



# Penn Treaty Network America Insurance Company<sup>SM</sup>

3440 Lehigh Street, PO Box 7066  
Allentown, PA 18105-7066  
(800) 362-0700

## INDEPENDENT LIVING<sup>®</sup> V

This Policy provides benefits for Long Term Care provided in your home and in your community.

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### Tax-Qualified Status

This Policy is not intended to be a federally-qualified Long Term Care Insurance Policy. A Tax-Qualified Policy generally requires, before you can be eligible for benefits, that you suffer a higher level of disability/incapacitation than this Policy requires. Because the Conditions of Eligibility (sometimes called benefit triggers) of this Policy are not as demanding as those of a Tax-Qualified Policy, this Policy may provide benefits in some situations that a Tax-Qualified Policy will not. This Policy is considered Non-Tax-Qualified and is not eligible for the more favorable tax treatment of a Tax-Qualified Policy.

### Guaranteed Renewable For Life

This Policy is Guaranteed Renewable for your lifetime as long as its benefits have not been exhausted. We can only cancel this Policy if you stop paying the required premiums or there are no longer any benefits available under the Policy. As long as there are benefits still available under this Policy, you have the right to keep it in force for as long as you live. You can do this by paying the premiums when they are due. (Payment of the renewal premium will not restore or replenish the benefits available under this Policy.)

### Premiums Subject To Change

The premiums of this Policy can never be changed because your age has changed or because of a change in your individual health. We can change the premiums for this Policy if we change them for everyone that bought this Policy in the same state yours was purchased. A change in premiums would first have to be filed with the state's Commissioner of Insurance. Notice of any such change in premiums will be sent at least 45 days in advance of the new premium becoming payable.

### Notice To Buyer - 30 Day Right To Examine Policy

**This policy may not cover all of the costs associated with Long Term Care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.**

If you are not completely satisfied with the coverage you have purchased, you can receive a refund of the entire premium paid if you return this Policy by mailing it to us at the address listed above within 30 days of your receiving it. If you return this policy for a refund within its 30 day Examination Period, we will mail a refund of the entire premium paid directly to you within 30 days of the Policy being returned and the Policy will immediately be considered void from the beginning, as if it had never been issued.

**CAUTION: WE ISSUED THIS POLICY BASED UPON YOUR ANSWERS TO THE QUESTIONS ON YOUR APPLICATION. A COPY OF YOUR APPLICATION IS ATTACHED TO THIS POLICY. IF YOUR RESPONSES ARE INCORRECT OR UNTRUE, WE MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY. IF, FOR ANY REASON, ANY OF YOUR ANSWERS ARE INCORRECT, UNTRUE OR INCOMPLETE, PLEASE NOTIFY US IMMEDIATELY BY SENDING A WRITTEN EXPLANATION OF WHAT IS INACCURATE OR MISSING FROM YOUR APPLICATION. PLEASE MAIL THIS EXPLANATION TO THE ATTENTION OF OUR UNDERWRITING DEPARTMENT AT THE ADDRESS LISTED ABOVE. THE BEST TIME TO CLEAR UP ANY QUESTIONS IS NOW, BEFORE YOU HAVE A CLAIM!**

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## Policy Schedule

**Policy Number: P12345** .....

**Insured: John Doe** .....

**Effective Date: 1/1/04**

**First Renewal Date: 1/1/05**

**Age: 65**

|                       |           |
|-----------------------|-----------|
| Initial Premium ..... | \$1005.00 |
| Policy Fee .....      | \$25.00   |
| Renewal Premium ..... | \$980.00  |

### Premiums

|  |          |
|--|----------|
| Annual .....                             | \$980.00 |
| Semi-Annual.....                         | \$509.60 |
| Quarterly .....                          | \$259.70 |
| Monthly.....                             | \$88.20  |
| Automatic Bank Withdrawal (Monthly)..... | \$83.30  |

The premiums shown above include premiums for any riders issued on the same date as this Policy.

### Benefits

#### Maximum Amount

|  |          |
|--|----------|
| Home and Community Care Daily Benefit..... | \$100.00 |
| Maximum Lifetime Benefit .....             | 730 Days |
| Deductible Period .....                    | 0 Days   |

### Type of Care

#### Maximum Amount

#### Home Care Benefits

|   |                 |
|---|-----------------|
| Homemaker Care.....                     | \$100.00per day |
| Home Health Care.....                   | \$100.00per day |
| Family Member & Private Caregiver ..... | \$100.00per day |
| Family Member Training.....             | \$1,000.00      |

#### Community Care Benefits

|                      |                 |
|----------------------|-----------------|
| Adult Day Care ..... | \$100.00per day |
| Hospice Care .....   | \$100.00per day |
| Meals on Wheels..... | \$100.00per day |

#### Additional Benefits

|                                |          |
|--------------------------------|----------|
| Alternative Plan of Care ..... | Included |
| Respite Care .....             | Included |

**Policy Schedule Continued**

**Riders Issued on the Same Date as this Policy**

**Rider Name**

**Premium Amount**

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**THIS SCHEDULE PAGE IS EFFECTIVE [XX/XX/XX] AND REPLACES ANY PRIOR SCHEDULE PAGE.**

## Claims Under This Policy

### What should you do if you have a claim or are going to have a claim?

When you need care/assistance that may be covered by this Policy, you should immediately call our Claims Department at (800) 362-0700 so that we can let you know if you are eligible for benefits as quickly as possible.

This Policy provides an incentive, in the form of enhanced benefits, for notifying us you need care/assistance that may be covered by this Policy within 15 days of the care/assistance beginning. There is an added incentive for notifying us, if possible, 10 or more days before your care/assistance actually begins. For more information on these incentives, please refer to the **Early Notification of Claim Benefit** in Section 3.

### What should you do if you need help setting up your care?

If you need help locating a caregiver and/or arranging for your care, we may be able to offer you assistance through our free **Care Solutions<sup>SM</sup>** services. To access our **Care Solutions<sup>SM</sup>** service, you simply have to call us at (800) 362-0700. Please refer to the **Care Solutions<sup>SM</sup>** benefit in Section 3.

## Section 1: **Home Care Benefits**

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This section tells you about the benefits available for care and assistance received in your **Home**.

Important words and terms, which will help you understand the benefits available under this Policy, and the circumstances under which these benefits are payable, appear in **bold print** throughout the Policy. “We”, “us” and “our” refers to Penn Treaty Network America Insurance Company<sup>SM</sup>.

### **A. Homemaker Care Benefits**

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For each day you receive **Homemaker Care** in your **Home** and you meet the **Conditions of Eligibility** (listed in Section 4), we will pay the lesser of:

- 1) the actual charge incurred; or
- 2) the **Home and Community Care Daily Benefit** listed in the Policy Schedule.

In no event will we pay more than the amount similar **Home Health Care Agencies** typically charge for similar services rendered in the same geographic area.

#### **H**omemaker Care

Assistance with the **Instrumental Activities of Daily Living**. **Homemaker Care** also includes supervision that is required due to **Cognitive Impairment**, which may be caused by Alzheimer’s disease, Organic Brain Syndrome, senile dementia, etc.

**Homemaker Care** must be provided through a **Home Health Care Agency**, however, the individual caregiver need not be skilled or certified. (If you would prefer not to utilize a **Home Health Care Agency**, please refer to the **Family Member and Private Caregiver Benefits** available under this Policy.)

#### **I**nstrumental Activities of Daily Living

Those tasks that are necessary to and consistent with one’s ability to safely reside in a private, unsupervised dwelling. They are comprised of the following five activities:

- 1) Meal Preparation is the preparation of food for human consumption, including cooking and cleanup.
- 2) Shopping/Travel is the use of public or private transportation to get to a store and shop for groceries, pick up prescriptions and to get to medical appointments.
- 3) Light Housekeeping/Laundry is maintaining a clean **Home** living environment so that your health, safety and welfare are not jeopardized. Light Housekeeping is limited to those tasks necessary to maintain a clean immediate living area, which is comprised of your bedroom, kitchen, living room and bathroom. This includes washing, drying and storing your clothing, bed linens, etc. Light Housekeeping does not include the cleaning of any additional rooms, such as extra bedrooms. Light Housekeeping also does not include any heavy cleaning such as annual “spring cleaning”, any type of **Home** construction or

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**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

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maintenance, work on the exterior of the **Home**, lawn care, snow removal, maintenance of a vehicle, or any other service provided outside the **Home**.

- 4) Handling Money/Bill Paying is depositing and/or withdrawing funds at a financial institution and paying bills.
- 5) Medication Management is safely controlling, dispensing, administering and/or assisting with administration of medications, properly prescribed by a medical professional, in the proper dosages and at the proper times.

## **H**ome

An unsupervised dwelling which is your personal residence, whether it is owned or leased by you. **Home** includes a home for the retired or aged. It does not include a hospital, sanitarium or **Long Term Care Facility**.

## **L**ong Term Care Facility

Includes any facility, such as a Nursing Facility or Assisted Living Facility, operated for the primary purpose of providing assistance and/or services intended to meet the daily living needs of individuals with functional and/or cognitive deficits, and licensed to provide this assistance/service if so required.

## **H**ome Health Care Agency

An organization that provides **Home Care Services** and is licensed by the state in which services are rendered, if so required. If the state in which the services are provided does not require such licensure, the agency will be considered a **Home Health Care Agency** if it meets the following requirements:

- 1) it has a full-time administrator;
- 2) it maintains written records of care/assistance provided to the patient; and
- 3) it maintains an independent office that is staffed no less than 40 hours per week.

## **H**ome Care Services

**Homemaker Care, Home Health Care, and Hospice Care.**

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## **B. Home Health Care Benefits**

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For each day you receive **Home Health Care** in your **Home** and you meet the **Conditions of Eligibility** (listed in Section 4), we will pay the lesser of:

- 1) the actual charge incurred; or
- 2) the **Home and Community Care Daily Benefit** listed in the Policy Schedule.

In no event will we pay more than the amount similar **Home Health Care Agencies** typically charge for similar services rendered in the same geographic area.

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**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

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## **H**ome Health Care

Can be personal care, which is assistance with the **Activities of Daily Living** and/or supervision that is required due to **Cognitive Impairment**, which may be caused by Alzheimer's disease, Organic Brain Syndrome, senile dementia, etc. This personal care may also include assistance with the **Instrumental Activities of Daily Living**. **Home Health Care** also includes skilled nursing services or other professional medical services, such as physical therapy and speech therapy.

**Home Health Care** must be provided through a **Home Health Care Agency**. Additionally, any skilled services must be performed by a licensed registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), chemotherapy specialist, enterostomal specialist, total parenteral nutrition specialist, physical therapist, speech therapist, occupational therapist or any other duly-qualified licensed provider of said services. (If you would prefer not to utilize a **Home Health Care Agency**, please refer to the **Family Member and Private Caregiver Benefits** available under this Policy.)

## **C. Family Member & Private Caregiver Benefits**

To be eligible for the **Homemaker Care** and **Home Health Care** benefits provided by this Policy, the **Homemaker Care** and **Home Health Care** must be provided by a **Home Health Care Agency**. **Homemaker Care** and **Home Health Care** provided by a **Family Member** or other **Private Caregiver** can also be covered by this Policy and eligible for benefits if the caregiver is pre-approved by us.

### **F**amily Member

Your spouse, and your and your spouse's respective parents, grandparents, siblings, children, grandchildren, aunts, uncles, cousins, nephews, nieces and in-laws. The **Family Member** can be skilled or unskilled. **(Spouses, and other individuals that live with you and do not maintain a separate residence, will not be eligible for benefits under any circumstances.)**

### **P**rivate Caregiver

Anyone that can provide **Homemaker Care** or **Home Health Care** that is not a **Family Member** and is not working through a **Home Health Care Agency**. The **Private Caregiver** can be skilled or unskilled. **(Individuals that live with you and do not maintain a separate residence will not be eligible for benefits under any circumstances.)**

To obtain pre-approval of a **Family Member** and/or **Private Caregiver** that you have selected to care for you, you simply have to call our Claims Department at (800) 362-0700 to inform us that you need care/assistance covered by this Policy and that you would like to utilize the services of a **Family Member** and/or **Private Caregiver**. We will then conduct an assessment, which is usually performed by a Registered Nurse over the telephone or through a face-to-face visit. This assessment will help us determine whether you meet the policy's **Conditions of Eligibility** and what type of care/assistance you need.

We will also send you a form that the proposed caregiver will need to complete in order to be considered for pre-approval. If the proposed caregiver is approved, we will notify you in writing. If

**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)



pre-approval of a **Family Member** and/or **Private Caregiver** is not obtained, no benefits will be payable for the care/assistance provided by that caregiver.

We reserve the right to disapprove any proposed caregiver for any reason and to withdraw the approval of a previously approved caregiver without prior notice. We also reserve the right, as a condition of pre-approval, to require that benefits be paid directly to the **Family Member** and/or **Private Caregiver**.

For each day care/assistance is provided by a **Family Member** and/or **Private Caregiver** that is pre-approved by us and you meet the **Conditions of Eligibility** (listed in Section 4), we will pay the lesser of:

- 1) the actual charge incurred; or
- 2) the **Home and Community Care Daily Benefit** listed in the Policy Schedule; or
- 3) 80% of what **Home Health Care Agencies** typically charge for similar services rendered in the same geographic area.

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## D. Family Member Training Benefits

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If a **Family Member** requires training to provide the care/assistance you need at **Home**, we will provide a **Family Member Training Benefit** for reimbursement of this training. You must meet the **Conditions of Eligibility** and the training must be for the purpose of preparing the **Family Member** to provide for your care and be pre-approved by us.

To obtain pre-approval, you simply have to call our Claims Department at (800) 362-0700 to notify us that a **Family Member** will be providing care/assistance and will need training to do so. We will then ask for information pertaining to your needs, the type of care/assistance to be provided by the **Family Member**, the skills and experience of the **Family Member** and the type and cost of the training proposed.

The **Family Member** does not have to be eligible for the **Family Member and Private Caregiver Benefits** to be considered for this benefit. For example, while we will not approve your spouse as an eligible caregiver, we will certainly consider your spouse for the **Family Member Training Benefit**. Through this benefit, your spouse can be trained to provide the care/assistance you require, even though we will not consider paying benefits for that care/assistance.

If the training is approved, we will pay up to ten times the **Home and Community Care Daily Benefit** for the reasonable and customary costs of training the **Family Member**.

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**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

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## Section 2: *Community Care Benefits*

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This section tells you about the benefits available for care and assistance that may be available in the community in which you live.

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### A. Adult Day Care Benefits

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For each day you receive **Adult Day Care** and meet the **Conditions of Eligibility** (listed in Section 4), we will pay the lesser of:

- 1) the actual charge incurred; or
- 2) the **Home and Community Care Daily Benefit** listed in the Policy Schedule.

In no event will we pay more than the amount similar **Adult Day Care Centers** typically charge for similar services rendered in the same geographic area.

#### **A** **Adult Day Care**

A day program which provides social and health-related services, and supports frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the **Home**, including assistance with the **Activities of Daily Living** and taking medications. **Adult Day Care** must be provided in an **Adult Day Care Center**.

#### **A** **Adult Day Care Center**

A facility which is established and operated in accordance with any applicable state or local laws required in order to provide **Adult Day Care** and is licensed, if so required.

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### B. Hospice Care Benefits

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For each day you receive **Hospice Care** and you meet the **Conditions of Eligibility** (listed in Section 4), we will pay the lesser of:

- 1) the actual charge incurred; or
- 2) the **Home and Community Care Daily Benefit** listed in the Policy Schedule.

In no event will we pay more than the amount similar **Hospice Care** providers typically charge for similar services rendered in the same geographic area.

#### **H** **Hospice Care**

Care provided in your **Home** which is designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts associated with experiencing the last phases of life due to the existence of a terminal disease; and provide supportive care to your primary caregiver and your family.

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**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

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## C. Meals on Wheels Benefits

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When you require care/assistance covered by this Policy, we will pay the charge incurred for **Meals on Wheels** to be delivered to your **Home**, subject to a maximum of \$25.00 per day. This benefit is available for a maximum of 90 days per calendar year. Any days not utilized cannot be carried over to any subsequent years. (Once these 90 days in benefits have been exhausted, additional benefits for **Meals on Wheels** can be considered under this Policy's **Alternative Plan of Care Benefits**. Please refer to the **Alternative Plan of Care Benefits** in Section 3.)

### **M**eals on Wheels

A community-based service administered by the local Area Agency on Aging or similar nonprofit organization which provides hot meals to your **Home**.

In order to be eligible for this benefit, you must satisfy the **Conditions of Eligibility** and you must obtain pre-approval from us. To obtain pre-approval, you simply have to call us at (800) 362-0700.

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**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

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## Section 3: *Additional Benefits*

This section tells you about the extra benefits available with this Policy and explains how you can receive them.

### **A. Early Notification of Claim & Waiver of Premium Benefits**

We encourage you to notify us as soon as you recognize that you require care/assistance that may be covered by this Policy. This will enable us to advise you as early as possible about whether you meet the **Conditions of Eligibility** and qualify for the benefits of this Policy. To notify us, you or your representative, simply have to call our Claims Department at (800) 362-0700 and tell us that you are receiving, or will be receiving, care/assistance covered by this Policy. You should specifically tell us that you are calling to give us “**Early Notification**” that you will have a claim.

When you call our office, we may have a Registered Nurse speak to you to gather information about your condition and evaluate your needs. We may also have a health care professional (usually a Registered Nurse) from your local area visit you to conduct a face-to-face assessment. The purpose of such an assessment is to provide us with information about what you can and cannot do for yourself and the type of care/assistance you need. For more information on the Claims process, please refer to Section 7.

#### **Waiver of Premium Benefit:**

Once you satisfy the **Waiver of Premium Waiting Period**, we will waive the payment of premiums for this Policy and any riders attached to this Policy for as long as you continue to be so eligible for benefits. We will refund any premium paid for coverage that extends beyond the date you become eligible for the **Waiver of Premium Benefits**.

To continue to be eligible for the **Waiver of Premium Benefits**, you must receive care/assistance that is covered by this Policy at least 21 days per **Calendar Month**. If you receive care/assistance fewer than 21 days per **Calendar Month**, premiums will not be waived for that month.

#### **Calendar Month**

Begins on the first day of the month and ends on the last day of the month.

You need to satisfy the **Waiver of Premium Waiting Period** only once during the lifetime of this Policy. If, after becoming eligible for the **Waiver of Premium Benefit**, you have one or more **Calendar Months** during which you did not receive at least 21 days of care/assistance that is covered by this Policy, premiums will again be waived beginning with the first of the month in which you resume receiving at least 21 days of care/assistance that is covered by this Policy.

If you are receiving benefits under the **Alternative Plan of Care Benefit**, you will not be eligible for this **Waiver of Premium Benefit**.

**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

## **Waiver of Premium Waiting Period**

Number of days you must receive care/assistance that is covered by this Policy (even if subject to the **Deductible Period**), before renewal premiums will be waived. The **Waiver of Premium Waiting Period** is 90 days.

### **ADVANCE NOTIFICATION**

**If you notify us 10 or more days before care/assistance begins:**

- 1) We will reduce the **Waiver of Premium Waiting Period** from 90 days to 30 days; and
- 2) We will count each **Calendar Week** during which you receive at least five days of care/assistance that is covered by this Policy as seven days towards the satisfaction of the **Waiver of Premium Waiting Period**; and
- 3) We will begin applying days towards the satisfaction of the **Waiver of Premium Waiting Period** with the first day you receive care/assistance that is covered by this Policy (even if subject to the **Deductible Period**).

### **Calendar Week**

Begins at 12:01 AM on Sunday, and ends seven calendar days later, on the immediately following Sunday at 12:01 AM.

### **TIMELY NOTIFICATION**

**If you notify us within 15 calendar days of the care/assistance beginning:**

- 1) We will reduce the **Waiver of Premium Waiting Period** from 90 days to 60 days; and
- 2) We will count each **Calendar Week** during which you receive at least five days of care/assistance that is covered by this Policy as seven days towards the satisfaction of the **Waiver of Premium Waiting Period**; and
- 3) We will begin applying days towards the satisfaction of the **Waiver of Premium Waiting Period** with the first day you receive care/assistance that is covered by this Policy (even if subject to the **Deductible Period**).

### **LATE NOTIFICATION**

**If you do not notify us within 15 calendar days of the care/assistance beginning:**

- 1) You must satisfy the 90 day **Waiver of Premium Waiting Period**; and
- 2) Only days during which you receive care/assistance covered by this Policy that occur after you notify us will be counted towards the satisfaction of the **Waiver of Premium Waiting Period**. (Days during which you receive care/assistance covered by this Policy that occur before you notify us will not count towards the satisfaction of the **Waiver of Premium Waiting Period**.)

**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

## **B. Alternative Plan of Care Benefit**

In the future, we expect that there will continue to be developments in the delivery of Long Term Care services and that new alternatives to **Home Care** and **Community Care** may emerge. Through the **Alternative Plan of Care** benefit, your Policy will be able to keep pace with changes in the Long Term Care delivery system by offering benefits for new forms of **Home Care** and **Community Care** and new methods of care delivery.

The **Alternative Plan of Care** can also be utilized to provide benefits for care/assistance, durable medical equipment or other items that would allow you to remain in your **Home**, and without which **Home Care** or **Community Care** would otherwise be necessary. An example of such an **Alternative Plan of Care** would be to equip your **Home** with adaptive devices, such as shower bars, a special toilet and a wheelchair ramp, which would enable you to live independently at **Home**. Confinement to any type of facility, such as a **Long Term Care Facility**, will not be considered as an **Alternative Plan of Care**.

To be considered for this benefit, you must meet the **Conditions of Eligibility** and the alternative must be in lieu of **Home Care** or **Community Care**. If you would like us to consider an **Alternative Plan of Care** for benefits, you must submit a written request in advance and describe, in detail, the proposed alternative, as well as the costs of said alternative. The **Alternative Plan of Care** must be a medically acceptable option and be agreed on in advance by you, your **Physician** and us. (An **Alternative Plan of Care** can be suggested by you or us.)

We will review the proposed **Alternative Plan of Care** and, if it is acceptable, let you know specifically under what terms we will pay benefits and the amount of benefits to be paid. We are not obligated to provide benefits for any services received prior to the date of our approval of the **Alternative Plan of Care**. Your eligibility for this benefit and the benefit amount(s) payable will be made on an individual basis and at our sole discretion.

In the event you would still need **Home Care** or **Community Care** subsequent to receiving benefits under the **Alternative Plan of Care**, any benefits paid under the **Alternative Plan of Care** may serve as a deductible if they are paid in a lump sum(s) rather than on an ongoing basis. For example, if we pay \$10,000 for home modifications to enable you to live independently in your **Home** but your condition deteriorates at the same time these modifications are completed and you need **Home Care** or **Community Care** within a few days anyway, the \$10,000 paid under the **Alternative Plan of Care** will serve as a separate deductible. (This separate deductible does not serve to satisfy the Policy's **Deductible Period**). If your **Home and Community Care Daily Benefit** is \$100, we will not pay for the first 100 days ( $\$100 \times 100 = \$10,000$ ) you would otherwise be eligible for benefits. Given this example, however, if the home modifications enable you to live independently in your **Home** for at least 100 days, the benefits extended under the **Alternative Plan of Care** will not serve as a separate deductible. Any such restrictions will normally be explained to you if and when the **Alternative Plan of Care** is approved and we set forth the terms under which we will pay benefits for the alternative plan.

**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

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## C. Respite Care Benefits

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This benefit allows you to receive **Respite Care** without the care/assistance being subject to the Policy's **Deductible Period**.

**R**espite Care  
May be **Homemaker Care**, **Home Health Care**, or care provided in a **Long Term Care Facility** or **Adult Day Care Center**, the purpose of which is to temporarily relieve the primary caregiver.

For each day you receive **Respite Care** and meet the **Conditions of Eligibility**, we will pay the benefits that correspond with the type of care/assistance you are receiving. Please refer to the **Homemaker Care**, **Home Health Care**, and **Adult Day Care** benefit provisions for the benefits payable for each of these types of care/assistance. For each day you are **Confined to a Long Term Care Facility**, we will pay the lesser of:

- 1) the **Long Term Care Facility's Daily Fee**; or
- 2) the **Home and Community Care Daily Benefit** listed in the Policy Schedule.

**C**onfined  
Assigned to a bed and physically present within the facility.

**L**ong Term Care Facility's Daily Fee  
Daily rate for room and board, nursing care and/or assisted living care provided by the **Long Term Care Facility's** staff, and ancillary supplies and services. Incidental expenses, such as **Physician's** services, medications, pharmaceuticals, toiletries, transportation charges and beautician's services, will not be considered as part of the **Long Term Care Facility's Daily Fee**, nor will any amount that exceeds what the **Long Term Care Facility** normally charges its private-pay patients with similar daily care needs for the same accommodations and care/assistance.

This benefit is payable for a maximum of 30 days per calendar year. Any days not used in a calendar year cannot be carried over to any subsequent years.

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## D. Care Solutions<sup>SM</sup>

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When you need care/assistance covered by this Policy, we can offer you access to a **Care Coordinator** through the **Care Solutions<sup>SM</sup>** services we make available to our Policyholders free of charge. The **Care Coordinator** will perform an assessment of your needs and work with you, your family and your **Physician**, if necessary, to see that those needs are met. The **Care Coordinator** will develop a **Plan of Care**, which describes the level of care/assistance you require, the type of caregiver necessary, the schedule of the care/assistance to be rendered, and the period over which this level of care is projected to be required. The **Care Coordinator** will also follow-up with you to ensure the **Plan of Care** continues to be appropriate in the likely event that your needs change.

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**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)

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If you elect to utilize our **Care Solutions<sup>SM</sup>** service, we will help you identify the providers available in your community. You will still have the freedom to select the provider you desire. If, for any reason, you are not satisfied with a caregiver, you may request that the **Care Coordinator** identify other providers from which to choose. The **Care Coordinator** will contact the caregivers you select to arrange for the delivery of the care/assistance required.

### **Care Coordinator**

Health care professional, usually a Registered Nurse, we employ or contract with to provide our Policyholders the **Care Solutions<sup>SM</sup>** services described above.

### **Care Solutions<sup>SM</sup>**

Free service we offer all of our Policyholders who need assistance making arrangements for care. Whether you use it is entirely up to you. Use of this service will not reduce, or be paid for through, the benefits of the Policy.

### **Physician**

Any doctor, other than you or a **Family Member**, properly licensed as a practitioner of the healing arts and operating within the scope of that license.

**Early Notification Of Claim:** This Policy provides enhanced benefits when you notify us 10 days before care/assistance begins, or within 15 days of care/assistance beginning. Please refer to the **Early Notification of Claim Benefit**. (Some benefits of this Policy are subject to our pre-approval. Please refer to the individual benefit to determine if pre-approval is required.)



## Section 4: *Conditions of Eligibility*

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This section explains how you qualify for the benefits of this Policy.

Subject to all other provisions, you become eligible to receive the benefits of this Policy when, due to illness or injury:

1) you require **Human Assistance** with one or more **Activities of Daily Living**;

OR

2) you have **Cognitive Impairment**, (which may be caused by Alzheimer's disease, Organic Brain Syndrome or senile dementia, etc.);

OR

3) the care/assistance is **Medically Necessary**;

OR

4) for **Homemaker Care** only, you require assistance with two or more **Instrumental Activities of Daily Living**.

### **H**uman Assistance

Hands-on assistance and support, stand-by assistance and/or supervision. **Human Assistance** can take the form of someone physically helping you perform the activity; or someone being at arm's length to intervene and help you perform the activity when necessary; or someone prompting you and providing verbal cues so you can perform the activity.

### **A**ctivities of Daily Living

Basic, day-to-day, human functions and are comprised of the following seven activities:

- 1) Eating is feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table).
- 2) Bathing is washing oneself by sponge bath; or in a tub or shower, including the task of getting into or out of the tub or shower.
- 3) Dressing is putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- 4) Ambulating is walking or moving around inside or outside the home, whether or not the use of a cane, crutches, braces, walker or wheelchair is required.
- 5) Transferring is moving into and out of a bed, chair or wheelchair.
- 6) Toileting is getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- 7) Continence is the ability to maintain control of bowel and bladder functions; or when unable to maintain control of bowel and bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

## **C**ognitive Impairment

Confusion and/or disorientation resulting from a deterioration or loss of intellectual capacity that can result from Alzheimer's Disease and other forms of Organic Brain Syndrome. **Cognitive Impairment** must result in your requiring supervision to maintain your safety (which may result from wandering) and/or the safety of others.

The deterioration or loss of intellectual capacity may be established through the use of standardized tests that reliably measure impairment in the following areas: short-term and/or long term memory; orientation as to person, place and time; and deductive or abstract reasoning.

## **M**edically Necessary

The care/assistance is essential to your health, safety and welfare, and your **Physician** certifies it to be essential to your health, safety and welfare. This certification is made in accordance with the usual standards of medical practice for your injury or sickness.

## **Section 5: Benefit Limitations**

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This section explains the limitations on the benefits available under this Policy.

### **Home and Community Care Daily Benefit**

The **Home and Community Care Daily Benefit** is the maximum amount we will pay under the **Homemaker Care, Home Health Care, Family Member and Private Caregiver Benefit, Adult Day Care, Hospice Care or Respite Care Benefits**, or any combination of these benefits, for care/assistance received during the same calendar day. The **Home and Community Care Daily Benefit** is listed in the Policy Schedule.

### **Maximum Lifetime Benefit**

The **Maximum Lifetime Benefit** is the maximum number of days in benefits we will pay during your lifetime under this Policy. Each day you receive **Homemaker Care, Home Health Care, Adult Day Care, Hospice Care, or Respite Care Benefits**, for which benefits are payable under this Policy, will count as one full day of the **Maximum Lifetime Benefit**. Your Policy's **Maximum Lifetime Benefit** is listed in the Policy Schedule. (Only days in which you receive care/assistance covered by this Policy will be counted against the **Maximum Lifetime Benefit**.)

### **Deductible Period**

The **Deductible Period** must be satisfied before benefits will be available. Specifically, it is the number of days you must meet the **Conditions of Eligibility** and receive care/assistance that would otherwise be covered by the Policy, before you can receive benefits. Days for which Medicare covered all or part of your care/assistance will also count towards satisfaction of the **Deductible Period**. When benefits do begin, they will not be retroactive to the beginning of the **Deductible Period**.

The **Deductible Period** must be satisfied only once during the lifetime of this Policy and applies to all of the benefits available under this Policy on a combined basis, except for **Respite Care**, which is not subject to the **Deductible Period**. (For example, if you satisfy the **Deductible Period** for **Homemaker Care** and would then require **Hospice Care**, it will not be necessary for you to satisfy the **Deductible Period** again.) The **Deductible Period** is listed in the Policy Schedule.

## **Section 6:** ***Exclusions***

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This section explains the circumstances under which benefits will not be payable even if you have satisfied all of the other terms of the Policy.

The Policy will not pay benefits for:

- 1) Care/assistance that begins before this Policy is in force or is received while this Policy is not in force.
- 2) Care/assistance provided by a **Family Member**, unless pre-approved by us, or by a **Home Health Care Agency** or **Long Term Care Facility** owned or operated by a **Family Member**.
- 3) Care/assistance that you would not be legally obligated to pay for in the absence of this insurance.
- 4) Care/assistance provided outside of the 50 United States or the District of Columbia.
- 5) Care/assistance payable under any Worker's Compensation or Occupational Disease Law.
- 6) Care/assistance for mental, nervous or emotional disorders without demonstrable organic origin. (NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THE POLICY AS ANY OTHER SICKNESS).
- 7) Care/assistance required as a result of terrorism, war, or an act of war, whether declared or not.
- 8) Care/assistance required as a result of attempted suicide or intentionally self-inflicted injuries.
- 9) Care/assistance required as a result of alcoholism and/or drug addiction. Drug addiction does not include a condition brought about by your use of drugs prescribed by and taken in accordance with the directions of a **Physician**.
- 10) Care/assistance paid by Medicare or eligible to be paid by Medicare. If any portion of the charges for such care/assistance is not paid by Medicare, they will be covered, subject to the terms of this Policy.

“Care/assistance” refers to the long term care services this Policy otherwise provides benefits for.

## **Section 7: Contract Provisions**

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Your Long Term Care Insurance Policy is a contract between you and us. This section explains the contract provisions that govern this Policy.

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### **A. Premiums**

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#### **Modal Payments**

Premiums may be paid annually, semi-annually, quarterly, monthly or through automatic bank withdrawal (monthly). The applicable premium amount for each of these modes is listed in the Policy Schedule. Paying more frequently than once a year will cost more than paying once a year. For example, you will note that paying 12 monthly payments will cost more than if you paid one annual payment. Modal payment factors are as follows: Annual 100%; Semi-Annual 52%; Quarterly 26.5%; Monthly 9%; and Automatic Bank Withdrawal (Monthly) 8.5%.

#### **Grace Period**

A Grace Period of 31 days is granted for the payment of each premium due after the first premium, during which time your Policy continues in force, provided the renewal premium is paid prior to the expiration of the Grace Period. If the renewal premium is not paid before the Grace Period ends, your Policy will be cancelled as of the renewal premium due date. (If you have elected a third party to receive notice of your Policy lapsing, it will lapse 30 days after such notice has been provided, and the Policy will be cancelled as of the renewal premium due date.)

#### **Third Party Notification of Lapse**

You have the right to designate at least one person who will be notified in the event your Policy is about to lapse because the renewal premium has not been paid. This is to protect you from losing this valuable coverage in the event you forget to pay the renewal premium or are traveling when it is due.

If you elect to designate such a person, your Policy cannot be canceled for nonpayment of premium unless we have notified the designated person at least 30 days in advance of the lapse date. Notice shall be given by first class United States mail; postage prepaid, and will be given 31 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of our mailing to the third party.

Your written designation shall include the person's full name and home address and shall become a part of our records. If you do not elect to designate a third party to receive notice of cancellation for nonpayment of premium, a written waiver dated and signed by you will become part of our records. You may elect to designate a third party or change the third party previously designated, at any time, by submitting a written request to our Home Office.

(Designation of this third party does not constitute acceptance of any liability by this person for the cost of any care/assistance you receive.)

#### **Reinstatement**

If your Policy lapses, we can consider reinstating it if we receive the renewal premium and a reinstatement application within six months of the renewal premium due date, at which time you will be given a conditional receipt. If we approve your reinstatement application, your Policy will be reinstated as of the date of our approval. If we disapprove your application, we must do so in writing

within 45 days of the date of the conditional receipt, otherwise, your Policy will be reinstated 45 days after the date of the conditional receipt.

The reinstated Policy will cover only loss resulting from accidental injury that occurs after the date of reinstatement and loss due to sickness begins more than ten days after the date of reinstatement. In all other respects, both your and our rights under the Policy will be the same as before the Policy lapsed. Any premiums we accept for a reinstatement will be applied to the period for which premiums have not been paid, however, no premium will be applied to any period more than 60 days before the date of reinstatement.

### **Reinstatement for Alzheimer's Disease, Other Forms of Cognitive Impairment and/or Loss of Functional Capacity**

If your Policy is cancelled because you did not pay the renewal premium when it was due, you may obtain reinstatement of this Policy if we receive the following within six months of the last renewal premium due date:

- 1) satisfactory proof you had **Cognitive Impairment** (including, but not limited to Alzheimer's Disease) and/or a loss of functional capacity (the inability to perform two or more of the **Activities of Daily Living**), on the renewal date; and
- 2) payment of all unpaid overdue premiums for this Policy and any riders attached to this Policy that were in force on the renewal premium due date.

This reinstatement will provide uninterrupted coverage to the same extent that the Policy would have provided had it not been cancelled and premiums will be required to be paid accordingly.

### **Cancellation**

We cannot cancel this Policy at any time unless premiums are not paid when due, as set forth above. Once this Policy's 30 day examination period has expired, you may only cancel this Policy on its renewal date. To cancel this Policy, you must submit a written request to our Home Office. If you request we cancel this Policy, the termination of this Policy will take effect on the first renewal premium due date following our receipt of your request.

### **Death While Insured**

If you die while insured under the Policy, we will refund the part of any premium paid for coverage that extends beyond the date of your death. The refund will be made within 30 days of our receipt of written notice of your death. Such refund will be made to your surviving spouse, if any, otherwise it will be made to your estate.

## B. Claims

### What should you do if you have a claim or are going to have a claim?

#### **Notice of Claim – Call us as soon as possible!**

This Policy provides an incentive, in the form of enhanced benefits, to notify us you need care/assistance that may be covered by this Policy within 15 days of the care/assistance beginning. There is an added incentive for notifying us, when possible, 10 or more days before your care/assistance actually begins. For more information on these incentives, please refer to **Early Notification of Claim** in Section 3.

To notify us you require care/assistance, or will require care/assistance, that may be covered by this Policy, you simply have to call us at (800) 362-0700 and tell us that you are calling to give us “**Early Notification**” that you will have a claim.

If you elect not to provide **Early Notification of Claim**, you can provide written Notice of Claim. You should provide written notice as soon as reasonably possible. Written notice should include your name, policy number, the identity of caregiver/provider, the date care/assistance began, and any bills listing the charges incurred to date.

### What we will do when you provide Notice of Claim:

#### **Claim Forms & Proof of Loss – What you will need to submit:**

When you notify us you require care/assistance that may be covered under this Policy, we will, within 15 days, provide you with the forms necessary to submit your claim and prove your loss. (If we fail to furnish the required claim forms within 15 days, you will be considered to have complied with this requirement if you give us written proof specifically describing the loss within the time limit stated below.)

You should complete and return the forms we send to you within 90 days of our mailing them to you. We will not be able to accept these forms and consider your claim unless they are submitted within one year of the loss occurring, which means they must be submitted within one year of the date the care/assistance you are submitting a claim for began.

As Proof of Loss, we may request full documentation relating to the care/assistance you received. This may include actual proof of payment of the actual expenses incurred. When we request proof of payment, only cancelled checks or documentation of the electronic transfer of funds will be accepted.

We will provide instructions about any other documentation you will need to submit so that we can consider your claim.

#### **How we will determine if you are eligible for benefits:**

We will determine if you meet the **Conditions of Eligibility**. In order to make this determination:

- We may contact you, your **Physician** or other persons familiar with your condition; and/or

- We may access your medical records to get information about your condition (we cannot determine whether you are eligible for benefits if we are not given access to your medical records); and/or
- We may request, at our expense, to have a **Physical Assessment** performed.

This determination will not exceed 60 days.

## **P**hysical Assessment

At our expense, we shall have the right and opportunity to have you examined and/or obtain an independent assessment of your functional and/or cognitive abilities when, and as often as, we may reasonably require while a claim is pending. When your needs are assessed by either an in-house Registered Nurse or other health care professional we contract with, he/she may also develop a written **Plan of Care** designed to meet your individual needs.

## **P**lan of Care

Specifies what you can and cannot do for yourself. It also specifies the type and frequency of care/assistance you require, as well as a projection of how long you will require this level of care/assistance.

The benefits we pay under this Policy will be based on what the **Plan of Care** we develop indicates is appropriate, subject to the terms, definitions, provisions, limitations and exclusions of this Policy. The amount of benefits we pay will not exceed what the **Plan of Care** indicates is necessary. If you believe the **Plan of Care** is inaccurate or inadequate in any way, you have the right to request that we review the **Plan of Care** in accordance with the Policy's Appealing a Plan of Care provision, which can be found below.

(The **Plan of Care** may indicate more care/assistance is needed than is covered by the Policy. The cost of any care/assistance you receive which exceeds the benefits available under the Policy will be your responsibility. You can, of course, elect to receive less care/assistance than the **Plan of Care** indicates is necessary if you so desire.)

## **Time of Payment of Claims**

Benefits payable under the Policy for any loss incurred will be paid immediately upon receipt of written Proof of Loss. Any balance remaining unpaid at the end of our liability will be paid immediately upon receipt of written Proof of Loss.

## **Payment of Claims**

All benefits will be payable to you, unless there is an assignment of benefits by you, or someone legally authorized to act in your behalf. An assignment of benefits is your or your legal representative's request for payments to be made payable directly to the care provider(s). (We may require, as a condition of pre-approval for **Family Members** and **Private Caregivers**, that benefits be paid directly to the **Family Member** or **Private Caregiver**.)

Any accrued benefits unpaid at your death will be paid to your estate, or any care provider or individual to whom you or your legal representative have assigned benefits, or, if applicable, shall descend as personal property according to the law of distribution in your state. At our option, any benefit of \$1,000 or less may be paid to an alternative payee who is deemed by us to be justly entitled to the benefit. The alternative payee must be related to you by blood or marriage. We will be fully discharged to the extent of any payment made in good faith under this provision.



## What if you don't agree with our decision to deny benefits?

### Appealing a Denial of Benefits

You, or someone authorized to act in your behalf, shall have the right to appeal any denial of a claim, or portion of a claim, made under this Policy. Such appeal should be submitted in writing within 60 calendar days from the date you receive the decision and should include any information and/or documentation which supports your position. Additionally, the appeal should identify whom we could contact (including names, addresses, and telephone numbers) to gather any additional pertinent information regarding your care.

You will receive acknowledgment of your appeal within ten days of our receipt of it. We will then consider your appeal. If we need additional information to objectively evaluate your appeal, we may use one or more of the following resources at our expense:

- 1) A **Physician** who will assess your condition and report it to us;
- 2) An on-site geriatric assessment;
- 3) Medical records from your **Physician(s)** and/or provider(s) of care; or
- 4) Other information that is determined to be relevant to address the appeal.

We will send you a written explanation of the results of our review within 30 days of our receiving your appeal, or within 30 days of our receiving any additional information needed to adequately review your appeal. If the decision cannot be made within 30 days from the date we receive all pertinent information, we will notify you and explain the reasons more time is required. If the decision is not made within an additional 30 days, we will notify you, at that time, and every 45 days thereafter, the reasons why additional time is needed for the investigation of your claim. This notice will also state when a decision on the claim may be expected.

## What if you don't agree with the benefits we approve?

### Appealing a Plan of Care

You, or someone authorized to act in your behalf shall have the right to appeal a **Plan of Care** if you believe it is inappropriate or inadequate. Such appeal can be submitted in writing or by telephone and should explain your disagreement with the **Plan of Care**. The appeal should include specifics about how the **Plan of Care** is inaccurate or inappropriate and should also include any information and/or documentation which supports your position. Also, if you would like us to contact your **Physician**, you may request that we do so. We will review this information with the Registered Nurse or, other health care professional and/or the agency/entity he/she is affiliated with, that developed the **Plan of Care** and your **Physician** if necessary, and provide you with a written explanation of the result of this review as quickly as possible, but in no event, in more than 30 days from the date we receive your appeal.

### Appealing the Amount of Benefits Payable

When we determine, for the purpose of establishing the benefits payable for **Homemaker Care, Home Health Care, Adult Day Care and Hospice Care**, that the provider of said services is charging more than what a similar provider of similar services charges in the same geographic area, or we determine, for the purpose of establishing the benefits payable for the **Family Member and Private**

**Caregiver Benefit**, what a **Home Health Care Agency** typically charges for similar services, we will make this determination by:

Surveying five **Home Health Care Agencies** in the same geographic area to determine their fees for similar services. The fourth highest of these fees will represent what **Home Health Care Agencies** normally charge for similar services in the same geographic area. In the case of **Adult Day Care** or **Hospice Care** providers, we will survey five similar providers in the same geographic area to determine their fees for similar services. The fourth highest of these fees will represent what **Adult Day Care** or **Hospice Care** providers or similar providers normally charge for similar services.

If there are not five **Home Health Care Agencies** that provide care/assistance in your geographic area, we will use fees from five **Home Health Care Agencies** or similar providers in the geographic area which is geographically nearest and similar in terms of socioeconomic make-up and cost of living to the area where the care/assistance is provided.

You, or someone authorized to act in your behalf, shall have the right to appeal the amount of benefits payable under this Policy. Such appeal should be submitted in writing and should explain the basis for your disagreement with our decision. The appeal should also include any information and/or documentation which supports your position, such as fees from other providers in your geographic area. We will send you a written explanation of the results of our review within 30 days of our receiving your appeal, or within 30 days of our receiving any additional information needed to adequately review your appeal.

#### **Contestability/Time Limit on Certain Defenses**

Our issuance of this Policy is based on the information disclosed in your application, a copy of which is attached. If your Policy has been in force for less than six months, we may rescind your Policy or deny an otherwise valid Long Term Care Insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

If your Policy has been in force for at least six months but less than two years, we may rescind your Policy or deny an otherwise valid Long Term Care Insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

After your Policy has been in force for two years it is not contestable upon the grounds of misrepresentation alone. Your Policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

If, subsequent to purchasing this Policy, you elect to increase its coverage and evidence of insurability is required, any such increase will be subject to a new Contestability/Time Limit on Certain Defenses provision. The two year contestable period applicable to this additional coverage shall begin with the Effective Date of said additional coverage. For example, if you choose an inflation increase or a higher benefit option, that additional portion of coverage could be rescinded due to a misrepresentation.

If you realize there is any inaccurate information on the application, or information missing from your application, you should notify us immediately by writing to our Home Office at the address listed on the first page of this Policy.

In the event this Policy is rescinded after we have paid benefits, we may not recover the payments already made.

**Coordination of Benefits with Other Penn Treaty Network America Insurance Company<sup>SM</sup> Policies**  
Should benefits for care/assistance covered by this Policy also be payable under any other policy and/or rider issued by Penn Treaty Network America Insurance Company<sup>SM</sup>, the benefits to be paid under this Policy shall not, when combined with the benefits payable under said other policies/riders, exceed the actual charge incurred for the care/assistance received.

### **Right to Recovery**

If we make payments with respect to benefits in a total amount which is, at any time, in excess of the benefits payable under the provisions of this Policy, we will have the right to recover such excess from:

- 1) your or any persons to whom such payments were made; and
- 2) any organization which should have made such payments.

### **Unpaid Premium**

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

### **Extension of Benefits**

If this Policy terminates while you are eligible for benefits, benefits shall continue to be payable provided the care/assistance continues without interruption and is otherwise covered by the Policy and will be continued until the earlier of the following dates:

- 1) the date you are no longer receiving care/assistance; or
- 2) the date your Policy's **Maximum Lifetime Benefit** is exhausted; or
- 3) the date you die.

(Benefits may be reduced by the amount of premium payable for the duration of the **Maximum Lifetime Benefit** in accordance with the Unpaid Premium provision.)

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## **C. General**

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### **Consideration**

We agree to insure you for the benefits stated in this Policy in consideration of the application received and the payment of the premium, subject to all of the terms, definitions, provisions, limitations and exclusions contained herein.

### **Effective Date**

Evidence of insurability is required before coverage is provided. Upon approval of your application, coverage will begin at 12:01 AM, standard time, at your residence on the Effective Date shown in the Policy Schedule. It ends at 12:01 AM, standard time, on the first renewal premium due date if the renewal premium is not paid when due.

### **Conformity with State Statutes**

Any provision of the Policy, which, on its Effective Date, conflicts with the statutes of your state on such date, is hereby amended to conform to its minimum requirements.

### **Governing Jurisdiction**

This Policy is governed by the laws of the state in which you purchased it.

### **Entire Contract; Changes**

This Policy, including any attached papers, constitutes the entire contract. No change is valid until approved by one of our executive officers and endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. No verbal statement by an executive officer of Penn Treaty Network America Insurance Company<sup>SM</sup> or other employee is binding upon us.

### **Legal Actions**

No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required by this Policy. No action shall be brought after the expiration of two years from the time written Proof of Loss is required to be given.

### **Misstatement of Age**

If your age has been misstated at the time you applied for this Policy, all amounts payable shall be such as the premium paid would have purchased given the correct age. If no coverage would have been issued had your correct age been given, this Policy will be considered null and void and all premiums paid will be refunded.

### **Other Long Term Care Insurance**

The application for this Policy lists all other Long Term Care policies in force or applied for on the date of application for this Policy. Any Long Term Care policy fully admitted on the application may stay in force after this Policy is issued unless you agreed in the application to terminate or replace it.

**Our Pledge – Your Right to Convert to a Tax-Qualified Policy**

Because we recognize neither the U.S. Congress nor the Treasury Department have ruled on whether this Policy's benefits will be tax-free, as is the case with a tax-qualified policy we will allow you to convert this Policy to a tax-qualified policy in the event the benefits of this Policy are ruled to be taxable income, or at any other time you desire. We will make this conversion even if you are receiving benefits under this Policy at the time. All you have to do is submit a written request to our Home Office. The premiums of the new policy will be based on your original issue age and you will not have to submit additional evidence of insurability for any benefit amounts not exceeding those elected with the original Policy. (The benefit eligibility criteria in the new Policy will be those imposed by the Health Insurance Portability and Accountability Act of 1996.)

## Glossary of Defined Terms

**Activities of Daily Living** - Basic, day-to-day, human functions and are comprised of the following seven activities:

- 1) Eating is feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table).
- 2) Bathing is washing oneself by sponge bath; or in a tub or shower, including the task of getting into or out of the tub or shower.
- 3) Dressing is putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- 4) Ambulating is walking or moving around inside or outside the home, whether or not the use of a cane, crutches, braces, walker or wheelchair is required.
- 5) Transferring is moving into and out of a bed, chair or wheelchair.
- 6) Toileting is getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- 7) Continence is the ability to maintain control of bowel and bladder functions; or when unable to maintain control of bowel and bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

**Adult Day Care** - A day program which provides social and health-related services, and supports frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the **Home**, including assistance with the **Activities of Daily Living** and taking medications. **Adult Day Care** must be provided in an **Adult Day Care Center**.

**Adult Day Care Center** - A facility which is established and operated in accordance with any applicable state or local laws required in order to provide **Adult Day Care** and is licensed, if so required.

**Calendar Month** - Begins on the first day of the month and ends on the last day of the month.

**Calendar Week** - Begins at 12:01 AM on Sunday, and ends seven calendar days later, on the immediately following Sunday at 12:01 AM.

**Care Coordinator** - Health care professional, usually a Registered Nurse, we employ or contract with to provide our Policyholders the **Care Solutions<sup>SM</sup>** services described above.

**Care Solutions<sup>SM</sup>** - Free service we offer all of our Policyholders who need assistance making arrangements for care. Whether you use it is entirely up to you. Use of this service will not reduce, or be paid for through, the benefits of the Policy.

**Cognitive Impairment** - Confusion and/or disorientation resulting from a deterioration or loss of intellectual capacity that can result from Alzheimer's Disease and other forms of Organic Brain Syndrome. **Cognitive Impairment** must result in your requiring supervision to maintain your safety (which may result from wandering) and/or the safety of others.

**Confined** - Assigned to a bed and physically present within the facility.

**Family Member** - Your spouse, and your and your spouse's respective parents, grandparents, siblings, children, grandchildren, aunts, uncles, cousins, nephews, nieces and in-laws. The **Family**

**Member** can be skilled or unskilled. **(Spouses, and other individuals that live with you and do not maintain a separate residence, will not be eligible for benefits under any circumstances.)**

**Home** - An unsupervised dwelling which is your personal residence, whether it is owned or leased by you. **Home** includes a home for the retired or aged. It does not include a hospital, sanitarium or **Long Term Care Facility**.

**Home Care Services - Homemaker Care, Home Health Care, and Hospice Care.**

**Home Health Care** - Can be personal care, which is assistance with the **Activities of Daily Living** and/or supervision that is required due to **Cognitive Impairment**, which may be caused by Alzheimer's disease, Organic Brain Syndrome, senile dementia, etc. This personal care may also include assistance with the **Instrumental Activities of Daily Living**. **Home Health Care** also includes skilled nursing services or other professional medical services, such as physical therapy and speech therapy.

**Home Health Care Agency** - An organization that provides **Home Care Services** and is licensed by the state in which services are rendered, if so required. If the state in which the services are provided does not require such licensure, the agency will be considered a **Home Health Care Agency** if it meets the following requirements:

- 1) it has a full-time administrator;
- 2) it maintains written records of care/assistance provided to the patient; and
- 3) it maintains an independent office that is staffed no less than 40 hours per week.

**Homemaker Care** - Assistance with the **Instrumental Activities of Daily Living**. **Homemaker Care** also includes supervision that is required due to **Cognitive Impairment**, which may be caused by Alzheimer's disease, Organic Brain Syndrome, senile dementia, etc.

**Hospice Care** - Care provided in your **Home** which is designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts associated with experiencing the last phases of life due to the existence of a terminal disease; and provide supportive care to your primary caregiver and your family.

**Human Assistance** - Hands-on assistance and support, stand-by assistance and/or supervision. **Human Assistance** can take the form of someone physically helping you perform the activity; or someone being at arm's length to intervene and help you perform the activity when necessary; or someone prompting you and providing verbal cues so you can perform the activity.

**Instrumental Activities of Daily Living** - Those tasks that are necessary to and consistent with one's ability to safely reside in a private, unsupervised dwelling. They are comprised of the following five activities:

- 1) Meal Preparation is the preparation of food for human consumption, including cooking and cleanup.
- 2) Shopping/Travel is the use of public or private transportation to get to a store and shop for groceries, pick up prescriptions and to get to medical appointments.
- 3) Light Housekeeping/Laundry is maintaining a clean **Home** living environment so that your health, safety and welfare are not jeopardized. Light Housekeeping is limited to those tasks necessary to maintain a clean immediate living area, which is comprised of your bedroom, kitchen, living room and bathroom. This includes washing, drying and storing your clothing, bed linens, etc. Light Housekeeping does not include the cleaning of any additional rooms, such as extra bedrooms. Light Housekeeping also does not include any heavy cleaning such as annual

“spring cleaning”, any type of **Home** construction or maintenance, work on the exterior of the **Home**, lawn care, snow removal, maintenance of a vehicle, or any other service provided outside the **Home**.

- 4) Handling Money/Bill Paying is depositing and/or withdrawing funds at a financial institution and paying bills.
- 5) Medication Management is safely controlling, dispensing, administering and/or assisting with administration of medications, properly prescribed by a medical professional, in the proper dosages and at the proper times.

**Long Term Care Facility** - Includes any facility, such as a Nursing Facility or Assisted Living Facility, operated for the primary purpose of providing assistance and/or services intended to meet the daily living needs of individuals with functional and/or cognitive deficits, and licensed to provide this assistance/services if so required.

**Long Term Care Facility’s Daily Fee** - Daily rate for room and board, nursing care and/or assisted living care provided by the **Long Term Care Facility’s** staff, and ancillary supplies and services. Incidental expenses, such as **Physician’s** services, medications, pharmaceuticals, toiletries, transportation charges and beautician’s services, will not be considered as part of the **Long Term Care Facility’s Daily Fee**, nor will any amount that exceeds what the **Long Term Care Facility** normally charges its private-pay patients with similar daily care needs for the same accommodations and care/assistance.

**Medically Necessary** - The care/assistance is essential to your health, safety and welfare, and your **Physician** certifies it to be essential to your health, safety and welfare. This certification is made in accordance with the usual standards of medical practice for your injury or sickness.

**Meals on Wheels** - A community-based service administered by the local Area Agency on Aging or similar nonprofit organization which provides hot meals to your **Home**.

**Physical Assessment** - At our expense, we shall have the right and opportunity to have you examined and/or obtain an independent assessment of your functional and/or cognitive abilities when, and as often as, we may reasonably require while a claim is pending. When your needs are assessed by either an in-house Registered Nurse or other health care professional we contract with, he/she may also develop a written **Plan of Care** designed to meet your individual needs.

**Physician** - Any doctor, other than you or a **Family Member**, properly licensed as a practitioner of the healing arts and operating within the scope of that license.

**Plan of Care** - Specifies what you can and cannot do for yourself. It also specifies the type and frequency of care/assistance you require, as well as a projection of how long you will require this level of care/assistance.

**Private Caregiver** - Anyone that can provide **Homemaker Care** or **Home Health Care** that is not a **Family Member** and is not working through a **Home Health Care Agency**. The **Private Caregiver** can be skilled or unskilled. (**Individuals that live with you and do not maintain a separate residence will not be eligible for benefits under any circumstances.**)

**Respite Care** - May be **Homemaker Care**, **Home Health Care**, or care provided in a **Long Term Care Facility** or **Adult Day Care Center**, the purpose of which is to temporarily relieve the primary caregiver.



**Waiver of Premium Waiting Period** - Number of days you must receive care/assistance that is covered by this Policy (even if subject to the **Deductible Period**), before renewal premiums will be waived. The **Waiver of Premium Waiting Period** is 90 days.

**IN WITNESS WHEREOF**, we have caused this Policy to be signed by our President and Secretary.



President



Secretary