PENN TREATY NETWORK AMERICA INSURANCE COMPANYSM

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

ASSISTED LIVING PLUSSM

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 as defined by the Internal Revenue Code of 1986, § 7702B(b) and may qualify You for federal and state tax benefits.

GUARANTEED RENEWABLE FOR LIFE – PREMIUMS SUBJECT TO CHANGE

This Policy is guaranteed renewable for Your Lifetime, subject to the Policy maximums, and 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 that it is in force. We also cannot change the premium rates due to a change in Your age or health. We can change the premiums only when 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 forty-five (45) 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 14 to learn how benefits may be restored.)

YOUR RIGHT TO CANCEL

You may cancel this Policy at any time by giving written notice to Us. This Policy will be canceled the day We receive Your notice, or a later date if stated in the notice. We will promptly return the unearned portion of any premium paid. Cancellation will not affect any claim incurred before the Policy is canceled.

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 return 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 policyholder during the period of coverage. This policyholder is advised to review carefully all Policy limitations. In addition, if Inflation Protection was not purchased, the policyholder is advised that based on current health care cost trends, the benefits provided by this Policy may be significantly diminished in terms of real value to the policyholder, depending on the amount of time which elapses between the date of purchase and the date upon which the policyholder first becomes eligible for those benefits.

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.

SPECIMEN

TABLE OF CONTENTS

		Page
1.	Tax-Qualified Status	1
2.	Renewability Terms	1
3.	30 Day Right to Examine Policy	1
4.	Notice to Buyer	1
5.	Caution Statement	1
6.	Important Notice	3
7.	Policy Schedule Page	4
8.	Definitions	5
9.	Section I: Policy Benefit Provisions	9
	Assisted Living Facility Benefits	9
	Assisted Living Facility Benefits Eligibility for Benefits	9
	Nursing Facility Benefits	10
	Nursing Facility Benefits Eligibility for Benefits	10
	Hospice Care Benefits	11
	Hospice Care Benefits Eligibility for Benefits	11
	Respite Care Benefits	12
	Respite Care Benefits	12
10.	Section III: Additional Benefits	13
	Bed Reservation Benefits	13
	Alternative Plan of Care Benefits	13
	Restoration of Benefits	14
	Waiver of Premium Benefits	14
	Contingent Benefit Upon Lapse	14
11.	Section IV: Benefit Limitations	17
	Maximum Daily Benefit	17
	Maximum Lifetime Benefit	17
	Elimination	17
	Pre-Existing Conditions Limitation	17
12.	Section V: Additional Features	18
	Third Party Notification of Lapse	18
	Reinstatement for Loss of Severe Cognitive/Functional Capacity	18
	Our Promise – Your Right to Convert to a Non-Tax-Qualified Policy	19
	Extension of Benefits	19
13.	Section VI: Exclusions	20
14.	General Contract Provisions	21
15.	Claims Under this Policy – What to do when You have a Claim	22
16.	Application	Attached

SPECIMEN

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Penn Treaty Network America Insurance Company℠ at:

1-800-362-0700

You may also write to Penn Treaty Network America Insurance Company℠ at:

Penn Treaty Network America Insurance Company℠
3440 Lehigh Street
Allentown, PA 18103

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

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

1-800-252-3439

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact Penn Treaty Network America Insurance Company℠ first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar el gratis numero de telefono de Penn Treaty Network America Insurance Company℠ para informacion o para someter una queja al:

1-800-362-0700

Usted tambien puedes escibir al Penn Treaty Network America Insurance Company℠ en:

Penn Treaty Network America Insurance Company℠
3440 Lehigh Street
Allentown, PA 18103

Puede excribirle al Texas Departamento de Seguros en:

Texas Departmento de Seguros
P.O. Box 149104
Austin, TX 78714-9104

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tienes una disputa concerniente a su prima o a un reclamo, debe comunicarse con Penn Treaty Network America Insurance Company℠ primero. Si no se resuelve la disputa, puede entonces comunicarse con Texas Departmento de Seguros.

UNE ESTES AVISO CON SU POLIZA:

El Proposito de este aviso es solo para informacion y no se convierte en parte o condicion del documento adjunto.

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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

SPECIMEN

SPECIMEN

Activities of Daily Living

The **Activities of Daily Living** are the basic, day-to-day, human functions and are comprised of the following:

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 sufficient mobility to move into or out of a bed, chair, or wheelchair or to move from place to place, either by walking, a wheelchair or other means.
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.

SPECIMEN

Assisted Living Facility An **Assisted Living Facility** is a facility that is licensed by and operated pursuant to the appropriate state and federal law to engage primarily in providing care and unscheduled services to resident inpatients. If not licensed, it must meet the following requirements:

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 **Severe 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.

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**.

An **Assisted Living Facility** is not a **Home**, facility or part thereof used primarily for rest, sheltered living accommodations, residence home, or similar living arrangements.

Assisted Living Facility's Daily Fee **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.

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.

SPECIMEN

Chronically Ill	To be certified as a **Chronically Ill Individual** 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 a loss of functional capacity; You must have a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability or You must require supervision to protect You from threats to health and safety due to **Severe Cognitive Impairment**.
Confined	**Confined** is assigned to a bed and physically present within the facility.
Elimination Period	The **Elimination Period** serves as a deductible which must be satisfied before benefits will be available.
Family Member	A **Family Member** is You and Your spouse, and Your and Your spouse's respective parent, grandparents, siblings, children, grandchildren, aunts, uncles, cousins, nephews, nieces and in-laws.
Hand-on Assistance	**Hands-on Assistance** is the physical assistance of another person, without which You would be unable to perform the **Activity of Daily Living**.
Home Health 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 other caregiver, whether skilled or unskilled.
Homemaker 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.
Hospice Care	**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.
Licensed Health Care Practitioner	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.
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.

SPECIMEN

Maximum Lifetime Benefit

The **Maximum Lifetime Benefit** is the maximum number of days in benefits We will pay during Your lifetime under the Policy, unless benefits are restored.

Nursing Facility

A **Nursing Facility** is a facility, or distinctly separate part of a hospital or other institution, which is licensed by and operated pursuant to the appropriate state and federal law to engage primarily in providing nursing care and related services to inpatients. If not licensed, it must meet the following requirements:

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 procedures for handling and administering drugs and biologicals.

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's definition of a **Nursing Facility**.

A **Nursing Facility** is not a **Home**, facility or part thereof used primarily for rest, sheltered living accommodations, residence homes, or similar living arrangements.

Nursing Facility's Daily Fee

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 a 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.

Physician

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**.

Plan of Care

The **Plan of Care** specifies the type of care/assistance that is necessary and certifies that You are a **Chronically Ill i**ndividual.

SPECIMEN

Pre-Existing Condition

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.

Respite Care

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

Severe Cognitive Impairment

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

Standby Assistance

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**.

Substantial Assistance

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

SPECIMEN

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 **Eligibility for Benefits**, 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.

ASSISTED LIVING FACILITY BENEFITS
ELIGIBILITY FOR BENEFITS

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 have a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in item (1);

OR

3) 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 ninety (90) days. Any periodic certifications required by the Company will be at Our expense.)

SPECIMEN

NURSING FACILITY BENEFITS

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

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

NURSING FACILITY BENEFITS
ELIGIBILITY FOR BENEFITS

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 have a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in item (1);

OR

3) 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 ninety (90) days. Any periodic certifications required by the Company will be at Our expense.)

SPECIMEN

HOSPICE CARE BENEFITS

For each day You receive **Hospice Care** and meet the **Eligibility for Benefits**, 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.

HOSPICE CARE BENEFITS ELIGIBILITY FOR BENEFITS

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 have a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in item (1);

OR

3) 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 ninety (90) days. Any periodic certifications required by the Company will be at Our expense.)

SPECIMEN

RESPITE CARE BENEFITS

For each day You receive **Respite Care** and meet the **Eligibility for Benefits**, 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.

This benefit is payable for a maximum of fifteen (15) days per calendar year and is not subject to the. Any days not used in a calendar year cannot be carried over to any subsequent years. (Please refer to Page 17 for the definition of **Elimination Period**.)

RESPITE CARE BENEFITS ELIGIBILITY FOR BENEFITS

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 have a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in item (1);

OR

3) 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 ninety (90) days. Any periodic certifications required by the Company will be at Our expense.)

SPECIMEN

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.

Neither **Home Health Care** nor **Homemaker Care** will be considered for benefits under the **Alternative Plan of Care**.

SPECIMEN

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 **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 **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.

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 **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 beyond 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 returned to Your estate.

CONTINGENT BENEFIT UPON LAPSE

The following benefit only applies if You did not select a nonforfeiture benefit rider offered to You when You applied for this Long Term Care Policy.

In the event premiums are increased in the future, and the amount of said premium increase exceeds the amount shown in Table I on Page 16, then on or before the effective date of such premium increase, You will have the following options:

1. Pay the increased premium in order to keep Your current coverage in force;
2. Decrease the benefits of Your Policy to offset the increase in premiums (so that Your premium payments will not increase);
3. Convert Your coverage to reduced paid-up coverage.

SPECIMEN

If You choose to decrease Your benefits, no evidence of insurability will be required. The premium for the reduced coverage will be based on Your age when You originally purchased Your Policy.

If You choose to convert Your coverage to reduced paid-up coverage, You will be entitled to keep a portion of the coverage offered by the Policy even after it lapses until benefits have been exhausted under the Policy.

To determine the amount of the reduced paid-up coverage benefit You are entitled to, We will add together all of the premiums actually paid for the Policy on the date the Policy lapses. The total of these premiums shall constitute a pool of benefit dollars that will be available in the form of reduced paid-up coverage and shall hereinafter be referred to as the **Nonforfeiture Maximum Lifetime Benefit**.

> The ***Nonforfeiture Maximum Lifetime Benefit*** is the maximum amount of benefits available under the reduced paid-up coverage benefit. Each dollar in benefits paid under this Policy's reduced paid-up coverage benefit shall reduce the remaining **Nonforfeiture Maximum Lifetime Benefit** by an equal amount.

Benefits payable under this Policy's reduced paid-up coverage benefit will only be payable if they would have otherwise been payable under the Policy, had it not lapsed. These benefits will be available under the same circumstances, and subject to the same terms, (including any **Elimination Period)**, provisions, exclusions and maximums of the Policy, except as is expressly set forth herein.

The maximum amount in benefits available for any one day of care/services shall be equal to the Policy's **Maximum Daily Benefit** in effect at the time the Policy lapses. In no event shall the amount payable for any one day of care/services exceed this amount. (Please refer to page 17 for the **Maximum Daily Benefit**.)

If Your Policy lapses within 120 days of the date increased premiums are due, We will consider the lapse an election of the reduced paid-up coverage.

The amount of the benefit may be adjusted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Secretary of Treasury for this Policy.

In no event shall the **Nonforfeiture Maximum Lifetime Benefit** provide fewer than 30 days in benefits. If, according to the method of calculation set forth above, the **Nonforfeiture Maximum Lifetime Benefit** is less than thirty (30) times the **Maximum Daily Benefit** in effect at the time the Policy lapses, the **Maximum Daily Benefit** will be available for thirty (30) days of care/services that would otherwise have been covered under the Policy, had it not lapsed.

Notwithstanding the above, in no event shall the **Nonforfeiture Maximum Lifetime Benefit** exceed the maximum amount of benefits available under the Policy at the time it lapsed. If benefits were paid or are payable under the Policy for care/services received prior to the date of lapse, the benefits available under the reduced paid-up coverage benefit will be reduced by the amount of benefits paid and/or payable under the Policy. If, at any time, the benefits of the Policy were restored in accordance with the Policy's **Restoration of Benefits** provision, any benefits paid prior to the date of restoration shall not serve to reduce the benefits available under the reduced paid-up coverage benefit. (Please refer to page 14 for the **Restoration of Benefits** provision.)

SPECIMEN

Premiums waived or refunded in accordance with the **Waiver of Premium Benefit** shall not be considered as premiums paid when calculating the **Nonforfeiture Maximum Lifetime Benefit**. (Please refer to page 14 for the **Waiver of Premium Benefit** provision.)

If an Inflation option was in force at the time the Policy lapses, it shall not serve to further increase the **Maximum Daily Benefit** after the Policy lapses.

The **Nonforfeiture Maximum Lifetime Benefit** is not restorable under any circumstances. Once the **Nonforfeiture Maximum Lifetime Benefit** has been exhausted, no further benefits will be available under the Policy or any riders attached to the Policy.

TABLE I

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

The specific percentage is called the "Percent Increase Over Initial Premium". The percentage that applies to You depends on Your age when Your Policy was purchased. The Percent Increase Over Initial Premium is cumulative; it applies to all premium increases which occur over the life of Your Policy.

SPECIMEN

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 14. 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 **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 **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 **Hospice 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 occurs six (6) months or more after the Effective Date shown in the Policy Schedule.

SPECIMEN

SECTION V: ADDITIONAL FEATURES

This section explains 5 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.

Your Policy cannot be canceled for nonpayment of premium unless We have notified You and 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 You and 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 SEVERE 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 **Severe 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 or at any time within the sixty-five (65) day grace period; 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.

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

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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 23.)

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SECTION VI: EXCLUSIONS

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

Exclusions: The Policy will not pay benefits for:

1) Care/assistance provided by a **Family Member**, unless pre-approved by Us, or in a facility owned or operated by a **Family Member**.
2) Care/assistance You would not be legally obligated to pay for in the absence of this insurance.
3) Care/assistance provided outside of the United States or its possessions.
4) Care/assistance payable under any Worker's Compensation or Occupational Disease Law.
5) Care/assistance for mental or nervous or emotional disorders without demonstrable organic origin. (**NOTE:** This shall not permit exclusion or limitation of benefits on the basis of 1) Alzheimer's disease or related disorders, where a clinical diagnosis of Alzheimer's Disease by a physician licensed in this state, including history and physical, neurological, psychological and/or psychiatric evaluation, and laboratory studies, has been made to satisfy any requirement for demonstrable proof of organic disease or other proof under the coverage or; 2) biologically based brain disease/serious mental illness, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar and depressive).
6) Care/assistance required as a result of war, or an act of war, whether declared or not.
7) Care/assistance required as a result of attempted suicide or intentionally self-inflicted injury.
8) Care/assistance required as a result of alcoholism and/or drug abuse.
9) Care/assistance required as a result of Your commission of a felony or Your being engaged in an illegal occupation.
10) Care/assistance paid by Medicare or expenses under Medicare or which would be reimbursable under Medicare but for the application of a deductible or coinsurance amount, except expenses which are reimbursable under Medicare only as a secondary payor.

"Care/assistance" refers to confinement in an **Assisted Living Facility** and/or **Nursing Facility**, **Hospice Care**, **Respite Care**, **Home Health Care**, **Adult Day Care** and **Homemaker Care. (Home Health Care**, **Adult Day 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.)

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REIMBURSEMENT TO THE TEXAS DEPARTMENT OF HUMAN RESOURCES

In the event that the cost of Your medical care, for which benefits are payable under this Policy, is paid through a medical assistance program of the Texas Department of Human Resources, the benefits of this Policy will be paid to the said Department. Such payment will be made up to the actual amount of the Texas Department of Human Resource's coverage, but not to exceed the amount of benefits due under this Policy.

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 return the part of any premium paid for coverage that extends beyond the date of Your death. This return will be made within thirty (30) days of Our receipt of written notice of Your death. It will be paid to Your estate.

Insuring Clause/Effective Date: This Policy is evidence of an agreement between You and the Penn Treaty Network America Insurance Company[SM] (hereafter referred to as "We," "Our" or "Us"). This agreement is a contract of insurance whereby We agree to pay You the benefits provided by this Policy for a covered loss incurred on or after the Effective Date and while this Policy is in force. This Policy takes effect as of 12:01 A.M., standard time, at Your residence on the Effective Date shown in the Policy Schedule.

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: You will receive notice of Your Policy lapsing. Your Policy will lapse thirty (30) days after such notice has been provided. Notice to You and the Third Party, if elected, shall be deemed to have been given five (5) days after the date We have mailed the notice to You and the Third Party. The total period of time before Your Policy will lapse equals sixty-five (65) days. (Please refer to Page 18 for the **Third Party Notification of Lapse** feature.)

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 incurred for covered care or confinement which occurs 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.

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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 **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, Home Health Care** or **Adult Day 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 immediately 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.

Claim Denial: In the event a claim is denied, We shall make available all information directly relating to such denial within sixty (60) days of the date of a written request by You, unless such disclosure is prohibited under state or federal law.

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.

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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.

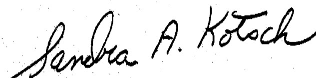
Contestability/Time Limit on Certain Defenses No claim for care/assistance which is received after six (6) months from the Effective Date of coverage will be reduced or denied because a physical condition had existed before the Effective Date of coverage, (refer to the **Pre-Existing Conditions Limitation** on Page 17), unless this Policy is voided due to misrepresentation and an intent to deceive made in the application. After two (2) years from the Effective Date of coverage, no misrepresentation, 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 three (3) years after the time written proof of loss is required to be furnished.

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

SPECIMEN