PENN TREATY NETWORK AMERICA INSURANCE COMPANY[SM]
3440 Lehigh Street, PO Box 7066
Allentown, PA 18105-7066
(800) 362-0700

ASSISTED LIVING PLUS[SM]

TAX-QUALIFIED LONG TERM CARE INSURANCE POLICY

TAX-QUALIFIED STATUS

This contract for Long Term Care Insurance is intended to be a federally-tax-qualified Long Term Care Insurance contract and may qualify You for federal and state tax benefits.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is guaranteed renewable for the rest of Your lifetime, subject to the Policy maximums. It may be kept in force by the timely payment of premiums. We cannot refuse to renew this Policy as long as You pay the premiums when due. We cannot change the renewal premium rates for this Policy during the first three (3) years it is in force. We also cannot change the premium rates due to a change in Your age or health; we can only change them if they are changed for all policies in Your state on this Policy form. Such a change would have to be filed with Your state commissioner of insurance. Notice of any such change in premiums will be sent at least thirty-one (31) days in advance. (Payment of the renewal premium will not restore or replenish the benefits available under this Policy. Please refer to the Policy's **Restoration of Benefits** provision on Page 12 to learn how benefits may be restored.)

NOTICE OF THIRTY (30) DAY RIGHT TO EXAMINE POLICY

Carefully read this Policy as soon as You receive it. If You are not satisfied for any reason, You may return it to Us, or Our authorized agent, within thirty (30) days of Your receiving it. We will refund the entire premium paid directly to You within thirty (30) days of the Policy being returned. Upon Our receipt of the returned Policy, the Policy will be considered void from the beginning.

NOTICE TO BUYER: 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.

CAUTION: THE ISSUANCE OF THIS POLICY IS BASED UPON YOUR RESPONSES TO THE QUESTIONS ON YOUR APPLICATION. A COPY OF YOUR APPLICATION IS ATTACHED. IF YOUR ANSWERS ARE INCORRECT OR UNTRUE, WE MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY. THE BEST TIME TO CLEAR UP ANY QUESTIONS IS NOW, BEFORE A CLAIM ARISES! IF, FOR ANY REASON, ANY OF YOUR ANSWERS ARE INCORRECT, CONTACT US AT OUR HOME OFFICE: 3440 LEHIGH STREET, PO BOX 7066, ALLENTOWN, PA 18105-7066.

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POLICY SCHEDULE

POLICY NUMBER **EFFECTIVE DATE**

INSURED **FIRST RENEWAL DATE**

AGE

INITIAL PREMIUM	POLICY FEE	RENEWAL PREMIUM
$	$	$

PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY
$	$	$

MONTHLY	AUTOMATIC BANK WITHDRAWAL (MONTHLY)
$	$

BENEFITS

MAXIMUM DAILY BENEFIT $_____

MAXIMUM LIFETIME BENEFIT _____ **DAYS**

ELIMINATION PERIOD _____ **DAYS**

(THE PREMIUMS SHOWN ABOVE INCLUDE PREMIUMS FOR ANY RIDERS ISSUED ON THE SAME DATE AS THIS POLICY).

RIDERS ISSUED ON THE SAME DATE AS THIS POLICY

SECTION I: POLICY BENEFITS

This section tells You about the benefits available for care and assistance received in a Long Term Care facility.

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. They appear in ***italicized bold print*** where they are defined.

Whenever "You" and "Your" appears in this Policy, it refers to the Insured listed in the Policy Schedule. "We", "Us" and "Our" refers to Penn Treaty Network America Insurance Company[SM].

ASSISTED LIVING FACILITY BENEFITS

For each day You are **confined** to an **Assisted Living Facility** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the **Assisted Living Facility's Daily Fee**; or
2) the **Maximum Daily Benefit** listed in the Policy Schedule.

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Confined is assigned to a bed and physically present within the facility.

An ***Assisted Living Facility*** is a facility licensed by the appropriate federal or state agency to engage primarily in providing care and unscheduled services to resident inpatients; and which:

1) provides twenty-four (24) hour a day care and services sufficient to support needs resulting from inability to perform **Activities of Daily Living** and/or **Cognitive Impairment**;
2) has a trained and ready to respond employee on duty at all times to provide care and services;
3) provides three (3) meals a day and accommodates special dietary needs; and
4) has the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.
   (Please refer to Page 10 for the definition of **Activities of Daily Living** and Page 11 for the definition of **Cognitive Impairment**.)

If a facility or institution (such as a congregate care facility or life care community) has multiple licenses and/or multiple purposes, only the section, wing, ward or unit (including a separate room or apartment) that specifically qualifies as an **Assisted Living Facility** will be covered by this Policy.

An **Assisted Living Facility** may sometimes be called a Residential Care Facility, Adult Congregate Living Facility, Personal Care Facility or Sheltered Living Facility. Any facility, or section thereof, known by one of these names, or any other name, will be considered eligible if it meets this Policy definition of an **Assisted Living Facility**.

Assisted Living Facility's Daily Fee is the facility's daily rate for room and board, assisted living care provided by the **Assisted Living 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 **Assisted Living Facility's Daily Fee**, nor will any amount that exceeds what the **Assisted Living Facility** normally charges its private-pay patients with similar daily care needs for the same accommodations and care/assistance.

A ***Physician*** is anyone properly licensed as a practitioner of the healing arts operating within the scope of his/her license who is other than You or a **Family Member**.

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

NURSING FACILITY BENEFITS

For each day You are **confined** to a **Nursing Facility** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the **Nursing Facility's Daily Fee**; or
2) the **Maximum Daily Benefit** listed in the Policy.

(Please refer to Page 4 for the definition of **confined** and Page 10 for the **Conditions of Eligibility**.)

A ***Nursing Facility*** is a facility, or distinctly separate part of a hospital or other institution, which is licensed by the appropriate federal or state agency to engage primarily in providing nursing care and related services to inpatients; and which:

1) provides twenty-four (24) hour a day nursing services;
2) has a nurse on duty or on call at all times;
3) maintains clinical records for all patients; and
4) has appropriate methods and
5)

If a facility or institution (such as a congregate care facility or life care community) has multiple licenses and/or multiple purposes, only the section, wing, ward or unit (including a separate room or apartment) that specifically qualifies as a **Nursing Facility** will be covered by this Policy.

A **Nursing Facility** may sometimes be called a Skilled Nursing Facility, Intermediate Care Facility or Custodial Care Facility. Any facility, or section thereof, known by one of these names, or any other name, will be considered eligible if it meets this Policy definition of a **Nursing Facility**.

Nursing Facility's Daily Fee is the daily rate for room and board, nursing care provided by the **Nursing 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 **Nursing Facility's Daily Fee**, nor will any amount that exceeds what the **Nursing Facility** normally charges its private-pay patients with similar daily care needs for the same accommodations and care/assistance.

ADULT DAY CARE BENEFITS

For each day You receive **Adult Day Care** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the actual charge incurred; or
2) 50% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) the reasonable and customary charge for **Adult Day Care** rendered in the same geographic area.

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Adult Day Care is medical or non-medical care provided on a less than 24-hour basis in an **Adult Day Care Center** for persons in need of personal services, supervision, protection and/or assistance in sustaining daily needs, including the **Activities of Daily Living** and taking medications. (Please refer to Page 10 for the definition of **Activities of Daily Living**.)

Adult Day Care Center is 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.

HOSPICE CARE BENEFITS

For each day You receive **Hospice Care** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the actual charge incurred; or
2) 50% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) the reasonable and customary charge for **Hospice Care** rendered in the same geographic area.

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Hospice Care is an outpatient service designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts when You are experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to Your primary care-giver and family.

RESPITE CARE BENEFITS

For each day You receive **Respite Care** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the actual charge incurred; or
2) 50% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) the reasonable and customary charge for similar services rendered in the same geographic area.

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Respite Care may be **Adult Day Care, Hospice Care, Home Health Care** or care provided in an **Assisted Living Facility** or **Nursing Facility**, the purpose of which is to temporarily relieve the **Primary Caregiver** who has been providing care.

Home Health Care is skilled nursing services and/or assistance with the **Activities of Daily Living** provided by a nurse, certified nurse's aide, home health aide or any other caregiver, whether skilled or unskilled. (Please refer to Page 10 for the definition of **Activities of Daily Living**.)

This benefit is payable for a maximum of fifteen (15) days per calendar year and is not subject to the **Elimination Period**. Any days not used in a calendar year cannot be carried over to any subsequent years. (Please refer to Page 14 for the definition of **Elimination Period**.)

SECTION II: CONDITIONS OF ELIGIBILITY

This section explains how You become eligible for the benefits of this Policy.

The care/assistance You require must be provided pursuant to a **Plan of Care** developed by a **Licensed Health Care Practitioner** which certifies You are **Chronically Ill**. To be certified as ***Chronically Ill:***

1) You must be unable to perform at least two (2) **Activities of Daily Living** without **Substantial Assistance** for a period of at least ninety (90) days due to the loss of functional capacity;

OR

2) You must require supervision to protect You from threats to health and safety due to **Severe Cognitive Impairment**.

The ***Plan of Care*** specifies the type of care/assistance that is necessary and certifies that You are a **Chronically Ill Individual**. This certification must be made at the time the care/assistance is received, or during the preceding twelve (12) months. (Certification of Your condition may be required periodically, but not more than once every thirty-one (31) days.)

A ***Licensed Health Care Practitioner*** is any **Physician** or any registered professional nurse, licensed social worker, or other individual who meets the requirements prescribed by the Secretary of Health and Human Services. (Please refer to Page 5 for the definition of **Physician**.)

Activities of Daily Living are the basic human functional abilities required for You to remain independent. They are as follows:

1) Eating is feeding oneself by getting food into the body from a receptacle, (such as a plate, cup or table), or by a feeding tube or intravenously.
2) Bathing is washing oneself by sponge bath; or in either a tub or shower, including getting into and 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) Transferring is moving into or out of a bed, chair or wheelchair.
5) Toileting is getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6) Continence is the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and/or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

Substantial Assistance may be **Hands-on Assistance** and/or **Standby Assistance**.

Hands-on Assistance is the physical assistance of another person, without which You would be unable to perform the **Activity of Daily Living**.

Standby Assistance is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to You while You are performing an **Activity of Daily Living**.

Severe Cognitive Impairment is confusion and/or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to, or a result of, mental illness, but which can result from Alzheimer's Disease and other forms of Organic Brain Syndrome. **Severe Cognitive Impairment** must result in Your requiring supervision to maintain Your safety and/or the safety of others. This 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.

SECTION III: ADDITIONAL BENEFITS

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

BED RESERVATION BENEFIT

We will pay a ***Bed Reservation Benefit*** when You are charged to hold Your room in an **Assisted Living Facility** or **Nursing Facility** when hospitalized during the course of an **Assisted Living Facility** or **Nursing Facility** confinement. The amount payable per day under the **Bed Reservation Benefit** shall be equal to the **Assisted Living Facility Benefit** or **Nursing Facility Benefit** payable on the day prior to the hospitalization. This benefit will be limited to thirty (30) days per calendar year on a combined basis. Any days not used in a calendar year cannot be carried over to any subsequent year.

ALTERNATIVE PLAN OF CARE

If You would otherwise qualify for benefits for a confinement to an **Assisted Living Facility** or **Nursing Facility**, You may request that We consider providing benefits for an alternative to such a confinement. A written request must be submitted 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. 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.

The **Alternative Plan of Care** must be in lieu of a confinement to an **Assisted Living Facility** or a **Nursing Facility**. An example of 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 remain at **Home**, and without which You would need to enter an **Assisted Living Facility** or **Nursing Facility**.

Benefits extended under the **Alternative Plan of Care** will be deducted from the **Maximum Lifetime Benefit** listed in the Policy Schedule and will, correspondingly, reduce the benefits available for the other forms of care/assistance covered by this Policy by an equal amount. (Please refer to Page 14 for the definition of **Maximum Lifetime Benefit**.)

Neither **Home Health Care** nor **Homemaker Care** will be considered for benefits under the **Alternative Plan of Care**. (Please refer to Page 9 for the definition of **Home Health Care**.)

> ***Homemaker Care*** is assistance with the Instrumental Activities of Daily Living, which include meal preparation, shopping/travel, light housekeeping, laundry, telephoning, handling money/bill paying and medication management.

RESTORATION OF BENEFITS

We will restore the **Maximum Lifetime Benefit** of this Policy to the full original amount listed in the Policy Schedule when:

1) You have not been confined to an **Assisted Living Facility** or **Nursing Facility** and You did not receive **Adult Day Care, Hospice Care, Home Health Care** or **Homemaker Care** for a period of one hundred and eighty (180) consecutive days; and
2) Your **Physician** certifies that:
   a) You recovered sufficiently to not require confinement to, and you were not advised to be confined to, an **Assisted Living Facility** or **Nursing Facility**; and
   b) You recovered sufficiently to not receive, and You were not advised to receive, **Adult Day Care, Hospice Care, Home Health Care** or **Homemaker Care** (whether provided by a **Family Member** or any other caregiver) during that one hundred eighty (180) day period. (Please refer to Page 9 for the definition of **Home Health Care** and Page 12 for the definition of **Homemaker Care**.)

There is no limit to the number of times the **Maximum Lifetime Benefit** will restore as long as You meet the above requirements.

WAIVER OF PREMIUM BENEFITS

Once You have received benefits for ninety (90) continuous days for confinement to an **Assisted Living Facility** or **Nursing Facility** and/or for **Adult Day Care** and/or **Hospice Care** received on a regular basis, (a regular basis is five (5) days or more per week), We will waive the payment of premiums for this Policy and any riders attached to this Policy while You continue to be so eligible for benefits. Premiums that have been paid for coverage that extends after the date You become eligible for the **Waiver of Premium** will be held by Us and applied to any premiums payable once You are no longer eligible for the **Waiver of Premium Benefit**. If You die while eligible for this benefit, the waived premiums held by Us will be refunded to Your estate.

SECTION IV: BENEFIT LIMITATIONS

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

MAXIMUM DAILY BENEFIT

The ***Maximum Daily Benefit*** is the maximum amount We will pay under any one (1) benefit, or combination of benefits, for care/assistance received during the same calendar day. The **Maximum 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, unless benefits are restored as described in the **Restoration of Benefits** provision on Page 12. Each day You are eligible for and receive the **Assisted Living Facility Benefits** and/or **Nursing Facility Benefits** will count as one (1) full day of the **Maximum Lifetime Benefit**. Each day You are eligible for and receive the **Adult Day Care Benefits, Hospice Care Benefits** and/or **Respite Care Benefits** will count as one-half (1/2) day of the **Maximum Lifetime Benefit**. Your Policy's **Maximum Lifetime Benefit** is listed in the Policy Schedule.

ELIMINATION PERIOD

The ***Elimination Period*** serves as a deductible which must be satisfied before benefits will be available. Specifically, it is the number of days You must receive care/assistance before You can receive benefits. For each day of care/assistance to be applied towards the satisfaction of the **Elimination Period**, the care/assistance must be otherwise covered by the Policy and You must otherwise be eligible for benefits. When benefits do begin, they will not be retroactive to the beginning of the **Elimination Period**.

Each day You are otherwise eligible for the **Assisted Living Facility Benefits** or the **Nursing Facility Benefits** will count as one (1) full day towards the satisfaction of Your **Elimination Period**. Each day You are otherwise eligible for the **Adult Day Care Benefits** or **Hospice Care Benefits** will count as one-half (1/2) day towards the satisfaction of Your **Elimination Period**. (The **Respite Care Benefits** are not subject to the **Elimination Period**.)

The **Elimination 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. (For example, if You satisfy the **Elimination Period** for **Adult Day Care** and would then require admission to an **Assisted Living Facility**, it will not be necessary for You to satisfy the **Elimination Period** again.) The **Elimination Period** is listed in the Policy Schedule.

PRE-EXISTING CONDITIONS LIMITATION

A ***Pre-Existing Condition*** is a condition for which medical advice or treatment was recommended by or received from a **Physician** within six (6) months preceding the Policy's Effective Date as shown in the Policy Schedule.

Pre-Existing Conditions listed on the application are covered immediately. **Pre-Existing Conditions** which are not listed on the application are not covered unless the care/assistance begin six (6) months or more after the Effective Date shown in the Policy Schedule.

SECTION V: ADDITIONAL FEATURES

This section explains 4 additional Policy Features designed to protect You.

THIRD PARTY NOTIFICATION OF LAPSE

You have the right to designate at least one (1) 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 become mentally incompetent or physically incapable of paying the renewal premium when 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 thirty (30) days in advance of the cancellation date. Notice shall be given by first class United States mail, postage prepaid, and will be sent thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given five (5) days after the date We have mailed it 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. We shall notify You of the right to change this written designation at least once every two (2) years. 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 FOR ALZHEIMER'S DISEASE, OTHER FORMS OF COGNITIVE IMPAIRMENT AND/OR LOSS OF FUNCTIONAL CAPACITY

If Your Policy lapses, We will provide a retroactive continuation of coverage if We receive the following within five (5) months of the date it lapses:

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 (2) or more of the **Activities of Daily Living**) on the renewal date; and
2) Payment of all past-due premiums for this Policy and any riders attached to the Policy that were in force on the date of lapse.
   (Please refer to Page 11 for the definition of **Cognitive Impairment** and Page 10 for the definition of **Activities of Daily Living**.)

This reinstatement will provide uninterrupted coverage to the same extent that the Policy would have provided had it not lapsed.

OUR PROMISE – Your Right To Convert To A Non-Tax-Qualified Policy

In the event the U.S. Congress or the Treasury Department rules the premiums and/or benefits of a non-tax-qualified policy will receive preferential treatment, as is the case with this Policy, You may convert this Policy to a non-tax-qualified policy at any time prior to its first anniversary. 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 premiums for the non-tax-qualified policy may be higher because of the additional coverage it provides.) You may also convert this Policy to a non-tax-qualified policy after its first anniversary if You provide evidence of insurability acceptable to us. The premiums of the new policy will be based on Your original issue age.

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. The extension of benefits beyond the date the Policy is terminated is limited to the benefits remaining in the **Maximum Lifetime Benefit**. (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, which can be found on Page 20.)

SECTION VI: EXCLUSIONS

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.

Exclusions: The Policy will not pay benefits for:

1) Care/assistance provided while this Policy is not in force.
2) Care/assistance provided by a **Family Member**, unless pre-approved by Us, or in a facility owned or operated by a **Family Member**.
3) Care/assistance You would not be legally obligated to pay for in the absence of this insurance.
4) Care/assistance provided outside of the United States or its possessions.
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 war, or an act of war, whether declared or not.
8) Care/assistance required as a result of attempted suicide or intentionally self-inflicted injury.
9) Care/assistance required as a result of Your being intoxicated or under the influence of a non-**Physician** prescribed narcotic.
10) Care/assistance required as a result of alcoholism and drug abuse.
11) Care/assistance required as a result of Your commission of a felony or Your being engaged in an illegal occupation.
12) Care/assistance paid by Medicare. Any portion of the charges not paid by Medicare, will be covered, subject to the terms of this Policy.
13) Care/assistance required as a result of cosmetic surgery.

"Care/assistance" refers to confinement in an **Assisted Living Facility** and/or **Nursing Facility, Adult Day Care, Hospice Care, Respite Care, Home Health Care,** and **Homemaker Care. (Home Health Care** and **Homemaker Care** benefits are available only if the optional **Home Health Care Rider** is attached to this Policy. If attached, the **Home Health Care Rider** will be listed in the Policy Schedule.)

SECTION VII: GENERAL CONTRACT PROVISIONS

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

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.

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 thirty (30) days of Our receipt of written notice of Your death. It will be paid to Your estate.

Cancellation: We cannot cancel this Policy at any time. Once this Policy's thirty (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 date following Our receipt of Your request.

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 date.

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.

Grace Period: A grace period of thirty-one (31) days is granted for the payment of each premium due after the first premium, during which time Your Policy continues in force. If the renewal premium is not paid before the Grace Period ends, Your Policy will lapse. (If You have elected a Third Party to received notice of Your Policy lapsing, it will lapse thirty (30) days after such notice has been provided.)

Reinstatement: If Your Policy lapses, We can consider reinstating it if We receive the renewal premium and a reinstatement application within six (6) months of the date the premium was due. 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 forty-five (45) days after the date of Our receiving the reinstatement application.

The reinstated Policy will cover only loss resulting from accidental injury as may occur after the date of reinstatement and loss due to sickness as may begin more than ten (10) 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. No premium will be applied to any period more than sixty (60) days before the date of reinstatement.

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 amended to conform to its minimum requirements.

CLAIMS UNDER THIS POLICY:

What You Should Do When You Have A Claim:

When You need to enter an **Assisted Living Facility** or **Nursing Facility**, or You need **Adult Day Care, Hospice Care** or **Respite Care**, the Claim Forms You will need to complete are enclosed. Please follow the instructions on these forms as they will tell You precisely what You have to do. Following these instructions and submitting the information required will help Us expedite the processing of Your claim. If You have any questions, or if You need Claim Forms, please call Us at (800) 362-0700.

If You purchased a Home Health Care Rider with this Policy, (if purchased, this Rider will be listed on the Policy Schedule):

When You need **Homemaker Care, Personal Care**, or **Home Health Care** that may be covered by the Home Health Care Rider, You should immediately call Our Claims Department at (800) 362-0700 if You would like to be eligible for up to 100% of Your Rider's Maximum Daily Benefit. Please refer to the **Early Notification of Claim** provision listed in the Rider.

When You call Us, We will give You further instructions on what forms/information You need to submit. If You elect not to notify Us of Your claim within fifteen (15) calendar days of the care/assistance beginning in accordance with the **Early Notification of Claim** provision, the Claim Forms You will need to complete are enclosed. Please follow the instructions on these forms as they will tell You precisely what You have to do. Following these instructions and submitting the information required will help Us expedite the processing of Your claim. If You have any questions, or if You need Claim Forms, please call Us at (800) 362-0700.

Claim Forms/Proof of Loss: You must submit the required Claim Forms or other written proof of loss within ninety (90) days of the occurrence of the loss. If You have a good reason for not doing so, We will not contest the claim, however, You must give us proof no later than one (1) year from the time normally required, unless legally incapable. As sufficient proof of loss, We may request full documentation of the loss, such as proof of the actual expenses incurred.

Payment of Claims: All benefits will be payable to You, unless You, or someone legally authorized to act in Your behalf, assigns these benefits by providing Us written instructions to pay another party. Any accrued benefits unpaid at Your death will be paid to Your estate, unless said benefits were so assigned to another party.

Time of Payment of Claims: Benefits payable under the Policy for any loss incurred will be paid within thirty (30) days after 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.

Claims Involving Other Policies: Should benefits for care/assistance covered by this Policy also be available through other coverage, benefits shall be paid in accordance with the age of each respective policy/plan, with the policy/plan having the earliest effective date being the first to provide benefits. After all benefits available under the oldest policy/plan have been paid, any remaining eligible charge(s) shall then be considered under the policy/plan with the second oldest effective date. After benefits have been paid under the second policy/plan, any remaining charge(s) will then be considered under the third oldest policy/plan, and so on, until You have been reimbursed in full for the charge(s) in question. All such charges remain subject to the other terms and conditions of this Policy. (Benefits will not be paid under this Policy to the extent that they would serve to reimburse You, when combined with the benefits paid through any and all other policies/plan, for more than the actual expense incurred.)

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.

Appealing a Denial of Benefits: You, or someone authorized to act on 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 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. We will send You a written explanation of the results of Our review within thirty (30) days of Our receiving Your appeal, or within thirty (30) days of Our receiving any additional information needed to adequately review Your appeal.

Contestability/Time Limit on Certain Defenses: No claim for care/assistance which begins after six (6) months from the Effective Date of coverage will be reduced or denied because a physical condition had existed before the Effective Date of coverage, (refer to the Pre-Existing Conditions Limitation on Page 13), unless this Policy is voided due to a material misstatement made in the application. After two (2) years from the Effective Date of coverage, no misstatements, except fraudulent ones, made in the application may be used to void this Policy.

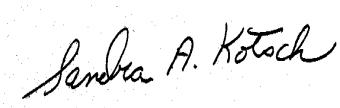
Legal Actions: No legal action may be brought to recover on the Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No action shall be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required 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.

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

IN WITNESS WHEROF, We have caused this Policy to be signed by Our President and Secretary.

President



Secretary