AeroVironment, Inc

Your Group Long Term Care Insurance Plan

Policy No. 949209

Home, Community-Based and Immediate Family Member Care with Inflation

Underwritten by Unum Life Insurance Company of America

04-2019

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

This Certificate of Insurance is a part of the entire contract. This certificate is subject to the terms and conditions stated on the attached pages, all of which are part of the Policy.

Policy Number: 949209 001

COMPREHENSIVE LONG TERM CARE INSURANCE
Nursing Facility, Residential Care Facility, Home & Community-Based Care and Immediate Family Member Care

Caution: If you completed an Application for Long Term Care Insurance, the issuance of this long term care insurance certificate was based upon your responses to the questions on your application. A copy of your Application for Long Term Care Insurance will be delivered to you. If your answers are incorrect or untrue, Unum may have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Unum at this address: Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

Renewability: The Policy is renewable at the option of the Policyholder and Unum. This means that your coverage under the plan may be changed or ended at the option of the Policyholder or Unum. If your coverage is ended by the Policyholder or Unum, you will have a guaranteed right to elect continuation of coverage.

THE POLICY FOR LONG TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.

THIS CERTIFICATE IS AN APPROVED LONG TERM CARE INSURANCE CERTIFICATE UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS CERTIFICATE WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1-800-434-0222.

- You are entitled to examine a copy of the Policy during regular office hours at the Policyholder's place of business.
- You have a 30 day right to examine this certificate.

  If, after examining this certificate, you are not satisfied for any reason, you may withdraw your enrollment in this plan by returning this certificate within 30 days of its delivery to you. The certificate, together with a written request for such withdrawal, must be sent to the Policyholder's Plan Administrator.

  Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned.

NOTICE TO BUYER: This certificate may not cover all of the costs associated with long term care incurred by you during the period of coverage. You are advised to review carefully all coverage limitations.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare, available from Unum.

Unum is not representing Medicare, the federal government or any state government.

Throughout this certificate:

"You" or "your" means the insured person covered under the Policy.

"Unum" or "we" means Unum Life Insurance Company of America, and

"Policyholder" means AeroVironment, Inc. and its covered divisions, subsidiaries, and affiliated companies.

President

CALIFORNIA
CONTACT NOTICE

GENERAL QUESTIONS: If you have any general questions about your insurance, you may contact the Insurance Company by:

CALLING:
1-800-421-0344
(Customer Information Call Center)

-OR-

WRITING TO:
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

COMPLAINTS: If a complaint arises about your insurance, you may contact the Insurance Company by:

CALLING:
1-800-321-3889, option 2
(Compliance Center Complaint Line)

-OR-

WRITING TO:
Deborah J. Jewett, Manager, Customer Relations
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

WHEN CALLING OR WRITING TO THE INSURANCE COMPANY, PLEASE PROVIDE YOUR IDENTIFICATION NUMBER.

If the Certificate of Coverage was issued or delivered by an agent or broker, please contact your agent or broker for assistance.

You also can contact the California Department of Insurance. However, the California Department of Insurance should be contacted only after discussions with the Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Department of Insurance
Consumer Communications Bureau
300 South Spring Street - South Tower
Los Angeles, California 90013
Toll Free Hotline Telephone Number: 1-800-927-4357
Local Telephone Number: 213-897-8921
Office Hours: 8:00 a.m. - 5:00 p.m.

This form is for contact information only, and it is not to be considered a condition for the Policy.

TABLE OF CONTENTS

SUMMARY OF BENEFITS

THIS PAGE SUMMARIZES ALL THE BENEFITS AVAILABLE FOR THE EMPLOYEES OF AEROVIRONMENT, INC.. REFER TO YOUR SCHEDULE OF BENEFITS FORM WHICH OUTLINES YOUR INDIVIDUAL BENEFIT SELECTION(S).

Available March 1, 2005

Active Employees-
At your expense

Monthly Benefit Amount

Nursing Facility
$3,000 to $8,000 in $1,000 increments

Residential Care Facility
70% of the Nursing Facility Monthly Benefit

Daily Benefit Amount

Home Care- Home, Community-Based and Immediate Family Member Care
50% of the $3,000 Nursing Facility Monthly Benefit= $50/Day
50% of the $4,000 Nursing Facility Monthly Benefit= $66.67/Day
50% of the $5,000 Nursing Facility Monthly Benefit= $83.33/Day
50% of the $6,000 Nursing Facility Monthly Benefit= $100/Day
50% of the $7,000 Nursing Facility Monthly Benefit= $116.67/Day
50% of the $8,000 Nursing Facility Monthly Benefit= $133.33/Day

Respite Care
Benefit payment is based on where care is received.
See BENEFIT INFORMATION section for details.
This applies to all employees of AeroVironment, Inc..

Uncapped Compound Growth Inflation Protection- 5% compounded annually
See BENEFIT INFORMATION section for details

Lifetime Maximum Amount (the maximum Unum will pay you for all Long Term Care benefits)

3 Year Duration

36X the Nursing Facility Monthly Benefit amount

OR

6 Year Duration

72X the Nursing Facility Monthly Benefit amount

OR

Unlimited

Elimination Period- 90 consecutive days
See BENEFIT INFORMATION section for details
This applies to all employees of AeroVironment, Inc..

SUMMARY OF BENEFITS

THIS PAGE SUMMARIZES ALL THE BENEFITS AVAILABLE FOR FAMILY MEMBERS OF AEROVIRONMENT, INC.. REFER TO YOUR SCHEDULE OF BENEFITS FORM WHICH OUTLINES YOUR INDIVIDUAL BENEFIT SELECTION(S).

Available March 1, 2005

Family Members-
At your expense

Monthly Benefit Amount

Nursing Facility
$3,000 to $8,000 in $1,000 increments

Residential Care Facility
70% of the Nursing Facility Monthly Benefit

Daily Benefit Amount

Home Care- Home, Community-Based and Immediate Family Member Care
50% of the $3,000 Nursing Facility Monthly Benefit= $50/Day
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3 Year Duration

36X the Nursing Facility Monthly Benefit amount

OR

6 Year Duration

72X the Nursing Facility Monthly Benefit amount

OR

Unlimited

Elimination Period- 90 consecutive days
See BENEFIT INFORMATION section for details
This applies to all employees of AeroVironment, Inc..

Application Limits:

You will be required to complete an Application for Long Term Care Insurance satisfactory to Unum for:

- Monthly Benefit Maximum Amount(s) greater than $6,000; or
- an Unlimited Lifetime Maximum Amount.

If Unum approves your Application for Long Term Care Insurance, the **"PREEXISTING CONDITION"** will be waived for your entire amount(s) of insurance. If Unum disapproves your Application for Long Term Care Insurance, you will be insured for the amount(s) selected up to the amount that does not exceed the application limit(s). The **"PREEXISTING CONDITION"** will apply.

CHANGES IN COVERAGE

For an Active Employee and their spouse

Increases in Coverages:

You have the option to elect to increase coverage from the benefits shown in the SUMMARY OF BENEFITS, no less frequently than on each anniversary date after the Policy is issued. Additional premium will be charged for any increases.

You can apply to increase coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Increases in coverage will take effect at 12:01 a.m. on

- the first of the month after Unum approves your Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or

- the first of the second month after Unum approves your Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.

The premium rate to be paid for any increase in coverage is based on your insurance age. To determine insurance age, subtract your date of birth from the date you are applying for the increase in coverage.

Decreases in Coverage:

You have the right, exercisable any time after the first year, to lower premium by reducing coverage from the benefit shown in the insured person's SCHEDULE OF BENEFITS, or to discontinue Home Care coverage.

You can apply to decrease coverage by filling out a new Benefit Election Form. Decreases in coverage will take effect at 12:01 a.m. on the first day of the month on or next following the month in which Unum receives the Benefit Election Form. The premium rate to be paid for any decrease in coverage is based on your original issue age.

For all other eligible persons

Increases in Coverages:

You have the option to elect to increase coverage from the benefits shown in the SUMMARY OF BENEFITS, no less frequently than on each anniversary date after the Policy is issued. Additional premium will be charged for any increases.

You can apply to increase coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Increases in coverage will take effect at 12:01 a.m. on the first day of the month after Unum approves your Application for Long Term Care Insurance.

The premium rate to be paid for any increase in coverage is based on your insurance age. To determine insurance age, subtract your date of birth from the date you are applying for the increase in coverage.

Decreases in Coverage:

You have the right, exercisable any time after the first year, to lower premium by reducing coverage from the benefit shown in the insured person's SCHEDULE OF BENEFITS, or to discontinue Home Care coverage.

You can apply to decrease coverage by filling out a new Benefit Election Form. Decreases in coverage will take effect at 12:01 a.m. on the first day of the month on or next following the month in which Unum receives the Benefit Election Form. The premium rate to be paid for any decrease in coverage is based on your original issue age.

WHEN CHANGES IN COVERAGE WILL BE DELAYED FOR ACTIVE EMPLOYEES

Changes in your coverage will not begin if you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence on the date that the coverage would normally begin. Coverage will begin at 12:01 a.m. on the first day of the month after you return to work as an **Active Employee**.

DISCRETIONARY AUTHORITY

In making any benefits determination under the Policy, Unum will have the discretionary authority both to determine an insured person's eligibility for benefits and to construe the terms of the Policy.

ELIGIBILITY FOR COVERAGE

If you are an **Active Employee** or a **Family Member** covered under the Policy, you are eligible for coverage.

"**Active Employee**" means an employee working for the Policyholder:

- on a full-time basis for earnings that are paid regularly;
- for a minimum of 30 hours per week; and
- at the Policyholder's usual place of business or at a location to which their job requires them to travel.

"**Family Members**" means:

- the legally married spouse or registered domestic partner of an **Active Employee**. A registered domestic partner is the person named in a declaration of domestic partnership filed with the Secretary of State of California;
- the natural, adoptive or step-parents/grandparents of an **Active Employee** and their spouse or registered domestic partner;
- the natural, adoptive or step-siblings of an **Active Employee** and their spouse or registered domestic partner;
- the natural, adoptive or step-children of an **Active Employee** and their spouse or registered domestic partner.

Family Members who are eligible for coverage as an **Active Employees** are only eligible for coverage as an employee.

To be eligible for coverage, **Family Members** must be between the ages of 18 and 80.

ELIGIBILITY FOR BENEFITS

You are eligible for a Monthly Benefit if, after the effective date of your coverage and while your coverage is in effect:

- you suffer the loss of 2 or more **Activities of Daily Living** (ADLs); or

  you suffer **Severe Cognitive Impairment**; and
- a **Physician** has certified that you are unable to perform (without **Substantial Assistance** from another individual) two of six **Activities of Daily Living** (ADLs) for a period that is expected to last at least 90 days, or that you require **Substantial Supervision** by another individual to protect you and others from threats to health or safety due to **Severe Cognitive Impairment**. You will be required to submit a **Physician** certification every 12 months.

The treatment and services you receive for your **Chronic Illness** must be provided pursuant to a **Plan of Care**.

"**Activities of Daily Living**" **(ADLs)** are:

- EATING - feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- BATHING - washing oneself by sponge bath; or in either a tub or shower, including the act of getting into or out of the tub or shower.
- CONTINENCE - the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- DRESSING - putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- TOILETING - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- TRANSFERRING - the ability to move into and out of a bed, a chair, or wheelchair, or the ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

"Chronic Illness" and "Chronically Ill" mean:

- you are unable to perform, without **Substantial Assistance** from another individual, at least two **Activities of Daily Living**; or
- you require **Substantial Supervision** by another individual to protect you from threats to health and safety due to **Severe Cognitive Impairment**.

"Immediate Family Member" means your spouse, parent, daughter, son, sister or brother.

"Licensed Health Care Practitioner" means any **Physician**, and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

"Physician" means a person, other than yourself, who is operating within the scope of his/her license, and is either:

- licensed to practice medicine and surgery and prescribe and administer drugs; or
- legally qualified as a medical practitioner and required to be recognized, under this plan for insurance purposes, according to the insurance laws of the governing jurisdiction.

Unum will consider a person to be a **Physician** only when the person is performing tasks that are within the limits of the person's medical license. Unum will not recognize the following as **Physicians** for claims that you make to us under the Policy:

- you, or
- your **Immediate Family Member** who is your spouse, parent, daughter, son, sister or brother.

"Plan of Care" means a program of treatment or care. It must be developed by your **Physician**, multi-disciplinary team or **Licensed Health Care Practitioner** and approved, in writing, by your **Physician** before care or services begin. The

written **Plan of Care** is subject to updating, in writing, no more often than every 60 days. You will be responsible for submitting:

- the **Physician** approved **Plan of Care**; and
- the periodic updates to such plan.

"Severe Cognitive Impairment" means a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests in:

- your short or long term memory;
- your orientation as to person, place and time; or
- your deductive or abstract reasoning.

Such deterioration or loss requires **Substantial Supervision** by another individual for the purpose of protecting you from harming yourself or others. The loss can result from a **Chronic Illness**, Alzheimer's disease, or similar forms of dementia.

Unum will make payments to you for conditions that are psychological, psychiatric or mental in nature, including Alzheimer's disease, organic disorders, or related degenerative and dementing illnesses.

"Substantial Assistance" means hands-on or stand-by assistance by another person without which you would not be able to safely and completely perform the **ADL**.

"Substantial Supervision" means the presence of another individual for the purpose of protecting you from harming yourself or others.

"Independent Licensed Health Care Practitioner Certification"

You have the right to provide us with a certification of your **Chronic Illness** from a **Licensed Health Care Practitioner**. You also have the right to request that we coordinate an assessment of your condition by an independent **Licensed Health Care Practitioner** that is not an employee of our company, and whose compensation is not related in any manner to the outcome of the certification.

If a practitioner determines that you do not meet the definition of a **Chronically Ill** individual, you have the right to request a second in person assessment by a **Licensed Health Care Practitioner**. The requirement for a second assessment shall not be made available to you if the initial assessment was performed by a practitioner who personally examined you.

If requested, these certification assessments will be performed promptly, shall be renewed every 12 months, and the costs associated with the assessment requests will be paid for by us and will not count against the lifetime maximum of your certificate. If a practitioner completes a personal examination, that practitioner will develop a written plan of care for you.

FACILITY BENEFITS

Once you become eligible for benefits, a **Nursing Facility** or **Residential Care Facility** monthly benefit will become payable after you have completed the **Facility Elimination Period**, and you are residing in a **Nursing Facility** or **Residential Care Facility**. The treatment and services you receive for your **Chronic Illness** must be provided pursuant to a **Plan of Care**.

"**Facility Elimination Period**" means the number of consecutive days during which you must be eligible for benefits before benefits become payable. It must be satisfied while residing in a **Nursing Facility** or **Residential Care Facility**. The entire **Facility Elimination Period** must be satisfied only once in your lifetime.

Recurrent Chronic Illness

You will not have to complete a new **Facility Elimination Period** if you become **Chronically Ill** again after the date we stopped making monthly benefit payments to you for your previous eligibility.

"**Nursing Facility**" means:

- an institution, or a distinctly separate part of a hospital, that is licensed or certified as a nursing home (if licensing or certification is required) or operates under the law as a nursing home to provide skilled, intermediate and custodial care and operates under state licensing laws and any other laws that apply; or
- any other institution that meets all of the following tests:
  - is operated as a health care facility under applicable state licensing laws and any other laws;
  - primarily provides nursing care under the orders of a **Physician**;
  - provides patient care under the supervision of a registered nurse or a licensed vocational nurse;
  - regularly provides room and board and continuous 24 hour a day nursing care of sick and injured persons;
  - maintains a daily medical record of each patient who must be under the care of a **Physician**;
  - is authorized to administer medication to patients on the order of a **Physician**; or
- a similar institution approved by Unum.

"**Residential Care Facility**" means:

- a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code; or
- facilities that meet applicable licensure standards; if any, that:
  - are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in **Activities of Daily Living** or impairment in cognitive ability;
  - provides care and services on a 24-hour basis;

- has a trained and ready-to-respond employee on duty in the facility at all times to provide care and services;
- provides three meals a day and accommodates special dietary needs;
- has agreements to ensure that residents receive medical care services of a **Physician** or nurse in case of emergency; and
- has appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications; or

• a similar institution approved by Unum.

"Plan of Care" means a program of treatment or care. It must be developed by your **Physician**, multi-disciplinary team or **Licensed Health Care Practitioner** and approved, in writing, by your **Physician** before care or services begin. The written **Plan of Care** is subject to updating, in writing, no more often than every 60 days. You will be responsible for submitting:

• the **Physician** approved **Plan of Care**; and

• the periodic updates to such plan.

Bed Reservation Benefit

If you are receiving a **Nursing Facility** or **Residential Care Facility** monthly benefit and your stay in the Facility is interrupted because you are hospitalized, we will continue to pay the monthly benefit if a charge is made to reserve your accommodations in the Facility.

If your stay is interrupted because you are hospitalized while you are completing your **Facility Elimination Period**, such days will be used to help satisfy this period.

Bed Reservation days will be limited to 15 days per calendar year.

Amount of Facility Monthly Benefit

The amount of your Facility monthly benefit will be based on the Facility coverage options you chose from the SUMMARY OF BENEFITS. The amount of your Facility monthly benefit is shown on the SCHEDULE OF BENEFITS form attached to and made a part of this Certificate.

Unum will send you a lump sum payment to cover the period between the day you became eligible for monthly benefit payments and the day you were approved for these payments. Unum will then send you a payment each month for the number of days you were eligible to receive benefits during the prior month. Benefit payments will cease as provided in the provision **"WHEN MONTHLY BENEFIT PAYMENTS END"**.

Facility Waiver of Premium

Once a **Nursing Facility** or **Residential Care Facility** benefit becomes payable, there will be no more cost for your coverage as long as you are **Chronically Ill** and residing in a **Nursing Facility** or **Residential Care Facility**. If benefits are no longer payable, you **must** resume premium payments to continue your coverage.

Premium payments are not waived while you are receiving a payment for **Respite Care**.

We will notify you of the amount of your next premium payment and the date it is due.

HOME CARE BENEFIT

Home, Community-Based and Immediate Family Member Care

Once you become eligible for benefits, a **Home Care** monthly benefit will become payable after you have completed the **Home Care Elimination Period** and you are receiving **Home Care Services**. The treatment and services you receive for your **Chronic Illness** must be provided pursuant to a **Plan of Care**. This care can be provided at any type of facility such as an **Adult Day Care Facility** or your home. Care can be provided to you by:

- a formal caregiver, such as a home care provider or a licensed home health care professional; or
- an informal caregiver, such as an **Immediate Family Member** or friend.

"**Home Care Elimination Period**" means the number of consecutive days during which you must be eligible for benefits before benefits become payable. The entire **Home Care Elimination Period** must be satisfied only once in your lifetime.

Recurrent Chronic Illness

You will not have to complete a new **Home Care Elimination Period** if you become **Chronically Ill** again after the date we stopped making monthly benefit payments to you for your previous eligibility.

"**Home Care Services**" means care, treatment or services provided to you under a **Plan of Care** at any type facility or in your home by formal or informal caregivers. **Home Care Services** includes:

- **Adult Day Care** - medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside your residence for persons in need of personal services, supervision, protection or assistance in sustaining daily needs, including bathing, dressing, toileting, transferring, eating and taking medications.
- **Home Health Care** - skilled nursing or other professional services in your residence (i.e., where you live).
- **Homemaker Services** - assistance with activities necessary to or consistent with your ability to remain in your residence that is provided by a skilled or unskilled person under a **Plan of Care**.
- **Hospice Services** - inpatient or outpatient services that are designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a person who is experiencing the last phases of life due to the existence of a terminal disease and to provide supportive care to the primary caregiver and the family. Care may be provided by a skilled or unskilled person under a **Plan of Care** in your home or in a hospice facility.
- **Personal Care** - assistance with **Activities of Daily Living (ADLs)**, including the instrumental ADLs, provided by a skilled or unskilled person under a **Plan of Care**. Instrumental ADLs include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry and light housekeeping.
- **Respite Care** - care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities. Care may be provided by a skilled or unskilled person under a **Plan of Care**.

"Plan of Care" means a program of treatment or care. It must be developed by your **Physician**, multi-disciplinary team or **Licensed Health Care Practitioner** and approved, in writing, by your **Physician** before the start of **Home Care Services**. The written **Plan of Care** is subject to updating, in writing, no more often than every 60 days. You will be responsible for submitting:

- the **Physician** approved **Plan of Care**; and
- the periodic updates to such plan.

Respite Care Benefits

If you are eligible for a **Home Care** benefit but are not yet receiving monthly payments because you have not yet completed the **Home Care Elimination Period**, we will pay a benefit equal to 1/30th of your **Home Care** benefit for each day that you receive **Respite Care**, up to a maximum of 15 days per calendar year.

Respite Care days will not count toward satisfying the **Home Care Elimination Period**.

Payments made to you for **Respite Care** will not reduce your Lifetime Maximum Amount.

Respite Care may be provided to you by:

- a formal caregiver, such as a provider of **Personal Care** or, **Adult Day Care**; or
- an informal caregiver, such as your friend or immediate family member.

Amount of Home Care Monthly Benefit

The amount of your **Home Care** monthly benefit is shown in the SUMMARY OF BENEFITS and on the SCHEDULE OF BENEFITS form attached to and made a part of this Certificate.

Unum will send you a lump sum payment to cover the period between the day you became eligible for monthly benefit payments and the day you were approved for these payments. Unum will then send you a payment each month for the number of days you were eligible to receive benefits during the prior month. Benefit payments will cease as provided in the provision **"WHEN MONTHLY BENEFIT PAYMENTS END"**.

Home Care Waiver of Premium

Once a **Home Care** benefit becomes payable, there will be no more cost for your coverage as long as you are **Chronically Ill** and are receiving a **Home Care** monthly benefit. If benefits are no longer payable, you **must** resume premium payments to continue your coverage.

If you do not receive a **Home Care** benefit for a period of 30 consecutive days, premium payments will again become due.

Premium payments are not waived while you are receiving a payment for **Respite Care**.

We will notify you of the amount of your next premium payment and the date it is due.

INFLATION PROTECTION

If you have chosen this benefit, your monthly benefit will increase each year on January 1st by 5% of the monthly benefit in effect on that date. As long as your coverage remains in effect, inflation increases will occur automatically for your Monthly Benefit Amounts and Lifetime Maximum Amount as shown in the SUMMARY of BENEFITS, regardless of your health or whether or not you are **Chronically Ill**. Your premium will not increase due to automatic increases in these amounts.

An example of a 5% uncapped compound growth inflation protection increase is:

A monthly benefit amount of $1,000 will be increased:

1. by 5% to $1,050 on January 1st of the next calendar year;
2. by 5% of $1,050 to $1,102.50 on the next January 1st; and
3. by 5% of the previous benefit amount on each following January 1st.

WHEN MONTHLY BENEFIT PAYMENTS END

We will continue monthly benefit payments until the earliest of the following dates:

- the date you are no longer **Chronically Ill**;
- the expiration of your **Physician** certification;
- the date you are no longer eligible for a monthly benefit under the plan of coverage you chose;
- the date your total benefit payments equal the Lifetime Maximum Amount; or
- the date you die.

LIMITATION AND EXCLUSIONS

Unum will not make any Long Term Care payments to you for **any** benefits for:

- a **Chronic Illness** caused by war (whether declared or not) or any act of war;
- a **Chronic Illness** caused by suicide, whether sane or insane, attempted suicide, or intentionally self-inflicted injury;
- a **Chronic Illness** caused by participation in a felony, riot, or insurrection;
- **Chronic Illness** or confinements during which you are outside the United States, its territories or possessions for longer than 30 days;
- treatment for alcoholism or drug addiction;
- a period in which you are confined in a hospital other than if you are confined in a **Nursing Facility** that is a distinctly separate part of a hospital, (this exclusion does not apply to those periods covered under the Bed Reservation Benefit); or
- care, treatment, services or claims certification by a **Physician** who is you or your **Immediate Family Member** who is your spouse, parent, daughter, son, sister or brother.

PREEXISTING CONDITIONS

A **Preexisting Condition** is a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

Every Long Term Care insurance policy or certificate shall cover **Preexisting Conditions** that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

ENTIRE CONTRACT- CHANGES

The Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

INCONTESTABLE CLAUSE

Time Limit on Certain Defenses: (a) After two years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by the applicant in the application for such Certificate shall be used to void the Certificate or to deny a claim for loss incurred or **Chronic Illness** commencing after the expiration of such two year period.

(b) No claim for loss incurred or **Chronic Illness** commencing after two years from the date of issue of this Certificate shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Certificate.

If Unum does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the Certificate, then Unum may only rescind the Certificate or deny an otherwise valid claim, upon clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant. The evidence shall:

1. Pertain to the condition for which benefits are sought.
2. Involve a chronic condition or involve dates of treatment before the date of application.
3. Be material to the acceptance for coverage.

A **Preexisting Condition** is a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

Every Long Term Care insurance policy or certificate shall cover **Preexisting Conditions** that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

GRACE PERIOD

A **Grace Period** of 60 days, which runs from the effective date of the lapse notice, will be granted for the payment of each premium falling due after the first premium, during which **Grace Period** the Policy shall continue in force (subject to the right of the insurer to terminate in accordance with the **Termination of Coverage** provision hereof).

Designation of individuals to receive notice of lapse or termination of policy or certificate for nonpayment of premium

(a) No individual Long Term Care policy or certificate shall be issued until the applicant has been given the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy or certificate for nonpayment of premium. The insurer shall receive from each applicant one of the following:

(1) A written designation listing the name, address, and telephone number of at least one individual, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium.

(2) A waiver signed and dated by the applicant electing not to designate additional persons to receive notice.

(b) The insurer shall notify the insured of the right to change the written designation, no less often than once every two years.

(c) When the policyholder or certificate holder pays the premium for a Long Term Care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision (a) need not be met until 60 days after the policyholder or certificate holder is no longer on that deduction payment plan. The application or enrollment form for a certified Long Term Care insurance policy or certificate shall clearly indicate the deduction payment plan selected by the applicant.

(d) No individual Long Term Care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the insured and to the individual or individuals designated pursuant to subdivision (a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, not less than 30 days after a premium is due and unpaid.

Reinstatement Due to Chronic Illness: Each Long Term Care insurance policy or certificate shall include a provision which, in the event of lapse, provides for reinstatement of coverage, if the insurer is provided with proof of the insured's cognitive impairment or loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of a past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy or certificate.

REINSTATEMENT

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after

such date. In all other respects, the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

CLAIM INFORMATION

NOTICE OF CLAIM

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at 2211 Congress Street, Portland, Maine, 04122, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

CLAIM FORMS

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS

Written Proof of Loss must be furnished to the insurer at its said office, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM

Indemnities payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written Proof of Loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

If any indemnity of the Policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto.

Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by the Policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the hospital or person rendering those services; but it is not required that the service be rendered by a particular hospital or person.

PHYSICAL EXAMINATION

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

LIMITATION OF ACTIONS ON POLICY

Legal Actions: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written Proof of Loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written Proof of Loss is required to be furnished.

RIGHT OF APPEAL

Unum will notify you, in writing, immediately, but in no event more than forty (40) calendar days after the claim form was filed, if a claim or any part of a claim is denied. The denial letter will state:

- the specific reason(s) for the denial with reference to the applicable policy provision(s);
- a description of any additional material or information that is necessary to complete the claim; and
- an explanation of why the additional material is necessary.

If you are not satisfied with the reason for the denial, you or your representative may ask to have the claim reviewed by our Quality Review Section. The request must be in writing and should include any supporting material or information that may help us to review the claim.

With proper authorization, you may request copies of pertinent documents used for the claim review. In some cases, we may request that you provide additional information to assist in the review.

Within 30 days after receipt of the request, or after the date all the needed information has been received, we will notify you or your representative of our determination, in writing. An explanation of the determination will also be provided.

PREMIUM INFORMATION

The premium rate will not increase because you grow older or because of your use of the benefits. However, the premium rate schedule may change in the future depending on the overall use of the benefits by all insured persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to Unum's underwriting risk studies under this type of insurance.

RENEWABILITY AND TERMINATION OF COVERAGE

POLICY RENEWABILITY

The Policy is renewable at the option of the Policyholder and Unum. This means that your coverage under the plan may be changed or ended at the option of the Policyholder or Unum. If your coverage is ended by the Policyholder or Unum, you will have a guaranteed right to elect continuation of coverage.

TERMINATION OF COVERAGE

Your coverage will end on the latest of these dates:

- the date the Policy ends,
- the date you are no longer an **Active Employee** with the Policyholder,
- the date you no longer work for the Policyholder,
- the end of the period for which premiums were last paid to Unum for your coverage,
- the date your total benefit payment equals your Lifetime Maximum Amount, or
- the date you die.

If you are absent from work at the Policyholder for any reason, you will continue to be covered for group coverage if the Policyholder continues to pay premiums to Unum.

EXTENSION OF BENEFITS

Termination of coverage will not affect any benefits payable if **Chronic Illness** began while your Long Term Care insurance was in force, and continues without interruption after termination. Such extension of benefits will be limited to the duration of the payment of the Lifetime Maximum Amount.

CONTINUATION OF COVERAGE

You may elect to continue the same coverage you had under the group policy on a direct billing basis, if your group coverage ends. **You may not elect to continue coverage if you are not insured under the group policy. You may not elect to continue coverage if your group coverage ended because:**

- **you failed to make any required premium payment when due; or**
- **you failed to make any contribution when due.**

Election for continued coverage must be made within 31 days from:

- the date your group coverage ends; or
- the date the group policy terminates.

Your continued coverage will be on a direct billing basis, if your premium is payroll deducted. Your continued coverage:

- will be maintained under the existing group policy, if your coverage terminated because you are no longer eligible for coverage; or

- will be continued under a continuation group policy, if the existing group policy terminates.

If you are already direct billed, your coverage will automatically continue:

- under the existing group policy, if you are no longer eligible for coverage; or
- under a group continuation policy, if the existing group policy terminates.

Your continued coverage will remain in force, as long as you continue timely payment of premium when due. You must pay premium directly to Unum for continued coverage.

The premium rate schedule for continued coverage may change in the future, depending on:

- the overall use of the benefits by all insured persons; or
- changes in the benefit levels or other risk factors.

Any such change will be made on a class basis according to Unum's underwriting risk studies.

Once you have continued your coverage, you can apply at any time to change your continued coverage. To change your coverage, you must contact Unum's home office. You will need to complete the necessary forms.

Additional Summary Plan Description Information

If this Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the Summary Plan Description. The Summary Plan Description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

Name of Plan:
AeroVironment, Inc. Plan

Name and Address of Employer:
AeroVironment, Inc.
181 W Huntington Drive
Suite 202
Monrovia, CA 91016

Plan Identification Number:
a. Employer IRS Identification #: 95-2705790
b. Plan #: 501

Type of Welfare Plan:
Long Term Care

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Policy issued to the Plan.

ERISA Plan Year Ends:
January 31

Plan Administrator, Name, Address and Telephone No.:
AeroVironment, Inc.
181 W Huntington Drive
Suite 202
Monrovia, CA 91016
626-357-9983

AeroVironment, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Same as above

Service of legal process may also be made upon the Plan Administrator, and any Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number/identification number 949209 001. Contributions to the Plan are made as stated under the Summary of Benefits in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a Policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Policy.

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The Policy or a plan under the Policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may terminate the Policy by written notice of at least 45 days if:

- fewer than 10 employees insured under a Plan; or
- the Employer does not promptly give Unum any information that Unum requires; or
- the Employer fails to perform any of its obligations that relate to the Policy.

The Policy will automatically terminate if the Employer does not pay all premiums due within the Grace Period. The Policy will terminate at 12:00 midnight on the last day of the Grace Period.

The Employer must pay all the premiums for the entire time that the Policy is in effect and will be liable to Unum for any premiums that it does not pay.

However, Unum cannot refuse to renew or otherwise terminate this Policy because the insured persons grow older or because of the insured persons' use of benefits.

The Employer can terminate the Policy on any date if it delivers written notice to Unum at least 45 days before the termination date.

If the Employer and Unum both agree, the Policy may be terminated less than 45 days after the Employer or Unum gives notice of termination. However, the Policy will not be terminated during any period for which the Employer has paid premium.

If the Policy is terminated, Unum will still pay any payable claim for an insured person's Disability which began while the Policy was in effect.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. Unum must receive a completed claim form. The form must be completed by you or your authorized representative. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIM PROCEDURES

The time periods provided in this section will apply to claims procedures under the Policy unless a shorter time period is stated in the Policy.

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

1. the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and

3. a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

The time period provided in this section for submitting an appeal will apply unless a longer time period for submitting an appeal is stated in the Policy.

The time period provided in this section for making a final appeal decision will apply unless a shorter time period for making a final appeal decision is stated in the Policy.

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

1. submit a request for review, in writing, to Unum;

2. upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and

3. submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Policy provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notices of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials. This does not apply if the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, (for example, if the courts find your claims frivolous) the court may order you to pay these costs and fees.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.