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

HOME HEALTH CARE INSURANCE POLICY

THIS POLICY PROVIDES BENEFITS FOR CARE AND ASSISTANCE PROVIDED IN YOUR HOME AND COMMUNITY.

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. **Note that the Georgia Insurance Department does not in any way warrant that this Policy meets the requirements of Section 7702B(b) of the Internal Revenue code of 1986, as amended.**

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 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 and approved by Your state commissioner of insurance. Notice of any such change in premium will be sent at least sixty (60) 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 16 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.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

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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 **$_____**
(If You use the Early Notification of Claim, benefits may be payable up to 100% under the Policy. If the Early Notification of Claim is not used, benefits may be payable up to 80% under the Policy.)

MAXIMUM WEEKLY BENEFIT **$_____**

MAXIMUM BENEFIT PERIOD **_____ WEEKS**

ELIMINATION PERIOD **_____ DAYS**

RESTORATION OF BENEFITS **INCLUDED**

(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

	Additional Premium Amount
LIFETIME INFLATION RIDER – FORM (CINF-P) Increases the Maximum Daily benefit by 5% (compounded annually) on the Policy anniversary date for the lifetime of the Rider	$ 0.00
ASSISTED LIVING PLUS RIDER – FORM (RALP-TQ-P(GA)) Provides benefits for confinement to Assisted Living Facilities and Nursing Facilities	$ 0.00

SECTION I: POLICY BENEFITS

This section tells You about the care and assistance covered by this Policy and explains how You qualify for benefits.

Benefits are available for **Homemaker Care, Personal Care, Home Health Care, Adult Day Care, Hospice Care** and **Respite Care**. 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].

HOMEMAKER CARE BENEFITS

For each day You receive **Homemaker Care** in Your **Home** and meet the **Homemaker Care Benefits Conditions of Eligibility**, We will pay the lesser of:

1) 80% of the actual charge incurred; or
2) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) 80% of the **Reasonable and Customary Charge**.

You can qualify to receive up to 100% of the actual charge incurred, subject to 100% of the **Maximum Daily Benefit**, by notifying Us that You will be receiving care/assistance prior to, or within fifteen (15) calendar days of, the care/assistance beginning. To notify U s, You must call Our Claims Department at (800) 362-0700. (Please refer to the **Early Notification of Claim** provision on Page 11 for more details.)

Homemaker Care is assistance with the **Instrumental Activities of Daily Living**. **Homemaker Care** may be provided by a skilled or unskilled person capable of helping with these activities.

The ***Instrumental Activities of Daily Living*** are the basic functional activities necessary for You to remain safely in Your **Home** and include the following:

1) Meal Preparation is the preparation of food for human consumption, including cooking and cleanup.
2) Shopping/Travel is utilizing 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 is maintaining a clean **Home** living environment so that Your health, safety and welfare are not jeopardized. Light Housekeeping does not include any type of **Home** construction or maintenance, work on the exterior of the **Home**, heavy cleaning such as annual "spring cleaning", lawn care, snow removal, maintenance of a vehicle, or any other service provided outside the **Home**.
4) Laundry is washing, drying and storing Your clothing, bed linens, etc.
5) Telephoning is using a telephone to make calls.
6) Handling Money/Bill Paying is depositing and/or withdrawing funds at a financial institution, writing checks to pay bills, etc.

7) Medication Management is safely controlling, dispensing and/or administering medications prescribed by a **Physician** in the proper dosages and at the proper times.

Home is Your personal residence, whether in a private dwelling owned or leased by You, and includes a home for the retired or aged. It does not include a hospital, sanitarium or **Long Term Care Facility**.

A ***Long Term Care Facility*** includes any facility, such as a Nursing Home 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 defici ts, and licensed to provide this assistance/services if so required.

Physician is anyone, other than You or a **Family Member,** properly licensed as a practitioner of the healing arts and operating within the scope of that license.

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.

Reasonable and Customary Charge is the regular, ordinary charge for, or the fair and reasonable value of, the care/assistance You receive. The **Reasonable and Customary** charge will be determined by comparing the expenses You incur with the usual and typical charges made for similar care/assistance provided in the same geographic locality by a si milar provider.

PERSONAL CARE BENEFITS

For each day You receive **Personal Care** in Your **Home** and meet the **Personal Care Benefits Conditions of Eligibility**, We will pay the lesser of:

1) 80% of the actual charge incurred; or
2) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) 80% of the **Reasonable and Customary Charge** for similar services provided in the same geographic area. (Please refer to Page 5 for the definition of **Reasonable and Customary Charge**.)

You can qualify to receive up to 100% of the actual charge incurred, subject to 100% of the **Maximum Daily Benefit**, by notifying Us that You will be receiving care/assistance prior to, or within fifteen (15) calendar days of, the care/assistance beginning. To notify Us, You must call Our Claims Department at (800) 362-0700. (Please refer to the **Early Notification of Claim** provision on Page 11 for more details.)

Personal Care is assistance with the **Activities of Daily Living** and/or assistance with the **Instrumental Activities of Daily Living**. **Personal Care** may be provided by a skilled or unskilled person capable of helping with these activities. (Please refer to Page 12 for the definition of **Activities of Daily Living** and Page 4 for the definition of **Instrumental Activities of Daily Living**.)

HOME HEALTH CARE BENEFITS

For each day You receive **Home Health Care** in Your **Home** and meet the **Home Health Care Benefits Conditions of Eligibility**, We will pay the lesser of:

1) 80% of the actual charge incurred; or
2) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) 80% of the **Reasonable and Customary Charge** for similar services provided in the same geographic area. (Please refer to Page 5 for the definition of **Reasonable and Customary Charge**.)

You can qualify to receive up to 100% of the actual charge incurred, subject to 100% of the **Maximum Daily Benefit**, by notifying Us that You will be receiving care/assistance prior to, or within fifteen (15) calendar days of, the care/assistance beginning. To notify Us, You must call Our Claims Department at (800) 362-0700. (Please refer to the **Early Notification of Claim** provision on Page 11 for more details.)

Home Health Care is skilled nursing services or other medical services, performed by a licensed registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), chemotherapy specialist, enterostomal specialist, total parental nutrition specialist, physical therapist, speech therapist, occupational therapist or any other duly-licensed provider of said services.

ADULT DAY CARE BENEFITS

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

1) 80% of the actual charge incurred; or
2) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) 80% of the **Reasonable and Customary Charge** for **Adult Day Care** rendered in the same geographic area. (Please refer to Page 5 for the definition of **Reasonable and Customary Charge**.)

You can qualify to receive up to 100% of the actual charge incurred, subject to 100% of the **Maximum Daily Benefit**, by notifying Us that You will be receiving care/assistance prior to, or within fifteen (15) calendar days of the care/assistance beginning. To notify Us, You must call Our Claims Department at (800) 362-0700. (Please refer to **the Early Notification of Claim** provision on Page 11 for more details.)

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.

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 **Hospice Care Benefits Conditions of Eligibility**, We will pay the lesser of:

1) 80% of the actual charge incurred; or
2) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) 80% of the **Reasonable and Customary Charge** for **Hospice Care** rendered in the same geographic area. (Please refer to Page 5 for the definition of **Reasonable and Customary Charge**.)

You can qualify to receive up to 100% of the actual charge incurred, subject to 100% of the **Maximum Daily Benefit**, by notifying Us that You will be receiving care/assistance prior to, or within fifteen (15) calendar days of, the ca re/assistance beginning. To notify Us, You must call Our Claims Department at (800) 362-0700. (Please refer to the **Early Notification of Claim** provision on Page 11 for more information.)

Hospice Care is an outpatient service designed to provide palliati ve care; alleviate the physical, emotional, social and spiritual discomforts when You are experiencing the last phases of life due to the existence of a terminal disease with a life expectancy of six (6) months or less as certified by a physician; and prov ide supportive care to Your primary caregiver and Your family.

RESPITE CARE BENEFITS

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

1) 80% of the actual charge incurred; or
2) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) 80% of the **Reasonable and Customary Charge** for similar services rendered in the same geographic area. (Please refer to Page 5 for the definition of **Reasonable and Customary Charge**.)

You can qualify to receive up to 100% of the actual charge incurred, subject to 100% of the **Maximum Daily Benefit**, by notifying Us that You will be receiving care/assistance prior to, or within fifteen (15) calendar days of, the care/assistance beginning . To notify Us, You must call Our Claims Department at (800) 362-0700. (Please refer to the **Early Notification of Claim** provision on Page 11 for more details.)

Respite Care may be **Homemaker Care, Personal 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. (Please refer to Page 5 for the definition of **Long Term Care Facility**.)

This benefit is payable for a maximum of fifteen (15) days per c alendar 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 18 for the definition of **Elimination Period**.)

Early Notification of Claim

As previously stated, You will be eligible to receive 100% of the actual charge incurred, subject to a maximum of 100% of the Policy's **Maximum Daily Benefit**, for care/assistance covered by this Policy if You, or someone authorized to act on Your behalf, notifies Us that You are receiving, or will be receiving, care/assistance for which benefits may be payable under this Policy. To notify Us, You must 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.

To be eligible for up to 100% of the **Maximum Daily Benefit**, You must call Us within fifteen (15) calendar days of the care/assistance beginning. If You do not notify Us until after this fifteen (15) day period has expired, We will pay 80% of the actual charge incurred, 80% of the **Maximum Daily Benefit**, or 80% of the **Reasonable and Customary Charge**, whichever is less, for any care/assistance You receive prior to Your notifying Our office, provided the care/assistance is covered and benefits are otherwise payable. We will pay up to 100% of the actual charge incurred, or 100% of the **Reasonable and Customary Charge**, whichever is less, subject to a maximum of 100% of the **Maximum Daily Benefit**, for any care/assistance received on and after the date You notify Our office, provided the care/assistance is covered and benefits are otherwise payable.

We will acknowledge Your having satisfied this **Early Notification of Claim** provision by mailing You a written confirmation within five (5) business days of Your contacting Our office.

Notifying Your agent does not satisfy the **Early Notification of Claim** provision. You, or Your personal representative, must call Our office at (800) 362-0700 to satisfy this provision.

When You call Our office, We may have an in-house Registered Nurse speak to You to gather information about Your condition and evaluate Your needs. If this telephone interview does not provide Us with the information We need to properly assess Your claim, We may follow-up by having 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 what type of care/assistance You need to be able to safely live at **Home**.

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 a nd 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. If You choose to use Our free **Care Solutions**[SM] service, We can provide a **Care Coordinator** who may act as the **Licensed Health Care Practitioner**. (Please refer to Page 5 for the definition of **Physician** and Page 14 for the definitions of **Care Solution**[SM] and **Care Coordinator**.)

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 gettin g 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 or 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.

CARE SOLUTIONS[SM]

When You need care/assistance covered by this Policy, We can offer You the assistance of a **Care Coordinator** through the **Care Solutions**[SM] services We make available to Our Policyholders fre e of charge. The **Care Coordinator** will perform an assessment of Your needs and work with You, Your family and Your **Physician** to see that those needs are met. The **Care Coordinator** will develop a plan of care, which describes the level of care/assistance Y ou require, the type of caregiver necessary and the schedule of the care/assistance to be rendered. 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.

The **Care Coordinator** can also help You identify the care resources available in Your community and contact the caregivers You select to arrange for the delivery of the care/assistance required.

A ***Care Coordinator*** is a health care professional, usually a Regis tered Nurse, We contract with to provide Our Policyholders the **Care Solutions**[SM] services described above.

Care Solutions[SM] is a free service We offer all of Our Policyholders who need assistance making arrangements for care. Whether You use it is entirel y up to You. Use of this service will not reduce, or be paid for through, the benefits of the Policy.

FAMILY MEMBER AS CAREGIVER BENEFITS

Homemaker Care, Personal Care and **Home Health Care** provided by a **Family Member** (other than a spouse) is covered by this Policy, if the caregiver is pre -approved by Us. (Please refer to Page 5 for the definition of a **Family Member**.)

To obtain pre-approval of care/assistance provided by a **Family Member,** other than a spouse or someone living with You prior to the inc eption of, or need for, the care/assistance, 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 a **Family Member** to provide a portion or all of the care/a ssistance. We will then ask for information pertaining to Your needs, the **Family Member** and the schedule of the care/assistance to be provided by the **Family Member**.

(Spouses and individuals living with You prior to the inception of, or need for, the care /assistance will not be eligible for benefits under any circumstances.)

FAMILY MEMBER TRAINING BENEFITS

If the **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. The training must be for the purpose of preparing the **Family Member** to provide for Your care and be pre-approved by Us.

We will pay a lifetime maximum benefit of up to five (5) times the **Maximum Daily Benefit** for the reasonable and customary costs of training the **Family Member**.

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 **Family Member** and the type of care/assistance to be provided by the **Family Member**.

MEALS ON WHEELS BENEFITS

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 thirty (30) days per calendar year. Any days not utilized cannot be carried over to any subsequent years. (Once this thirty (30) days in benefits has been exhausted, additional benefits for **Meals on Wheels** can be considered under this Policy's **Alternative Plan of Care Benefits**.)

> ***Meals on Wheels*** is a community-based service administered by the local Agency for the Aging which provides hot meals to Your **Home**.

In order to be eligible for this benefit, You must satisfy the **Conditions of Eligibility** listed on Page 12 and You must obtain pre-approval from Us. To obtain pre-approval, You simply have to call Us at (800) 362-0700. (You must also satisfy the eligibility requirements of your community's **Meals on Wheels** program.)

ALTERNATIVE PLAN OF CARE

If You would otherwise qualify for **Homemaker Care**, **Personal Care or Home Health Care Benefits**, You may request that We consider providing benefits for an alternative to such care/assistance. 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 a substitute to **Homemaker Care**, **Personal Care**, **or Home Health Care**. 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 **Homemaker Care**, **Personal Care**, or **Home Health Care**. Confinement to any type of facility, such as a **Long Term Care Facility**, will not be considered as an **Alternative Plan of Care**.

Benefits extended under the **Alternative Plan of Care** will be deducted from the **Maximum Benefit Period** 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 17 for the definition of **Maximum Benefit Period**.)

RESTORATION OF BENEFITS

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

1) You have not been confined to a **Long Term Care Facility** and You did not receive **Homemaker Care, Personal Care, Home Health Care, Adult Day Care** or **Hospice 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, a **Long Term Care Facility**; and
   b) You recovered sufficiently to not receive, and You were not advised to receive, **Homemaker Care, Personal Care, Home Health Care, Adult Day Care** or **Hospice 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 Benefit Period** 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 **Homemaker Care**, **Personal Care**, **Home Health Care**, **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 WEEKLY BENEFIT

You can receive more than the **Maximum Daily Benefit** for any one or more days of care/assistance received during the same **Calendar Week** by combining the **Maximum Daily Benefit** available for each day during that **Calendar Week** into a **Maximum Weekly Benefit**. The ***Maximum Weekly Benefit*** is seven (7) times the **Maximum Daily Benefit** and is the maximum amount We will pay for care/assistance received during the same **Calendar Week**.

A ***Calendar Week*** begins at 12:01 AM on Sunday, and ends seven (7) calendar days later, on the immediately following Sunday at 12:01 AM.

You may use the **Maximum Weekly Benefit** to pay for care/assistance received on fewer than seven (7) days during the same **Calendar Week**. For example, if the Policy's **Maximum Daily Benefit** is $100, the **Maximum Weekly Benefit** would be seven (7) times this amount, or $700. You could allocate this maximum of $700 to pay for fewer than seven (7) days of care/assistance received during the same **Calendar Week**, provided the care/assistance is otherwise covered by this Policy. If, for instance, You require care/assistance for three (3) days during the **Calendar Week** and this care/assistance costs $150 per day, We will exceed the **Maximum Daily Benefit** of $100 and pay the $150 for each day (a total of $450).

In no event will the amount We pay for care/assistance received during the same **Calendar Week** exceed the **Maximum Weekly Benefit** or the **Reasonable and Customary Charge** for the care/assistance received. This **Maximum Weekly Benefit** is available only when **Early Notification of Claim** is provided. (Please refer to Page 5 for the definition of **Reasonable and Customary Charge** and Page 11 for the **Early Notification of Claim** provision.) The **Maximum Weekly Benefit** is listed in the Policy Schedule.

MAXIMUM BENEFIT PERIOD

The ***Maximum Benefit Period*** is the maximum number of **Calendar Weeks** during which You can receive **Homemaker Care, Personal Care, Home Health Care, Adult Day Care** and/or **Hospice Care,** or any combination thereof, and be eligible for benefits during the lifetime of this Policy, unless benefits are restored as described in the **Restoration of Benefits** provision on Page 16 of this Policy. The **Maximum Benefit Period** begins with the first **Calendar Week** immediately following the first day during which you receive care/assistance covered by this Policy. (In other words, the **Maximum Benefit Period** begins on the first Sunday which follows the first day during which You receive care/assistance covered by this Policy. If the first day You receive care/assistance is a Sunday, the **Maximum Benefit Period** will begin on that day.)

For each **Calendar Week** You receive one or more days of **Homemaker Care, Personal Care, Home Health Care, Adult Day Care, Hospice Care** and/or **Respite Care** for which benefits are payable under this Policy, the number of **Calendar Weeks** remaining in the **Maximum Benefit Period** will be reduced by one (1). (**Calendar Weeks** during which You do not receive one or more days of care/assistance covered by this Policy will not reduce the number of weeks remaining available in the **Maximum Benefit Period**.) The **Maximum Benefit Period** 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 will be eligible for benefits. For each day of ca re/assistance to be applied towards the satisfaction of the **Elimination Period**, the care/assistance must be otherwise covered by the Policy and eligible for benefits. When benefits do begin, they will not be retroactive to the beginning of the **Elimination Period**.

The **Elimination Period** must be satisfied only once during the lifetime of this Policy and, with the exception of **Respite Care**, applies to all of the benefits available under this Policy on a combined basis. (For example, if You satisfy the **Elimination Period** for **Personal Care** and would then require **Home Health Care**, 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 begins six (6) months or more after the Effective Date shown in the Policy Schedule.

SECTION V: ADDITIONAL FEATURES

This section explains 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 canc eled 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 given thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) 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. 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 a cceptance 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 **Severe Cognitive Impairment** (including, but not limited to Alzheimer's Disease) and/or a loss of functional capacity (th e 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 this Policy that were in force on the date of lapse.
(Please refer to Page 13 for the definition of **Severe Cognitive Impairment** and Page 12 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 Benefit Period**. (Benefits may be reduced by the amount of premium payable for the duration of the **Maximum Benefit Period** in accordance with the Unpaid Premium provision, which can be found on Page 25.)

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, subject to the **Extension of Benefits** provision.
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 that 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 or Nervous** or emotional disorders without demonstrable organic origin. ***Mental or Nervous Disorder*** may be neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. **(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 injuries.
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/or 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 for by Medicare. If any portion of the charges for such care/assistance is not paid by Medicare, they will be recovered, subject to the terms of this Policy.
13) Care/assistance required as a result of cosmetic surgery.

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

SECTION VII: GENERAL CONTRACT PROVISIONS

Your Home 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 the 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 receive 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 of receiving the application, otherwise, Your Policy will be reinstated 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 **Homemaker Care, Personal Care, Home Health Care, Adult Day Care, Hospice Care** or **Respite Care** that may be covered by this Policy, You should immediately call Our Claims Department at (800) 362-0700 if You would like to be eligible for up to 100% of Your Policy's **Maximum Daily Benefit**. Please refer to the **Early Notification of Claim** provision on Page 11.

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 additional Claim Forms, please call Us at (800) 362 -0700.

Notice of Claim: Written notice of claim must be given within twenty (20) days after a covered loss starts or as soon as reasonably possible. The notice can be given to Us at 3440 Lehigh Street, PO Box 7066, Allentown, PA 18105-7066 or to an authorized agent. Notice should include Your name and Policy number. (This should not be confused with the Policy's Early Notification of Claim provision, which will allow You to access 100% of this Policy's Maximum Daily Benefit for Home/Community-Based Care. Please refer to the Early Notification of Claim provision listed on Page 11.)

Claim Forms: We will furnish forms to prove loss. We will do so upon Our receipt of notice of claim. If the forms are not furnished within ten (10) days, You will be considered to have complied if, within the time for filing proofs, You give Us written proof specifically describing the loss within the time limit stated in the Proof of Loss provision below.

Proof of Loss: The required Claim Forms or other written Proof of Loss must be furnished to Us in case of claim for loss which this Policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which We are liable, and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

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: All benefits payable under the Policy will be payable immediately upon receipt of due written Proof of Loss. Should we fail to pay benefits payable upon receipt of proof, We will have fifteen (15) working days to mail You a reason for failing to make such payment, either in whole or in part. We will also give You a list of anything needed to finish processing the claim. When all needed information is received, We will have an additional fifteen (15) working days to either deny or pay the claim, giving Our reasons for the action taken.

We will pay You interest at the rate of eighteen percent (18%) per annum on the proceeds or benefit due hereunder for Our failure to comply with the foregoing.

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 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 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.

Right of Recovery: If You have a claim for damages or a right to recover damages from a third party or parties for care/assistance for which benefits are payable under this Policy, We may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical covered care/assistance under this Policy. Money received for future care/assistance may not be recovered. Our right of recovery may include compromise settlements. You or Your attorney must inform Us of any legal action or settlement agreement at least ten (10) days prior to settlement or trial. We will then notify You of the amount it seeks to recover from covered benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

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 any information called for by the application is inaccurate or missing, and We offered You coverage We would not have offered had complete and accurate information been listed on the application, We can rescind this coverage or deny any otherwise valid claim for care/assistance that begins within two (2) years from the Policy Effective Date. For any claim for care/assistance that begins after two (2) years from the Policy Effective Date, no misstatements, except fraudulent ones, can be used to void this Policy.

If, subsequent to purchasing this Policy, You elect to increase its coverage and evidence of insurability is required, any such increase will also be subject to this Contestability/Time Limit on Certain Defenses provision. The two (2) year contestable period applicable to this additional coverage shall begin with the Effective Date of said additional coverage.

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.

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 legal action shall be brought after three (3) years from the time written Proof of L oss 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.

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

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

President

Secretary