VIRGINIA SICKNESS AND DISABILITY PROGRAM

LONG-TERM CARE PLAN

(Effective, December 1, 2007)

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VIRGINIA SICKNESS AND DISABILITY PROGRAM
LONG-TERM CARE PLAN

ARTICLE I
Purpose

1.1 **General**. The purpose of the Virginia Sickness and Disability Program Long-Term Care Plan (the "Plan") is to provide Eligible Employees financial assistance towards long-term care services needed as a result of a catastrophic illness, injury or aging.

1.2 **Long-Term Care Plan**. The Plan is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits paid or reimbursed shall be paid out of the Trust upon presentation of the approved claim therefore.

ARTICLE II
Definition of Terms

The following words and terms as used in the Plan shall have the meaning set forth below, unless a different meaning is clearly required by the context:

2.1 **"Administrator".** The Board pursuant to the authority granted under the Code of Virginia § 51.1-1135.2, including any designee of the Board with respect to any functions the Board deems appropriate to delegate.

2.2 **"ASO".** An administrative services organization or other contract administrator (other than the Administrator) under the Plan to whom claims review, processing and/or payment duties and responsibilities or other administrative services under the Plan have been allocated, delegated or contracted.

2.3 **"Benefit Period".** A period of days of a covered Loss of Functional Capacity which begins on the first day of such loss. It does not include any day prior to the Participant's effective date of coverage under the Plan. It shall end at the close of ninety (90) consecutive days during which the Participant has not had a Loss of Functional Capacity and has not received services for which benefits are payable under the Plan.

2.4 **"Board".** The Board of Trustees of the Virginia Retirement System appointed and serving pursuant to Chapter 1, Article 2.1 of Title 51.1 of the Code of Virginia.

2.5 **"Code".** The Internal Revenue Code of 1986, as the same may be amended from time to time or the corresponding section of any subsequent Internal Revenue Code, and the regulations issued thereunder.

2.6 **"Effective Date".** The Effective Date of the Plan is December 1, 2007.

2.7 **"Eligible Employee".** The term has the same meaning as "Participating Employee" as defined in the Code of Virginia § 51.1-1100.

2.8 **"Elimination Period".** Means ninety (90) calendar days starting at the date a Loss of Functional Capacity is determined to have commenced and during which the Participant is not receiving services for which benefits are payable under the Plan. The ASO shall determine when a Loss of Functional Capacity commenced. In no event shall the Elimination Period include:

(a) any day prior to the date the Participant becomes a Participant in the Plan; or

(b) any day that the Participant is not suffering a Loss of Functional Capacity and is not receiving services for which benefits are payable under the Plan.

2.9 **"Employer".** An employer who employs an Eligible Employee.

2.10 **"Lifetime Maximum Benefit".** Not more than the Lifetime Maximum Benefit as indicated in Section 5.2(a)(iii) may be paid under the Plan to any one Participant, in the aggregate, during the lifetime of such person. However, if one Benefit Period has closed as to a Participant and a new Benefit Period has begun in accordance with Section 2.3, the Lifetime Maximum Benefit shall be restored by the amount then charged against it. The restored amount may not be used to pay benefits for any expenses incurred prior to the date the Lifetime Maximum Benefit is restored.

2.11 **"Loss of Functional Capacity".** This means that a Participant on a given day meets either of the following requirements:

(a) the Participant has been certified by a Licensed Health Care Practitioner (as defined in ARTICLE V hereof) as being unable, due to physical incapacity resulting from a disease, injury or the effects of aging, to perform at least two (2) Activities of Daily Living (as defined in ARTICLE V hereof) without the Substantial Assistance (as defined in ARTICLE V hereof) of another person each time the activity is performed; or

(b) the Participant has been certified by a Licensed Health Care Practitioner (as defined in ARTICLE V hereof) as having a Severe Cognitive Impairment (as defined in ARTICLE V hereof), requiring Substantial Supervision (as defined in ARTICLE V hereof) or verbal cueing by another person in order to protect that person and others from serious threats to health and safety.

The ASO shall make the determination of the Loss of Functional Capacity, taking into account, as appropriate, evidence furnished by the Participant and written documentation furnished by the Assessment (as defined in ARTICLE V hereof), Care Advisory Services Agency (as defined in ARTICLE V hereof), or the Participant's Licensed Health Care Practitioner (as defined in ARTICLE V hereof).

2.12 **"Participant".** An Eligible Employee who has satisfied the eligibility requirements set forth in Article III hereof and who remains eligible for benefits under the Plan.

2.13 **"Plan".** The Commonwealth of Virginia Long-Term Care Plan as contained herein or duly amended.

2.14 **"Plan Sponsor".** The Virginia Retirement System.

2.15 **"Plan Year".** The twelve (12) month period commencing on the first day of January of each year.

2.16 **"Ported Participant".** Any person who elects to continue coverage under the Plan in accordance with the terms of the portability provisions of ARTICLE VI hereof.

2.17 **"Trust".** Means the Disability Insurance Trust Fund as described in the Code of Virginia § 51.1-1140.

2.18 **"Trustee".** Means the trustee under the Trust.

ARTICLE III
Eligibility and Participation

3.1 **Eligibility and Date of Participation**. An employee shall become a Participant in the Plan as follows:

(a) Each Eligible Employee who on November 30, 2007 is participating in the Group Long-Term Care Insurance Policy for Commonwealth of Virginia Employees, as insured by Aetna Life Insurance Company, and who is an Eligible Employee on December 1, 2007 shall become a Participant in the Plan as of December 1, 2007.

(b) Each other employee shall become a Participant in the Plan on the date he becomes an Eligible Employee; provided, however, if such Eligible Employee is not actively at work on such date, he shall become a Participant in the Plan on the first date he is actively at work.

3.2 **Termination of Participation.** A Participant shall cease to be a Participant upon the later of:

(a) the date he ceases to be an Eligible Employee; or

(b) the date a Ported Participant fails to make payment for his cost of coverage, as provided in Section 6.2.

Notwithstanding the foregoing, each Participant shall cease to be a Participant on the date the Plan is terminated.

3.3 **Reinstatement of Former Participant**. If a former Participant again becomes an Eligible Employee, he shall again become a Participant in the Plan in the same manner as though he were a new Eligible Employee, subject to Section 3.1 and ARTICLE VI hereof.

ARTICLE IV
Contributions

4.1 **Employer Contributions**. An Employer shall make Employer contributions as determined by the Board to provide the long-term care benefits under the Plan and to administer the Plan, including providing case management and cost containment programs.

4.2 **Employee Contributions**. The Participant shall make contributions as determined by an actuary of the Plan to cover the costs of any additional benefits under the Plan or other ancillary costs of the Plan not covered by Employer contributions.

ARTICLE V
Long-Term Care Benefits

5.1 **Definitions.** For purposes of this ARTICLE V, the following words and terms shall have the meaning set forth below, unless a different meaning is clearly required by the context.

(a) **"Activities of Daily Living".**

(i) bathing - means washing oneself by a sponge bath or washing oneself in either a tub or shower, including the task of getting into and out of the tub or shower.

(ii) transferring - means moving into or out of a bed, chair or wheelchair.

(iii) dressing - means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(iv) toileting - means getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

(v) continence - means the ability to maintain control of bowel and bladder functions and when unable to maintain control of bowel and bladder functions, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

(vi) 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. Eating does not include shopping for food or preparing food for consumption.

(b) **"Adult Day Care Center".** A program for six (6) or more persons, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the home. An eligible provider of an Adult Day Care Center must be state-licensed or certified in those states that require licensing or certification.

(c) **"Alternate Plan of Care".** A written plan developed by or with a Licensed Health Care Practitioner to specify care, services or devices that shall meet a Participant's care and treatment needs as an alternative to confinement in a hospital, nursing care facility or other institution. The Alternate Plan of Care must be agreed upon by the ASO, the Participant and the Participant's Physician.

(d) **"Assisted Living Facility".** A facility, or a distinct part of one, which meets all applicable licensing requirements and all of the following requirements:

(i) as its primary purpose, it provides twenty-four (24) hour care and services to support its patients' needs resulting either from the inability to perform certain Activities of Daily Living or from Severe Cognitive Impairment;

(ii) it charges its patients for the services it provides;

(iii) it provides trained staff at all times to provide care;

(iv) it has procedures in place for overseeing the administration of medications;

(v) it is not a hospital, a nursing care facility or similar establishment; and

(vi) it is not a place for: drug addicts; alcoholics; mental retardates; educational care; or care of mental disorders, excluding Alzheimer's Disease.

(e) **"Assessment".** An evaluation arranged by the ASO to determine or verify the Participant's deficiencies in Activities of Daily Living or the Participant's Severe Cognitive Impairment. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

(f) **"Care Advisor".** A person who is qualified by training and experience to assess and coordinate the overall medical, personal and social needs of a person who suffers long-term physical or cognitive disability and who is employed by or under contract to a Care Advisory Services Agency designated by the ASO to provide Care Advisory Services.

(g) **"Care Advisory Services".** Services that identify a person's physical, cognitive, social and medical needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

(i) the performance of comprehensive, individualized face-to-face Assessments, including reassessments at least every six (6) months;

(ii) the development of Care Advisory Services Plans, including an initial Care Advisory Services Plan and subsequent Care Advisory Services Plans as needed for changes in the Participant's condition;

(iii) when desired by the individual and determined necessary by the Care Advisory Services Agency, coordination of appropriate services and ongoing monitoring of the delivery of such services; and

(iv) a discharge plan when the Care Advisory Services or the Plan benefits are about to be terminated and further care is required.

(h) **"Care Advisory Services Agency".** An agency or other entity designated by the ASO that provides Care Advisory Services and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, and reporting and records maintenance requirements.

(i) **"Care Advisory Services Plan".** A written individualized plan of services approved by a Care Advisory Services Agency designated by the ASO which specifies the Participant's long-term care needs and the type, frequency and providers or the services appropriate to meet those needs, and the costs, if any, of those services. The Care Advisory Services Plan shall be modified as required to reflect changes in the Participant's medical or social situation, the Participant's functional, behavioral or cognitive abilities, and the Participant's service needs.

(j) **"Home Health Care Agency".** An agency or organization which meets all applicable licensing requirements and all of the following requirements:

(i) it mainly provides skilled nursing and other therapeutic services;

(ii) it is associated with a professional group which makes policy; this group must have at least one Physician and one R.N.;

(iii) it has full-time supervision by a Physician or an R.N.;

(iv) it keeps complete medical records on each person; and

(v) it has a full-time administrator.

(k) **"Hospice Care".** Care given by or under arrangement with a Hospice Care Agency or Hospice Facility to a Participant who is Terminally Ill.

(l) **"Hospice Care Agency".** An agency or organization which meets all applicable licensing requirements and all of the following requirements:

(i) it has Hospice Care available twenty-four (24) hours a day;

(ii) it provides skilled nursing services, medical social services and psychological and dietary counseling;

(iii) it provides or arranges for other services which shall include services of a Physician, physical and occupational therapy, part-time home health aide services which mainly consist of caring for Terminally Ill persons and

inpatient care in a facility when needed for pain control and acute and chronic symptom management;

(iv) it has personnel which include at least one Physician, one R.N. and one licensed or certified social worker employed by the Hospice Care Agency;

(v) it establishes policies governing the provision of Hospice Care;

(vi) it assesses the patient's medical and social needs;

(vii) it develops a hospice care program to meet those needs;

(viii) it provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the Hospice Care Agency;

(ix) it permits all area medical personnel to utilize its services for their patients;

(x) it keeps a medical record on each patient; and

(xi) it has a full-time administrator.

(m) **"Hospice Facility".** A facility, or distinct part of one, which meets all applicable licensing requirements and all of the following requirements:

(i) it mainly provides inpatient Hospice Care to Terminally Ill persons;

(ii) it provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the Hospice Facility;

(iii) it permits all area medical personnel to utilize its services for their patients;

(iv) it utilizes volunteers trained in providing services for non-medical needs; and

(v) it has a full-time administrator.

(n) **"Hospital".** An institution which meets all applicable licensing requirements and all of the following requirements:

(i) it mainly provides inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons;

(ii) it charges its patients for the services it provides;

(iii) it is supervised by a staff of Physicians;

(iv) it provides R.N. services twenty-four (24) hours a day; and

(v) it is not mainly a nursing home or a place for rest, the aged, drug addicts or alcoholics.

(o) **"Informal Caregiver".** A person who has responsibility for caring for or providing assistance to a Participant in his home. A person who charges for any services provided may be considered an Informal Caregiver, but only if no benefits are payable for such charges under any benefit provision of the Plan.

(p) **"Licensed Health Care Practitioner".** Any Physician, R.N., licensed social worker or other individual who meets such requirement as may be prescribed by the Secretary of the Treasury. A licensed social worker includes any social worker who has been issued a license, certificate, or similar authorization by a state or jurisdiction or a body authorized by a state or jurisdiction to issue such authorization.

(q) **"L.P.N".** An individual who has received specialized nursing training as a licensed practical nurse, and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

(r) **"L.V.N".** An individual who has received specialized nursing training as a licensed vocational nurse, and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

(s) **"Nursing Care Facility".** A facility, or a distinct part of one, which meets all applicable licensing requirements and all of the following requirements:

(i) it provides, on an inpatient bases, for persons convalescing from injury or disease: skilled nursing care, intermediate nursing care or custodial care rendered by a R.N. or a L.P.N. under the direction of an R.N.; or physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;

(ii) it charges its patients for the services it provides;

(iii) the services are supervised full-time by a Physician or R.N.;

(iv) it provides nursing services by licensed nurses (seven (7) days a week on the day shift), under the direction of a full-time R.N.;

(v) it keeps a complete medical record on each patient; and

(vi) it is not mainly a place for: rest, the aged, drug addicts, alcoholics, mental retardates, educational care or care of mental disorders, excluding Alzheimer's Disease.

(t) **"Physician".** A legally qualified physician who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs medical services.

(u) **"Qualified Long-Term Care Services".** Necessary, diagnostic, preventive, therapeutic, mitigating and rehabilitative services and maintenance or personal care services which are:

(i) required by a Participant as a result of the Loss of Functional Capacity; and

(ii) provided pursuant to a plan of care prescribed by a Licensed Health Care Practitioner.

(v) **"Respite Care".** Care furnished during a period of time when the Participant's family or usual primary caregiver is not attending to the Participant's needs.

(w) **"R.N.".** An individual who has received specialized nursing training as a licensed registered nurse, and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

(x) **"Severe Cognitive Impairment" or "Severely Cognitively Impaired".** A deterioration or loss in the Participant's intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning or judgment as it relates to safety awareness.

(y) **"Substantial Assistance".** Either hands-on assistance or standby assistance. Hands-on assistance is the physical assistance of another person without which the Participant would be unable to perform the Activities of Daily Living. Standby assistance means continual (24-hour) supervision (including cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Participant from threats to their health or safety (such as may result from wandering).

(z) **"Substantial Supervision".** Means the continual (24-hour) supervision (including cueing by verbal prompting, gestures, or other demonstrations) of the Participant by another person that is necessary to protect the Severely Cognitively Impaired Participant from threats to his health or safety (such as may result from wandering).

(aa) **"Terminally Ill".** A medical prognosis of six (6) months or less to live as determined by a Physician.

5.2 **Long-Term Care Benefits and Limitations or Conditions on Eligibility for Benefits**. Following the Elimination Period and subject to the other conditions and limitations contained herein, a Participant who suffers a Loss of Functional Capacity shall receive reimbursement for Qualified Long-Term Care Services incurred by the Participant during his

period of participation in the Plan as defined in ARTICLE III hereof. All such reimbursements shall be subject to the applicable Daily Benefit Amount (as provided in subsection (a)(i) below), the Maximum Daily Benefit Amount (as provided in subsection (a)(ii) below) and the Lifetime Maximum Benefit (as provided in subsection (a)(iii) below). No benefits are payable for a Loss of Functional Capacity that starts before and continues beyond the date a Participant's coverage becomes effective. The Participant or his representative must submit substantiation acceptable to the Administrator of the expenses incurred for Qualified Long-Term Care Services in accordance with ARTICLE VII hereof.

(a) Schedule of Long-Term Care Coverage:

(i) Daily Benefit Amount (DBA):

A. Nursing Care Facility DBA is an amount equal to $96.

B. Community Based Services DBA equals 50% of the Nursing Care Facility DBA.

C. Informal Care DBA equals 25% of the Nursing Care Facility DBA.

(ii) Maximum Daily Benefit Amount is an amount equal to the Nursing Care Facility DBA.

(iii) Lifetime Maximum Benefit is an amount equal to 730 times the Nursing Care Facility DBA.

(b) Transitional Care Benefit. A Transitional Care Benefit is a cash benefit payable to assist in meeting immediate needs resulting from the Loss of Functional Capacity. Only one Transitional Care Benefit is payable to a Participant during his lifetime. The amount of the benefit payable is equal to three (3) times the applicable Nursing Care Facility DBA. This benefit is payable without regard to any other Long-Term Care Benefits payable. The amount of any benefit payable under the Transitional Care Benefit shall not count toward the Lifetime Maximum Benefit.

(c) Nursing Care Facility Benefit. A Nursing Care Facility Benefit is payable for each day a Participant is confined in a Nursing Care Facility. The amount of the benefit payable for any one day is equal to the lesser of:

(i) the Nursing Care Facility DBA; or

(ii) the charges made for that day by the Nursing Care Facility for Qualified Long-Term Care Services.

(d) Assisted Living Facility Benefit. An Assisted Living Facility Benefit is payable for each day a Participant is confined in an Assisted Living Facility. The amount of the benefit payable for any one day is equal to the lesser of:

(i) the Nursing Care Facility DBA; or

(ii) the charges made for that day by the Assisted Living Facility for Qualified Long-Term Care Services.

(e) Adult Day Care Benefit. An Adult Day Care Benefit is payable for each day a Participant incurs charges made by an Adult Day Care Center. The amount of the benefit payable for any one day is equal to the lesser of:

(i) the Community Based Services DBA; or

(ii) the charges made for that day by the Adult Day Care Center for Qualified Long-Term Care Services.

(f) Home Health Care Benefit. A Home Health Care benefit is payable for each day a Participant incurs charges made by a Home Health Care Agency for the Qualified Long-Term Care Services listed below, which are provided to a Participant in his home:

(i) care by an R.N., L.P.N. or L.V.N.;

(ii) home health aide for personal care services;

(iii) homemaker services; and

(iv) physical occupational, speech or respiratory therapy.

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

(I) the Community Based Services DBA; or

(II) the charges made for that day by the Home Health Care Agency.

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

(g) Hospice Care Benefits.

(i) Hospice Care While Confined. A benefit is payable for each day a Participant is confined in a Hospice Facility for Hospice Care. The amount of the benefit payable for any one day is equal to the lesser of:

A. the Nursing Care Facility DBA; or

B. the charges made for that day by the Hospice Facility for Qualified Long-Term Care Services.

(ii) Community Based Hospice Home Care. A benefit is payable for each day a Participant incurs charges made by a Hospice Care Agency for the Qualified Long-Term Care Services listed below, which are provided to such Participant in his home for Hospice Care:

A. care by an R.N., L.P.N. or L.V.N.;

B. home health aide for personal care services;

C. homemaker services; and

D. physical, occupational, respiratory or speech therapy.

The amount of the Community Based Hospice Home Care benefit payable for any one day is equal to the lesser of:

(1) the Community Based Services DBA; or

(2) charges made for that day by the Hospice Care Agency.

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

(h) Respite Care Benefit. A benefit is payable for each day of Respite Care, up to a maximum of twenty-one (21) days during a calendar year. The Respite Care Benefit for any one day is equal to the Community Based Services DBA. It is payable in addition to other benefits payable on that day, subject to the Maximum Daily Benefit Amount. The amount of any benefit payable under the Respite Care Benefit shall not count toward the Lifetime Maximum Benefit.

(i) Alternate Care Benefit. If, pursuant to an Alternate Plan of Care, a Participant needs care, services or devices for which no benefits are payable under the Plan, the Plan, at the sole and absolute discretion of the Administrator, shall pay a benefit for such care, services or devices in an amount equal to the lesser of:

(i) the Community Based Services DBA; or

(ii) the charges made for the Alternate Care.

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

(j) Bed Reservation Benefit. A Bed Reservation Benefit is available for a Participant who is hospitalized and is also incurring charges to reserve a bed in a Nursing Care Facility or Assisted Living Care Facility. The maximum benefit period for the Bed

Reservation Benefit is twenty-one (21) days per calendar year. Benefits for any one day are equal to the lesser of:

(i) the DBA; or

(ii) the daily bed reservation charge.

(k) World Wide Coverage. If a Participant incurs charges for services equivalent to those covered by the Plan and such services are received outside the United States or its territories, or Canada, the Plan shall reimburse the Participant for such charges. The amount of the benefit payable shall equal the benefit amounts described in subsections (a)-(j) above for the type of care or services received. However, not more than 365 days of charges shall be covered.

(l) Additional Long-Term Care Benefits. If the ASO determines that, in accordance with the terms of the Plan:

(i) a Participant has suffered a Loss of Functional Capacity;

(ii) a Benefit Period has started; and

(iii) any applicable Elimination Period has been met:

the additional benefits described below are available:

(1) Informal Care Benefit. Benefits are payable if:

A. a Participant, on any day, receives care in his home only from an Informal Caregiver; and

B. a statement that the care has been given is signed by the Informal Caregiver and given to the ASO.

An Informal Care Benefit is payable for that day, up to a maximum of fifty (50) days per calendar year. The amount payable for each day is the Informal Care DBA. The Informal Care Benefit does not count toward the reduction of the Lifetime Maximum Benefit.

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

A. three (3) times the Nursing Care Facility DBA; and

B. the charges made for the training.

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

(m) Care Advisory Services Benefit. A benefit is payable for Care Advisory Services that the Participant receives when the Participant is eligible for other benefits covered under the Plan. Care Advisory Services help identify specific care needs and the long-term care services and programs in the Participant's area which can best meet those needs. Care Advisory Services provide the Participant with the knowledge and training of a Care Advisor who shall review their unique situation and develop Care Advisory Services Plans to meet participant's needs. The Care Advisor shall:

(i) assess the Participant's physical, cognitive, social and medical needs for care and services on an ongoing basis;

(ii) work with the Participant to determine the specific services required;

(iii) develop and suggest initial and subsequent Care Advisory Services Plans to assist the Participant in meeting needs;

(iv) coordinate and monitor Participant care needs on an ongoing basis to help the Participant receive appropriate care; and

(v) help the Participant arrange for care, if he desires.

Care Advisory Services benefits are voluntary. The Participant is not required to use the Care Advisory Services Benefit, to follow the recommendations of the Care Advisory Services Plan, or to use the services or providers identified in the Care Advisory Services Plan. The benefit is advisory only. However, all benefits paid under the Plan must be provided pursuant to a plan of care prescribed by a Licensed Health Care Practitioner.

5.3 **Limitations and Exclusions**. The Plan does not provide benefits for services needed as a result of any of the following:

(a) a loss which is caused by war or any act of war;

(b) a loss which is caused by a suicide attempt or intentionally self-inflicted injury;

(c) a loss which is caused during a participation in a felony, riot or insurrection;

(d) any service provided by the Participant's immediate family other than as an Informal Care Giver;

(e) hospital charges for any day that a Participant is confined in a Hospital, except on any day, up to a maximum of twenty-one (21) days per calendar year, the Participant is also incurring charges to reserve a bed in a Nursing Care Facility or Assisted Living Care Facility;

(f) any day of a confinement in a government institution, unless a charge is made which the Participant is obligated to pay;

(g) any day on which benefits are provided or required because of the past or present service of any person in the armed forces of a government;

(h) any charges incurred by a Participant for which benefits are provided or required under any law, or in connection with any governmental program. (This does not include a medical plan established by a government for its own employees or their dependents, Medicare, or Medicaid); or

(i) any charges for care specifically provided for detoxification of or rehabilitation for alcohol or drug abuse (chemical dependency).

5.4 **Extension of Benefits**. Termination of long-term care coverage under the Plan shall be without prejudice to any benefits payable during a Benefit Period which (a) began while the long-term care coverage under the Plan was in force; and (b) continues without interruption after termination. This extension of benefits beyond the period the long-term care coverage was in force shall be limited to the duration of the Benefit Period, to payment of the maximum benefits available under the Plan and may be subject to the Elimination Period and all other applicable provisions of the Plan.

5.5 **Cost of Benefits**. All benefits paid or reimbursed shall be paid out of the Trust upon presentation of the approved claim therefore.

5.6 **Coordination with Medicare**. If a Participant incurs charges for which benefits are payable under Medicare (including benefits that would be payable except for application of Medicare's deductible or coinsurance features), the benefits payable under the Plan for such charges shall be reduced by the benefits payable under Medicare.

ARTICLE VI
Portability

6.1 **Ported Participant.**

(a) Election and Cost of Coverage. If a Participant's coverage would otherwise terminate under the Plan because the Participant ceases to be an Eligible Employee, such Participant shall be eligible to continue coverage under the Plan as a Ported Participant by electing to continue participation in the Plan. The Ported Participant shall be required to pay the entire cost of his coverage in an amount

determined by the Administrator to be the cost of coverage under the Plan, which may increase from time to time. The cost of coverage under the Plan shall be based on (1) the cost of coverage as of the Participant's original issue age under the Plan, plus (2) the cost of coverage as of the Participant's age at the time he received an inflation protection increase, if any. Any such election shall be made within sixty (60) days of termination as an Eligible Employee in the manner set forth by the Administrator. Failure of the Participant to elect continued coverage during the sixty (60) day period following his termination as an Eligible Employee shall result in a waiver of such continued coverage.

(b) Reinstatement as a Participant. In the event a Ported Participant becomes reinstated as a Participant in the Plan, pursuant to Section 3.3, and subsequently becomes a Ported Participant as provided above in Section 6.1(a) , the cost of coverage under the Plan shall be based on (a) the cost of coverage as of the Participant's original issue age under the Plan, plus (b) the cost of coverage as of the Participant's age at the time he received an inflation protection increase after originally becoming a Ported Participant, whether such inflation protection increase occurred while such individual was a Ported Participant or when such individual subsequently became reinstated as a Participant.

6.2 **Payment of Cost of Coverage**. A Ported Participant shall be direct billed by the ASO for the cost of coverage under the Plan. Failure of the Ported Participant to make payment within thirty (30) days after premium is due shall result in the Ported Participant's coverage being terminated as of the last date through which premiums have been paid.

6.3 **Reinstatement of Coverage**. If a Ported Participant's coverage lapses due to non-payment of the cost of coverage as provided in Section 6.2 and the ASO is provided proof that the Ported Participant was cognitively impaired or had a Loss of Functional Capacity before the end of the thirty (30) day period after premium was due, coverage may be reinstated if (a) requested within thirty-six (36) months of the date coverage ceased; (b) the ASO gives written consent to the reinstatement of coverage; and (c) all past due amounts for the cost of coverage are paid.

6.4 **Unintentional Lapse**. In order to protect against unintentional lapse a Ported Participant shall provide to the ASO, on a form supplied by the Administrator, either a written designation of at least one person, in addition to the Ported Participant, who is to receive notice of lapse or termination of coverage under the Plan for nonpayment of premium, or a written waiver dated and signed by the Ported Participant electing not to designate additional persons to receive such notice. The designated person is not liable for the payment of the premium.

6.5 **Changes in Coverage Amounts**.

(a) Inflation Protection Increases. Beginning December 1, 2012 and every five (5) years thereafter, a Ported Participant shall be able to buy added coverage to help protect against the effects of inflation. There shall be a special enrollment period. The period shall be determined by the Administrator. During this period only, a Ported Participant may buy added amounts of coverage, and may do so without the Administrator's consent. The amount available shall equal any whole dollar amount from a minimum of $1 up to 5% of the Ported Participant's most recent Daily Benefit

Amount, compounded each year for each of the preceding five (5) years. This amount, plus the Ported Participant's previous Daily Benefit Amount, shall become his Modified Daily Benefit Amount.

The inflation protection amounts offered at future special enrollment periods shall equal any whole dollar amount from a minimum of $1 up to 5% of a Ported Participant's most recent Modified Daily Benefit Amount, compounded each year for each of the preceding five (5) years. During each such period, the inflation protection amount provided to the Ported Participant shall be added to his most recent Daily Benefit Amount to become the new Modified Daily Benefit Amount.

During the first special enrollment period, the Maximum Daily Benefit Amount (as provided in Section 5.2(a)(ii)) shall be increased to become the Modified Maximum Daily Benefit Amount. Thereafter, all benefits under the Plan subject to the Maximum Daily Benefit Amount shall be subject to the Modified Maximum Daily Benefit Amount. The amount of the increase shall equal 5% of the Maximum Daily Benefit amount on the Effective Date of the Plan, compounded each year for each of the preceding five (5) years. During each subsequent special enrollment period, the Modified Maximum Daily Benefit shall be increased. The amount of the increase shall equal 5% of the most recent Modified Maximum Daily Benefit Amount, compounded each year for each of the preceding five (5) years.

A Ported Participant shall not be offered inflation protection increases if:

(i) the Ported Participant has previously declined the increases offered during any special enrollment period;

(ii) the Ported Participant is in a Benefit Period;

(iii) any payments for the cost of coverage required contributions have not been paid for any reason;

(iv) the Ported Participant has elected to decrease their coverage amount as outlined in (b) below; or

(v) the Ported Participant has elected one of the Contingent Lapse Benefit features as outlined in Section 6.6.

The contribution rate for inflation protection amounts purchased shall be based on a Ported Participant's age as of the date the ASO receives the request for the increased coverage amount.

(b) Decreases in Coverage Amounts. A Ported Participant may elect to decrease in whole dollar amounts his Daily Benefit Amount anytime. The ASO must be given written notice. A Ported Participant may not decrease his Daily Benefit Amount:

(i) by less than $1; or

(ii) to an amount less than $96.

The decreased Daily Benefit Amount shall become effective as soon as administratively possible but in no event later than ninety (90) days after the date the Ported Participant notifies the ASO.

6.6 **Contingent Lapse Benefit**. The benefits described in this Section 6.6 are available to a Ported Participant as a means to offset the effect of a "substantial cost of coverage rate increase." When a substantial cost of coverage rate increase occurs, a Ported Participant may continue coverage at current benefit levels by paying the new premium amount or exercise his right to choose one of the contingent lapse benefit options described below in subsections (a) and (b).

A "substantial cost of coverage rate increase" is deemed to have occurred when a Ported Participant's cost of coverage rate has increased to a specified percentage over the initial cost of coverage. The applicable percentage is based upon an individual's age on the Effective Date. (Refer to Appendix A.) The percent of increase over the initial cost of coverage applies to all cost of coverage rate increases occurring while coverage is in force. The purchase of additional coverage is not considered a cost of coverage rate increase; however, the cost of coverage for such additional coverage is considered part of the initial cost of coverage amount. A reduction in benefits is not considered a cost of coverage rate change; however, the initial cost of coverage amount is based on the reduced benefits.

The ASO shall notify the Ported Participant of a substantial cost of coverage rate increase at least thirty (30) days before the due date applicable to the increase. A Ported Participant may then elect to decrease his Daily Benefit Amount (Decreased Benefit Option) or convert his coverage to paid-up status (Paid-Up Benefit Option).

If a Ported Participant makes no election within 120 days following the due date applicable to the increase and allows his coverage to lapse during this 120 day period, that person shall be deemed to have elected the Paid-Up Benefit Option.

(a) Decreased Benefit Option. Under the Decreased Benefit Option, the Ported Participant's Daily Benefit Amount is decreased to the amount that the premium immediately prior to the increase would purchase based on the increased premium structure and the Ported Participant's original issue age.

(b) Paid-Up Benefit Option. Under the Paid-Up Benefit Option, coverage is extended without further cost of coverage contributions. There is no reduction in the Daily Benefit Amount; however, the Lifetime Maximum Benefit is reduced. The new Lifetime Maximum Benefit shall be an amount equal to the greater of:

(i) the amount of the sum total of all cost of coverage contributions made on the Ported Participant's behalf on the date cost of coverage contributions cease. The cost of coverage contributions are the employer contributions made while the participant was an active employee and the contributions made by the participant once they ported their coverage; and

(ii) thirty (30) times the applicable Daily Benefit Amount.

Eligibility for benefits shall end on the first to occur of:

(I) the death of the Ported Participant; or

(II) the date the new Lifetime Maximum Benefit is reached.

In no event shall a benefit be paid under the Paid-Up Benefit Option after a Ported Participant has exhausted his Lifetime Maximum Benefit. As of the date a Ported Participant's coverage is extended under the Paid-Up Benefit Option, no benefit changes shall be allowed.

6.7 **Waiver of Payment for Cost of Coverage Contribution**. After a Ported Participant has satisfied the Elimination Period, benefits shall be paid for the Ported Participant in accordance with the terms of the Plan without further payment of any cost of coverage contribution. After the end of each Benefit Period, cost of coverage contributions shall resume.

ARTICLE VII
Claims for Benefits

7.1 **Application for Benefits**. A Participant who has incurred a Qualified Long-Term Care Service expense may apply to the ASO for reimbursement by submitting an application in writing to the ASO. Such application should be provided to the ASO within sixty (60) days of the date the Participant first incurs costs, or as soon thereafter as reasonably possible. Such application shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amounts of such expenses, together with any additional documentation which the Administrator may request. The time allowed for submitting an application for benefits cannot exceed one year unless the Participant is legally incapacitated.

7.2 **Benefit Determination, Payment and Appeals**.

(a) Determination. The ASO shall make all determinations concerning eligibility for benefits under the Plan, the time or terms of payment, and the form or manner of payment to the Participant. The ASO shall notify the Participant in writing of its benefit determination decision within ten (10) days of receiving all the information needed to make such determination. Such written notice shall state the benefits the Participant is authorized to receive, set forth specific reasons for any denial of benefits and, if appropriate, advise when the ASO shall again require an Assessment to determine whether the Participant continues to be eligible for benefits.

(b) Reconsideration Process. If the Participant disagrees with the ASO's benefit determination, the Participant should submit a request for reconsideration within 60 days of the letter notifying the Participant of the benefit determination. A detailed, written description supporting Participant's position should accompany the request, including Participant's name, coverage ID number, claim number (if applicable), and any further information or documentation Participant believes may have a bearing on the decision made, including the names, addresses and phone numbers of any care providers

with information regarding Participant's loss. Participant is responsible for the expense of securing any additional information to support a request for reconsideration.

(c) Appeal Process. If the Participant disagrees with the decision based on the reconsideration process, Participant may present information and arguments in writing and accompanied by documentation to support his or her position to ASO within 60 days of the date of the reconsideration decision. The appeal decision by the ASO under this appeal process shall be considered a final case decision under the Virginia Administrative Process Act.

(d) Time Frame for Reconsideration and Appeal Processes. The ASO will issue decisions regarding reconsideration or appeal within 60 days after receipt of complete information from Participant or Participant's Representative. However if, in the sole discretion of the ASO, special circumstances require an extension of time, the ASO will provide written notice of the extension to Participant prior to the expiration of the initial 60-day period. Participant will receive a written decision as soon as possible following the expiration of the initial 60-day period, but no later than 120 days following receipt of Participant's request for reconsideration or review, whichever is applicable.

(e) Judicial Review. Any person aggrieved by, and claiming the unlawfulness of, a final case decision under this Section 7.2 shall have a right to seek judicial review thereof. Such judicial review shall be in accordance with Article 5 (§ 2.2-4025 et seq.) of the Virginia Administrative Process Act. Articles 3 (§ 2.2-4018 et seq.) and 4 (§ 2.2-4024 et seq.) of the Virginia Administrative Process Act shall not apply to any portion of this appeal process.

7.3 **Determination of Loss of Functional Capacity**. The determination of whether a Participant has suffered a qualifying Loss of Functional Capacity shall be made by the ASO.

7.4 **Deductions for Withholding Taxes**. The Trust may deduct from payments under the Plan any federal, state or local withholding or other taxes or charges that it is required to deduct under applicable law.

7.5 **Payment in Event of Incapacity**. In the event there is no legally-recognized representative, guardian, or power of attorney, whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Trust to make payments to such person or to the person's legal representative or to a relative or friend of such person for such person's benefit, or the Administrator may direct the Trust to apply the payment for the benefit of such person in such manner as the Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this Section 7.5 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

7.6 **Repayment of Benefits**. In the event that it is established that a Participant is not entitled to a benefit which has been paid or that an excess benefit has been paid, the Trust shall be entitled to a refund of the erroneous or excess benefit payment plus interest.

7.7 **Payment from Trust**. All payments of benefits hereunder shall be made from the Trust.

7.8 **Reimbursement after Termination of Participation**. The Participant (or his estate) shall be entitled to reimbursement only for Qualified Long-Term Care Services incurred prior to the date participation is terminated, and only if the Participant (or his estate) applies for such reimbursement in accordance with Section 7.1 within sixty (60) days of the date on which the Participant's participation is terminated. In the event of the Participant's death or legal incapacity, such sixty (60) day period may be extended to a period not to exceed one year from the date on which the Participant's participation in the Plan is terminated.

7.9 **Fraud Against the Plan**. Any Participant who intentionally misrepresents information to the Plan or knowingly misinforms, deceives or misleads the Plan, or knowingly withholds relevant information, may have his coverage terminated retroactively to the date deemed appropriate by the Administrator. Further, such Participant may be required to reimburse the Plan for claims paid by the Plan, including but not limited to reasonable attorneys' fees, court costs, interest and other reasonable costs arising from or related to such fraud. Such claims may be recovered against future payments due to the Participant, his survivor and beneficiaries or by an action at law against the Participant.

7.10 **Legal Action.** No action at law or in equity may be brought to recover on the Plan after three (3) years from the time written notice is required to be furnished.

7.11 **Physical Exam**. The Administrator shall have the right to examine, at its own expense, the person of anyone whose injury or disease is the basis of a claim when and as often as it may reasonably require before and during a Benefit Period.

ARTICLE VIII
HIPAA Provisions

8.1 **General Prohibitions**. The Plan shall not disclose Protected Health Information to any Member of the Plan Sponsor's Workforce unless each of the conditions set out in this ARTICLE are met.

8.2 **Definitions**. For purposes of this ARTICLE, the following terms shall be defined as set out in the Privacy Standards, but generally shall have the following meanings:

(a) **"Electronic Media"** shall mean:

(i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk or digital memory card;

(ii) Transmission media used to exchange information already in electronic storage media, including, the internet (wide-open) extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial up lines, private networks, and the physical movement of removable/transportable electronic storage media; or

(iii) Transmissions of paper via facsimile and of voice via telephone are not considered transmission of electronic Protected Health Information.

(b) **"Electronic Protected Health Information"** shall mean Protected Health Information that is transmitted by or maintained in Electronic Media.

(c) **"Health Care Operations"** shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(d) **"Members of the Plan Sponsor's Workforce"** shall mean all employees and other persons under the control of the Plan Sponsor.

(e) **"Payment"** shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill responsibilities of the Plan with respect to coverage, provision of benefits, or reimbursement for health care.

(f) **"Privacy Official"** shall mean the person designated by the Plan to be responsible for development and implementation of the policies and procedures for compliance with the Privacy Standards.

(g) **"Privacy Standards"** shall mean Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164).

(h) **"Protected Health Information"** shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment, and which is created or received by or on behalf of the Plan.

8.3 **Permitted Uses and Disclosures**. Protected Health Information which is disclosed to a Member of the Plan Sponsor's Workforce shall be used or disclosed by them only for purposes of administrative functions of the Plan. The administrative functions shall include all Payment functions and Health Care Operations.

8.4 **Authorized Members of an Employer's Workforce**. The Plan shall disclose Protected Health Information only to Members of the Plan Sponsor's Workforce who are designated on Schedule I hereto and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his duties with respect to the Plan.

(a) Updates Required. The Plan Sponsor shall amend Schedule I promptly with respect to any changes in the Members of the Plan Sponsor's Workforce who are authorized to receive Protected Health Information. Such changes may be made as needed without requiring further amendment of the Plan.

(b) Use And Disclosure Restricted. An authorized Member of the Plan Sponsor's Workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

(c) Resolution of Issues of Noncompliance. In the event that any Member of the Plan Sponsor's Workforce uses or discloses Protected Health Information other than as permitted by this ARTICLE and the Privacy Standards, the incident shall be reported to the Privacy Official. The Privacy Official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

8.5 **Certification of Plan Sponsor**. The Plan Sponsor must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor and other participating Plan Sponsors;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this ARTICLE, or required by law;

(e) Make available Protected Health Information to any individual Participant or other person covered by the Plan in accordance with § 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by any individual Participant or other person covered by the Plan and incorporate any

amendments to Protected Health Information in accordance with § 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide an accounting of disclosures to any individual Participant or other person covered by the Plan in accordance with § 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information, when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure the adequate separation between the Plan and Members of the Plan Sponsor's Workforce, as required by § 164.504(f)(2)(iii) of the Privacy Standards and set out in Section 8.4 hereof.

8.6 **Safeguards for Electronic Protected Health Information**. The Plan Sponsor shall:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan;

(b) Ensure that the adequate separation between the Plan and Members of the Plan Sponsor's Workforce, as required by § 164.504(f)(2)(iii) of the Privacy Standards and set out in Section 8.4 hereof is supported by reasonable and appropriate security measures; and

(c) Report to the Privacy Official any security incident of which it becomes aware.

ARTICLE IX
Administration

9.1 **Authority of the Administrator**. The Administrator shall have the sole responsibility for the daily administration of the Plan which responsibility is specifically described in the Plan.

9.2 **Reliance on Information**. The Administrator is entitled to rely on information furnished by a Participant or his representative without further inquiry. The Administrator does not make any guarantee to any Participant in any manner for any loss or other forfeiture event because of the Participant's participation in the Plan.

9.3 **Expenses of Administration**. All usual and reasonable expenses of administration shall be paid by the Trust.

9.4 **Records and Reports**. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements applicable to the Plan.

9.5 **Other Powers and Duties of the Administrator**. The Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payments of any benefits hereunder and to maintain records with respect to decisions regarding such questions;

(b) to prescribe procedures to be followed by Participants filing applications for benefits;

(c) to prepare and distribute, in such manner as the Administrator determines to be appropriate, information explaining the Plan;

(d) to receive from an Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(e) to receive, review and keep on file (as it deems convenient and proper) reports of contributions by an Employer and Participants, as applicable; benefit payments by the Trust and reports of disbursements for expenses;

(f) to receive, review and keep on file (as it deems convenient and proper) any other reports and information that may be necessary and proper for administration of the Plan; and

(g) to appoint individuals or organizations to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuarial counsel.

ARTICLE X
Amendment and Termination of Plan

10.1 **Amendment of the Plan**. The Plan Sponsor may amend the Plan at any time and from time to time to any extent that it may deem advisable, but in no event, shall any amendment to the Plan retroactively deprive a Participant of any benefits.

10.2 **Plan Termination**. The Plan Sponsor acting through the General Assembly reserves the right to terminate the Plan at any time. In the event the Plan is terminated in its entirety, the Plan Sponsor shall transfer any asset reserves of the Trust to an insurance carrier in order to continue providing long-term care benefits to Eligible Employees.

ARTICLE XI
Miscellaneous

11.1 **No Guarantee of Employment**. Nothing contained in the Plan shall be construed as a contract of employment between an Employer and any employee, or as a right of any employee to be continued in the employment of an Employer, or as a limitation of the right of an Employer to discharge any of its employees, with or without cause.

11.2 **Rights to Trust's Assets**. No employee shall have any right to, or interest in, any assets of the Trust upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such employee.

11.3 **Non-alienation of Benefits**. Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder, shall be void. The Plan Sponsor shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

11.4 **Divestment of Benefits**. The Plan shall be maintained for the exclusive benefit of employees. Subject only to the specific provisions of the Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of the Plan.

11.5 **Construction**. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender where appropriate. Words used herein in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

11.6 **Governing Law**. The Plan shall be construed, enforced and administered and the validity determined in accordance with the Code, and the substantive laws of the Commonwealth of Virginia.

11.7 **Severability**. If any provision of the Plan is determined to be void by any court of competent jurisdiction, the Plan shall continue to operate, and shall be deemed not to include the provision determined to be void. Nevertheless, as provided in Section 10.2, the Plan Sponsor acting through the General Assembly retains the right to terminate the Plan at any time.

IN WITNESS WHEREOF and as conclusive evidence of the adoption of the Plan, the Plan Sponsor has caused the Plan to be executed by its duly authorized officers on this 28 day of April, 2008, but effective as of the Effective Date as hereinabove set forth.

PLAN SPONSOR

VIRGINIA RETIREMENT SYSTEM

By: _____

Title: DIRECTOR

APPENDIX A

Applicable Percentage

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

Schedule I

List of Authorized Members of the Plan Sponsor's Workforce

(Effective as of December 1, 2007)

The following persons are authorized to receive Protected Health Information in accordance with the provisions of ARTICLE VIII of the Plan:

Job Position	Administrative Function