified that such Covered Family Member meets either requirement.

Nursing Care Facility

A facility that meets any applicable licensing requirements of the jurisdiction in which it located and that is operated pursuant to state and federal law.

It is not mainly a place for: rest; the aged; drug addicts; alcoholics; mental retardates, educational care; or care of mental disorders.

Physician	A legally qualified physician.
Portable Insured	Any person who elects to continue coverage under this Plan in accordance with the terms of the portability provisions of the Termination of Coverage section.
Premium	The total periodic payments necessary to keep the coverage of a Covered Family Member in force under this Plan.
Premium Contribution (Contribution)	That portion of the total cost of coverage under this Plan for a Covered Family Member which is paid for by the Covered Family Member or on his or her behalf by an Employee or Retiree.
Premium Rate	The per dollar cost of a given Covered Family Member's coverage under the Plan.
Qualified Long Term Care Services	<p>Necessary, diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services, which are:</p> <ul style="list-style-type: none"> • required by a Covered Family Member; and • provided pursuant to a plan of care prescribed by a Licensed Health Care Practitioner.
R. N.	A Registered Nurse.
Respite Care	Care furnished during a period of time when the Covered Family Member's family or usual primary caregiver is not attending to the Covered Family Member's needs.
Terminally Ill	This means a medical prognosis of six months or less to live.
Unenrolled Eligible Employee or Retiree	An Employee or Retiree in an Eligible Class who, as of the date coverage under the group policy discontinues, has not elected coverage, has not been approved for coverage or is not otherwise enrolled.

Long Term Care Benefit

If a Covered Family Member suffers a Loss of Functional Capacity and a Benefit Period commences while coverage for such member is in force under this Plan, Aetna will, subject to the terms of this Plan, pay the benefits described in the benefit sections which follow. All benefits are payable only after any applicable Deductible Period has been met. The applicable Daily Benefit Amounts are shown on the Covered Family Member's Insert A.

For any one day, the maximum benefit payable will not exceed the Maximum Daily Benefit Amount as shown on the Covered Family Member's Insert A.

Transitional Care Benefit

As soon as a Covered Family Member has met any applicable Deductible Period, a Transitional Care Benefit is payable to assist in meeting immediate needs resulting from the Loss of Functional Capacity. Only one Transitional Care Benefit is payable to a Covered Family Member during his or her lifetime. The amount of the benefit payable is equal to three times the applicable Nursing Care Facility DBA selected. This benefit is payable without regard to any other Long Term Care Benefits payable. The Transitional Care Benefit does not count toward the reduction of the Lifetime Maximum Benefit.

Nursing Care Facility Benefit

This Plan pays a benefit for each day a Covered Family Member is confined in a Nursing Care Facility. The amount of the benefit payable for any one day is equal to the lesser of:

- (i) the Nursing Care Facility DBA selected; and
- (ii) the charges made for that day by the Nursing Care Facility for Qualified Long Term Care Services.

Assisted Living Facility Benefit

This Plan pays a benefit for each day a Covered Family Member is confined in an Assisted Living Facility. The amount of the benefit payable for any one day is equal to the lesser of:

- (i) the Nursing Care Facility DBA selected; and
- (ii) the charges made for that day by the Assisted Living Facility for Qualified Long Term Care Services.

Bed Reservation Benefit

If a Nursing Care Facility or an Assisted Living Facility makes a charge to reserve a bed for a Covered Family Member while he or she is confined in a Hospital, this Plan will pay the Nursing Care Facility Benefit or Assisted Living Facility Benefit described above for each day such a charge is made, up to a maximum of 21 days per calendar year.

Adult Day Care Benefit

This Plan pays a benefit for each day a Covered Family Member incurs charges made by an Adult Day Care Center. The amount of the benefit payable for any one day is equal to the lesser of:

- (i) the Community Based Services DBA selected; and
- (ii) the charges made for that day by the Adult Day Care Center for Qualified Long Term Care Services.

Home Health Care Benefit

This Plan pays a benefit for each day a Covered Family Member incurs charges made by a Home Health Care Agency for the Qualified Long Term Care Services listed below, which are provided to such family member in his or her home:

- Care by an R.N. or by an L.P.N.
- Care by an L.V. N.
- Home health aide for patient care.
- Homemaker services.
- Physical, occupational, speech or respiratory therapy.

The amount of the benefit payable for any one day is equal to the lesser of:

- (i) the Community Based Services DBA selected; and
- (ii) the charges made for that day by the Home Health Care Agency.

For purposes of this benefit provision, services provided by a licensed therapist, R.N., L.P.N., or L.V.N. operating within the scope of his or her license will be considered to be services provided by a Home Health Care Agency.

Hospice Care Benefits

Hospice Care While Confined

This Plan pays a benefit for each day a Covered Family Member is confined in a Hospice Facility for Hospice Care. The amount of the benefit payable for any one day is equal to the lesser of:

- (i) the Nursing Care Facility DBA selected; and
- (ii) the charges made for that day by the Hospice Facility for Qualified Long Term Care Services.

Community Based Hospice Care

This Plan pays a benefit for each day a Covered Family Member incurs charges made by a Hospice Care Agency for the Qualified Long Term Care Services listed below, which are provided to such family member in his or her home for Hospice Care:

- Care by an R.N. or by an L.P.N.
- Home health aide for patient care.
- Homemaker services.
- Physical, occupational, respiratory or speech therapy.

The amount of the benefit payable for any one day is equal to the lesser of:

- (i) the Community Based Services DBA selected; and
- (ii) the charges made for that day by the Hospice Care Agency.

For purposes of this benefit provision, services provided by a licensed therapist, R.N., L.P.N., or L.V.N. operating within the scope of his or her license will be considered to be services provided by a Hospice Care Agency.

Respite Care Benefit

This Plan pays a cash benefit for each day of Respite Care, up to a maximum of 28 days during a calendar year. The Respite Care Benefit for any one day is equal to the Community Based Services DBA selected. It is payable in addition to other benefits payable on that day, subject to the Maximum Daily Benefit Amount. The Respite Care Benefit does not count toward the reduction of the Lifetime Maximum Benefit.

Alternate Care Benefit

If, pursuant to an Alternate Plan of Care, a Covered Family Member needs Qualified Long Term Care Services for which no benefits are payable under this Plan, Aetna may, at its discretion, pay a benefit for such services in an amount equal to the lesser of:

- (i) the Community Based Services DBA selected; and
- (ii) the charges made for the Alternate Care.

However, this Alternate Care Benefit will not be payable in connection with expenses incurred for any services rendered by a member of the Covered Family Member's immediate family or a person who resides in the Covered Family Member's home.

World Wide Coverage

If a Covered Family Member incurs charges for services equivalent to those covered by this Plan and such services are received outside the United States or its territories, or Canada, Aetna will reimburse the Covered Family Member for such charges.

The amount of the benefit payable under this section will equal the benefit amounts described in the preceding benefit sections for the type of care or services received. However, not more than 365 days of charges will be covered.

Additional Long Term Care Benefits

If Aetna determines that, in accordance with the terms of this Plan:

- a Covered Family Member has suffered a Loss of Functional Capacity;
- a Benefit Period has started; and
- any applicable Deductible Period has been met;

the additional benefits described below are payable.

Informal Care Benefit

If:

- a Covered Family Member, on any day, receives care in his or her home only from an Informal Caregiver; and
- a statement that the care has been given is signed by the Informal Caregiver and given to Aetna;

an Informal Care Cash Benefit is payable for that day, up to a maximum of 100 days per calendar year.

The amount payable for each day is the Informal Care DBA. The Informal Care Benefit does not count toward the reduction of the Lifetime Maximum Benefit.

Informal Caregiver Training Benefit

If a Covered Family Member incurs expenses for training an Informal Caregiver to care for the Covered Family Member in his or her home, an Informal Caregiver Training Benefit is payable for charges made for such training by a Home Health Care Agency or other facility licensed to provide such training. The amount of the benefit is equal to the lesser of:

- (i) three times the Nursing Care Facility DBA selected; and
- (ii) the charges made for the training.

This benefit is payable without regard to any other Long Term Care Benefits payable. Not more than one Informal Caregiver Training Benefit is payable in connection with any one Benefit Period. The Caregiver Training Benefit does not count toward the reduction of the Lifetime Maximum Benefit.

Deductible Period

The number of days shown on the Covered Family Member's Insert A during which no benefits will be paid, starting at the date a Loss of Functional Capacity is determined to have commenced. Aetna will determine when a Loss of Functional Capacity commenced. The actual start date of the Deductible Period has no relationship to the date on which Aetna makes the determination of the Loss.

In no event shall the Deductible Period include:

- any day prior to the Covered Family Member's effective date of coverage under this Plan; or
- any day that the Covered Family Member is not suffering a Loss of Functional Capacity.

Benefit Period

A period of days of a covered Loss of Functional Capacity which begins on the first day of such loss. It does not include any day prior to a Covered Family Member's effective date of coverage under this Plan. It will end at the close of 90 consecutive days during which the Covered Family Member has not had a Loss of Functional Capacity. Only one Deductible Period applies to a Covered Family Member during his or her lifetime.

At the close of any Benefit Period, benefits for any subsequent Loss of Functional Capacity will not be paid until the one Deductible Period has been completed.

Lifetime Maximum Benefit

Not more than the Lifetime Maximum Benefit shown on the Covered Family Member's Insert A may be paid under this Plan to any one Covered Family Member, in the aggregate, during the lifetime of such Covered Family Member.

However, if:

- one Benefit Period has closed as to a Covered Family Member and a new Benefit Period has begun in accordance with the terms of the preceding "Benefit Period" provision; and
- the coverage of that Covered Family Member is not being extended under the "Nonforfeiture Benefits" provision of this Certificate;

the Lifetime Maximum Benefit will be restored by the amount then charged against it. The restored amount may not be used to pay benefits for any expenses incurred prior to the date the Lifetime Maximum Benefit is restored.

Provision for Refund of Contributions

This coverage provides, only as shown below, for a refund or partial refund of premium contributions upon the death of a Covered Family Member who enrolled as:

- an Employee;
- the spouse of an Employee;
- a Retiree;
- the spouse of a Retiree;
- a parent or parent-in-law of an Employee; or

The Covered Family Member's age at death will determine the availability of any refund of contributions. Payment of any contribution due under this provision will be made upon satisfactory proof of death from any cause to the Covered Family Member's designated beneficiary.

No refund of contribution will be made if contributions or premium payments have been discontinued for any reason.

For a Covered Family Member who enrolled as an Employee

If an Employee either (i) remains employed by the Employer in an Eligible Class; or (ii) is under 65 years of age at the time of death; the refund will equal the contributions paid on the Employee's behalf.

However, in the following instances the amount of the refund available will reduce as shown.

- Starting on the date that an Employee retires from employment in an Eligible Class with the Employer or reaches age 65, whichever is later, the refund available will reduce each year by 10% of the contributions paid on the Employee's behalf by the time of death.
- If, prior to age 65, coverage becomes portable or an Employee retires, the 10% annual reduction will begin on the date the employee reaches age 65.
- If coverage becomes portable after the date the Employee reaches age 65, the 10% annual reduction will start on the date coverage becomes portable.

On the ninth anniversary after the reduction begins, refund of contribution amounts will no longer be available.

For a Covered Family Member who enrolled as something other than an Employee

Until the spouse reaches age 65, the refund will equal the contributions paid on the spouse's behalf. However, starting on the date a spouse reaches age 65, the amount of the refund available will reduce by 10% per year. If a spouse enrolls on or after the date he or she reaches age 65, the 10% annual reduction will start on the date of enrollment.

Refund of contribution amounts will no longer be available on the ninth anniversary after the reduction starts.

Beneficiary

At enrollment, Covered Family Members eligible for the refund of contribution feature may designate a beneficiary to receive any refund of contribution amount payable. The Covered Family Member may change the person named at any time by giving written notice to Aetna. If no person has been named, or if the named person dies before the Covered Family Member who named him or her, then any refund of contribution amount available will be paid to the executors or administrators of the Covered Family Member's estate.

General Exclusions

This Plan does not provide benefits for any of the following:

- A loss which is caused by war or any act of war.
- A loss which is caused by a suicide attempt, while sane or insane, or intentionally self-inflicted injury.
- Services for which no charge is normally made in the absence of insurance or charges that a Covered Family Member is not legally obliged to pay.
- Any day that a Covered Family Member is confined in a Hospital, except as otherwise provided under the Bed Reservation Benefit.
- Any day of a confinement in a government institution; unless a charge is made which the Covered Family Member is obligated to pay.
- Any day on which benefits are provided or required because of the past or present service of any person in the armed forces of a government.
- Any charges incurred by a Covered Family Member for which benefits are provided or required under any law, for example, Medicare or other governmental program. (This does not include a medical plan established by a government for its own employees or their dependents, or Medicaid.)

Coordination With Medicare

If a Covered Family Member incurs charges for which benefits are payable under Medicare (including benefits that would be payable except for application of Medicare's deductible or coinsurance features), the benefits payable under this Plan for such charges will be reduced by the benefits payable under Medicare, excluding benefits payable by Medicare only as a secondary payor.

Non-Forfeiture Benefits

Benefits After Termination of Contributions

When coverage of a Covered Family Member who has made premium contributions under this Plan for at least 3 years terminates because of failure to make the required contributions when due, he or she will receive the non-forfeiture benefit described below under Shortened Benefit Period.

The Shortened Benefit Period non-forfeiture benefit also applies:

- when decreasing his or her Daily Benefit Amount; and
- when surrendering his or her coverage in the case of an Employee or Retiree who surrenders coverage but remains in an Eligible Class, or the dependents of such a person.

Coverage will be extended under the Shortened Benefit Period without further contributions.

Shortened Benefit Period

This feature allows for an extended coverage with no reduction in the applicable Daily Benefit Amount, but with a change in the Lifetime Maximum Benefit. The new Lifetime Maximum Benefit will be an amount equal to the greater of:

- the amount of the sum total of all premium contributions made on the Covered Family Member's behalf on the date premium contributions cease; and
- 30 times the applicable Daily Benefit Amount.

Eligibility for benefits will terminate at the first to occur of:

- the death of the Covered Family Member; or
- the date the new Lifetime Maximum Benefit is reached.

In no event will a benefit be paid under the Shortened Benefit Period after a person has exhausted his or her Lifetime Maximum Benefit.

As of the date a Covered Family Member's coverage is extended under the Shortened Benefit Period, the following shall apply:

- No benefit changes will be allowed.
- No refund of contribution will be available.

Premiums/Contributions

Payment of Contributions

Contributions for the cost of long term care coverage will be deducted from an employee's pay or pension; except that: Portable Insureds and Direct Pay Insureds are required to make contributions directly to Aetna. Contributions must be made in advance at Aetna's Home Office or to its authorized agent on the designated due date. Portable Insureds and Direct Pay Insureds may designate a third party to be notified by Aetna when:

- contributions are 30 days late; or
- coverage has been terminated.

Waiver of Premiums/Contributions

After a Covered Family Member has satisfied the applicable deductible period, benefits will be paid for that family member in accordance with the terms of this Plan without further payment of any premiums or contributions. Payment of premiums or premium contributions shall resume at the end of each Benefit Period.

While the terms of this provision are in effect for a Covered Family Member:

- The terms of the "Provision for Refund of Contributions" and "Benefits After Termination of Contributions" sections will not apply.

Return of Unearned Premium Contributions

If premium contributions have been paid for a period of coverage which extends beyond:

- a Covered Family Member's death; or
- the date the Covered Family Member's coverage is surrendered for any reason.,

any unearned premium contributions will be refunded to the Covered Family Member, his or her designated beneficiary, if any, or to his or her estate.

Note: Surrender of coverage will result in eligibility for the benefits described in the "Nonforfeiture Benefits" section of this certificate, if any.

Extension of Benefits

Termination of long term care insurance shall be without prejudice to any benefits payable during a Benefit Period which began while the long-term care insurance was in force and continues without interruption after termination. This extension of benefits beyond the period the long term care insurance was in force may be limited to the duration of the Benefit Period, or to payment of the maximum benefits and may be subject to any policy Deductible Period and all other applicable provisions of the policy.

Termination of Coverage

Termination of Individual Coverage

Except as provided below, coverage of a Covered Family Member will terminate on the earliest to occur of the following:

- Discontinuance of group coverage as to Unenrolled Eligible Employees or Retirees.
- Failure to make individual premium contributions or failure of the Employer to make premium payments when due.
- The date of the Employee's or Retiree's death.
- Ceasing to be in an eligible class.

Termination of Dependent Coverage

All dependent coverage will terminate on discontinuance of such coverage under the group policy. Coverage as to a person will cease when the person ceases to be an eligible dependent, or, if earlier, on the date the coverage of the Employee or Retiree terminates under this Plan.

Please refer to the "Portability" section to see if coverage may be continued under this Plan.

Notice of Individual Coverage Termination

Before a Covered Family Member's coverage terminates for failure to make individual premium contributions when due, Aetna will give notice of the intent to terminate coverage to the Covered Family Member and to any person, or persons designated by the Covered Family Member. The notice will be given at least 30 days before coverage will terminate, but may not be given until 30 days after a premium contribution is due and unpaid. For the purpose of this provision, a notice will be deemed to have been given 5 days after the date it is mailed. The notice will be given by first class United States mail, postage prepaid.

The Family Member's coverage will terminate at the end of the 30 day period following the date the notice is given, if payment of the premium contribution is not made within the 30 day period.

Reinstatement

If:

- a person's coverage ceases for failure to make premium payments or premium contributions when due; and
- the person provides adequate proof to Aetna that the lapse is due to Loss of Functional Capacity;

coverage may be reinstated; provided that:

- the request to reinstate coverage is made within five months of the date coverage ceased; and
- any past due premiums are paid.

If:

- a person's coverage ceases for failure to make premium payments or premium contributions when due; and
- the lapse is **not** due to Loss of Functional Capacity;

coverage also may be reinstated; provided that:

- the request to reinstate coverage is made within 36 months of the date coverage ceased;
- Aetna gives its written consent; and
- any past due premiums are paid.

If Aetna's written consent is required to reinstate coverage, Aetna will not give such consent unless each of the questions on the health statement is answered. Answering each question does not obligate Aetna to give its consent and does not guarantee coverage.

Replacement

If the group policy discontinues and it is replaced by a like policy, a Covered Family Member may elect any one (but only one) of the options described below. He or she may:

- elect to continue coverage under the group policy according to the terms of the Portability provision; or
- discontinue required premium contributions and if he or she qualifies, receive Nonforfeiture benefits under the Shortened Benefit Period feature described in the "Nonforfeiture Benefits" provision; or
- elect coverage under the replacement policy. This option, however, may only be elected by a Covered Family Member who is not in a nonforfeiture status, claim status, or portability status on the effective date of replacement.

If a Covered Family Member elects coverage under the replacement policy, Aetna shall transfer a portion of the Employer's Aggregate Fund Balance to the replacing carrier. In this case, the value of such funds will be subject to a Market Value Adjustment determined by Aetna. The portion of the Employer's Aggregate Fund Balance to be transferred will be determined on a pro-rata basis, based on the amount of the Member Funds of transferring Covered Family Members relative to the Member Funds of all Covered Family Members.

Member Fund

An actuarial fund, herein called a Member Fund, will be established and maintained for each Covered Family Member. The fund will consist of the premium paid, plus interest, minus the annual term portion of the Long Term Care premium. The annual term portion of the Long Term Care premium will also include all expenses and profit incurred or charged in connection with the administration of this Plan.

The Fund described above will in no event be used in determining any amount payable under a Provision For Refund Of Contributions.

Market Value Adjustment

The market value adjustment is, on a given day, the adjustment determined by Aetna to reflect the fact that the asset value with respect to the Employer's Aggregate Fund on the date of withdrawal may be different than the Employer's Aggregate Fund balance accumulated from its inception.

Employer's Aggregate Fund

An actuarial fund, herein called the Employer's Aggregate Fund, will be established and maintained for each Employer Group Policyholder. The balance of the fund, as determined by Aetna, will consist of:

- premium paid, *plus*
- investment earnings credited, *less*
- charges for incurred claims, including provision for reserves for incurred claims and reserves for incurred but unreported claims, *less*
- charges for expenses, taxes, risk, and profit, *less*
- reserves for any individuals in non-forfeiture or portability status, *less*
- actuarial gains (or plus actuarial losses) due to mortality or lapse.

The amounts described under the third and sixth items above may reflect the degree of credibility of the policyholder's experience, as determined by Aetna. Aetna may base any non-credible portion on (1) Aetna's pricing assumptions; or (2) on the pooled experience across all policyholders of the same class or (3) on a combination of (1) and (2).

Portability

If a Covered Family Member's coverage would otherwise terminate:

- because the group policy discontinues as to Unenrolled Eligible Employees or Retirees and it is not replaced by a like policy; or
- because the group policy discontinues as to Unenrolled Eligible Employees or Retirees and is replaced by like coverage, and the Covered Family Member does not become covered under the replacement coverage; or
- because the Employee or Retiree ceases to be in an Eligible Class; or
- because of the death or divorce of an Employee or Retiree; or
- because of the death of an Employee's or Retiree's dependent spouse;

coverage for the Covered Family Member will continue under this Plan, provided premium payments are continued by means of direct payment to Aetna.

The Covered Family Member may elect not to continue coverage by notifying Aetna within 31 days of the event which would in the absence of this Portability provision terminate coverage. Failure to remit premium to Aetna within 31 days of the first premium due date following the continuation will result in termination of coverage.

A Covered Family Member who does not continue coverage under this Plan may be eligible for benefits as described in the "Non-Forfeiture Benefits" section of this Certificate, if applicable.

In no event may coverage of a Family Member be continued under the terms of this "Portability" provision if coverage would terminate for non-payment of premiums or premium contributions on that person's behalf.

Portability Rules

As of the date a Covered Family Member elects to continue coverage under this Plan, and becomes a Portable Insured, the following shall apply:

There will be no enrollment of additional family members; and

If premiums for a Portable Insured are not made within the period indicated in the "Notice of Individual Coverage Termination" provision, his or her insurance under this Plan will terminate at the end of that period.

All other applicable provisions of this Certificate shall continue to apply, including, but not limited to: "Changes in Coverage Amounts"; "Non-Forfeiture Benefits"; and "Provision for Refund of Contributions."

General Provisions

Assignment

No assignment of any kind will bind Aetna without its written consent.

Time Limit on Certain Defenses

Claim under any given coverage of a person, for a loss incurred or starting more than six months after the coverage becomes effective for the person, will not be reduced or denied because there existed, prior to the effective date, a disease or physical condition not expressly excluded from the coverage on the date of the loss.

Written Notice of Claim

Written notice of claim will be required, including notice of a claim of a Loss of Functional Capacity. During any one Benefit Period, the notice of a claim of a Loss of Functional Capacity must be given to Aetna within 90 days after start of the Loss of Functional Capacity. Notice of other claims must be given to Aetna within 90 days of the date the claim was incurred.

Failure to give notice within the required period of time will not affect a claim if notice is furnished as soon as reasonably possible. In any event, notice must be given within one year after the time it was otherwise required. The one year limit will not apply in the absence of a Covered Family Member's legal capacity.

Denial of Claims

If upon Aetna's denial of a Covered Family Member's claim, the member makes written request to Aetna for information relating to the claim, Aetna shall make available all information directly related to the claim within 60 days of the date of the written request, excluding, however, any information that may not be disclosed in accordance with any applicable federal or state law or regulation.

Legal Action

No action at law or in equity may be brought to recover on the group contract after three years from the time written notice is required to be furnished.

Determination of Loss of Functional Capacity

The determination of whether a Covered Family Member has suffered a qualifying Loss of Functional Capacity, shall be made by Aetna.

Payment of Benefits

All benefits are payable to the Covered Family Member. However, Aetna has the right to pay any health benefits to the service provider. This will be done unless the Covered Family Member has told Aetna otherwise by the time the claim is filed.

All benefit payments will be made in U.S. dollars. All benefits will be paid not more than 60 days after Aetna receives proof of loss.

Physical Exam

Aetna will have the right to examine, at its own expense, the person of anyone whose injury or disease is the basis of a claim when and as often as it may reasonably require before and during a Benefit Period.

Facility of Payment

If any benefit under this Plan is payable to a person who is, in Aetna's opinion, legally not able to give a valid receipt and discharge of payment, Aetna may pay such benefit to any relative (by blood or connection by marriage) who is deemed by Aetna to be entitled to the payment.

Any such payment will fully discharge Aetna's duties to that extent. Aetna will not have to see how the payment is applied.

Misstatements

If any fact as to a person to whom the insurance relates is found to have been misstated, an equitable adjustment of premiums will be made. If the misstatement affects the existence or amount of insurance, the true facts will be used to decide if insurance is in force and its amount.

Records of Expenses

Covered Family Members should keep complete records of all charges incurred during a Benefit Period. They will be required when a claim is made for payment of benefits.

Records kept should include the dates expenses are incurred and copies of all bills and receipts.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, Aetna has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery Aetna may have with respect to such overpayment.

Statements

Except in the case of fraud, no statement made by the Employer or any Covered Family Member shall avoid coverage or reduce benefits or be used in defense to a claim unless it is in writing.

Incontestability Period

If the coverage of a Covered Family Member has been in force for less than 2 years, Aetna may rescind the coverage or deny an otherwise valid claim upon a showing of material misrepresentation and an intent to deceive by the insured in the application for insurance.

After a Covered Family Member's coverage has been in force for two years, it shall not be contested, except for non-payment of premium.

Aetna may not recover benefits in the event that coverage is rescinded due to a contest.

Grievance Procedure

Aetna has established a procedure for resolving complaints by Covered Family Members. If a Covered Family Member has a complaint, he or she should follow this procedure:

- Grievance is defined as a written request for review of a decision which has denied in whole or part, after consideration of any relevant information, a request for claim payment. No special form is required. This request for review can include formal reconsideration, formal appeal and, if not resolved, an external independent review.
- Aetna will send the Covered Family Member a response within 60 days of reviewing the Grievance. The response will be based on the information provided with or subsequent to the Grievance.
- If additional time is needed to resolve the Grievance, Aetna will provide a written notification indicating that additional time is needed, explaining why such time is needed and setting a new date for a response.
- Aetna will keep the records of the Covered Family Member's complaint for three years following the date a Covered Family Member's coverage terminates.

For more information regarding the grievance procedure process, please contact:

Aetna Life Insurance Company
Long Term Care Claim and Underwriting Department
Risk Manager
1-800-248-0591



Notice of Privacy Practices Long Term Care Plans

Para recibir esta notificación en español por favor llamar al número provisto en este documento.

This Notice of Privacy Practices applies to Aetna's long term care plans. It does not apply to any long term care plans that are self-funded by an employer. Your employer will be able to tell you if your plan is self-funded. If your plan is self-funded, you may want to ask for a copy of your employer's privacy notice.

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.***

Aetna considers personal information to be confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies.

This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information.

When we use the term "personal information," we mean financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information," we mean information that identifies you and relates to your medical history (e.g., the health care you receive or the amounts paid for that care).

How Aetna Uses and Discloses Personal Information

In order to provide you with insurance coverage, we need personal information about you, and we obtain that information from many different sources – particularly your employer or benefits plan sponsor, other insurers, HMOs or Third Party Administrators (TPAs), and health care providers. In administering your health benefits, we may use and disclose this information in various ways, including:

Health Care Operations: We may use and disclose personal information during the course of running our health business – that is, during operational activities such as quality assessment and improvement; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Aetna with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; collecting premiums; and responding to complaints, appeals and requests for external review. For example, we may use your

medical history and other health information about you to determine if you have suffered a loss of functional capacity – and during the process, we may disclose information to your provider. We also mail notices of benefit determination, Explanation of Benefits forms and other information to the address we have on record for the member.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may send certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

Additional Reasons for Disclosure

We may use or disclose health information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to your employer, when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Associates** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, U.S. Department of Labor and other government agencies that regulate us.
- **Law Enforcement** – to federal, state and local law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

Disclosure to Others Involved in Your Health Care

We may disclose health information about you to a relative, a friend, or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling our toll-free hotline at 1-800-537-8521.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us by calling our toll-free hotline at 1-800-537-8521.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call our toll-free hotline at 1-800-537-8521.

Your Legal Rights

The federal privacy regulations give you the right to make certain requests regarding health information about you. You may ask us to:

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- Communicate with you in a certain way or at a certain location. We will accommodate reasonable requests.
 - Restrict the way we use or disclose health information about you in connection with health care operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.
 - Obtain a copy of health information that is contained in a “designated record set” – records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.
 - Amend health information that is in a “designated record set.” Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
 - Provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.

You may make any of the requests described above, or may request a paper copy of this notice, by calling *our toll-free hotline at 1-800-537-8521*. You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please follow the complaint procedures described in your plan documents or on our Web site at www.Aetna.com. You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Aetna’s Legal Obligations

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy your personal information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

If you have questions regarding this notice, please contact Aetna’s Legal Support Services Department by mail at 151 Farmington Avenue, W121; Hartford, CT 06156; by phone at 860-952-8600; or by fax at 860-907-3017. Include your name, area code, daytime telephone and fax number.

Your coverage is underwritten by Aetna Life Insurance Company.