PENN TREATY NETWORK AMERICA INSURANCE COMPANY
3440 Lehigh Street, P.O. Box 7066
Allentown, PA 18105-7066
(800) 362-0700

TAX-QUALIFIED SECURED RISK[SM] NURSING FACILITY POLICY

This Policy is intended to be a Tax-Qualified Long-Term Care Insurance Policy as defined under section 7702B(b) of the Internal Revenue Code of 1986, as amended. You may be able to deduct the premium You pay for this policy as medical care expenses on Your federal income tax return. The maximum amount of premium You may deduct is limited and based on Your age at the end of the taxable year. Consult your accountant or income tax preparer to determine if you are eligible to take this deduction and the amount of this deduction.

THIS IS A LIMITED BENEFITS POLICY--PLEASE READ IT CAREFULLY

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.

CONSIDERATION

This Policy is issued to the person named in the Policy Schedule as the Insured in consideration of the answers to the questions contained in the application, copy of which is attached to and made a part of this Policy, and the payment of the Initial Term Premium sent in with such application. The person named is the primary insured and Policy owner and will be referred to as "You" or "Your" in this policy.
If You die while insured under the policy, We will refund the part of any premium paid for the period after 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.

EFFECTIVE DATE

This Policy is evidence of an agreement between You and Penn Treaty Network America Insurance Company, hereafter referred to as "We," "Us" or "Our". This agreement is a contract of insurance whereby we agree to pay You the benefits provided by this Policy in accordance with the terms, definitions, provisions, limitations and exclusions contained herein. This Policy takes effect as of 12:01 A.M., standard time, at Your residence on the Effective Date shown on the Policy Schedule.

GUARANTEED RENEWABLE FOR LIFE -- PREMIUMS SUBJECT TO CHANGE

This Policy is guaranteed renewable for Your lifetime. 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. We can change the renewal premium rates. We cannot change your 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. Renewal premiums due after a change is implemented will be based on the new rate. Notice of any change in rates will be sent at least thirty-one (31) days in advance.

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 after You receive it. We will refund all of the premiums paid in full directly to You within thirty (30) days after the policy is returned. The policy will then be considered void from the beginning.

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 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. OUR ADDRESS IS 3440 LEHIGH STREET, P.O. BOX 7066, ALLENTOWN, PA 18105-7066.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Us.

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POLICY SCHEDULE PAGE

POLICY NUMBER	***EFFECTIVE DATE***
INSURED	***FIRST RENEWAL DATE***
AGE	

INITIAL PREMIUM	***POLICY FEE***	***RENEWAL PREMIUM***
$	***$***	***$***

PREMIUM MODES AND AMOUNTS

ANNUAL	***SEMI-ANNUAL***	***QUARTERLY***	***MONTHLY***
$	***$***	***$***	***$***

AUTOMATIC BANK WITHDRAWAL (ACH)
$ ***(MONTHLY)***

BENEFITS

MAXIMUM DAILY BENEFIT	***$***
MAXIMUM BENEFIT PERIOD	
ELIMINATION PERIOD	***120 DAYS***

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

BENEFIT RIDERS ISSUED ON THE SAME DATE AS THIS POLICY

SECTION I: POLICY BENEFIT PROVISIONS

This section provides You with information about the benefits available for **Assisted Living Facilities** and **Nursing Home Facilities** under this policy**.** What follows is an explanation of these benefits, the conditions of eligibility that explain how You qualify to receive these benefits and definitions of important words and terms, which will help You understand the benefits. Throughout the Policy, important words and terms appear in **bold print.** They appear in ***italicized bold print*** where they are defined.

ASSISTED LIVING FACILITY BENEFITS

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

1.) 100% of the **Assisted Living Daily Fee**; or
2.) the **Maximum Daily Benefit** listed in the Policy Schedule Page; or
3.) the reasonable and customary charge for similar services rendered in the same geographic area.

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

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

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

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

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 eligible for benefits.

The ***Assisted Living Facility Daily Fee*** is the daily rate for room and board and assisted living services provided by the **Assisted Living Facility's** staff. Incidental expenses, such as **Physician's** services, medical supplies, medications, pharmaceuticals, toiletries, transportation charges and beautician's services, will not be considered as part of the **Assisted Living Facility Daily Fee.**

NURSING FACILITY BENEFITS

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

1.) 100% of the **Nursing Facility Daily Fee**; or
2.) the **Maximum Daily Benefit** listed in the Policy Schedule Page; or
3.) the reasonable and customary charge for similar services rendered in the same geographic area.

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

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

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

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 eligible for benefits.

The ***Nursing Facility Daily Fee*** is the daily rate for room and board and nursing facility care provided by the **Nursing Facility's** staff. Incidental expenses, such as physician's services, medical supplies, medications and pharmaceuticals, toiletries, transportation charges and beautician's services will not be considered as part of the **Nursing Facility Daily Fee**.

SECTION II: CONDITIONS OF ELIGIBILITY

You will become eligible to receive the benefits available under Section I of this Policy if the care/services are received while this Policy is in force and are provided pursuant to a **Plan of Care** developed by a **Licensed Health Care Practitioner.**

Plan of Care is a written plan of **Qualified Long-Term Care Services** prepared by a **Licensed Health Care Practitioner** which: (a) specifies the type of such services that are necessary; and (b) certifies that You are a **Chronically Ill Individual**. Certification of Your condition may be required periodically, but not more than once every thirty-one (31) days.

Qualified Long-Term Care Services include any necessary diagnostic, preventive, therapeutic, curing, treating, mitigating or rehabilitative services, and maintenance services, which (a) are required by a **Chronically Ill Individual** ; and (b) provided pursuant to a **Plan of Care** prescribed by a **Licensed Health Care Practitioner**.

A ***Chronically Ill Individual*** is an individual who has been certified by a **Licensed Health Care Practitioner**, at any time in the preceding twelve (12) month period, as:

(1) being unable to perform, without **Substantial Assistance**, at least two (2) **Activities of Daily Living** for a period of at least ninety (90) days due to the loss of functional capacity; or, having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services;

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**.

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

1.) Eating means 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 means washing oneself by sponge bath; or in either tub or shower, including getting into or out of the tub or shower.
3.) Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4.) Transferring means moving into or out of a bed, chair or wheelchair.
5.) Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6.) Continence means 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).

OR

(2) requiring Supervision to protect such individual from threats to health and safety due to **Severe Cognitive Impairment**.

Severe Cognitive Impairment is confusion and/or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to, or a result of, mental illness, but which can result from Alzheimer's Disease and other forms of Organic Brain Syndrome. **Severe Cognitive Impairment** must result in Your requiring supervision to maintain Your safety and/or the safety of others. The deterioration or loss of intellectual capacity is established through the use of standardized tests that reliably measure impairment in the following areas:

1.) Short-term or long-term memory;
2.) Orientation as to person, place and time;
3.) Deductive or Abstract Reasoning.

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. A **Licensed Health Care Practitioner** may be any licensed practitioner of the healing arts operating within the scope of his or her license who is other than You or a **Family Member.**

A ***Family Member*** is anyone related to You in any degree by blood, marriage or operation of law. This includes the following relatives of You and Your spouse: parents, grandparents, brothers, sisters, children, grandchildren, aunts, uncles, cousins, nephews, nieces and in-laws.

SECTION III: BENEFIT LIMITATIONS

MAXIMUM DAILY BENEFIT

The ***Maximum Daily Benefit*** is the maximum amount We will pay for any one day of confinement to a **Nursing Facility** and/or **Assisted Living Facility**. The **Maximum Daily Benefit** is listed on the Policy Schedule Page.

MAXIMUM BENEFIT PERIOD

The **Maximum Benefit Period**, shown in the Policy Schedule, is the maximum number of days of benefits are available for a confinement in an **Assisted Living Facility** and/or **Nursing Facility** or any combination of **Assisted Living Facility** and **Nursing Facility** confinements, during Your lifetime. Each day benefits are paid, whether it be for a confinement in an **Assisted Living Facility** or confinement in an **Nursing Facility**, will count as one (1) full day of the **Maximum Benefit Period.**

ELIMINATION PERIOD

The ***Elimination Period*** of one-hundred and twenty (120) days must first be satisfied before benefits will be paid. For a day of confinement to a **Nursing Facility** and/or **Assisted Living Facility** to be applied towards the satisfaction of the **Elimination Period**, the confinement must be covered by the Policy and You must be otherwise eligible to receive 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.

PRE-EXISTING CONDITIONS LIMITATION

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 on the Policy Schedule Page.

Pre-Existing Conditions are not covered until this Policy has been in force six (6) months. Any confinement beginning within six (6) months of the Effective Date and resulting from a **Pre-Existing Condition** will not be covered.

SECTION IV: ADDITIONAL FEATURES

THIRD PARTY NOTICES

You have the right to designate at least one (1) person who is to receive notice of cancellation of Your Policy for the nonpayment of premiums. Designation of this person does not constitute acceptance of any liability by this person for services provided to You. Your written designation shall include the person's full name and home address and shall become 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 elect to designate such a person, Your Policy cannot be canceled for nonpayment of premium unless We have notified the designated person at least ten (10) days in advance of the cancellation date. Notice shall be given by first class United States mail, postage prepaid, and notice may not be given until 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 mailing to a third party.

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.

CONTINUATION FOR ALZHEIMER'S DISEASE AND OTHER FORMS OF COGNITIVE IMPAIRMENT

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

1.) Satisfactory proof that You had **Severe Cognitive Impairment** on the renewal date (including but not limited to Alzheimer's Disease); 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.

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

EXTENSION OF BENEFITS

Termination of Your Policy shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the Policy was in force and continues without interruption after termination. The extension of benefits beyond the period the Policy is in force is limited to the duration of the benefit period.

SECTION V: EXCLUSIONS: WHAT'S NOT COVERED

This section sets forth the conditions under which payment will not be made, even if You otherwise qualify for benefits.

Exclusions: The Policy will not pay benefits for:

1.) Charges for care or services that are provided while this coverage is not in force.

2.) Charges for care or services provided by a **Family Member**, unless pre-approved by Us.

3.) Charges for rest care, hotel or retirement home expense or other expenses which are related to Your residence and not Your health.

4.) Charges for care/services that You would not be legally obligated to pay in the absence of this insurance.

5.) Charges for care or services provided outside of the United States or its possessions.

6.) Charges for care or services that are payable under any Worker's Compensation or Occupational Disease Law.

7.) Charges for care or services for mental, nervous or emotional disorders without demonstrable organic origin. **(NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THE POLICY AS ANY OTHER SICKNESS).**

8.) Charges for care or services that are paid by Medicare. Any portion of such charges not paid by Medicare will be considered, subject to the terms of this Policy.

If you have other policies with Penn Treaty Network America . . . .

Should benefits for care/services covered by this policy on a charge-incurred basis also be payable under any other policy and/or rider issued by Penn Treaty Network America Insurance Company, the benefits to be paid under this policy shall not, when combined with the benefits payable under said other policies/riders, exceed the actual charge incurred or the reasonable and customary fee for similar care/services rendered in the same geographic region, whichever is less. **Benefits will be paid under this policy without regard to any coverage maintained with, or benefits paid by, any private insurer other than Penn Treaty Network America Insurance Company.**

SECTION VI: GENERAL CONTRACT PROVISIONS

This section provides You with information about the General Provisions included in Your Policy.

Entire Contract; Changes*:* This Policy, including any attached papers, constitutes the entire contract. No change is valid until:

1.) approved by one of Our executive officers; and

2.) endorsed hereon or attached hereto.

No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses*:*

1.) No claim for loss incurred starting 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, unless the coverage is voided due to a material misstatement made in the application;

2.) After two (2) years from the Effective Date of coverage, no misstatements, except fraudulent ones, made in the application may be used to void this Policy.

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.

Reinstatement: If the renewal premium is not paid before the Grace Period ends, Your Policy will lapse. Later acceptance of the premium by Us, or by Our agent authorized to accept payment, without requiring an application for reinstatement will reinstate Your Policy. If We require a reinstatement application, You will be issued a conditional receipt for the premium. 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 the conditional receipt. Otherwise Your Policy will be reinstated forty-five (45) days after the date of the conditional receipt. 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.

CLAIMS UNDER THIS POLICY

Notice of Claim: We must receive written notice of claim within thirty (30) days of loss. If not, as soon as reasonably possible. Notice to the Home Office or authorized agent is acceptable. Notice should include Your name and Policy Number.

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 fifteen (15) days, You will be considered to have complied if, within the time for filing proofs, You give Us written proof specifically describing the loss.

Proof of Loss: You must give Us written proof of loss within ninety (90) days from the occurrence of 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.

Time of Payment of Claims: Benefits payable shall be paid within forty-five (45) days after We receive written proof of loss. Valid claims not paid in forty-five (45) days will have interest added at the rate of 1.5% (one and a half percent) per month until finally settled. If not paid when due, You may bring action to recover such benefits and any other damages.

Payment of Claims: All benefits will be payable to You. Any accrued benefits unpaid at Your death will be paid to Your estate.

Physical Examination: At Our expense, We shall have the right and opportunity to have You examined when and as often as We may reasonably require while a claim is pending.

Legal Actions: No legal or equitable action shall be brought to recover on the policy sooner than sixty (60) days after written proof of loss has been furnished. 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, all amounts payable shall be such as the premium paid would have purchased at the correct age.

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

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.

Please keep this Policy in a safe place with Your other important documents.

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

Secretary President