WEA Trust

Group Long Term Care Plan

A WEA Insurance Corporation
Insurance Policy

45 Nob Hill Road (53713-3959)
P.O. Box 7338 (53707-7338)
Madison, Wisconsin
Voice/TDD:
(608) 276-4000
(800) 279-4000

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IC LGL 3435-255-0108

Important Notice

(Keep this notice with your insurance papers)

Problems with your insurance?

If you are having problems with WEA Insurance Corporation, do not hesitate to call or write WEA Insurance to resolve your problem. The address and phone numbers are:

WEA Insurance Corporation
P.O. Box 7338
Madison, WI 53707-7338
Voice/TDD: (608) 276-4000 or (800) 279-4000

You may also write to the ***OFFICE OF THE COMMISSIONER OF INSURANCE***, a state agency that enforces Wisconsin's insurance laws, and file a complaint. The address is:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or, you may call (800) 236-8517 outside of Madison or (608) 266-0103 in Madison, and request a complaint form.

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WEA Trust Group Long Term Care Plan

Tax-Qualified Long Term Care Insurance Policy Underwritten by WEA Insurance Corporation

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

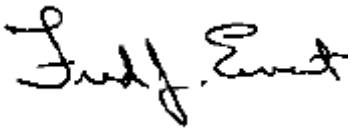
This document is a description of group long term care insurance benefits. If you are covered by this policy and are Chronically Ill, then this insurance policy provides reimbursement for a portion of the actual covered expenses you incur for Long Term Care services received in an institutional, community-based, or home care setting. To be eligible for benefits under this policy, you must be either unable to perform the requisite number of Activities of Daily Living without substantial assistance or have a Severe Cognitive Impairment. Your inability to perform the Activities of Daily Living must be expected to last for at least 90 days.

Your entitlement to the benefits described in this policy may be changed by the Optional Benefit Provisions if those provisions were selected by the policyholder. Your Benefit Summary indicates which Optional Benefit Provisions, if any, apply to your coverage. Premiums are to be paid monthly on or before the 20th day of the month preceding the month of coverage.

If you have any questions about the benefits or requirements of this policy, call us at (800) 279-4000 or (608) 276-4000 (Voice/TDD).

The WEA Insurance Corporation hereby agrees to provide benefits in accordance with all of the provisions, exclusions, and limitations of this policy.

WEA Insurance Corporation
Madison, Wisconsin



Fred J. Evert, President

Michael L. Stoll, Vice President

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Section 1
Rights and Obligations of the Policyholder, Individuals With Conversion Coverage, and the WEA Insurance Corporation

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General Information About This Policy

This policy is intended to be a tax-qualified long term care insurance policy.
This is an indemnity insurance policy. This policy provides reimbursement for a portion of the actual covered expenses incurred by a Chronically Ill covered individual for Long Term Care services received in an institutional, community-based, or home care setting. To be eligible for benefits, a covered individual must be either:

- Unable to perform the requisite number of Activities of Daily Living without substantial assistance, ***or***

- Have a Severe Cognitive Impairment.

If you have any questions about the benefits or requirements of this policy, call us at (800) 279-4000 or (608) 276-4000 (Voice/TDD).

Right to Return and Cancel Policy

Read this policy carefully. It is a legal contract. If the employer policyholder is not satisfied for any reason with the terms of this policy, the employer policyholder may return the policy within 30 days of the date the policy was delivered, whether by mail or in person, and we will refund the full premium.

Conditions of Issuance and Renewal for an Employer Policyholder

This policy will take effect on the date, and in accordance with the terms, specified on the agreement between the employer and us if the following requirements are met. If these requirements are not maintained, we may terminate this policy.

1. The employer and a bargaining agent affiliated with the Wisconsin Education Association Council must have negotiated the coverage provided by this policy.

2. The employer's plan that provides the benefits of this policy must satisfy the nondiscrimination requirements of sec. 501(c)(9) and 505(b) of the Internal Revenue Code.

3. One hundred percent (100%) of the employees eligible for coverage must submit the required written enrollment form and, where required, evidence of insurability. All employees determined to be eligible for coverage must enroll and remain enrolled while this policy is in effect.

Eligible employees are those whose job and hours of regular employment meet the criteria for inclusion in the eligible class of employees specified on the agreement between the employer and us.

4. The employer must meet any minimum contribution requirements we have established for this policy.

We will not permit this plan to be offered in a dual choice situation with another Trust or non-Trust plan without our prior written approval.

Premium Computation for Employer Policyholder

The premium for coverage under this employer group policy is a composite premium. This means that the amount of the individual premium required for coverage under this policy is the ***same*** for:

- A covered employee alone (if that covered employee has no spouse, or if we have determined that the spouse is not eligible for coverage on the basis of the evidence of insurability submitted); ***or***

- A covered employee ***and*** his or her covered spouse.

The monthly premium due is the sum of the premiums for all covered individuals. Premium is owed for each individual for each month in which he or she is covered by this policy for at least one day. Exception: When an employee's coverage begins after the 15th day of a month, the premium liability for that employee will begin on the first day of the following month.

The employer must notify us immediately whenever a covered employee ceases to be eligible for coverage. The premium liability for such an employee will cease on the last day of the last month of coverage. We will not be obligated to provide benefits to any individual who is not eligible for coverage even if premiums have been paid for that individual.

The premium will always be based on the rates for the benefits that are in effect on the date that the premium is due. We may establish a new rate for any or all of the policy's benefits on the policy renewal date in accordance with state law. We may also establish a new premium rate on any date on which any provision of this policy is materially changed by agreement between the employer and us, by federal or state law, or by the governmental administration of a statute.

Premium Computation for Individuals With Conversion Coverage

If you enroll in our group conversion policy, as described in "Your Rights to Conversion Coverage" in Section 3, your premium may change. Your premium for conversion coverage will be based on the rate for coverage under the employer's policy ***but*** will be modified for several actuarially relevant factors, such as:

- Your age.

- Your gender.

- Your marital status.

- Your geographic location.

- The additional cost to us of providing personalized administration of this policy.

These modifications may increase your premium above the rate for coverage under the employer's group policy.

When Premiums Are Due

The premium is due each month on or before the 20th day of the month that precedes the month of coverage. This payment deadline applies whether the premium is due from the employer or from a covered individual who pays his or her own premium directly to us.

Grace Period for Employers

We will allow a grace period of 31 days for the receipt of any premium due from the employer after the first premium. This policy will continue in force during the grace period. The grace period will start on the first day of the month following the day the premium is due. There will be no grace period, however, if either we or the employer has given written notice of termination to the other as stipulated below.

Grace Period for Individuals With Continuation or Conversion Coverage

Grace Period and Third Party Notification

If you have continuation or conversion coverage, you may designate one additional person to receive notice of lapse of coverage due to nonpayment of premium. If the premium remains unpaid 30 days after it was due, we will send a notice to you and your chosen designee. We will not terminate your coverage until 30 days after we send that notice. If full retroactive premium is paid in that 30-day period, your coverage will not lapse. You may designate a person to receive the notice, or change the designated person, any time by notifying us in writing of the name and address of your designee.

As an example, premium for April coverage is due March 20. If it is not paid, we send a notice of nonpayment of premium on April 20. If you or your designee sends in payment for the months of April, May, and June so that we receive it by May 20, your coverage continues without interruption. If we receive no response by May 20, your coverage terminates March 31.

Reinstatement of Continuation or Conversion Coverage

Normally, if premium is not timely paid, your coverage will terminate on the last day of the month for which premium has been paid. We will, however, retroactively reinstate coverage if ***both*** of the following conditions are met within 5 months of the date coverage terminated:

1. You, or someone on your behalf, submits a written request for reinstatement that includes evidence demonstrating to our satisfaction that your failure to make timely payment of premium was caused by the fact that you were Functionally Incapacitated or had a Severe Cognitive Impairment at the time your premium payments were due.

2. You or someone on your behalf pays the full retroactive premium due.

If these conditions are met, we will retroactively reinstate your continuation or conversion coverage. We will also consider any claim for benefits that you incurred during the period of lapse, subject to all other policy provisions.

For example, premium for April coverage is due March 20. If it is not paid, we send you a notice of lapse on April 20. If we receive no response by May 20, your coverage terminates effective March 31. On August 15, your adult child requests retroactive reinstatement, pays all retroactive premium owed, and provides satisfactory evidence that you have had a Severe Cognitive Impairment since before March 20, which caused you to miss your premium payments. In this case, we retroactively reinstate your

coverage because the request and all necessary information were provided within 5 months of the termination of coverage. If the same request was made after August 30, it would be rejected as untimely.

Termination of the Policy by the Employer Policyholder

The employer may terminate this policy on the first day of any month by giving us written notice at least 31 days before that date.

If the employer does not pay the premium when it is due or within the grace period, this policy will terminate at the end of the grace period. The employer is liable for payment of all premiums due and unpaid, including the premium for coverage during the grace period, as well as the costs and reasonable legal fees we incur in collecting any premiums owed.

We may agree to waive the automatic termination of this policy resulting from nonpayment of the premium. If we do, we have the right to charge interest on the delinquent premium, and the employer will be obligated to pay that interest. The interest rate charged will be the prime interest rate published in *The Wall Street Journal* on the first business day of that month plus 1%.

Termination of the Policy by Individuals With Conversion Coverage

If you have conversion coverage, you may terminate this policy on the first day of any month by informing us before that date that termination is desired. If you die while this policy is in force, we will refund to your estate, upon notification of your death and a request for refund, a pro rata portion of any premium actually paid for the month in which you died.

Right to Renew Conversion Coverage

If you have conversion coverage under the provisions described in "Conversion Coverage" in Section 3, you have the right to renew your coverage for the rest of your life as long as premiums are paid as required. We will not cancel, nonrenew, or otherwise terminate or alter your coverage based upon your particular claims experience, health status, or age. We may alter the policy's benefit design or increase premium only if we do so for all covered individuals in the same class.

Termination or Nonrenewal of the Employer's Group Policy by Us

We will not terminate this policy midterm except for one or more of the following reasons:

- The employer's failure to pay premium when due.
- Fraud or misrepresentation by the employer.
- Substantial breaches of contractual duties, conditions, or warranties by the employer.
- The employer's failure to remain in compliance with all of the conditions of issuance and renewal described above.
- The employer has aligned this plan in a dual choice situation with another plan without our prior written approval.

If the policy is terminated for any of these reasons, we will give written notice to the employer at least 31 days before the termination date.

Renewal of This Policy

The employer has the right to renew its group coverage unless one of the reasons cited in the prior paragraph exists, or there is some other legally permissible reason for us to nonrenew this policy.

We have the right to alter the policy's benefit design consistent with that available to other employer policyholders as long as the alterations are not based upon the employer's particular claims experience.

If we terminate this policy on any policy renewal date, we will give written notice to the employer at least 60 days before that date.

Employer's Duty to Furnish Information

The employer must furnish us with any information that we require to administer the employer group policy. For example, the employer must notify us within 30 days of any change in an employee's eligibility. Examples include, but are not limited to:

- A new employee becomes eligible for coverage.
- A change in job or hours renders an employee eligible for coverage.
- A covered employee is no longer eligible for coverage because of termination, retirement, reduction in hours, change in jobs, etc.
- A covered employee dies.

This information enables us to pay claims accurately and extend continuation coverage as required by law.

We have the right to inspect, at any reasonable time, any of the employer's records that are relevant to administering this policy, including verification that the policy's 100% participation requirement and the minimum contribution requirements are being met.

How Clerical Errors by Employers Will Be Handled

If, due to a clerical error, the employer fails to notify us of an employee who is eligible for coverage, that error will not deprive the employee and the employee's spouse of coverage or affect their entitlement to benefits if we receive the correct enrollment information no later than 6 months after the employee first became eligible for coverage. There will be no retroactive coverage to correct a clerical error unless that error is reported to us within 6 months after it occurs.

If, due to a clerical error, the employer fails to report the termination of coverage for an employee, that error will not extend coverage for that employee or spouse beyond the appropriate termination date as defined by this policy. We will refund premium paid beyond the appropriate termination date for such an employee, up to a maximum of 6 months' premium, if claims were not paid during that time.

Such an error by the employer will not change or extend any individual's legal rights with respect to group continuation coverage. The period of continuation coverage will be calculated from the date the individual was no longer eligible for coverage under this policy's provisions.

An employer's error will not create any liability whatsoever for us.

Statements by Our Employees or Agents

No statement or representation by any of our employees or agents can alter or waive any requirement or provision of this policy. No statement or representation relating to the interpretation or application of any provision of this policy will be binding unless it is issued in writing by an officer of our company.

Under no circumstances will the employer be deemed our agent without our written authorization.

Entire Contract

The entire contract of insurance consists of:

1. This policy and any Optional Benefit Provisions.

2. The Benefit Summary.

3. The Rate Summary.

4. The insurance agreement between the employer and us.

5. The employees' enrollment forms.

6. The evidence of insurability forms submitted by or on behalf of employees or spouses.

No change in this policy will be valid unless written and signed by an officer of the company.

Conformity With State and Federal Statutes

Any provision of this policy that conflicts with the applicable statutes of Wisconsin or applicable federal laws regulating tax-qualified long term care insurance is hereby amended to conform to the minimum requirements of such laws. The effective date of any such required amendment will be the latest date permitted by those laws.

Section 2
Definitions That Apply to All Provisions

The terms defined below appear throughout this policy. When these terms are capitalized in the text of the policy, they have the definition that is provided below.

Activities of Daily Living (ADLs) are Bathing, Continence, Dressing, Eating, Toileting, and Transferring, as defined here:

Bathing means 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, without Substantial Assistance from another person.

Continence means 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 a catheter or colostomy bag, without Substantial Assistance from another person.

Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs without Substantial Assistance from another person. An individual will be considered able to dress himself or herself even if these tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls.

Eating means 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 without Substantial Assistance from another person. An individual will be considered able to eat even if he or she requires assistance preparing or serving the food, such as cutting food or opening cartons.

Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene without Substantial Assistance from another person.

Transferring means the ability to move into or out of a bed, chair, or wheelchair without Substantial Assistance from another person. An individual will be considered able to transfer even if he or she uses or requires equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices, including mechanical or motorized devices, in order to transfer or ambulate.

Adult Day Care means assistance in the performance of the Activities of Daily Living, or Substantial Supervision, provided to a Chronically Ill individual in an Adult Day Care Center by appropriately trained and/or licensed persons through an individual program of health, social, custodial, and related support services that are appropriate to the needs of the individual.

Adult Day Care Center means a facility that meets ***all*** of the following criteria:

- The facility provides a program of Adult Day Care in an organized, nonresidential setting, and providing the program is its primary function.

- The Adult Day Care program is provided at least 5 days a week for a minimum of 6 hours and a maximum of 12 hours each day, to 3 or more unrelated adults who require assistance in the Activities of Daily Living or Substantial Supervision.
- The facility is established, licensed, and operated as an Adult Day Care Center in accordance with all applicable laws of the state in which it is located, or is approved by us in our sole discretion.

Alternate Care Facility means a residential facility that meets ***all*** of the following criteria:

- The facility provides care, treatment, or services to 5 or more unrelated Chronically Ill adults.

- The services provided are above the level of room and board, but less than the level required to be licensed as a nursing home.

- The facility provides general supervision and assistance with Activities of Daily Living on a 24-hour basis for those who cannot perform the Activities of Daily Living for themselves.

- Its supervisory personnel are trained in the techniques and aspects of caring for Chronically Ill individuals.

- It has a trained, awake, and ready-to-respond employee on duty in the facility at all times to provide care.

- It provides supportive services such as meals.

- It has appropriate measures and procedures to provide onsite assistance with prescription medications.

- The facility maintains patient care records, including the plan of care and the name and location of the personal physician for each resident.

- It has formal arrangements for the services of a physician or Nurse to furnish medical care in case of emergencies.

- The facility is established, licensed, and operated in accordance with all applicable laws of the state in which it is located, or approved by us in our sole discretion.

An Alternate Care Facility may include, but is not limited to, the following facilities if ***all*** of the above requirements are met: community-based residential facilities, residential care apartment complexes, assisted living facilities, or residential care facilities for the elderly.

Benefit Period means the 12-month period specified on the Benefit Summary.

Chronically Ill or ***Chronic Illness*** means that within the 12-month period immediately preceding the application for benefits, the covered individual has been certified by a physician to have either a Functional Incapacity or a Severe Cognitive Impairment.

Custodial Care means care that can generally be provided by persons without professional medical training or skills and that is primarily for one or more of the following purposes:

- Maintaining an individual's existing physical or mental condition of health.

- Preserving an individual's condition from further decline.

- Assisting an individual in performing the Activities of Daily Living.
- Protecting an individual from threats to health and safety due to Severe Cognitive Impairment.

- Meeting an individual's personal needs.

We consider such care to be Custodial even if provided by registered nurses, licensed practical nurses, or other trained medical personnel.

Disability or ***Disabled*** means the inability of an employee to perform adequately the material and substantial duties of his or her regular occupation due to involuntary, medically proven, and documented physical or mental impairment(s). The physical or mental impairment(s) causing the Disability must be substantiated in objective, contemporaneous medical records and documentation. For purposes of this definition, the regular occupation is the position the employee held on the date that we determine to be the first day on which the employee was Disabled.

Elimination Period means the number of days you are a Chronically Ill individual, as confirmed by us, before you are eligible to receive benefits. The Elimination Period is the period of consecutive days, specified on the Benefit Summary, for which no benefits will be paid under this policy even though you have satisfied all other requirements for receipt of benefits. You must remain Chronically Ill for each consecutive day to satisfy the Elimination Period. The Elimination Period begins, at the earliest, on the date a physician, after assessing your condition, signs a certification verifying that you are a Chronically Ill individual due to either Functional Incapacity or Severe Cognitive Impairment. You must meet the Elimination Period only once in your lifetime.

Functional Incapacity means the inability to perform, without Substantial Assistance from another person, 3 or more Activities of Daily Living, defined above, as a result of physical or cognitive impairment(s).

Home Health Care means part-time or intermittent health care services or assistance with the Activities of Daily Living, provided through a Home Health Care Agency to a Chronically Ill individual in his or her home under a plan of care established, approved in writing, and reviewed at appropriate intervals by his or her physician. Home Health Care may include any of the following:

- Home nursing care by or under the supervision of a registered nurse.

- Home health aide services under the supervision of a registered nurse or medical social worker.

- Homemaker services.

- Nutritional counseling provided by or under the supervision of a registered or certified dietician.

- Physical, respiratory, occupational, or speech therapy.

Home Health Care Agency means an agency or organization that meets ***all*** of the following criteria:

- It is state-licensed or Medicare-certified to provide coordinated Home Health Care, or is approved by us in our sole discretion.
- Its primary function is to provide Home Health Care.
- It is established and operated in accordance with all applicable laws of the state in which it is located.
- It maintains complete and accurate patient care records for each patient.
- It employs one or more physicians or registered nurses.

Hospice Care means palliative and supportive care provided to a terminally ill individual by a state-licensed or Medicare-approved program, agency, or organization. Hospice Care includes services provided by a licensed public agency or private organization intended primarily to provide pain relief, symptom management, and psychosocial support services. Services may be rendered at state-licensed hospice facilities or in the individual's place of residence.

Hospice Care Facility means a facility in which Hospice Care services are provided to terminally ill individuals. A Hospice Care Facility may be housed within a structure in which other services are provided (for example, a hospital or a Nursing Facility) or it may be a freestanding unit.

Immediate Family means the covered individual's spouse or domestic partner, and a daughter, son, daughter-in-law, son-in-law, father, mother, sister, brother, grandparent, or grandchild of the covered individual or the covered individual's spouse.

Intermediate Nursing Care means basic care, including physical, emotional, social, and other rehabilitative services, provided under periodic medical supervision. This type of nursing care requires the skill of a registered nurse in the administration (including the observation and recording of reactions and symptoms) and supervision of the nursing care, and provides a planned, continuous program of nursing care that is preventive or rehabilitative in nature. The level of skill required and the nature of the nursing care provided are less than that required and provided for Skilled Nursing Care, but greater than that required and provided for Custodial Care.

Long Term Care means care or services provided to a Chronically Ill individual for which a charge is made, pursuant to a plan of care prescribed by a physician, that are necessary to either assist or enable the individual to successfully perform the Activities of Daily Living, or protect the individual from threats to health and safety due to Severe Cognitive Impairment.

In this policy, Long Term Care includes Skilled Nursing Care, Intermediate Nursing Care, Custodial Care, Home Health Care, Adult Day Care, Hospice Care, Respite Care, and care that we have approved under an alternate care plan. Such care or services must be provided in a Nursing Facility, in an Alternate Care Facility, in the covered individual's residence by a Home Health Care Agency, in an Adult Day Care Center, or in a Hospice Care Facility.

Maximum Lifetime Benefit is the total amount of benefits that will be paid for Long Term Care received by a covered individual during his or her lifetime. This amount includes any combination of

benefits paid under any group long term care policy issued by us. The Benefit Summary specifies the amount of the Maximum Lifetime Benefit.

Nurse means a legally qualified person, other than a member of the covered individual's Immediate Family, who is licensed by the state as either a registered nurse or a licensed practical nurse.

Nursing Facility means a facility other than a hospital that meets ***all*** of the following criteria. It is:

- Primarily engaged in providing 24-hour continuous nursing care and related services, including room and board, on an inpatient basis.
- Established and operated in accordance with all applicable laws of the state in which it is located.
- Licensed or certified in the state in which it is operating to provide Skilled Nursing Care, Intermediate Nursing Care, or Custodial Care, or approved by us in our sole discretion.

A Nursing Facility may be a freestanding facility, including a skilled nursing facility, an intermediate nursing care facility, a convalescent nursing facility, a custodial care facility, and an extended care facility. It may also be a distinct part of a facility, including a ward, wing, or unit of a hospital or other institution. Nursing Facility does not include a hospital or any of the following:

- An institution operated primarily for the treatment and care of mental health disorders, drug abuse, or alcoholism.
- A facility that provides only room and board.
- A facility that primarily provides residential or retirement services.
- A private home or apartment.

Nursing Facility Care means care or treatment received in a Nursing Facility. In this policy, Nursing Facility Care includes Skilled Nursing Care, Intermediate Nursing Care, and Custodial Care.

Respite Care means either nursing or custodial care that is necessary to assist the Chronically Ill individual with the Activities of Daily Living, or to protect a Chronically Ill individual with Severe Cognitive Impairment from threats to health and safety. Respite Care is provided on a temporary, substitute basis, to enable the regular caregiver, who must live with the Chronically Ill individual, to take a rest or vacation from providing care. Respite Care is limited to the number of days specified on your Benefit Summary for each Benefit Period. It may be provided by nonlicensed providers or by members of the Chronically Ill individual's Immediate Family.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that has been demonstrated by clinical evidence and standardized tests that reliably measure impairment in short-term or long-term memory; deductive or abstract reasoning; and orientation as to people, places, or time; ***and*** that is comparable to Alzheimer's disease and similar forms of irreversible dementia.

Irreversible dementia is deterioration or loss of intellectucal faculties, reasoning, power, memory, and will due to organic brain disease characterized by confusion, disorientation, apathy, and stupor of varying degree which is not capable of being reversed and from which recovery is impossible.

Skilled Nursing Care means care furnished on a physician's orders that is available 24 hours a day, that requires the skills of professional personnel such as a Nurse, and that is provided either directly or indirectly by or under the supervision of such personnel.

Substantial Assistance means one or both of the following:

- The physical assistance of another person without which the Chronically Ill individual would be unable to perform the Activities of Daily Living. This is sometimes referred to as "hands-on assistance."

- The presence of another person within arm's reach of the Chronically Ill individual that is necessary to prevent, by physical intervention, injury to the Chronically Ill individual while he or she is performing an Activity of Daily Living. This is sometimes referred to as "standby assistance."

Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Severely Cognitively Impaired individual from threats to his or her health or safety (such as may result from wandering).

Note: In addition to the above-capitalized terms, the following definitions also apply:

- Any time the words ***"you"*** or ***"your"*** appear in this policy, they refer to any individual who is covered by the policy. The exception to this is Section 3, "Eligibility and Coverage of Employees and Their Spouses," where ***"you"*** and ***"your"*** refer only to the employee of the employer who purchased this long term care insurance policy.

- Any time the words ***"we," "us,"*** or ***"our"*** appear in this policy, they refer to the WEA Insurance Corporation.

- Any time the word ***"employer"*** appears in this policy, it refers to the employer policyholder who signed the agreement with us that provides this coverage.

- Any time the term ***"plan of care"*** appears in this policy, it refers to a written, individualized plan of services, prescribed by a physician and approved by us, that specifies your Long Term Care needs; the type, frequency, and providers of the services appropriate to meet those needs; and the costs, if any, of those services. We require that your plan of care be modified, for our approval, to reflect changes in your functional or cognitive abilities, your social situation, and your care needs.

Section 3
Eligibility and Coverage of Employees and Their Spouses

This section describes the individuals who are eligible for coverage under this policy. It explains when those individuals become eligible for coverage, when their coverage begins, and when coverage ends. It also describes their rights and obligations with respect to group continuation coverage and conversion coverage.

The date you become eligible for coverage is subject to any applicable waiting period. The waiting period is the length of time you must be continually at work for your employer before you are eligible for coverage under this policy. The waiting period, if any, is established by your employer and is specified in the insurance agreement between your employer and us.

Note: Whenever the terms ***"you"*** or ***"your"*** appear in this section, they refer only to an employee of the employer who purchased this group long term care insurance policy, unless a different use of the term is noted. Whenever the term ***"eligible class of employees"*** is used, it refers to the occupational group(s) of employees specified by the employer as being eligible for coverage as part of an insured group.

How to Obtain Coverage

In order to obtain coverage, you must provide an enrollment form to us within 30 days of your initial date of eligibility as described below. If you are Disabled or already have a Functional Incapacity or Severe Cognitive Impairment on your initial date of eligibility, you are not eligible for coverage.

If you are covered by this policy, your legal spouse is eligible for coverage on the date your coverage takes effect, subject to the provisions described below under "Spouses of Covered Employees." Therefore, you should list your spouse as your dependent on your enrollment form, and provide that form within 30 days of your initial date of eligibility, together with the required evidence of insurability form signed by your spouse.

Eligibility and When Coverage Begins

Current Active Employees

You are eligible for coverage on the date this policy takes effect only if you are engaged in the active performance of your regular job duties on that date (or would be so engaged if that date were a regularly scheduled workday) and you belong to the eligible class of employees specified by your employer. Your coverage will begin on the date this policy takes effect if we receive your enrollment form within 30 days of that date.

New Employees

If you belong to the eligible class of employees specified by your employer, you become eligible for coverage on the later of these dates:

- The date you begin the active performance of your regular job duties.
- The date you complete any waiting period specified by your employer.

Your coverage will begin on the date you become eligible if we receive your enrollment form within 30 days of that date.

Employees on Paid Leave of Absence
If you are on an employer-approved paid leave of absence on the date this policy takes effect and would be actively at work on that date but for that fact, you are eligible for coverage if ***all*** of the following apply:

- You belong to the eligible class of employees specified by your employer.
- Your leave is a type that is available to all employees in the eligible class (for example, paid sick or sabbatical leave).
- Both you and your employer anticipate that you will return to work at the end of your leave.
- You are not Disabled nor do you have a Functional Incapacity or Severe Cognitive Impairment on the date this policy takes effect.
- Your employer pays the required premium.

If ***all*** these criteria are fulfilled, you are eligible for coverage on the date the policy takes effect. Your coverage will begin on that date if we receive your enrollment form within 30 days of the date this policy became effective. Your coverage will extend for a maximum of two years from the date your leave began unless you return to work as a member of the eligible class of employees specified by your employer.

Disabled Employees
If you would be an active employee except that you are Disabled on the date this policy takes effect, you are not eligible for coverage until you are no longer Disabled and you resume the active, regular performance of all of your job duties as a member of the eligible class of employees.

Retired Employees Who Are Enrolled in the WEA Trust Individual Long Term Care Plan
If you are an employee who is retired on the date this policy takes effect, you are eligible for coverage under this policy if ***all*** of the following apply:

1. You are not Disabled.
2. You do not already have a Functional Incapacity or Severe Cognitive Impairment.
3. You are not receiving Long Term Care benefits under any long term care insurance policy.
4. At the time you retired, you were a member of an occupational group included in the eligible class of employees specified by the employer for coverage under this policy.
5. You are currently enrolled in the WEA Trust Individual Long Term Care Plan (Individual Plan) with an original effective date that is no later than 2 years after your retirement date, and your coverage has been continuous.

6. On the date you enrolled in the Individual Plan or on the date your application for a coverage increase was approved, you were covered at or above the minimum daily benefit in effect (specified in the Individual Plan) for credit toward the paid-up feature of this policy.

7. We receive your enrollment form either before or within 90 days after the date this policy takes effect.

If you meet the above criteria, your coverage will begin without further evidence of insurability. If we receive your enrollment form before this policy takes effect, your coverage will begin on the date this policy takes effect.

If we receive your enrollment form after the policy takes effect, but within 90 days after that date, your coverage will begin on the first of the month following our receipt of your enrollment form.

If you are covered by this policy, your legal spouse is eligible for coverage. Coverage for your spouse will begin on the date your coverage takes effect, without further evidence of insurability, if ***all*** of the following apply:

1. Your spouse is not Disabled.

2. Your spouse does not already have a Functional Incapacity or Severe Cognitive Impairment.

3. Your spouse is not receiving Long Term Care benefits under any long term care insurance policy.

4. Your spouse is currently enrolled in the Individual Plan with an original effective date that is no later than 2 years after your retirement date, and your spouse's coverage has been continuous.

5. We receive an application for your spouse's enrollment within the time limits described in #7 above.

Spouses who do not meet the conditions above must provide, at no expense to us, evidence of insurability that we, in our sole discretion, deem satisfactory. In this case, coverage for your spouse will begin on the date your coverage takes effect if you have timely applied for his or her coverage, ***and*** we deem the evidence of insurability to be satisfactory. We will normally refuse coverage to a spouse who has a condition that either currently results in Functional Incapacity or a Severe Cognitive Impairment, or, in our sole opinion, is likely to do so.

Other Nonactive Employees

If you are a nonactive employee for any reason other than an employer-paid leave of absence on the date this policy takes effect, you are eligible for coverage if ***all*** of the following apply:

1. You are not Disabled.

2. You do not already have a Functional Incapacity or Severe Cognitive Impairment.

3. You are not receiving Long Term Care benefits under any long term care insurance policy.

4. You are a member of the eligible class of employees specified by your employer.

However, your coverage will not begin until the date you resume the active performance of your regular job duties as a member of the eligible class of employees specified by your employer, ***and only*** if we receive your enrollment form within 30 days of that date.

Spouses of Covered Employees
If you are covered by this policy, your legal spouse is eligible for coverage. However, all spouses are subject to individual underwriting. This means they must provide, at no expense to us, evidence of insurability that we, in our sole discretion, deem satisfactory. Your spouse's coverage will begin on the date your coverage takes effect if ***both*** of the following apply:

- We receive a written application for your spouse's coverage, including our evidence of insurability form, completed and signed by your spouse, within 30 days of your initial date of eligibility.

- We deem your spouse's evidence of insurability to be satisfactory. We will normally refuse coverage to a spouse who has a condition that either currently results in Functional Incapacity or a Severe Cognitive Impairment or, in our sole opinion, is likely to do so.

If you marry after you are covered by this policy, you may apply for coverage for your spouse by providing a written application and evidence of insurability form to us within 30 days of your marriage. If we deem your spouse's evidence of insurability to be satisfactory, your spouse's coverage will begin on the date of your marriage. If you do not apply for your spouse's coverage within 30 days after your spouse first becomes eligible, or if we do not approve your spouse's evidence of insurability, you may apply later. In these cases, if we deem your spouse's evidence of insurability to be satisfactory, coverage for your spouse will begin on the first of the month following the date of our approval.

If your spouse is eligible for coverage as an employee, under either this policy or another group long term care policy issued by us, he or she will not be required to provide evidence of insurability to be enrolled as a spouse under your coverage. In this case, you must enroll your spouse under your policy within 30 days of the date your spouse initially becomes eligible.

Coverage Based on Evidence of Insurability
When we make decisions about enrollment based on evidence of insurability, we rely on the accuracy and completeness of the information submitted. We monitor all claims for such individuals for 2 years following our approval. If, during that period, we learn that the information we relied on was incorrect, or relevant information was omitted, we may rescind coverage and deny claims, as described below.

- If coverage has been in force for less than 6 months, we may retroactively rescind coverage and deny otherwise valid claims if the omission or inaccuracy is material to our enrollment decision.

- If coverage has been in force for at least 6 months but less than 2 years, we may retroactively rescind coverage and deny otherwise valid claims if the omission or inaccuracy is both material to our enrollment decision and related to the condition for which benefits are sought.

- If coverage has been in force for 2 years or more, we will not contest coverage unless you or your spouse knowingly and intentionally misrepresented relevant facts relating to your health.

Dual Eligibility
If you meet the eligibility requirements for coverage ***both as an employee and as the spouse of a covered employee*** under this policy and/or another group long term care policy issued by us, you are eligible for dual coverage. Dual coverage entitles you to enhanced benefits should you become Chronically Ill. Read about these enhanced benefits in Section 4.

Although you may have dual coverage under the circumstances described in the preceding paragraph, you are ***not*** eligible for dual coverage ***as an employee*** under one or more group long term care policies issued by us. For example:

- You may work for two employers who provide group long term care coverage under a policy issued by us and meet the eligibility requirements for coverage under both.
- You may be a member of more than one eligible class specified by your employer.

- You may have purchased continuation or conversion coverage upon termination of employment and subsequently returned to work in a position for which you are again eligible for coverage as an employee.

Similarly, you are ***not*** eligible for dual coverage ***as a spouse*** of a covered employee under one or more group long term care policies issued by us.

If any of the above circumstances apply to you and you have questions about your entitlement to coverage, we encourage you to call and talk with one of our eligibility services representatives about your options.

Your Duty to Provide Information
If you are covered by this policy, you must provide the information we need to administer its provisions and pay benefits. Examples include but are not limited to:

- ***You must let us know when your covered spouse, if applicable, is no longer eligible for coverage.*** This will enable us to extend continuation coverage as required by law and accurately administer any claims.

- ***You must provide, at your own expense, the medical documentation we need to determine if you or your spouse are eligible for coverage, if benefits are payable to you or your covered spouse, and/or if you qualify for waiver of premium.*** We will tell you what we need to make these determinations. This may include authorization for your medical providers and appropriate agencies and organizations to provide us with all information and records we need to determine eligibility for coverage and waiver of premium and verify, calculate, and pay your claims.

- ***You must inform us when you or your covered spouse receive long term care services as a result of a work-related illness or injury, and you must notify us of any worker's compensation claim you or your covered spouse make.*** You must also notify us of any worker's compensation benefits you receive as a result of an award, compromise, or settlement. Because we will use this information to determine whether any benefits are owed to you under this policy, you must promptly provide us with any related information or documentation that we require. This policy does not duplicate benefits for expenses that are eligible for payment under a worker's compensation, employer's liability,

occupational disease, or other payment program established by similar law, whether or not you apply for or receive them. If we later discover that we have paid claims for benefits that were necessitated by work-related illnesses or injuries, we have the right to recover the overpayment. See "Our Right of Review and Recoupment" in Section 8.

When Coverage Ends

Your coverage will end on the earliest of the following dates:

- The end of the period for which the last premium was paid for you.

- The date you enter the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces.

- The date you cease to be an employee, cease to be a member of the eligible class of employees, or otherwise cease to be eligible for coverage under the terms of this policy.

Generally, the date you cease to be an employee is the last date you actively perform job duties for your employer. However, your coverage may continue beyond that date, even if your individual employment contract is not renewed, if a preexisting collective bargaining agreement or employer policy provides for extended coverage and we receive all premiums for your coverage. In this case, coverage will continue until the earliest of:

1. The duration specified in the collective bargaining agreement or employer policy.
2. August 31 of the year in which your individual employment contract is not renewed.
3. The date you begin the active, regular performance of job duties as an employee of another employer in a nontemporary occupation.

- The date you exhaust your Maximum Lifetime Benefit.

Coverage for your spouse will not end solely because you exhaust your Maximum Lifetime Benefit and, thus, are no longer eligible for benefits yourself.

- The date this policy terminates for any legal reason.

- The date of your death.

Your spouse's coverage will end on the earliest of the following dates:

- The end of the period for which the last premium was paid for your spouse.

- The date your spouse enters the military forces of any state or country, including the United States. This includes being called to active duty as a member of a reserve unit of the armed forces.

- The date you cease to be eligible for coverage under the terms of this policy.

- The date your spouse ceases to be eligible for coverage under the terms of this policy.

- The date your spouse exhausts his or her Maximum Lifetime Benefit.
- The date this policy terminates for any legal reason.
- The date of your spouse's death.

Exceptions to Termination of Coverage
These are possible exceptions to the termination of coverage described above:

- You have qualified for the paid-up feature described in Section 4.
- Continuation coverage as required by law. See "Your Legal Rights to Continuation Coverage" below.
- Extension of benefits as required by law. See "Extension of Benefits" in Section 5.
- Our additional option to continue coverage that is available to employees who retire at age 55 or older while covered by this policy. See "Additional Option for Retired Employees to Continue Coverage" later in this section.
- Our additional option to continue coverage that is available to surviving spouses. See "Additional Option for Surviving Spouses to Continue Coverage" later in this section.
- The onset of Disability while covered by this policy.

If you become Disabled while covered under this policy as an active employee, your eligibility will not end solely because you are no longer actively working. You may continue your coverage for as long as you are Disabled (as determined by us from supporting objective, contemporaneous medical records) if we receive the required premiums for your coverage and we continue to insure the active employees in the occupational group within the eligible class of employees to which you belonged before becoming Disabled. This option is in addition to your rights to continuation coverage required by state law.

If and when you are entitled to continuation coverage required by law, that period of continuation coverage will run concurrently with the continued coverage provided for in this provision. The coverage you are eligible to continue will be the same as that in effect for the eligible class to which you belonged before becoming Disabled.

If, while you enjoy the continued coverage provided by this provision, you become eligible for Medicare Parts A and B, you should enroll for those benefits because we will not duplicate benefits that are eligible for payment by Medicare whether or not you apply for and/or receive those benefits. See "Nonduplication of Benefits" in Section 7 for further information.

Your Legal Rights to Continuation Coverage

Note: Whenever the terms "you" or "your" appear in this subsection, they refer to any covered individual.

If you lose coverage under this policy due to one of the qualifying events described below, you are entitled by state law to continue coverage under this policy for 18 months if ***all*** of the following conditions are met:

- You have been continuously covered under this policy for at least 3 months.
- You notify us of your choice to continue coverage within the specified time limit described below.
- We continue to insure the active employees in the occupational group within the eligible class of employees to which the covered employee belonged on the day before the qualifying event.
- You pay the required premiums on time.
- You are not eligible for similar coverage under another group long term care plan.

The coverage you are eligible to continue is that in effect for the active employees in the eligible class of employees to which the covered employee belonged on the day before the qualifying event.

If continuation coverage is not required by state law, or if you prefer conversion coverage, then you have the right to elect conversion coverage if you would otherwise lose coverage because of a qualifying event. Your rights and obligations regarding continuation coverage are summarized in this subsection. Your rights and obligations regarding conversion coverage are summarized in the next subsection.

Qualifying Events
Any one of the following is a qualifying event if it causes you to lose coverage:

- The termination of the covered employee's employment for reasons other than job misconduct.
- A reduction in the covered employee's work hours that results in the loss of regular coverage.
- The covered employee beginning a leave of absence.
- The covered employee's death.
- The divorce or annulment of the covered employee's marriage.

Maximum Period of Continuation Coverage
If you lose eligibility for coverage under this policy due to a qualifying event, you are entitled to continue coverage for a maximum of 18 months. Your 18-month period begins on the date you lose eligibility for coverage.

Obligation to Notify Us When a Qualifying Event Occurs
We will offer continuation coverage only after we have been timely notified that a qualifying event has occurred. Depending on the qualifying event, either you or the employer is responsible for notifying us of its occurrence.

The employer must notify us within 30 days after you experience any of the following qualifying events:

- The termination of the covered employee's employment.
- A reduction in the covered employee's work hours that results in loss of regular coverage.
- The covered employee beginning a leave of absence.
- The covered employee's death.

You or your former spouse must notify us in writing within 60 days after the date of your divorce or the annulment of your marriage.

If we don't receive notice within the time specified (see Notice Procedures below), we have the right to refuse to provide either continuation coverage or conversion coverage.

Notice Procedures

You or your employer may provide any notice required by these continuation coverage provisions by calling or writing:

Eligibility Services Department
WEA Trust
P.O. Box 7338
Madison, WI 53707-7338
(608) 276-4000 Voice/TDD
(800) 279-4000 Voice/TDD

If mailed, your signed notice must be postmarked no later than the last day of the required notice period. If you give your notice by phone, you must call us no later than the last day of the required notice period. We will need this information when you call or write:

1. Your name and the subscriber number.
2. Your employer's name and group number, if known.
3. The specific qualifying event that is causing, or will cause, a loss of coverage.
4. The date of the qualifying event.
5. The names of all individuals who have lost or will lose coverage due to the qualifying event.
6. The telephone numbers and addresses of all individuals losing coverage.

How to Obtain Continuation Coverage

After we receive timely notice that a qualifying event has occurred, we will send you a written offer of continuation coverage. We will mail this information to the most current address we have on file for you.

You will have a 60-day period, known as an election period, during which you can elect to continue coverage under this policy or to enroll in our conversion plan. The election period will end on the later of these two dates:

- Sixty days after the date coverage ends as the result of a qualifying event.

- The date we send you information about your rights to continue coverage.

If you do not return your election notice indicating your choice to continue your coverage within that 60-day period, you will lose your right to continue coverage. If you return the election form and pay the initial premium within the required time, continuation coverage will take effect on the day following termination of coverage under the employer's policy.

Premiums
Premiums for continuation coverage will be your responsibility. The premium rate for continuation coverage will be the same as the rate in effect, on each date that premium is due, for the eligible class of employees to which the covered employee belonged while working. Premiums will change on the annual renewal date of the employer's group plan under which you were/are covered, or when the benefits of the employer's group plan are changed.

The initial premium payment for continuation coverage is due within 45 days after the election is made. This payment must include premiums for all months from the time you lost coverage under the employer's group plan through the current month of coverage. Claims will not be processed and paid until we have received your first premium payment. If you do not make the first payment in full within this time limit, you will lose your coverage continuation rights.

All subsequent premium payments are due on the 20th of the month that precedes the month of coverage. A grace period of 31 days applies. The grace period starts on the first day of the coverage month for which the premium is due. See "Grace Period for Individuals With Continuation or Conversion Coverage" in Section 1 for additional information about the grace period.

When Continuation Coverage Ends
The continuation coverage of any individual will end on the earliest of the following dates:

- The end of the period for which the last premium was timely paid.

- The date the required 18-month period of continuation coverage ends.

- The date you establish residence outside Wisconsin.

- The date the Maximum Lifetime Benefit is exhausted.

- The date we no longer insure, under this policy, the active employees in the occupational group within the eligible class of employees to which the covered employee belonged on the day before the qualifying event.

- For a covered spouse, the date the covered employee is no longer eligible for coverage under this policy.
- The date you become eligible for similar coverage under another group long term care plan.
- The date this policy terminates for any legal reason.
- The date of your death.

Your Rights to Conversion Coverage

Note: Whenever the terms ***"you"*** or ***"your"*** appear in this subsection, they refer to ***any*** covered individual.

Loss of Coverage Due to a Qualifying Event
If you lose coverage under this policy due to one of the events described under "Qualifying Events" listed above, you are entitled to either:

- Continue your coverage under this policy, as described in "Your Legal Rights to Continuation Coverage," in the preceding subsection; ***or***
- Enroll in our conversion policy, as described in this subsection.

Obligation to Notify Us When a Qualifying Event Occurs
Depending on which qualifying event occurs, either you or the employer has an obligation to notify us. If we are not notified within the time specified, we have the right to refuse either continuation or conversion coverage. Read about these obligations and time limits earlier in the section entitled "Obligation to Notify Us When a Qualifying Event Occurs," under "Your Legal Rights to Continuation Coverage."

How to Obtain Conversion Coverage
As indicated in the preceding subsection, after we receive timely notice that a qualifying event has occurred, we will notify you of the 60-day election period during which you may choose to continue coverage or enroll in our conversion policy. If you do not notify us of your intent to continue coverage or enroll in our conversion policy within that 60-day period, you will have waived your right to do so.

If, during the 60-day election period, you choose to enroll in our conversion policy, coverage under the conversion policy will take effect on the date following the termination of coverage under the employer's group policy, if all required premiums are paid on time.

Loss of Continuation Coverage
You may also enroll in our conversion policy if your continuation coverage ends for any of the reasons listed above under "When Continuation Coverage Ends" other than failure to timely pay the required premium or exhaustion of the Maximum Lifetime Benefit. In this case, you must notify us of your choice to enroll in the conversion policy and pay the required premium within 60 days after continuation coverage ends. If you do so, coverage under the conversion policy will begin on the day after your continuation coverage ends.

Loss of Coverage Due to Employer Termination of This Policy
If you lose coverage under this policy because your employer terminates this long term care insurance coverage for the eligible class of employees or replaces this coverage with another group long term care policy, you are also entitled to enroll in our conversion policy. You must notify us of your decision to enroll in our conversion policy and pay the required premium within 60 days after the employer policy coverage ends. If you do, coverage under the conversion policy will begin on the day after the employer policy coverage ends.

Coverage
The conversion coverage you are eligible to purchase is the same coverage as that which was in effect on the day you lost coverage under the group policy.

Premiums
Premiums for conversion coverage will be your responsibility. Premiums are due each month on or before the 20th day of the month that precedes the month of coverage. The premium for conversion coverage will be based on the rate for coverage under the employer's policy ***but*** will be modified for several actuarially relevant factors that may increase your premium above the rate for coverage under the employer's policy. Those factors include:

- Your age.
- Your gender.
- Your marital status.
- Your geographic location.
- The additional cost to us of providing personalized administration of this policy.

When Conversion Coverage Ends
Coverage under the conversion policy will end on the earliest of the following dates:

- The end of the period for which the last premium was timely paid.
- The date the Maximum Lifetime Benefit is exhausted.
- The date of your death.

Additional Option for Retired Employees to Continue Coverage

Note: Whenever the terms ***"you"*** or ***"your"*** appear in the remainder of this Section, they refer ***only*** to an employee of the employer who purchased this group long term care insurance policy.

If you retire at age 55 or older while you are covered by this policy as an active employee, you have the option of continuing coverage under the same conditions as before your retirement. You may continue coverage under this option as long as we receive the required premiums and continue to insure the active employees in the

occupational group within the eligible class of employees from which you retired. The coverage you are eligible to continue will be the same as that in effect for the active employees in the eligible class of employees from which you retired.

This option is in addition to your rights to continuation coverage required by law. If and when you or your covered spouse are entitled to continuation coverage required by law, that period of continuation coverage will run concurrently, not consecutively, with the continued coverage described in this subsection.

If you do not choose to continue coverage under this option at the time you retire, you cannot do so later even during an open enrollment period. In that case, continued coverage for you and your covered spouse will be limited to that required by law and described under "Your Legal Rights to Continuation Coverage" earlier in this section.

Premiums
If you choose to continue coverage under this option, you will be responsible for paying the required premiums for coverage. Premiums are due each month on or before the 20th day of the month that precedes the month of coverage. Your premium will be the same as the employer's rate in effect, on each date that premium is due, for the eligible class of employees to which you belonged.

Marriage and Divorce
If you exercise this option, the following rules will apply in the event of divorce or marriage. If you divorce within 18 months of your retirement, your former covered spouse will have the right to continuation coverage required by law only for the remainder of the 18-month period following your retirement.
When that period of continuation coverage required by state law ends or if you divorce after you have been retired for more than 18 months, your former spouse may choose coverage under our conversion policy. If your former spouse remarries, his or her new spouse is not eligible for coverage under this policy.

If you marry, you may obtain coverage for your new spouse effective on the date of your marriage if ***both*** of the following apply:

- We receive a written application for your spouse's coverage, including our evidence of insurability form, within 30 days of your marriage.

- We deem your spouse's evidence of insurability to be satisfactory. We will normally refuse coverage to a spouse who has a condition that either currently results in Functional Incapacity or a Severe Cognitive Impairment or, in our sole opinion, is likely to do so.

Additional Option for Surviving Spouses to Continue Coverage

Surviving Spouses of Employees Who Are Age 55 or Older
If you are age 55 or older and covered by this policy when you die, your surviving covered spouse has the right to continue the coverage he or she had before your death, and that right will not be limited to continuation coverage required by law. The period of continuation coverage required by law will run concurrently, not consecutively, with the continued coverage provided by this option and described in this subsection. The coverage your spouse is eligible to continue will be the same as that in effect for the active employees in the eligible class of employees to which you belonged at the time of your death.

Premiums
If your surviving spouse chooses to continue coverage under this option, he or she will be responsible for paying the required premiums for coverage. Premiums are due each month on or before the 20th day of the month that precedes the month of coverage. The premium rate will be the same as the employer's

rate in effect, on each date that premium is due, for the eligible class of employees to which you belonged. Your surviving spouse may continue coverage under this option for as long as desired if we receive the required premiums and continue to insure the active employees in the occupational group within the eligible class to which you belonged at the time of your death.

Surviving Spouses of Employees Under Age 55
If you are under age 55 when you die, your covered surviving spouse has only the continuation coverage rights required by law. When the period of continuation coverage required by law ends, he or she may choose coverage under our conversion policy.

If your surviving spouse remarries, his or her new spouse is not eligible for coverage under this policy.

Section 4
General Benefit Provisions

Waiver of Premium
After a covered employee has met the qualification for benefits criteria described in Section 5 for at least 90 days, the monthly premiums required for coverage of the Chronically Ill employee (and his or her covered spouse, if applicable) will be waived. This waiver of premium will begin on the first of the month following the month in which the 90 days end. To qualify for this waiver of premium, the covered employee must remain Chronically Ill throughout the entire 90-day period. Any premium amounts you have paid for coverage beyond the date this waiver begins will be refunded or credited.

The premium will be waived until the ***earliest*** of the following dates:

- The date the covered employee ceases to be Chronically Ill.

- The date the covered employee exhausts the Maximum Lifetime Benefit.

- The date the covered employee dies.

In the event of the death of the covered employee, the covered spouse will have the right to continue coverage as provided in Section 3 if premiums are paid as required.

- The date the covered employee fails to furnish proof satisfactory to us of continued Chronic Illness.
- The date this policy terminates for any reason.
- The date the covered employee ceases to be eligible for coverage under the terms of this policy.

Waiver of premium applies only to a covered employee who becomes Chronically Ill ***after*** the effective date of the policy.

Note: This waiver of premium provision also applies to a covered employee who has properly elected continuation or conversion coverage under the provisions of this policy in Section 3. However, this waiver of premium provision never applies to a covered spouse, including a surviving spouse or a spouse continuing coverage under this policy or under the conversion policy.

Enhanced Benefits for Dual Coverage
If you are covered both as an employee and as the spouse of a covered employee under this policy or another group long term care policy issued by us, you will enjoy enhanced benefits. Specifically, if you have dual coverage on the date a physician signs a certification verifying that you are Chronically Ill, your benefits will be enhanced as follows:

- Your maximum daily benefit will be ***either*** the sum of the applicable maximum daily benefits payable under both policies, ***or*** 100% of the actual covered daily charges incurred, ***whichever is less***.

There is one exception: The enhanced benefit for Respite Care will be the sum of the days per Benefit Period under both policies. The amount payable per day, however, will not be enhanced; that is, the

amount payable per day will be the amount that applies to the policy under which you are covered as an employee.

- Your Maximum Lifetime Benefit will be the sum of the Maximum Lifetime Benefit amounts payable under both policies.

The maximum daily benefit and the Maximum Lifetime Benefit are specified on the Benefit Summaries that apply to the policies under which you are covered. The benefits payable are those in effect, for each policy under which you are covered, on the date your physician certifies that you are Chronically Ill.

How We Pay Enhanced Benefits
If you are entitled to these enhanced benefits, we pay your benefits in this order:

- First, we calculate and pay the benefit payable under the policy covering you as an employee.
- Then, if there is a remaining balance in your covered incurred costs, we pay the remaining balance up to the maximum payable under the policy covering you as the spouse of a covered employee.

If You Lose Dual Coverage
If you had dual coverage when you began receiving benefits, but you lose coverage under one of those group policies for any reason, your entitlement to enhanced benefits for dual coverage will end on the date coverage terminated under that policy. (Remember, however, that if you lose coverage due to a qualifying event, you have the right to continue coverage or enroll in conversion coverage and thus maintain your dual coverage. See "Your Legal Rights to Continuation Coverage" and "Your Rights to Conversion Coverage" in Section 3.)

If, while you are receiving the enhanced benefits described in this subsection, you exhaust the Maximum Lifetime Benefit of one of the policies, your entitlement to these enhanced benefits will end on the date you exhausted the Maximum Lifetime Benefit. You will, however, be entitled to the benefits of the other policy under which you are covered until you also exhaust the Maximum Lifetime Benefit of that policy.

The provisions in this subsection also apply to you if you are receiving benefits under the "Extension of Benefits" provision in Section 5.

Inflation Protection Benefit

The maximum dollar amount of each daily benefit specified on your Benefit Summary will be automatically increased each year on September 1 by 5% of the previous year's maximum dollar amount. The unused amount of your Maximum Lifetime Benefit will also be automatically increased each year on September 1 by 5% of the unused amount remaining on the preceding day.

The unused amount of the Maximum Lifetime Benefit will be based on the amount of Long Term Care expenses ***incurred*** by you as of August 31, whether or not a claim for those expenses has yet been filed with or paid by us. If the expenses you have incurred as of August 31 exhaust the Maximum Lifetime Benefit, this inflation protection benefit will ***not*** apply to you at all.

These increased benefit limits will apply to any charges you incur for covered Long Term Care services received after September 1.

Paid-up Feature

How Covered Employees Qualify

A covered employee will owe no further premiums for coverage beginning on the first of the month following the date that ***all*** of the following conditions are met:

1. The employee is at least 65 years of age.
2. The employee has retired.

3. Premiums have been paid by or on behalf of that employee for at least 360 months.

All three of these conditions must be satisfied before this paid-up feature becomes effective. Even if 360 months of premiums have been paid on behalf of an employee or retiree, premium payments must continue until the employee actually attains age 65 ***and*** retires.

Note: If the paid-up feature (or the accelerated paid-up option described below) is effective for a covered employee, it applies to the employee's covered spouse as well. In the event of a subsequent divorce, the paid-up feature will apply only to the covered employee. In this case, the former spouse has continuation and conversion coverage rights as described in Section 3. If the covered employee remarries and applies for coverage for a new spouse within 30 days of the date of the marriage, the paid-up feature will apply to the newly covered spouse if the spouse qualifies for coverage.

How We Calculate Months of Premium Payment for the Paid-up Feature

The 360 months of premium payment required by this paid-up feature need not be consecutive. In calculating the months that apply toward this 360-month requirement, we count all months for which premiums have been paid by or on behalf of the employee under any group long term care policy issued by us, except that we do ***not*** include:

- Any month for which we waived premium based on Chronic Illness. See "Waiver of Premium," above.

- Any month for which coverage did not include the paid-up feature.

Note: We do not count twice, toward the paid-up feature, the months in which both a husband and wife are enrolled in a group long term care policy issued by us, even if both are enrolled as employees. We calculate the months of premium payment paid on behalf of each individual as an employee and as a spouse separately. The individual may choose to satisfy the 360-month requirement in either role, but may not combine the two.

Example 1: John and Mary, husband and wife, are each covered employees for 10 years under a Trust group long term care policy in two different school districts where they are employed. Mary dies after 10 years of coverage, and John continues working for 5 more years before retiring. John has a total of 180 months (15 years) of premium paid on his behalf, not 300 months (25 years).

Example 2: John is covered by a Trust group long term care policy in his school district for 5 years. Mary then joins the district as a new employee and also becomes covered. Five years later, John and Mary get married and work in the same school district for 10 more years, during which they both are still covered by the long term care policy. John dies at age 65, and Mary decides to retire. Mary can

choose between the months of premium payment she accrued as an employee toward the paid-up feature or the months of premium payment the policy provides her as the surviving spouse of a covered employee (the months of premium payment John accrued as an employee). She has 180 months of premium payment as an employee (15 years). She has 240 months of premium payment as John's spouse (20 years) because John had 20 years of coverage when he died. In this case, it is likely that Mary will choose the 240 months of premium payment toward satisfying the paid-up feature. However, if she continues John's paid-up policy as a surviving spouse and later remarries, her new spouse will not be eligible for coverage.

How Covered Former Employees With Continuation or Conversion Coverage Qualify
This paid-up feature also applies to a covered former employee with continuation or conversion coverage obtained under the provisions of this policy in Section 3 if ***all*** three of the conditions listed above, under "How Covered Employees Qualify" have been satisfied.

How Retired Former Employees Covered Under a WEA Trust Individual Long Term Care Plan Receive Credit Toward the Paid-up Feature
A retired former employee (retiree) who enrolled in this policy (with the paid-up feature) as provided under "Retired Employees" in Section 3, will receive credit toward the 360-month requirement for the paid-up feature. To qualify for credit, the retiree must have either:

1. Enrolled in the WEA Trust Individual Long Term Care Plan (Individual Plan) at or above the required minimum daily benefit in effect on the original coverage date; or

2. Increased coverage under the Individual Plan to an amount at or above the required minimum daily benefit in effect on the date the increase in coverage was approved.

The minimum daily benefit required for credit toward the paid-up feature of this policy is specified in the Individual Plan. On the effective date of the retiree's coverage under this policy, the retiree will receive credit for each month for which premium was paid for coverage under the Individual Plan at the required minimum daily benefit level in effect on the original effective date of the policy or on the date of an increase in coverage. The months of premium payment under the Individual Plan need not be consecutive to apply toward the paid-up feature of this policy. However, in calculating months that apply toward the 360-month requirement, we do not include:

- Any month for which the retired employee decreased coverage under the Individual Plan to an amount less than the required minimum daily benefit level in effect on the date of the decrease.
- Any month during which premium payment was waived due to Chronic Illness.

Note: Months of premium payment made by or on behalf of a retiree's spouse under the Individual Plan will not be counted toward the paid-up feature of this policy unless the spouse is enrolled in this plan as an employee or retired former employee.

After retirees become covered by this policy (with the paid-up feature), they will cease to accrue credit from the Individual Plan toward the paid-up feature of this policy, even if they choose to retain their coverage under the Individual Plan.

When Covered Spouses Qualify for the Paid-up Feature
This paid-up feature does not apply to a covered spouse except in the following situations:

- If a deceased covered retiree had met the conditions for this paid-up feature before his or her death, the paid-up feature will continue to apply to the retiree's covered spouse. Note, however, that the surviving spouse may not add coverage for a new spouse in the event of remarriage.
- If a covered retiree had met the conditions for this paid-up feature before he or she exhausted the Maximum Lifetime Benefit, the paid-up feature will continue to apply to the retiree's covered spouse.
- If a deceased covered employee or retiree had not yet met the conditions for the paid-up feature before his or her death, this paid-up feature will apply to the surviving covered spouse under the conditions described below.

This paid-up feature will also apply to a covered spouse who is continuing coverage after the covered employee or retiree has exhausted the Maximum Lifetime Benefit, if ***both*** of these conditions are met:

1. The covered employee or retiree is or, if deceased, would have been age 65 or older.

2. Premiums have been paid by or on behalf of the covered spouse for at least 360 months. This includes the months for which premiums were paid by or on behalf of the covered employee or retiree.

The paid-up feature will be effective the first day of the month following the date that both of the above conditions have been met. See "How We Calculate Months of Premium Payment for the Paid-up Feature," earlier in this section.

Accelerated Paid-up Option

How Covered Employees Qualify

A covered employee who is retired but who does not qualify for the paid-up feature described above has the option to purchase paid-up coverage, with a single payment, if ***all*** of the following conditions are met:

1. The employee is 55 years of age or older.

2. The employee is retired from active work.

3. Premiums have been paid by or on behalf of the employee for at least 120 months.

How We Calculate Months of Premium Payment for the Accelerated Paid-up Option

In calculating the months that apply toward this 120-month requirement, we count all months for which premiums have been paid by or on behalf of the employee under any group long term care policy issued by us, except that we do ***not*** include:

- Any month for which we waived premium based on Chronic Illness. See "Waiver of Premium" above.

- Any month for which coverage did not include the paid-up feature.

If you are interested in pursuing this option or in obtaining information about it, call and talk with one of our eligibility services representatives.

How Covered Former Employees With Continuation or Conversion Coverage Qualify
A former covered employee with continuation or conversion coverage obtained under the provisions of this policy in Section 3 may exercise this option if ***all*** three of the conditions listed above, under "How Covered Employees Qualify," are met.

When Covered Spouses Qualify
This option is also available to a covered surviving spouse of a deceased employee or a covered spouse who has continued coverage after the covered employee exhausted his or her Maximum Lifetime Benefit. These spouses may exercise this option if ***both*** of the following conditions are met:

- The covered employee/retiree is or, if deceased, would have been age 55 or older.

- Premiums have been paid by or on behalf of the covered spouse for at least 120 months.

This includes the months for which premiums were paid by or on behalf of the covered employee or retiree. Remember, however, that if a surviving spouse later remarries, he or she may not add coverage for a new spouse. See "How We Calculate Months of Premium Payment for the Accelerated Paid-up Option," earlier in this section.

Noncompliance With Policy Requirements
Our waiver of any requirement of this policy will not constitute a continuing waiver of that requirement. Our failure to insist on compliance with any policy provision will not function as a waiver or amendment of that provision.

Section 5
Qualifying for and Receiving Benefits

This section tells you what you must do to qualify for benefits. It also describes your responsibilities after you begin receiving benefits.

Important: Please call us as soon as you become Chronically Ill and believe you may be eligible for benefits. This will enable us to provide you with applicable forms that will facilitate getting all of the information we need to approve your application for benefits.

Remember that should you become Chronically Ill, your benefits will begin, at the earliest, on the date you complete the Elimination Period specified on your Benefit Summary. Because the Elimination Period does not begin until your physician signs the required certification described in this section, ***it is important that you obtain the certification promptly.***

If you would like us to assist you in obtaining the necessary assessment and certification, developing the plan of care, and completing the application for benefits, call as soon as you believe you may need Long Term Care services.

How to Qualify for Benefits

You qualify for benefits under this policy when ***all*** of the following conditions have been met:

1. We verify that you have a Functional Incapacity or Severe Cognitive Impairment that first occurred after the effective date of your coverage under this policy.

2. We have received and approved ***all*** of the following from you:

    - A timely signed certification from your physician, following his or her assessment of your condition, that meets ***all*** of the certification requirements described below under "Certification Requirements."

    - Your physician's plan of care, describing the type of long term care being recommended.

      Any time the term "plan of care" appears in this policy, it refers to a written, individualized plan of services, prescribed by a physician and approved by us, that specifies your Long Term Care needs; the type, frequency, and providers of the services appropriate to meet those needs; and the costs, if any, of those services. We require that your plan of care be modified for our approval, to reflect changes in your functional or cognitive abilities, your social situation, and your care needs.

    - Your application for long term care benefits.

You are responsible for the cost of obtaining the required plan of care, assessment, and certification. To ensure that you provide all of the information we need and thus facilitate our approval of your

application, we recommend that you call us to obtain applicable forms. Applicable forms include a certification form to be completed by your physician, an application for benefits form, and a plan of care form.

3. You have not exhausted your Maximum Lifetime Benefit.

4. We have verified that you have satisfied the Elimination Period specified on your Benefit Summary. The Elimination Period begins on the date your physician signed the certification form. You must satisfy the Elimination Period only once in your lifetime.

   If you have dual coverage as a result of dual eligibility, described in Section 4, the Elimination Periods required under both policies will run concurrently. If the Elimination Periods under the two policies are different:

   - You will be eligible to begin receiving benefits under the policy whose Elimination Period you satisfy first.

   - You will be required to satisfy any remaining days of the other Elimination Period before you are eligible for the enhanced benefits for dual coverage described in Section 4.

Your eligibility for benefits will not be conditioned on a requirement of prior hospitalization or institutionalization.

Certification Requirements

To meet the certification requirements referred to above, you must meet one of two distinct benefit triggers—Functional Incapacity or Severe Cognitive Impairment. After assessing your condition, a physician must complete and sign a certification form verifying that you are Chronically Ill due to either Functional Incapacity or Severe Cognitive Impairment. The criteria for each are described below.

A physician's declaration that you are Chronically Ill, without supporting objective, contemporaneous medical and/or psychiatric evidence, is not sufficient to substantiate your Chronic Illness.

Functional Incapacity

You are Chronically Ill due to Functional Incapacity if ***both*** of the following criteria are satisfied:

1. You are unable to perform three or more Activities of Daily Living (ADLs), as defined in Section 2, without ***Substantial Assistance*** from another individual because of physical or cognitive impairment(s).

   Substantial Assistance means one or both of the following:

   - The physical assistance of another person without which you would be unable to perform the ADL.

   - The presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an ADL.

2. Your inability to perform three or more ADLs has continued or is reasonably expected to continue for at least 90 consecutive days.

You will not be eligible for benefits if your failure to successfully perform any of the ADLs is volitional or attitudinal in nature or origin and not due to physical or cognitive impairments.

Severe Cognitive Impairment
You are Chronically Ill due to Severe Cognitive Impairment if ***both*** of the following criteria are satisfied:

1. You have experienced a loss or deterioration in intellectual capacity that:

    - Has been demonstrated by clinical evidence and standardized tests that reliably measure impairment in your (a) short-term or long-term memory; (b) orientation as to people, places, or time; and (c) deductive or abstract reasoning; ***and***

    - Is comparable to Alzheimer's disease and similar forms of irreversible dementia.

2. ***In addition***, you require ***Substantial Supervision*** to protect yourself from threats to health and/or safety.

    Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to health and/or safety.

When You Are Eligible to Receive Benefits

You are eligible for benefits, at the earliest, on the date you complete the required Elimination Period. Remember that the Elimination Period does not begin until the required certification is signed by your physician. The certification cannot be backdated, so it should be obtained and sent to us promptly so we can evaluate it and begin our approval process. In most cases, the required assessment and certification by your physician will be completed at about the same time as you submit your application for benefits. If it is not, we must at least receive the signed certification within 12 months of the date it was signed. If the signed certification is not received within 12 months, you cannot qualify for benefits until you obtain a new certification.

When Benefits Begin

Benefits will begin when we verify that ***both*** of the following conditions have been met:

- You have satisfied the Elimination Period specified on your Benefit Summary. ***Remember:*** The Elimination Period does not begin until the date a physician, after assessing your condition, signs a certification verifying that you are a Chronically Ill individual due to either Functional Incapacity or Severe Cognitive Impairment. Certification requirements are described earlier in this section.

- You have provided us with satisfactory proof that you have incurred a covered loss. A covered loss is an expense you have incurred, as a result of your Chronic Illness, that is eligible for Long Term Care benefits described in Section 6. Benefits will be paid only for those covered Long Term Care services that you receive ***after*** you satisfy the Elimination Period.

The Benefits You Are Entitled To

The benefits you are entitled to during any period of Chronic Illness are those in effect on the date your physician signs the certification, which we have confirmed and approved, verifying that you are Chronically Ill. Only one of the daily benefits payable under this policy will be paid for each day on which you receive Long Term Care services. If you are entitled to more than one of these benefits on a particular day, we will pay the amount of the higher benefit. The only exception is the Respite Care benefit, which may be paid, where appropriate, in conjunction with another benefit.

Receiving Benefits for a Subsequent Period of Chronic Illness

If, after you have ceased receiving benefits under this policy, you experience a recurrence of Chronic Illness, you need not requalify for benefits if ***all*** of the following apply:

- You experience the recurrence within 180 consecutive days of the date we determined you were no longer Chronically Ill.
- You remain covered by this policy.
- We verify that you are Chronically Ill. In this case, benefits are payable from the date of your recurrence for as long as you remain Chronically Ill, satisfy all provisions of this policy, and have not exhausted your Maximum Lifetime Benefit.

If, however, you subsequently experience another period of Chronic Illness more than 180 consecutive days after the date we determined you were no longer Chronically Ill, you will have to requalify for benefits as described earlier in this section. This means you must submit a new application for benefits, plan of care, and physician certification. In this case, benefits are payable from the date your physician signs the new certification form if you remain Chronically Ill for at least 31 consecutive days or you die within those 31 days.

Benefits Paid Reduce the Maximum Lifetime Benefit

All expenses paid under this policy, except expenses we incur under the care coordination benefit described in Section 6, reduce the amount of your remaining Maximum Lifetime Benefit.

When Benefits End

Once we have determined that you are eligible for benefits, you will be entitled to such benefits until the ***earliest*** of:

- The date you no longer have a Functional Incapacity or Severe Cognitive Impairment as defined in Section 2 and supported by objective contemporaneous medical and/or psychiatric documentation.
- The date you fail to provide the required continuing proof of Functional Incapacity or Severe Cognitive Impairment.
- The date you cease to be eligible for benefits under the other terms of this policy.
- The date the Maximum Lifetime Benefit is exhausted.

- The date of your death

Extension of Benefits

If this policy is terminated while a covered employee is already receiving benefits for Long Term Care services, we will continue to pay claims for such services according to the terms of this policy. Thus, payment of the covered employee's claims will continue, for example, if the employer terminates long term care coverage for the eligible class or replaces this coverage with another long term care policy. This extension of benefits will terminate on the ***earliest*** of the following dates:

- The date the covered employee no longer has a Functional Incapacity or Severe Cognitive Impairment as defined in Section 2 and supported by objective contemporaneous medical and/or psychiatric documentation.

- The date the covered employee fails to provide the required continuing proof of Chronic Illness.

- The date the covered employee ceases to be eligible for benefits under the other terms of this policy.

- The date the Maximum Lifetime Benefit is exhausted.

- The date of your death.

If this policy is terminated while a covered spouse is already receiving benefits for Long Term Care services, benefits will cease on the policy termination date unless the spouse continues coverage under the continuation or conversion provisions in Section 3 and we receive the required premiums.

Policy Changes

If any changes are made in this policy's benefit design or benefit levels, other than by operation of the Inflation Protection Benefit, such changes will not apply to you if you are already receiving benefits under this policy on the effective date of the change.

If you subsequently experience the recurrence of a Chronic Illness more than 180 consecutive days after the date we determined you were no longer Chronically Ill, you will be treated as a new claim applicant for that succeeding period of Chronic Illness. As such, you must requalify for benefits as described earlier in this section, including obtaining a new certification of Chronic Illness from your physician. The changes in the benefit design or benefit levels that are in effect on the date the new certification is signed will apply to your new entitlement to benefits.

Section 6
Long Term Care Benefits

Care Coordination Benefit
At your request, we will assist you and your family in identifying available services and making the best use of your benefits. Care coordination includes, but is not limited to, such services as assisting you and your family with the following:

- Establishing an initial plan of care.
- Selecting the type of care and the type of provider.
- Investigating alternative care options that meet your needs.
- Reviewing the plan of care if you or your family has concerns about the type of care you are receiving.

Nursing Facility Care Benefit
For each day you receive Nursing Facility Care, we will pay the benefit specified on your Benefit Summary. To be eligible for this benefit, you must be confined in a Nursing Facility pursuant to a physician's plan of care, and your confinement must begin after you are covered by this policy.

In the event you are temporarily hospitalized while you are confined in a Nursing Facility, this daily benefit may continue for up to 30 days per hospital admission if that is necessary to preserve your residence at the Nursing Facility.

In the event you temporarily return to your home or place of residence while you are confined in a Nursing Facility, this daily benefit may continue for up to 7 days per home stay event, to a maximum of 30 days per Benefit Period, if that is necessary to preserve your residence at the Nursing Facility.

Alternate Care Facility Benefit
For each day you are confined in an Alternate Care Facility, we will pay the benefit specified on your Benefit Summary. To be eligible for this benefit, you must be confined in an Alternate Care Facility pursuant to a physician's plan of care, and your confinement must begin after you are covered by this policy.

In the event you are temporarily hospitalized while you are confined in an Alternate Care Facility, this daily benefit may continue for up to 30 days per hospital admission if that is necessary to preserve your residence at the Alternate Care Facility.

In the event you temporarily return to your home or place of residence while you are confined in an Alternate Care Facility, this daily benefit may continue for up to 7 days per home stay event, to a maximum of 30 days per Benefit Period, if that is necessary to preserve your residence at the Alternate Care Facility.

Home Health Care Benefit

For each day you receive Home Health Care, we will pay the benefit specified on your Benefit Summary. To qualify for this benefit, you must be receiving Home Health Care provided by a Home Health Care Agency pursuant to a physician's plan of care.

Adult Day Care Benefit

For each day you receive Adult Day Care, we will pay the benefit specified on your Benefit Summary. To qualify for this benefit, you must receive the services in an Adult Day Care Center as defined in Section 2.

Hospice Care Benefit

For each day you receive Hospice Care, we will pay the benefit specified on your Benefit Summary. To qualify for this benefit, you must be receiving Hospice Care from a state-licensed or Medicare-approved Hospice Care provider. The services may be received in a Hospice Care Facility or in your home or place of residence.

Respite Care Benefit

When you have been receiving regular care from someone who lives with you on a 24-hour basis and who receives no compensation for providing that care, you are eligible for the Respite Care Benefit. For each day you receive Respite Care, we will pay the Respite Care Benefit specified on your Benefit Summary, provided ***all*** of the following apply:

- You have received regular care and assistance because of your Functional Incapacity or Severe Cognitive Impairment from your regular live-in caregiver for at least 90 consecutive days prior to your request for the Respite Care Benefit.

- Your regular caregiver takes a rest or vacation from providing care to you.

- You temporarily receive Respite Care from someone other than your regular caregiver.

This benefit is limited to the number of days specified on your Benefit Summary. The days on which you receive Respite Care do not have to be consecutive. Unlike all other benefits of this policy, the benefit for Respite Care will be paid even if that Respite Care is provided by nonlicensed providers or by members of your Immediate Family.

If you are eligible for the Home Health Care Benefit or the Adult Day Care Benefit for a day on which you are also eligible for the Respite Care Benefit, the Respite Care Benefit will be paid in addition to one of these other Benefits. You are not eligible for the Respite Care Benefit for any day on which you are also receiving the Nursing Facility Care Benefit, the Alternate Care Facility Benefit, or the Hospice Care Benefit.

Alternate Care Benefit

If you believe that another form of long term care that is not covered under this policy is both more appropriate and cost-effective for your personal condition, we will evaluate a request for benefits for

such care. Your request must include a written plan of care, assessment, and certification from your physician. In addition, you must tell us how and why the alternate form of long term care is more appropriate and cost-effective. The decision to pay benefits for all such alternate care will be determined in our sole discretion and will create no obligation with respect to future claims filed by you or others.

Section 7
Exclusions and Limitations

All benefits are subject to the exclusions and limitations listed in this section.

Exclusions
We do not reimburse expenses for the following:

- Services received outside the United States or its territories or possessions.
- Any costs incurred if you already have a Functional Incapacity or Severe Cognitive Impairment on the effective date of this policy.
- Any costs incurred while you are not covered by this policy, except as specifically described in "Extension of Benefits" in Section 5.
- Services provided to you by a member of your Immediate Family, except as specifically described in "Respite Care Benefit" in Section 6.
- Services provided to you by any person other than an employee of a licensed provider of Long Term Care services, or a provider specifically approved by us, except as specifically described in "Respite Care Benefit" in Section 6.
- Any costs incurred by your dependent child or any dependent other than your covered spouse.
- Services or items furnished or paid for by a governmental entity, facility, or program other than Medicaid unless we are required to do so by specific law.
- Services or items furnished free of charge or for which you are not legally obligated to pay in the absence of insurance.
- Any personal care items. Personal care items are those articles or supplies that are used for the personal care, grooming, hygiene, entertainment, enjoyment, refreshment, or convenience of an individual and that are not necessary, as determined by us, to assist or enable the individual to successfully perform the Activities of Daily Living.
- Costs of mechanical assistance, machinery, or devices, including installation.
- Care for a condition that arises from, or originates during, services in the armed forces.
- Care for a condition resulting from participation in a felony or illegal occupation.
- Prescription and over-the-counter drugs and medications, supplies and equipment (e.g., needles, oxygen, gloves, etc), and physician visits.

- Transportation, including ambulance transfer.

- Services that fall outside the established plan of care that we have approved.

Nonduplication of Benefits

Even if you are otherwise eligible for benefits, we do not duplicate benefits for expenses that are eligible for payment under any of the following:

- Any governmental plan or program, including Parts A and B of Medicare, and any coverage that is required or provided by law, including coverage provided under no-fault and uninsured motorist statutes.

- Any employer-provided group health plan, whether insured or uninsured. This includes self-funded or self-insured plans.

- Any worker's compensation, employer's liability, occupational disease, or other payment program established by similar law.

This includes amounts received when a claim under worker's compensation or similar law is settled by stipulation or compromise. This limitation applies to any benefits that you are eligible to receive from these sources even if you do not apply for or receive such benefits.

If you incur charges for Long Term Care services that are reimbursable only in part from any of the sources described above, this is how we will calculate your benefits under this policy:

- First, we will determine the amount of your covered loss. A covered loss is an expense you have incurred, as a result of your Chronic Illness, for Long Term Care services that are covered by this policy.

- Next, we will calculate the maximum amount payable under this policy, in the absence of other sources of reimbursement, for your covered loss.

- Finally, if other reimbursement sources paid less than the amount of your covered loss, we will pay the difference, up to the amount we would have paid in the absence of other reimbursement.

Example No. 1: You are qualified for Nursing Facility Care benefits. The maximum amount payable under the terms of your policy is 75% of actual covered charges up to a maximum of $200 per day. Your covered Nursing Facility Care charges are $250 per day. Medicare reimburses you $100 per day for those services.

Amount we would reimburse in
the absence of other benefits
(75% of $250 up to a maximum
of $200 per day) $187.50

Nursing Facility Care actual
covered charges $250.00

Medicare's reimbursement	-100.00
Remaining balance	$150.00
Our reimbursement (the lesser of $187.50 [75% of $250] or $150.00)	-150.00
Your out-of-pocket expense	-0-

Example No. 2: The circumstances are the same as Example No. 1 except that Medicare pays only $50 per day.

Amount we would reimburse in the absence of other benefits (75% of $250 up to a maximum of $200 per day)	$187.50

Nursing Facility Care actual covered charges	$250.00
Medicare's reimbursement	-50.00
Remaining balance	$200.00
Our reimbursement (the lesser of $187.50 [75% of $250] or $200.00)	-187.50
Your out-of-pocket expense	$ 12.50

Section 8
Claim Procedures

To receive reimbursement for Long Term Care services, you must send us, within 90 days of its occurrence, a written claim and proof that you have incurred a covered loss. A covered loss is an expense you have incurred, as a result of your Chronic Illness, for Long Term Care services that are covered by this policy. This time limit applies to the application for long term care benefits to initially qualify for benefits under this policy (see Section 5) ***as well as*** individual claims and provider bills for Long Term Care services you have received after you have qualified for benefits.

Wisconsin law extends this period to 12 months beyond the 90 days required by this policy, but only if we are not prejudiced by the delay and it was not reasonably possible for you to meet our 90-day limit. You can get claim forms by calling us.

Application for Benefits, the First Step in Qualifying for Benefits

To be eligible for benefits under this policy, you must first file a written application with us that meets all of the requirements described in Section 5, "Qualifying for and Receiving Benefits." You should submit the application for benefits, including your physician's plan of care and certification of your status, to us as soon as your Functional Incapacity or Severe Cognitive Impairment is established. To ensure that you provide all of the information we need and thus facilitate our approval of your application, we recommend that you contact us to obtain the applicable forms. At your request, we will be happy to assist you in completing your application for benefits.

Claim and Proof of Loss

You must provide both satisfactory proof that you have incurred a covered loss and the information that we need to calculate your benefits. In many cases, your claim forms and provider bills for Long Term Care services provide that proof. In other cases, we require additional objective medical evidence verifying your Chronic Illness, or documentation that any services you received fulfill our criteria for coverage. A physician's declaration that you are Chronically Ill, without supporting objective, contemporaneous medical and/or psychiatric evidence, is not sufficient to substantiate qualification for benefits under this policy.

You must promptly provide us with all information that we need to administer your claim for benefits. This includes authorizing medical providers and appropriate agencies and organizations to provide us with all information and records we need to verify, calculate, and pay your claims. We will assist you in any way we can, but you are responsible for obtaining and providing this information.

Some providers charge for copying and/or submitting documentation. We do not pay or reimburse any fees charged for providing information, so you must pay any costs incurred.

Initial and Ongoing Proof of Eligibility for Benefits

Our Right to Examine

We have the right to require that you be examined by a health care professional of our choice whenever it is necessary to establish initial qualification for benefits or proof of loss and evaluate a claim. If we do so, we pay the cost of the evaluation or assessment. You have an obligation to cooperate with us in being evaluated and in obtaining and providing any information that we need to establish and confirm your eligibility for benefits.

Continuing Proof of Loss

After you begin receiving benefits, we will periodically require proof that you remain Chronically Ill. We may contact your physician or other health care provider and obtain medical records for review. We also have the right to require that your continued eligibility for benefits be reassessed at reasonable intervals by a health care professional of our choice. When we do so, we pay the cost of the examination, evaluation, or assessment. If a reassessment demonstrates that you are no longer eligible for benefits, we will notify you in writing of the reason for the termination of benefits.

How Claims Are Evaluated

When we receive a claim, we collect the information we need to determine whether you qualify for benefits, as described in Section 5. As part of our evaluation, we will review the assessment and certification from your physician, verify that you are Chronically Ill, and evaluate your plan of care. We may arrange for an assessment by a health care provider of our choice. We may also request permission to contact your physician or other health care provider and to review your medical records. Based on our evaluation of this information, we will determine if you are eligible to receive benefits. We will not pay benefits until we have determined that you are eligible for benefits.

Your claims for reimbursement of Long Term Care expenses will be compared to, and paid in accordance with, the plan of care that we have approved. If your plan of care needs modification to reflect changes in your care needs, we will be happy to assist you with that.

How and When Claims Will Be Paid

We pay benefits within 30 days after we receive a claim and the required proof of loss, which includes copies of the bills for Long Term Care services you have received, Explanation of Benefits forms from other insurers, and any other documentation we require. Note that we pay benefits after you receive covered services and provide us with proof that you have incurred a covered loss; we never pay benefits in advance of receiving a service. We reimburse the providers from whom you received the services, unless they have already been paid. If we know you have paid them, we reimburse you.

In the event of your death, we may pay any benefits to which you were entitled to your estate or to whomever we consider to be legally entitled to receive them.

Our Right of Review and Recoupment

We review claims both before and after payment. Whenever we find that any information is fraudulent, misleading, inaccurate, or incomplete, we have the right to reevaluate and retroactively modify our claim payment. We have this right regardless of whether we have paid some or all of the claim.

If we pay benefits that exceed those you are entitled to, you must repay the excess as soon as we notify you of the overpayment. We may, at our option, recover some or all of the overpayment by reducing subsequent benefits payable or by applying premium refunds due you. We have the right to charge reasonable interest on the delinquent amount.

If benefits are paid under this policy and you or your covered spouse receive worker's compensation benefits (for or related to the condition causing the Chronic Illness) through settlement, compromise, judgment, award or other arrangement, you must repay us promptly. If you do not, we may recover some or all of the amount owed us by reducing subsequent benefits payable, by filing suit against you, or by taking lesser legal action.

This policy also obligates you to cooperate with us in our attempts to recover payments we have made on your behalf when we determine that you are eligible for, or have received, worker's compensation benefits. This means that you will make no settlement or agreement with any party that prejudices our right to recovery. If we pay benefits that exceed those you are entitled to under this policy, we have the right to recover some or all of the overpayment, regardless of whether you have made a claim for worker's compensation benefits (provided we have a reasonable basis for our determination that you are eligible for worker's compensation benefits), whether the worker's compensation insurer disputes your claim for benefits, and regardless of how the settlement or agreement characterizes your compensation from the worker's compensation insurer.

Section 9
Our Right of Subrogation

In some circumstances, we may pay benefits to you or on your behalf even though another party or insurance company is liable for the costs associated with your Functional Incapacity or Severe Cognitive Impairment. We have the right in such circumstances to seek repayment from any liable party or parties. This is known as the right of subrogation.

We have a subrogation right against any party or insurance policy that is liable for the costs associated with your Functional Incapacity or Severe Cognitive Impairment for the amount of benefits we have paid. This includes any payments to which you are entitled under the uninsured or underinsured motorist provisions of an automobile insurance policy or a no-fault insurance policy.

This policy obligates you to cooperate with us in our investigation of an injury or accident and in our attempts to recover payments we have made on your behalf when another party is liable.

This means that you will make no settlement or agreement with any company or any person that prejudices our subrogation rights. It also means that if another company or person reimburses you for a loss that we have already paid, you must repay us promptly. If you do not, we may recover some or all of that amount by reducing subsequent benefits payable or by applying premium refunds due you.

Your right to be made whole for your loss will take priority over our right to recover the benefits we paid on your behalf from any liable party. However, this does not obligate us to waive our legal rights.

If you do not fulfill your obligations as described above, we may file suit against you or take lesser legal action. If we do, you will be liable for reasonable costs and attorney's fees that we incur in doing so.

Section 10
Your Right to Appeal a Denial of Entitlement to Benefits

This section describes your rights under this policy and by law in the event we deny your application for benefits or a claim for benefits.

If we deny either your application for coverage or a claim for benefits, you have the following rights:

- The right to submit, within the time required by this policy, all relevant evidence of your entitlement to benefits.
- The right to a full and fair review of your entitlement to benefits.
- The right to a written explanation of the reason(s) for our denial of your application or claim, including reference to the policy provisions upon which our denial is based.
- The right to examine any document in our possession that is relevant to your entitlement to benefits.
- The right to appeal the denial of your application or claim in accordance with our appeal procedure, if we receive your written appeal within 3 years of the date on our final notice of denial of the application or claim. We will send you our written decision within 30 days after we receive your appeal request.

To obtain a written explanation of the procedures and requirements of our appeal procedure, including any necessary forms, write to our General Counsel at WEA Insurance Corporation, P.O. Box 7338, Madison, WI 53707-7338.

Right to File a Complaint With the Office of the Commissioner of Insurance

You have the right to file a complaint with the ***Office of the Commissioner of Insurance***, a state agency that enforces Wisconsin's insurance laws. You can contact the ***Office of the Commissioner of Insurance*** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or, you can call (800) 236-8517 outside of Madison, or (608) 266-0103 in Madison, and request a complaint form.

Legal Actions

You may not bring an action at law or in equity to recover on this policy unless you have exhausted our appeal procedure. In addition, you cannot bring such an action after the expiration of 3 years from the date your claim was required to be submitted. However, the 3-year period in which you may file a legal action will not include the period of time starting from the date we receive your appeal and ending on the date we issue our written decision on the appeal.

Appendix

Optional Benefit Provisions

Domestic Partner Coverage

This benefit provision applies to you only if your Benefit Summary indicates "Domestic Partner"

Domestic partners of covered employees are eligible for coverage under the same terms as legal spouses. If we approve their coverage, domestic partners have the same rights, responsibilities, and entitlements as a covered spouse under this policy, with a few exceptions resulting from the different treatment of spouses and domestic partners under the law. Those exceptions are described below.

The term *Immediate Family*, as defined and used in this policy, is extended to include the covered domestic partner and his or her daughter, son, daughter-in-law, son-in-law, father, mother, sister, brother, grandparent, or grandchild.

Definition of Domestic Partner

We define a domestic partner as an individual with whom you have agreed to live as sole domestic partners in a relationship that is characterized by ***all*** of the following:

- You have a committed spousal-type relationship of mutual support and caring, and you intend to remain in the relationship indefinitely.
- Your domestic partnership is and has been for the past six months publicly acknowledged and commonly recognized within the communities in which you live and work.
- You share financial resources and have agreed to be responsible for each other's common welfare.

Qualifying for Eligibility as a Domestic Partner

To establish that the individual qualifies for eligibility as a domestic partner, both of you must attest to ***all*** of the following on our Designation of Domestic Partner form:

- You are both 18 years of age or older.
- You are both mentally competent to make the declarations required by the form.
- You are not related by blood closer than would bar marriage in the state of Wisconsin.
- For at least the past six months, ***all*** of the following have been true:

    1. You have lived together in the same dwelling unit.
    2. Neither of you was married or legally separated in marriage.
    3. Neither of you was a party to an action or proceeding for divorce or annulment.

4. Neither of you was in another domestic relationship.

5. You were financially interdependent as evidenced by at least two of the following:

   (a) Common or joint ownership of a residence.

   (b) Joint ownership of a motor vehicle.

   (c) Joint credit account; for example, a credit card.

   (d) Joint checking or savings account.

   (e) Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), or IRA(s).

   (f) Joint financial investments.

   (g) Other evidence of mutual financial interdependency that we deem acceptable.

The signed Designation of Domestic Partner form is part of the contract of insurance, and we reserve the right to verify the information at any time.

Your domestic partner is eligible for coverage on the ***later*** of these two dates:

- The date you are eligible for coverage.
- The earliest date on which your domestic partnership fulfilled all of the conditions we have described above.

How to Obtain Coverage

Your domestic partner's coverage begins on the date he or she is eligible if ***all*** of these apply:

- We receive the required documents within 30 days of that date.
- We approve enrollment based on information submitted on the Designation of Domestic Partner form.
- We deem the evidence of insurability provided by your domestic partner, in our sole discretion, to be satisfactory.

The required documents are these:

- An enrollment form listing your domestic partner as your dependent.
- The completed, signed Designation of Domestic Partner form described above.
- Our evidence of insurability form completed and signed by your domestic partner.

Policy Provision Exceptions That Apply to Domestic Partners

Policy provisions that pertain to an employee's covered spouse apply to your covered domestic partner. Exceptions are these:

1. Domestic partners are not entitled by state and federal law to continuation of coverage when their coverage ends due to certain qualifying events. However, this policy provides continuation privileges to covered domestic partners under circumstances and for temporary periods that are similar to those required by state law for spouses who are losing coverage.

   Note: We require you or your domestic partner to notify us in writing within 60 days of the date of the termination of the domestic partnership in order to preserve your partner's rights to continuation or conversion coverage. If we don't receive the written notice within the time period specified, continuation of coverage under this policy or under our conversion policy will not be offered.

2. The coverage continuation rights of surviving spouses of covered employees who are age 55 or older at the time of their death, described in Section 3 of this policy, will be provided to covered domestic partners ***only if***:

   - The domestic partnership has been in existence for at least three years at the time of the covered employee's death; ***and***
   - The covered employee is 55 or older at the time of death.

The three-year existence of the domestic partnership must be documentable as having continuously met all of the requirements on the Designation of Domestic Partner form, which you both signed, during the three years preceding the covered employee's death.

When the Domestic Partnership Ends

For purposes of this insurance, the domestic partnership ends on the ***earlier*** of these dates:

- The date your domestic partnership ceases to fulfill one or more of the criteria on the Designation of Domestic Partner form.

- The death of one of the two individuals in the domestic partnership.

The end of a domestic partnership has the same consequences under this policy as divorce or annulment of marriage. Consequently, the domestic partner is no longer eligible for coverage as of the date the domestic partnership ends, except if your partner qualifies for either of the continuation opportunities described above under "Policy Provision Exceptions That Apply to Domestic Partners."

Nonforfeiture Benefit

This benefit provision applies to you only if your Benefit Summary indicates "Nonforfeiture Benefit"

If you have been covered by this policy and this optional benefit for at least 3 years and your coverage then ceases due to nonpayment of premium, this nonforfeiture benefit will apply.

The nonforfeiture benefit is based on the policy provisions in effect on the Nonforfeiture Date, which is the date that coverage under this policy would otherwise end in the absence of this benefit. This means that you will be entitled only to those long term care benefits in effect on the Nonforfeiture Date. In addition, the Inflation Protection Benefit ceases to apply on that date. Thus, the amount of benefits payable under this nonforfeiture benefit will be calculated on the basis of the benefit amounts in effect on the Nonforfeiture Date.

How We Calculate the Months of Coverage

If the Nonforfeiture Date is less than 3 years (36 months) after the effective date of coverage, no nonforfeiture benefit is payable. The required 3 years, or 36 months, of coverage need not be consecutive. However, in calculating the months that apply toward this 3-year requirement, we count ***only*** the months for which your coverage included the nonforfeiture benefit. In addition:

- If you were covered as an employee, we count all months for which premiums were paid by you or on your behalf as a covered employee under any long term care policy issued by us that included the nonforfeiture benefit.

- If you were covered as the spouse of a covered employee, we count all months for which premiums were paid by you or on your behalf as a covered spouse under any long term care policy issued by us that included the nonforfeiture benefit.

- We do not combine months for which premium was paid for your coverage as an employee with months for which premium was paid for your coverage as the spouse of a covered employee.

- We calculate months of coverage as a covered employee separately from months of coverage as a covered spouse. If you have the required number of months of coverage for both, you qualify for this nonforfeiture benefit as both an employee and as the spouse of a covered employee.

Example: Jane is an employee of the ABC School District. She has been covered under the group long term care plan provided by the ABC School District for 2 years. Her husband, John, has been covered as her spouse for those 2 years. John goes to work for the ABC School District. He continues his coverage as Jane's spouse, and he also enrolls in the plan as an employee. John works 2 years for the ABC School District.

When he leaves employment, he does not purchase group continuation or conversion coverage to replace his coverage as an employee. However, he continues to be covered as Jane's spouse. In this case, John was covered as an employee for only 2 years and, thus, does not qualify for the nonforfeiture

benefit as an employee. However, he was covered for 4 years as Jane's spouse, and so he qualifies for the nonforfeiture benefit as a spouse.

How We Calculate the Nonforfeiture Benefit

The type of nonforfeiture benefit provided is a Reduced Paid-up (RPU) nonforfeiture benefit. The RPU benefit provides for continuation of coverage for a previously covered individual even after premium payments stop, but provides benefits at a reduced level, according to the formula that follows.

The Nursing Facility Care Benefit, Home Health Care Benefit, Adult Day Care Benefit, Alternate Care Facility Benefit, Hospice Care Benefit, and Respite Care Benefit will be calculated by multiplying the applicable benefit level effective on the Nonforfeiture Date by the RPU benefit factor. The RPU benefit factor is the ratio of A to B where:

A is the number of whole months of coverage that included the nonforfeiture benefit for which premium has been paid, and B is the number of months from the date you were first covered under this policy that included the nonforfeiture benefit until your 65th birthday, or 360 months, whichever is greater.

The RPU benefit factor cannot be greater than one. The Maximum Lifetime Benefit (MLB) will be calculated by multiplying the MLB in effect on the Nonforfeiture Date by the RPU benefit factor.

Example: Jane's coverage ends due to nonpayment of premium after 100 months of participation. The Nursing Facility Benefit on the Nonforfeiture Date is $200 per day. The MLB on the Nonforfeiture Date is $300,000. Jane provides certification of Functional Incapacity 5 years after the Nonforfeiture Date and enters a nursing home.

RPU benefit factor =
100 months ÷ 360 months = .278
Nursing Facility Benefit =
$200 x .278 = $55.60 per day
MLB = $300,000 x .278 = $83,400

When the RPU Benefit Ends

The RPU benefit will be paid until the ***earlier*** of the following dates:

- The date you are otherwise no longer eligible for benefits according to the terms of the policy in effect on the Nonforfeiture Date.

- The date you exhaust the MLB.

Paid-up Feature—Not Applicable

This provision applies to you only if your
Benefit Summary indicates "Paid-up Feature—Not Applicable"

The following provisions do not apply to your coverage:

- Paid-up Feature in Section 4.
- Accelerated Paid-up Option in Section 4.