

Individual Long Term Care Insurance Policy



READ YOUR POLICY CAREFULLY.

Prudential will provide the coverage described in this Policy, subject to all stated terms, conditions, limitations and exclusions. Your coverage consists of this Policy, any optional Benefit Riders and any Amendatory Riders attached to it. Please refer to your Policy's Glossary for definitions.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* that you received at the time of application.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING
CONDITIONS LIMITATION.**

NY Individual

The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102





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

CONTACT ADDRESS: The Prudential Long Term Care Customer Service Center
P. O. Box 8519, Philadelphia, PA 19176-8519

In your Policy, 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.

Thank you for choosing a Prudential Long Term Care Insurance Policy. Your Policy is a contract between you and Prudential. The coverage begins as stated herein at 12:01 A. M., Standard Time, if the first full modal premium is paid.

TAX STATUS: Your Policy is intended to be a federally tax-qualified long-term care insurance contract under **Section 7702B(b) of the Internal Revenue Code of 1986, as amended.** If a change to this law, or other Federal regulation affecting the tax status of your coverage occurs, your Policy may be modified upon agreement between you and Prudential. Your Policy is also intended to qualify for purposes of the New York State Tax Law, Section 612(c)(31) and the City of New York Administrative Code Section 11-1712(c)(31).

RENEWABILITY: Your Policy is guaranteed renewable. It begins on the Original Effective Date shown in the **Schedule of Policy Benefits.** You can continue your Policy as long as the full modal premium is paid on time and the Policy Lifetime Maximum has not been exhausted. Prudential cannot change the terms of your Policy on its own, except it may change the premiums. (See "Premiums" provisions.)

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

NOTICE TO BUYER: This Policy 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 Policy limitations.

A handwritten signature in black ink that reads "Kathleen M. Gibson".

Secretary

A handwritten signature in black ink, appearing to be "John H. ...".

Chairman of the Board

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YOUR LONG-TERM CARE INSURANCE BENEFITS

This Policy provides benefits for Qualified Long-Term Care Services. Benefit descriptions are stated below. Not all charges are covered. Please refer to the **Policy Exclusions** section.

The benefit payment for covered services and the Policy Lifetime Maximum are shown in the **Schedule of Policy Benefits**. These benefits are subject to change if you have elected additional optional inflation protection or exercise an option under the Guaranteed Increase Feature. Prudential will pay benefits for Eligible Charges up to the benefit limit that applies for the charges incurred, after all terms and conditions of coverage have been met. No dollar limit will be applied to any particular day you receive Qualified Long Term Care Services; however, there are limits on certain benefits. 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. Only charges related to services included in the Plan of Care will be considered Eligible Charges. Benefits for Eligible Charges are provided if the Calendar Day Elimination Period, if applicable, has been satisfied. All benefits are subject to the Calendar Day Elimination Period except the Hospice Care Benefit, the Starter Benefit and the Home Support Services Benefit. All benefits paid reduce your Policy Lifetime Maximum.

Your Policy gives you access to information on long-term care resources and care providers in your community. Prudential's Long Term Care Resource Center can help provide this information or you may access this information from Prudential's website at www.prudential.com. You do not need to meet the Benefit Eligibility Criteria in order to use this service. Call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 for assistance.

BENEFIT DESCRIPTIONS

FACILITY CARE

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

Your Policy provides benefits for Eligible Charges for covered services you receive as a resident of a Nursing Home, an Adult Foster Home or Board and Care Facility, Assisted Living Facility or Residential Health Care Facility. This includes covered services you receive as Respite Care.

80% of the Eligible Charges will be paid for each day you are a resident in one of the above listed facilities.

Benefits will not be paid for Facility Care or Home Care and the Starter Benefit on the same day.

**BED
RESERVATION
BENEFIT**

Your Policy provides benefits to retain your bed at a facility if you are a resident in such a facility and you are absent for any reason for 24 hours or more.

Charges for Bed Reservation are Eligible Charges if they satisfy the following requirements.

- 1) The charge is a separate, customary facility charge to reserve the bed during a temporary absence from the facility.
- 2) You would be required to pay the charge in the absence of insurance.
- 3) The charge is incurred while you are receiving benefits for care in a facility.
- 4) Benefits were payable immediately prior to your absence due to your need to receive Qualified Long-Term Care Services on a 24-hour per day basis.

80% of the Eligible Charges to reserve your bed will be paid. Benefits will not be paid for other Facility Care or Home Care for the same day on which a Bed Reservation benefit is paid.

**HOSPICE CARE
BENEFIT**

Your Policy provides benefits for Eligible Charges for Hospice Care when you are Terminally Ill. 80% of the Eligible Charges will be paid for each day you receive Hospice Care as a resident in a facility or in your Home.

HOME CARE

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

Your Policy provides benefits for Eligible Charges you receive as Home Health Care, Homemaker Services or Personal Care Services. Such services must be received from a Caregiver. This Policy also provides coverage when you receive Adult Day Care.

80% of the Eligible Charges will be paid for each day you receive Adult Day Care, Home Health Care, Homemaker Services or Personal Care Services from a Caregiver.

Benefits will not be paid for Facility Care or Home Care and the Starter Benefit on the same day.

ADDITIONAL POLICY BENEFITS

STARTER BENEFIT

At your option, your Policy will pay a Starter Benefit to you in cash in lieu of reimbursement for Eligible Charges for Facility Care or Home Care. The Starter Benefit is a fixed monthly amount shown in your **Schedule of Policy Benefits**.

The Starter Benefit is subject to the following criteria.

- 1) You can only elect this benefit on a monthly basis. This election is made on the claim form.
- 2) Benefits are paid in lieu of Facility Care or Home Care benefits.
- 3) The Starter Benefit Policy Maximum is 24 months.

The Starter Benefit is only available during the first 24 cumulative months that you are Chronically Ill. The Starter Benefit is not subject to the Calendar Day Elimination Period. The months in your Calendar Day Elimination Period during which you receive the Starter Benefit count towards the Starter Benefit Policy Maximum.

If your Policy Lifetime Maximum is exhausted in less than 24 months, you may continue to receive the Starter Benefit as long as you satisfy the Benefit Eligibility Criteria until the 24-month Starter Benefit Policy Maximum has been reached.

Under the Starter Benefit, charges for Qualified Long Term Care services do NOT need to be incurred and any **Policy Exclusions** related to covered charges shall not apply.

HOME SUPPORT SERVICES BENEFIT

Your Policy 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 recommended in writing by a Licensed Health Care Practitioner and be part of your Plan of Care. 100% of the Eligible Charges will be paid for Home Support Services. Benefits for Home Support Services are subject to the Home Support Services Policy Maximum. 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 meeting the standards of an eligible program 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 equipment you rent or purchase that is designed to be used more than once 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 items.

- 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 being Chronically Ill.

Private Care Manager means charges by a Private Care Manager or Geriatric Care Manager 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 or revisions to 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.

Transportation Services means transportation provided by a licensed transportation carrier, which carries passengers for a fare, to and from your Home directly from and to a Provider for

services included in your Plan of Care.

**ALTERNATE PLAN
OF CARE BENEFIT**

Your Policy provides coverage for a broad range of services including Facility and Home Care. Prudential will consider a claim for services designed to help you function independently in your home or for stays in facilities not otherwise covered by your Policy. 80% of such Eligible Charges will be paid.

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.
- 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. It must be either an appropriate alternative to services covered by your Policy or to supplement to services covered by your Policy. However, you may choose to stop the covered alternative services at any time and use other services covered by your Policy.

**WAIVER OF
PREMIUMS
BENEFIT**

After you meet the Benefit Eligibility Criteria and satisfy any applicable Calendar Day Elimination Period, the premiums for your Policy will be waived.

Waiver of premiums is subject to these rules.

- 1) Waiver begins on the day following the date you satisfy your Calendar Day Elimination Period.
- 2) Waiver ends on the date you are no longer Chronically Ill.

If premiums for your Policy are paid in advance at the time of waiver, Prudential will refund the pro-rated portion of the advanced premium. Premiums will again become due as of the first day after the date you are no longer Chronically Ill.

**GUARANTEED
INCREASE
FEATURE**

Every five years on your Policy Anniversary Date, Prudential will increase your Policy Lifetime Maximum with an associated increase in premium. You will be notified of this benefit increase at least 60 days prior to your Policy Anniversary Date. You will not have to provide proof of good health to receive this benefit increase.

All benefit increases will occur even if you are receiving benefits or have met the Benefit Eligibility Criteria at the time of the increase takes effect. No further benefit increases will be put into effect on or after the date of your 76th birthday.

The additional premium for the increase in coverage will be based on your attained age. These increases will occur without your

taking any action. If you want to decline any increase, you must notify Prudential in writing, within 30 days of receipt of the notification. You may decline any number of these increases without affecting the availability of or your acceptance of future increases.

With each benefit increase, your Policy Lifetime Maximum will be increased by 25% of the Policy Lifetime Maximum then in effect on that Policy Anniversary (not including any prior benefit increases applied under this Guaranteed Issue Feature, and excluding any amounts paid in claims).

The value of your remaining Policy Lifetime Maximum will be determined as follows. Your Policy Lifetime Maximum in effect on your Policy Anniversary plus all benefit increases applied under this Guaranteed Issue Feature, less the total of all benefits paid under your Policy.

With each benefit increase, your Starter Benefit will increase by \$375. The Home Support Services Policy Maximum will increase by \$2,500. However, if you have exhausted the Starter Benefit Policy Maximum or the Home Support Services Policy Maximum before accepting a benefit increase, these benefits will not increase.

You will receive a new **Schedule of Policy Benefits** following each benefit increase.

THE CLAIMS PROCESS

In accordance with the provisions below, this section describes what Prudential needs to determine if benefits are payable under your Policy. You must be Chronically Ill while Your Policy is in force. You must undergo an Assessment and be certified by a Licensed Health Care Practitioner as being Chronically Ill. 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 being Chronically Ill. Being Chronically Ill means meeting 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 days. This expectation is not a waiting or elimination 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. All benefits are paid pursuant to the Plan of Care.

NOTICE OF CLAIM

If you think you are Chronically Ill and expect your condition to last at least 90 days, you should call the Prudential Long Term Care 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 being Chronically Ill, or as soon as reasonably possible. Notice may be given to The Prudential Insurance Company of America at its Long Term Care Customer Service Center. The notice should include your name and Policy Number. The address for the Customer Service Center appears on the first page of your Policy.

CERTIFICATION PROCESS

Prudential will arrange for an Assessment to determine if you Chronically Ill. 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. The Assessment should take place in your home or in the setting in which care is to be rendered.

You must be certified by a Licensed Health Care Practitioner. After you are certified as being Chronically Ill, a Plan of Care 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 that you are Chronically Ill. 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 the 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 are Chronically Ill. 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 and 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 Policy.

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 items.

- 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. 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 and will be reasonable in determining that the Proof of Loss provides enough information to consider the claim. You are responsible for obtaining a sufficiently itemized bill from the facility you use.

A provider's bill does not need to be submitted for a claim under the Starter Benefit. Only a completed Claim Forms needs to be submitted.

This 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.
- 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 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 as soon as Prudential receives satisfactory proof of loss. An explanation of benefits notice that explains the resolution of your claim will be sent to you.

Benefits will be calculated in United States currency.

**PAYMENT OF
CLAIMS**

You can choose whether you want to receive the benefit payments or have them paid directly to the service Provider. Benefits are paid immediately when Prudential receives satisfactory proof of loss. A benefit unpaid at your death will be paid to your estate except as otherwise required or authorized by law or judicial decree to be paid to another person or entity. Any payment made in good faith will fully release Prudential of its responsibility to the extent of the payment.

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 by a Licensed Health Care Practitioner at least once in a 12-month period. Prudential reserves the right to verify at any time that all of the Benefit Eligibility Criteria have been satisfied and 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.

If you believe this decision is unfair, you may contact the Prudential with your complaint. To contact the Prudential, write or call:

The Prudential Insurance Company of America
Long Term Care Customer Service Center
P.O. Box 8519
Philadelphia, PA 19176

Phone: 800-732-0416

LEGAL ACTIONS

No action at law or in equity can be brought against Prudential to recover benefits from this Policy until 60 days after the required proof of loss is furnished to Prudential. No such action shall be brought more than three years after the expiration of the period within which proof of loss is required to be furnished.

**CALENDAR DAY
ELIMINATION
PERIOD**

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

Prudential will begin to count days to satisfy your Calendar Day Elimination Period with the date you are certified by a Licensed Health Care Practitioner as being Chronically Ill. Each day of the period you remain Chronically Ill will count toward the satisfaction of this Calendar Day Elimination Period.

Once a day of the Calendar Day Elimination Period is satisfied, it is satisfied for the life of your Policy.

POLICY EXCLUSIONS

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

- 1) 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.
- 2) 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.
- 3) Charges for services or supplies in excess of those normally charged by the Provider in the absence of insurance.
- 4) Charges for care or treatment received outside the United States of America, its territories or possessions.
- 5) Charges for care or treatment rendered by a member of your Immediate Family, unless he or she is a Caregiver (other than an Independent Health Care Professional or Independent Caregiver), and he or she receives no compensation other than the normal compensation for employees in his or her job category.
- 6) Charges for any care received while in a hospital, except in a unit specifically designated and licensed as a Nursing Home or Hospice facility.

NON-DUPLICATION OF MEDICARE BENEFITS

Benefits under your Policy are not payable for expenses for Qualified Long-Term Care Services to the extent that either of the following applies.

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

This provision does not apply if such expenses are reimbursable by Medicare as a secondary payer or to claims for the Starter Benefit.

PREMIUMS

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 this rate for the benefits you have chosen. Premiums for the base Policy and any options will not automatically increase solely due to your becoming older. Premiums will not automatically increase because benefits are paid.

CHANGES IN PREMIUMS

Premiums for your Policy are shown in the **Schedule of Policy Benefits**. Your initial premium is based on the rates in effect on the Effective Date of your insurance. Prudential has the right to change rates only if both items 1) and 2) occur.

- 1) The change occurs after the first Policy Anniversary Date.
- 2) The change applies to all insureds in your premium class.

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

The premium for your Policy can also change under the following circumstances.

- 1) You change your benefit amounts or plan options.
- 2) A benefit increase is automatically applied to your Policy under the Guaranteed Increase Feature, if available under your Policy.

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, we may either reduce your Policy benefits or rescind your Policy.

If we need to reduce your benefits, your benefits will be reduced to those that the premium paid would have purchased at your correct age.

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

MISSTATEMENT OF INFORMATION

Since Prudential relied on information provided by you to calculate your premium, if it is later discovered that you were not rated properly, the premium rate will be adjusted prospectively with the next premium due.

GRACE PERIOD

Your first full modal premium must be paid for your Policy 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 Policy 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 following grace period. During the grace period, your Policy 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 Policy will lapse (end) 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 Policy will lapse because your full modal premium was not received. You may exercise or waive this right at the time you apply for your Policy 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.

REINSTATEMENT

If your full modal premium is not paid within the time required, your Policy will lapse. To reinstate your Policy, 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 Prudential or its Producer accepts payment for the past due and unpaid premiums without requesting a reinstatement application, your Policy will be reinstated.

You will be given a conditional receipt for any premium paid with your request for reinstatement. If Prudential approves the reinstatement, your Policy will be reinstated as of the approval date.

If an application of reinstatement is required, and a conditional receipt is issued for the premium tendered, your Policy will be reinstated on the 45th day after the date of the conditional receipt unless we previously wrote you of its disapproval. If a reinstatement application is required and approved, the reinstated policy will only cover the period you are Chronically III that starts after your date of reinstatement.

If your Policy lapsed as a result of you being Chronically, 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) The period you were Chronically Ill is certified by a Licensed Health Care Practitioner and existed on the premium due date.

Your Policy 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 Policy lapsed. All benefits paid before the reinstatement count towards your Policy Lifetime Maximum under the reinstated policy.

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

SUSPENSION PROVISION

If you are a member of a Reserve component of the Armed Forces of the United States, including the National Guard, you are entitled, upon written request, to have your coverage suspended during a period of active duty. You are entitled to suspension if:

- 1) You voluntarily or involuntarily enter active duty (other than for the purpose of determining physical fitness or for training).
- 2) You have had your active duty voluntarily or involuntarily extended during a period when the President is authorized to order units of the ready reserve or members of a reserve component to active duty, provided that such additional active duty is at the request and for the convenience of the federal government.
- 3) You serve no more than five years of active duty.

Prudential will refund any unearned premiums for the period of such suspension.

You may resume coverage upon written application and payment of the required premium within sixty days after the date of termination of the period of active duty. Coverage shall be retroactive to the date of termination of the period of active duty.

For a limited period, benefits will not be paid for charges incurred in connection with a condition that arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty. This limited period extends for six months after the date your coverage is resumed.

REFUND OF

Unless satisfactory proof is provided to Prudential to indicate a third

**UNEARNED
PREMIUM**

party has the legal right to a refund of premiums made in connection with this Policy, all premium refunds shall be made to the insured or the insured's estate.

Upon proper notice of the cancellation of your Policy 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.

**[CONTINGENT
NON FORFEITURE
PROVISION**

If the Non-Forfeiture Benefit Rider is not a part of your Policy, these Contingent Non-Forfeiture provisions apply. These provisions change your Long-Term Care insurance to provide options to you in the event your Policy 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 coverage including benefit increases under the Guaranteed Increase Feature. The limits of cumulative increase as a percentage of your Annual Premium are based on your age as of the Policy's Original Effective Date shown in your **Schedule of Policy Benefits**.

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 Policy 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 benefit amounts in effect at the time of lapse will be payable, but the Policy Lifetime Maximum will be equal to the greater of the following items.
3. The total amount of premiums paid for your Policy.
4. 3% of your initial Policy Lifetime Maximum as of your Original Effective Date.

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

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

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

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%]

GENERAL INFORMATION

TAX STATUS OF PREMIUMS AND BENEFITS

Your Policy is intended to be a **Qualified Long-Term Care Insurance Contract as defined by the Internal Revenue Code Section 7702B(b)**. The benefits you may receive under your Policy should not be considered taxable income. In addition, some or all of the premiums you pay for your Policy 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 Policy does not comply with the requirements of Code Section 7702B. In this event, your Policy may be modified upon agreement between Prudential and you.

Please be advised that if you do not agree with the suggested modification, your Policy may no longer qualify as a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended

ENTIRE CONTRACT

The entire contract between you and Prudential consists of your Policy, all attached pages, any optional Riders and your Application. A change in this contract will be valid only when approved by a Prudential officer and made a part of the contract. A Producer may not change the contract or waive any part of it.

DIVIDENDS

Your Policy is non-participating. It will not share in Prudential's profits or surplus earnings. Prudential will pay no dividends on it.

CONFORMITY WITH STATE STATUTES

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes

COMMUNICATION THROUGH ELECTRONIC MEANS

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

With our prior consent, communications made by you or your representative pursuant to or in connection with your Policy, 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 Policy, 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.

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.

OWNERSHIP

You are the owner of your Policy.

REDUCING COVERAGE

You may make a request to reduce your Policy Lifetime Maximum to lower your premium while your Policy is in force.

Prudential may limit any reduction in coverage to options available for this Policy and to those for which benefits will be available after consideration of claims paid or payable. The age to determine the premium for reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. We will not require any additional proof of good health to reduce benefits.

To make a request, you can choose one of the following options.

- 1) You may contact your Producer to initiate a request to reduce your coverage.
- 2) You may write to us at the Contact Address in your Policy.
- 3) You may call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 for assistance.

WHEN YOUR POLICY ENDS

TERMINATION OF YOUR POLICY

Your Policy and any applicable Riders will end at 12:01 A. M., Standard Time on the earliest of the following dates.

- 1) The premium due date if you fail to pay the full modal premium required for your Policy 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 later of the date you have exhausted your Policy Lifetime Maximum or the date you have exhausted your Starter Benefit.
- 3) The date of your death.
- 4) The date we receive written notice requesting cancellation of your Policy or the date requested in such notice, if later.

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

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

As to other benefits, you must continue to meet the **Benefit Eligibility Criteria** and be in need of Long Term Care from the date the charge is incurred in order for Prudential to provide benefits.

Benefits will be extended until the earlier of:

- 1) The date on which you no longer incur Eligible Charges for such care;
- 2) The date you no longer meet the **Benefit Eligibility Criteria**; or
- 3) The date benefits up to your Lifetime Maximum Benefit have been paid.

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

INCONTESTABILITY PROVISIONS

Your Policy was issued based on information given in your Application. All statements made in your Application 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 Policy is in force, if:

- 1) Information on your Application 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 Policy or deny an otherwise valid claim.

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

- 1) Information on your Application 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 Policy or deny an otherwise valid claim.

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

- 1) Relevant facts relating to your health were knowingly and intentionally misrepresented on your Application; and
- 2) As a result, we offered you insurance that you otherwise would not have been offered,

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

These provisions also apply if you provide additional evidence of insurability to purchase additional coverage after your Policy Effective Date. However, the incontestability time frames begin anew only for any statements on the application for the additional coverage. The time frames from the initial application for policy coverage are not renewed.

GLOSSARY

This section defines certain of the terms used in your Policy. These definitions apply to the terms used in your Policy and any other attached forms.

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 individuals, 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 adults in a home-like environment for compensation. Residents must be unrelated to the Provider by blood or marriage and be elderly or physically disabled. 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. For facilities located in a jurisdiction that does not license or certify Adult Foster Homes or Board and Care Facilities, it is a facility that provides ongoing services to a maximum of five residents in one location and is determined by Prudential to meet the following requirements.

- 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.

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 Chronically Ill. 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. The Assessment should take place in your home or in the setting in which care is to be rendered.

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 requirements.

- 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.

**CALENDAR DAY
ELIMINATION
PERIOD**

The number of calendar days that you are Chronically Ill that must elapse before certain Policy benefits may be payable. The Calendar Day Elimination Period applies to all benefits except the Hospice Care Benefit, the Starter Benefit and the Home Support Services Benefit. The Calendar Day Elimination Period is shown in the **Schedule of Policy Benefits**.

CAREGIVER

Caregiver means any provider of Home Health Care, Homemaker Services or Personal Care Services who is licensed, certified or otherwise authorized by the state where the services are performed to perform Home Health Care, Homemaker Services or Personal Care Services.

Caregiver includes a Home Health Care Agency, Home Health Aide, Referral Agency, Nurse Registry, Independent Health Care Professional and Personal Care Agency, Assisted Living Facility or Residential Health Care Facility.

Prudential recognizes that licensure, certification, and the names of eligible care providers vary from state-to-state. Therefore, we have developed alternative criteria to credential eligible care providers.

Care providers who meet the alternative criteria below when licensure, certification or other authorization to perform Home Health Care, Homemaker Services or Personal Care Services is not required by the state shall be considered eligible care providers.

Caregiver also includes an entity that satisfies the Agencies as Caregivers requirements below, or an individual that satisfies the Independent Caregiver requirements below.

- 1) **Agencies as Caregivers.** If the Home Health Care, Homemaker Services or Personal Care Services are furnished through an agency but the state in which the services are provided does not require the agency to be licensed, certified or otherwise authorized by the state to

provide Home Health Care, Homemaker Services or Personal Care Services, then the agency must satisfy all of the following requirements, to be a Caregiver.

- a) The agency must employ a full-time agency administrator responsible for the following activities.
 - i) Developing and maintaining care standards for Home Health Care, Homemaker Services or Personal Care Services provided to individuals.
 - ii) Ensuring that care providers receive adequate training in medical and non-medical home care protocols, as appropriate, to effectively perform Home Health Care, Homemaker Services or Personal Care Services.
 - b) The agency must employ or contract with a Registered Nurse to direct and supervise care providers who provide Home Health Care, Homemaker Services or Personal Care Services.
 - c) The agency must create a customized care plan to meet the needs of each individual to whom it provides Home Health Care, Homemaker Services or Personal Care Services.
 - d) The agency must maintain written records of services provided during each home care visit.
 - e) The agency must employ or contract with care providers who are appropriately licensed, certified or otherwise authorized by the state to provide medical and/or non-medical Home Health Care, Homemaker Services or Personal Care Services, if the state in which services are provided requires care providers to be licensed, certified or otherwise authorized to provide such services. If the state does not require care providers to be licensed, certified or otherwise authorized to provide such services, then the agency must employ or contract with care providers who satisfy the Independent Caregivers requirements below, or are otherwise adequately and appropriately trained to provide medical and/or non-medical Home Health Care, Homemaker Services or Personal Care Services.
 - f) The agency must hold a current business license from the state in which Home Health Care, Homemaker Services or Personal Care Services are provided.
- 2) **Independent Caregivers.** If a care provider works independently and is not an agency or affiliated with an agency, and the state in which Home Health Care,

Homemaker Services or Personal Care Services are provided does not require the independent Home Health Care provider to be certified, licensed or otherwise authorized to provide such services, then the independent Home Health Care provider must satisfy all of the following requirements to be a Caregiver.

- a) The independent care provider must submit documentation to Prudential confirming that he or she successfully completed a formal training program providing instruction and/or classroom training in topics relating to the provision of assistance with Activities of Daily Living or the provision of other Qualified Long-Term Care Services, such as body mechanics, nutrition, infection control, and safe transfer techniques. The training must be obtained from one of the following places.
 - i) community college.
 - ii) similar accredited educational institution or vocational school.
 - iii) an agency that meets the Agencies as Caregiver definition above.
 - iv) a state-approved training program for home care workers.
 - v) another school, organization or individual that is authorized to provide such training by the state in which Home Health Care, Homemaker Services or Personal Care Services are provided.
- b) The independent care provider must submit to Prudential proof of identity, such as a valid state issued driver's license.
- c) Upon request, the independent care provider must submit to Prudential written records documenting the Home Health Care, Homemaker Services or Personal Care Services provided during each home care visit.
- d) An Independent Caregiver cannot be a member of your immediate family.

CHRONICALLY ILL

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 days. This expectation is not a waiting period. The Activities of Daily Living are defined and

**DOMESTIC
PARTNER**

listed above.

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

A person of the same or opposite sex who meets all the criteria listed below.

- 1) Is someone other than your Spouse.
- 2) Has lived with you for at least six months and intends to remain a member of your household for the period of Coverage.
- 3) He or she has a serious and committed relationship with you.
- 4) He or she is financially interdependent with you.
- 5) Is not related to you in a way that would prohibit legal marriage nor legally married nor a Domestic Partner to anyone else.
- 6) The partners are both eighteen years of age or older and are mentally competent to contract.
- 7) Neither individual has been registered as a member of another domestic partnership within the last six months.

Domestic Partner is subject to confirmation, either by proof of registration where such a registry exists, or for Domestic Partners residing where registration does not exist, by a notarized Affidavit of Domestic Partnership.

**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 Calendar Day Elimination Period, if any, is satisfied.
- 3) after the date you are certified as Chronically III.

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 (other than a Nursing Home) shall not be Eligible Charges unless a Licensed Health Care Practitioner

certifies in a Plan of Care both of the following requirements.

- 1) The primary reason for your residence in a 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 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 Calendar Day Elimination Period.

Eligible Charges also do not include charges for ancillary or miscellaneous items or services, provided in or by a facility or as part of 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, newspapers, routine over-the-counter medical supplies, guest charges and convenience items.

Starter Benefits are paid without regard to Eligible Charges.

HOME

The house, apartment or room that is the primary place where you live. You are not required to own your home. For example, if you live in an adult child's primary residence, that would be considered your Home.

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 the following requirements.

- 1) He or she meets the minimum training qualifications recognized by the Foundation for Hospice & Home Care, National League of Nursing or Health Care Financing Administration.
- 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 criteria.

- 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 activities.

- 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 a Terminally Ill individuals. 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 persons.

- 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, but is not limited to the following care and

services.

- 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.

IMMEDIATE FAMILY

Your spouse, Domestic Partner or anyone who is related to you or your spouse or Domestic Partner (including adopted, in-law and step-relatives) as a parent, child, grandchild, or sibling.

**INDEPENDENT
HEALTH CARE
PROFESSIONAL**

A Home Health Aide, Registered Nurse, Licensed Practical Nurse or Therapist not affiliated with an agency independently providing Home Health Care services within the scope of his or her license. An Independent Health Care Professional cannot be a member of your immediate family.

**LICENSED HEALTH
CARE
PRACTITIONER**

A Physician, a Registered Nurse, a licensed or certified social worker, or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury, or another professional individual who meets the requirements prescribed by the state in which he or she is licensed as appropriate to a tax-qualified policy.

**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.

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 Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

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 whose primary purpose is to provide skilled, intermediate or custodial nursing care and meets one of the following requirements.

- 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 requirements.
 - 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 that is primarily a facility for the treatment of alcoholism or chemical dependency.

PERSONAL CARE SERVICES

The provision of hands-on services to assist an individual with Activities of Daily Living.

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, individualized 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 based on the results of an assessment by a Licensed Health Care Practitioner, a review of your health status, medical records and other available information.
- 2) It is prescribed by a Licensed Health Care Practitioner.
- 3) It names the type, frequency and duration of services you need and the appropriate Providers to furnish such services.
- 4) It fairly, accurately and appropriately addresses your needs in accordance with accepted medical and nursing standards of practice for a person with a similar Chronic Illness or Disability.

Prudential reserves the right to review or discuss your Plan of Care with the Licensed Health Care Practitioner who prescribed it. We may also verify that the Plan of Care is consistent with accepted medical and nursing standards of practice for a person with a similar Chronic Illness or Disability. Your Plan of Care must be updated as your condition and care needs change. We must be provided with a revised Plan of Care each time it is updated. We may request periodic updates not more frequently than once every 30 days.

POLICY LIFETIME MAXIMUM

The maximum lifetime benefit payable for Eligible Charges according to the benefits you have chosen. Your initial Policy Lifetime Maximum is the amount available for all benefits payable under your Policy as of the Policy's Original Effective Date. The Policy Lifetime Maximum is shown on your **Schedule of Policy Benefits**. Benefits paid are deducted from the Policy Lifetime Maximum.

PRIMARY INFORMAL CAREGIVER

An unpaid person who regularly provides one of the following types of care.

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

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.

PRIVATE CARE MANAGER

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 Policy 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 Healthcare Organizations or other association that has substantially the same accreditation standards.

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.

SUBSTANTIAL ASSISTANCE

Hands-on assistance or stand-by assistance.

- 1) Hands-on assistance is the physical assistance (minimal, moderate or maximal) 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.

SCHEDULE OF POLICY BENEFITS

Prudential LTC EvolutionSM

POLICY NUMBER: 1234567890

ORIGINAL EFFECTIVE DATE: 01/01/2009

CHANGE EFFECTIVE DATE: Not Applicable

PREMIUM AGE: 50

INSURED: John Doe

RATE CLASS: Standard 1

123 Main Street

POLICY ANNIVERSARY DATE: 01/01/2010

Dresher, PA 19025

and each 01/01 thereafter

PLAN INFORMATION

CALENDAR DAY ELIMINATION PERIOD	90 days
BENEFIT PAYMENT FOR COVERED SERVICES	80% of Eligible Charges
CO-PAYMENT FOR COVERED SERVICES	20% of Eligible Charges
STARTER BENEFIT	\$1,500 per month
STARTER BENEFIT POLICY MAXIMUM	24 months
HOME SUPPORT SERVICES POLICY MAXIMUM	\$10,000
POLICY LIFETIME MAXIMUM (does not reflect claims paid or payable)	\$ 500,000

THIS POLICY INCLUDES THE FOLLOWING OPTIONAL BENEFIT RIDERS

OPTIONAL RIDER	EFFECTIVE DATE OF RIDER
INFLATION RIDER: 5% AUTOMATIC COMPOUND INCREASE OPTION RIDER	01/01/2009
NON-FORFEITURE BENEFIT RIDER	01/01/2009
SHARED CARE BENEFIT RIDER	01/01/2009
SHARED CARE PARTNER	Mary Doe
See next page for Premium Information.	

SCHEDULE OF POLICY BENEFITS (Continued)

Prudential LTC EvolutionSM

POLICY NUMBER: 1234567890

INSURED: John Doe

PREMIUM INFORMATION

Annual Premium For Base Policy		\$ 2,000.00
Optional Benefit Riders Premium		\$ 1,500.00
Optional Inflation Rider	\$ 500.00	
Non-Forfeiture Benefit Rider	\$ 500.00	
Shared Care Benefit Rider	\$ 500.00	
Annual Premium Including All Optional Riders		\$ 3,500.00
Partner Discount*	30%	
*Discounts are multiplicative.		
Total Annual Premium Including Optional Riders and Less Discounts		\$ 2,450.00
Modal Premiums		
Annual		\$2,450.00
Semi-Annual*		\$1,261.75
Quarterly		\$649.25
Monthly – EFT		\$208.25
*This is the modal premium you have elected. The total annual cost of your coverage will vary both by the frequency of premium payment (mode) as well as the method of payment chosen. The more frequent the premium payment mode the higher the annual cost.		

ALTERNATE BILLING ADDRESS
(if other than the insured)

ABC Company, Inc.
Attention: Jane Smith
456 Main Street
Dresher, PA 19025

Telephone Number:

215-555-1212

Producer: Sam Jones
789 Main Street
Dresher, PA 19025

Telephone Number:

215-555-2121

The Prudential
Insurance Company
of America

Long-Term Care
Insurance

