IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-252-3439

You may write the Texas Department of Insurance at:

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

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

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

AVISO IMPORTANTE

Para obtener información o para someter una queja:

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

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

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

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

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.

The terms of this page apply only to employees located in Texas.

Summary of Coverage

Employer: Devereux

Group Policy: GP-724622

SOC: 1A

Issue Date: May 4, 2004

Effective Date: January 1, 2003

With respect to employees located in Texas:
Death benefits will be reduced if an accelerated death benefit is paid.

At the time an accelerated death benefit is paid, a statement will be sent to you specifying the amount of benefits paid, the effect of the benefit on other certificate benefits, future charges and premiums.

The Accelerated Death Benefits (ADB) offered under this certificate are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the ADB qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to ADB are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive ADB excludable from income under federal law.

Employee:

Beneficiary:

The benefits shown in this Summary of Coverage are available for you.

This is an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company, Hartford, CT. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees

You are in an Eligible Class if you are:

- a regular full-time Devereux employee and you work at least 40 hours a week; or
- a regular full-time Cleo Wallace employee and you work at least 20 hours a week.

For Cleo Wallace employees:

AllDevereux employees for - Life, Sup. ADDC

Your Eligibility Date is the date you complete a probationary period of 90 days from the date of hire of continuous service for your Employer, but not before the later of the Effective Date of this Plan and the date you enter the Eligible Class. This rule applies even if your employment began as part-time service. For Accidental Death and Dismemberment benefit, you must follow the Enrollment Procedure.

For all other employees:
Your Eligibility Date, if you are in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the date you complete a probationary period of 90 days of continuous service for your Employer or, if later, the date you enter the Eligible Class. For Accidental Death and Dismemberment benefit you must follow the Enrollment Procedure.

Changes in Employment Status

Your benefit eligibility may be affected if your employment status changes. Ordinarily, employees are not eligible for certain benefits until the first of the month on or following 90 days of active, continuous employment. Life benefits are effective on the 91st day of active, full time employment. In certain circumstances, however, this standard waiting period may not apply.

Part-time to Full-time:

An employee's waiting period may be waived when changing status from part-time to full-time status, provided a properly completed Choice Benefit Enrollment form is completed and returned to Center Human Resources within thirty (30) days following the status change. A waiver of the waiting period requires that an employee be employed by Devereux for at least six months **and** have worked 624 hours in that six month period prior to the status change. The waiver does not apply to an employee who has previously changed status from full-time to part-time, and is again changing back to full-time employment status.

Full-time to Part-time to Full-time:

An employee who changes from full-time status to part-time status, and then returns to full-time status within 180 days **within the same plan year** will be eligible for reinstatement into his/her previous full time elections under Devereux's benefit plans. An employee who changes from full-time status to part-time status, and then returns to full-time status within 180 days **within a different plan year** will be eligible to make new elections under Devereux's benefit plans. The reinstatement date will be the effective date of full time status.

Reinstatements:

An employee who terminates employment and returns to work within ninety (90) days **within the same plan year** will be reinstated into his/her previous elections under Devereux's benefit plans. An employee who terminates employment and returns to work within ninety (90) days **within a different plan year** will be eligible to make new elections under Devereux's benefit plans. The reinstatement date will be the effective date of full time status.

You can remain in an Eligible Class as a retired employee and continue life insurance if:

you were hired prior to September 1, 1971, you had completed 10 years of service, and when you terminated active employee status, you had reached age 65.

were hired prior to September 1, 1987; you had completed 10 years of service, and when you terminated active employee status, you had reached age 65.

- you were hired prior to Setember 1, 1987, and you were under age 65 when you retired and had completed 30 years of service with your Employer.

Dependents

As to Accidental Death and Dismemberment benefit, you may cover your:

- wife or husband under 70 years of age; and
- unmarried children from 14 days to 19 years of age.

Any other unmarried child under age 25 who goes to school on a regular basis and depends on you for support will be covered as a dependent.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

The Life Insurance Benefits described in this Booklet-Certificate are not available to you or your beneficiary if a Life Insurance claim described in another Booklet-Certificate issued under the group policy is applicable.

Enrollment Procedure

As to Accidental Death and Dismemberment benefit, you will get a form to fill out. This form will be used to arrange the amount of your coverage. Be sure to sign and return by your eligibility date.

Your contributions, if any, toward the cost of this coverage are subject to change. Your Employer will advise you concerning the method and amount of any required contributions.

As to your Life Insurance benefit, you will be given a beneficiary card to complete. No application is necessary.

Effective Date of Coverage

Employees

As to Accidental Death and Dismemberment benefit, your coverage will take effect on the later to occur of:

- your Eligibility Date; or
- open enrollment of any plan year.

Active Work Rule: If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until you return to full-time work for one full day. This rule also applies to an increase in your coverage.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within 30 days of any dependent's eligibility date, evidence of his or her good health that is acceptable to Aetna will be required.

Life Insurance

Schedule of Life Insurance

Employees

Basic Schedule

Classification	Amount
All Active Employees	200% of your basic annual earnings, as determined by your Employer, rounded to the next higher $ 1,000, if not an integral multiple of $ 1,000. Maximum: $ 200,000 Minimum: $ 1,000

Supplemental Schedule

Grandfathered Employees only as determined by your Employer. See your Employer for details.	100% of your basic annual earnings, as determined by your Employer, rounded to the next higher $ 1,000, if not an integral multiple of $ 1,000. Maximum: $ 200,000 Minimum: $ 1,000

Schedule For Retired Employees

Retired Employees Hired Prior to September 1, 1987 who had completed 10 years of service and Retired At or After Age 65:	
Employees who were hired and became eligible for life insurance prior to September 1, 1971	75% of your basic annual earnings in force as of May 1981 (as determined by your Employer), rounded to the next higher $ 1,000, if not an integral multiple of $ 1,000.
All other employees hired prior to September 1, 1987	$3,000
Retired Employees Hired Prior to September 1, 1987 with 30 Years of Service and who Retired Prior to Age 65	$3,000

With respect to Cleo Wallace employees:

Evidence Requirements

You can become insured for an amount of Life Insurance in excess of $ 100,000 only if you submit evidence of good health to Aetna and such evidence is approved by Aetna.

Age Reduction Rule

With respect to active employees, your Life Insurance amount in force on the day before the first day of the month in which you reach age 65 will be reduced by: 35% at age 65 and 50% at age 70. The reduction will take effect on the first day of the calendar month in which you reach the age specified.

If you become insured during or after the month in which you reach the above ages, your amount of Life Insurance will be the applicable percentage of the amount shown for your classification.

Accelerated Death Benefit

Employees

ADB Months:	12
ADB Percentage:	50%
ADB Maximum:	$ 50,000

Accidental Death and Dismemberment Coverage

Schedule of Accidental Death and Dismemberment Coverage

Supplemental Schedule

Classification	**Principal Sum**
All Employees	Multiple of $ 10,000, not to exceed 10 times annual salary Minimum: $ 10,000 Maximum: $ 300,000
Employee and Family	
Spouse	50% of employee's Principal Sum
Child(ren)	15% of employee's Principal Sum

Additional Accidental Death Benefit Maximums

Employees and Dependents

Passenger Restraint Benefit Maximum	
for you	$ 10,000
for each covered dependent	The lesser of $ 10,000 or your covered dependent's Principal Sum
Airbag Benefit Maximum	One half of a person's Passenger Restraint Benefit
Common Accident Benefit Maximum	$ 200,000*

*In any event, no more than three times your Principal Sum, not to exceed $ 2,000,000, will be payable for all losses you and your dependents suffer as a result of the same accident.

Education Benefit Maximum	
for each dependent child	2.5% of your Principal Sum not to exceed $ 2,500
for your spouse	2.5% of your Principal Sum not to exceed $ 2,500

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

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

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29W.

KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET-CERTIFICATE

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA

For Employees Located In California

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the

Consumer Service Division
Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Additional Information Provided by
Devereux

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Employer Identification Number:
23-1390618

Plan Number:
505

Type of Plan:
Life Insurance and Accidental Death & Dismemberment Insurance Plan

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Devereux
2012 Renaissance Blvd.
King of Prussia, PA 19406

Agent For Service of Legal Process:
Devereux
2012 Renaissance Blvd.
King of Prussia, PA 10406

End of Plan Year:
December 31

Source of Contributions:
Employer

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the National Human Resources Director.

Claim Procedures

Your booklet-certificate contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

Note: If applicable state law requires the Plan to take action on a claim or appeal in a shorter timeframe, the shorter period will apply.

Filing Life Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means your legal spouse or adult child, or a person you authorize, in writing, to act on your behalf. In addition, the Plan will recognize a court order giving a person authority to submit claims on your behalf.

You will be notified of the decision not later than 90 days after the Plan's receipt of the claim. This time period may be extended up to an additional 90 days due to special circumstances. In that case, you will be notified of the extension before the end of the initial 90-day period. Notice of the extension will explain the special circumstances requiring the extension and the date by which a decision is expected.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedure.

Filing Health Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"Urgent Care" means services received for a sudden illness, injury or condition that is not an emergency condition but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person's health; this includes a condition that would subject a person to severe pain that could not be adequately managed without prompt treatment.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 24 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you are receiving an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Filing an Appeal of an Adverse Benefit Determination

Life Claims

You may request a review of the denied claim. You will have 60 days following receipt of an adverse benefit decision to appeal the decision. The request must be submitted, in writing, and include your reasons for requesting the review. Submit your request to the office of the Aetna Life Insurance Company to which you submitted your initial request for benefit payment. You will be notified of the decision not later than 60 days after the appeal is received. If an extension of time for processing the appeal is needed, the time period may be extended up to an additional 60 days, in which case you will be notified prior to the end of the first 60 day period. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Health Claims

With the exception of urgent care claims, you will have 180 days following receipt of an adverse benefit decision to appeal the decision. You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna’s Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. 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, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The 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.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

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 your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 materials 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 up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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, you should contact:

- the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

Additional Information

Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll - free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at **www.aetna.com**.