IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Penn Treaty Network America Insurance Company in Rehabilitation	No. 1 PEN 2009
AND	
In Re: American Network Insurance Company in Rehabilitation	No. 1 ANI 2009

BRIEF IN SUPPORT OF APPLICATION FOR RELIEF TO MODIFY THE PLAN TO ELIMINATE THE USE OF ESTATE ASSETS TO PAY "UNCOVERED BENEFITS" CLAIMS MADE UNDER POLICIES TERMINATED PURSUANT TO 40 P.S. §§ 221.20 and 221.21

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INTRODUCTION

Aetna Life Insurance Company, Anthem, Inc., Cigna Corporation, HM Life Insurance Company, QCC Insurance Company, United Concordia Life and Health Insurance Company, United Concordia Insurance Company and UnitedHealthcare Insurance Company (collectively, the "Health Insurers") through their undersigned counsel hereby submit this brief in support of their application for relief in connection with the proposed Second Amended Plan of Rehabilitation (the "Plan") for Penn Treaty Network America Insurance Company ("PTNA") and American Network Insurance Company ("ANIC" and, together with PTNA, the "Companies").

The Plan purports to establish an ongoing company ("Company A") and a company to be liquidated ("Company B"). Company A and Company B are comprised of the best and worst business of the Companies, respectively. Company B will be in formal liquidation proceedings. Plan § I.A. at 1. Claims by the policyholders in Company B will be paid by the Life and Health Guaranty Associations established pursuant to the laws of each state (the "Guaranty Associations") in accordance with their statutes. The Guaranty Associations provide coverage that is subject to coverage restrictions and, in all but one state, a coverage limit – typically $300,000 per insured. Thus, policyholders assigned to

Company B will receive coverage equal to the lower of their full policy benefits or the statutory cap set by the Guaranty Association statutes in their relevant states.

The Plan creates a pool of assets in connection with the liquidation of the Company B policies to provide coverage "where a policyholder's claim is within policy limits but exceeds the applicable Guaranty Association limits (the 'Uncovered Benefits')." Plan § I.B. at 2. The Plan establishes a trust outside of Company B (the "Uncovered Benefits Trust" or "Trust"), which will pay a portion of these "Uncovered Benefits." *Id.* The Trust will be funded with assets of the Companies totaling well in excess of $100 million.

The payment of claims for Uncovered Benefits out of assets of the Companies is directly contrary to established Pennsylvania law and the consistent position of the Pennsylvania Insurance Department in insurance receivership cases. Under Pennsylvania receivership law, policyholders are only entitled to receive assets from the estate if they have a claim. *See* 40 P.S. §§ 221.44 and 221.46 (providing for distribution of assets to holders of claims and the order of distribution to claims in liquidation). Uncovered Benefits are not claims under Pennsylvania law.

Under Article V of the Pennsylvania Insurance Department Act of 1921 (the "Act"), the right of policyholders to make claims for policy benefits against Company B is terminated as of the date that is 30 days after the date of the

liquidation order. 40 P.S. § 221.20(d); 40 P.S. § 221.21. The Pennsylvania Supreme Court has expressly confirmed that Sections 221.20 and 221.21 of the Act preclude any policyholder claim for a benefit that accrues more than 30 days after the date of the liquidation order. *See Warrantech Consumer Products, Inc. v. Reliance Ins. Co. in Liquidation*, 96 A.3d 346 (Pa. 2014) ("*Warrantech*") (holding that 40 P.S. §§ 221.20 and 221.21 preclude claims that accrue after the 30-day cutoff). Thus, Company B policyholders have no right to assets of the Companies for benefits that accrue more than 30 days after the order placing Company B in liquidation. For benefits accruing more than 30 days after the order placing Company B in liquidation, Company B policyholders are entitled to recover only from Guaranty Associations, subject to their statutory coverage restrictions and coverage limits.

As this Court noted in its Memorandum Opinion and Order of May 3, 2012, the only claims that policyholders can assert against Company B are those for loss that occurs prior to the termination of coverage under Sections 221.20 and 221.21. *See* Memorandum Opinion and Order of May 3, 2012, *Consedine v. Penn Treaty Network America Ins. Co.*, 63 A.3d 368 (Pa. Commw. Ct. 2012) (the "May 2012 Order") at 378 n.7 ("Of course, policyholder claims against an insolvent insurer estate may be filed after the insurer is liquidated. However, the claim must be one for a loss that occurred while the policy was in existence, *i.e.*, before the

liquidation."). Thus, Rehabilitator cannot use assets of the Companies to pay barred claims for Uncovered Benefits.

The Plan cannot be approved unless it is modified to eliminate the Uncovered Benefits Trust or any other use of the Companies' assets to provide Uncovered Benefits more than thirty days after the liquidation of Company B.

ARGUMENT

A. The Uncovered Benefits Trust and the Payment of Uncovered Benefits Violate Pennsylvania Law.

The Plan proposes to violate well-established Pennsylvania law by creating a Trust to pay the "Uncovered Benefits" of Company B policyholders. These benefits consist of policyholder claims in a liquidation proceeding that are in excess of the Guaranty Associations' statutory limits, and will necessarily accrue more than 30 days after the liquidation order is issued for Company B. The Plan provides that "a policyholder will have a right to receive Uncovered Benefits (on account of one or more policies originally issued by PTNA or ANIC) if he or she has a contractual right to receive benefits from PTNA that are not fully covered by the applicable Guaranty Association for that policyholder, for example because his or her Maximum Benefit Amount is greater than the applicable Guaranty Association coverage limit." Plan § IV.M. at 58. As a matter of law, the policyholder claims for the Uncovered Benefits are barred because Sections 221.20 and 221.21 eliminate those contractual rights.

1. Under The Plain Language Of Sections 221.20 And 221.21, Company B Policyholders Cannot Recover For Claims That Accrue More Than 30 Days After Entry Of The Liquidation Order.

Section 221.20(d) provides that upon the issuance of a liquidation order for an insurance company, "the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate **shall become fixed** as of the date of filing of the petition for liquidation, except as provided in sections 521 and 539." 40 P.S. § 221.20(d) (emphasis added). Thus, unless an exception to Section 221.20(d) applies, claims arising under a policy after the date of the liquidation petition are barred.

The only potentially applicable exception for policyholders of Company B is found in Section 529 (i.e., 40 P.S. § 221.21), which provides:

> **All insurance in effect at the time of issuance of an order of liquidation shall continue in force only with respect to the risks in effect, at that time** (i) **for a period of thirty days from the date of entry of the liquidation order**; (ii) until the normal expiration of the policy coverage; (iii) until the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or (iv) until the liquidator has effected a transfer of the policy obligations pursuant to section 523(8), **whichever time is less**.

40 P.S. § 221.21 (emphasis added).

Under this section, the insurance policies of Company B policyholders shall remain in force only for those claims that accrue, at the latest, within 30 days after the date the liquidation order for Company B is entered. Claims for benefits that

accrue after that 30-day cutoff date are barred under the statute. After expiration of the 30-day cutoff, Company B policyholders are limited to coverage provided by the Guaranty Associations (subject to the limitations of the Guaranty Association statutes), and cannot make claims against any assets of the Company B estate.

2. The Pennsylvania Supreme Court's Decision In *Warrantech* Confirmed That Policyholders Are Barred From Making Claims That Accrue More Than Thirty Days After The Liquidation Order.

The Pennsylvania Supreme Court confirmed the meaning of Sections 221.20 and 221.21 in *Warrantech*, a controlling decision that is directly on point. In that case, a policyholder (Warrantech) bought insurance from an insurer (Reliance) to cover claims made under Warrantech's warranties and service contracts for vehicles, homes, and consumer products. *Warrantech*, 96 A.3d at 348. Reliance was placed into liquidation by an order dated October 3, 2001. *Id.* at 349. As of that date, Reliance was obligated to provide insurance payments to Warrantech for all consumer claims made against Warrantech arising under service contracts that were in effect in 1999 or 2000, no matter when those future claims might be made. *Id.* The issue in the case was whether Warrantech would be entitled to make insurance claims against Reliance in its liquidation proceeding for service contract claims that were made against Warrantech on dates after November 2, 2001—i.e., after expiration of the 30 day post-liquidation period. *Id.* at 349-50. The Pennsylvania Supreme Court squarely held that such claims were barred by

Section 221.21 of the Act, and hence were properly determined by the liquidator to be valueless. *Id.* at 354-58.

The Court held that "[b]ut for Section 221.21 providing policyholders of insurers entering liquidation a thirty-day window to acquire replacement insurance, Section 221.20(d) would cut off coverage to every policyholder whose insurer enters liquidation as of the date the petition is filed, without notice and an opportunity to seek replacement coverage." *Warrantech*, 96 A.3d at 356. The impact of Section 221.21 is simply to extend this cut-off 30 days after the liquidation order. This cut off of coverage applies to any claim that had not accrued under the terms of the policy prior to the 30th day after the liquidation order. *Id.* at 357. The Court rejected Warrantech's argument that its claims were triggered prior to the cut-off because the "trigger" occurred when Warrantech issued the underlying service contracts. *Id.* at 356-57. The Court held that "the triggering event is a claim made after a product breakdown under one of Warrantech's service contracts." *Id.* at 357.

Claims for benefits that exceed the Guaranty Association limits (generally $300,000 per policyholder) necessarily will accrue long after the date that is 30 days after the liquidation order. Those claims are therefore directly barred by the plain text of Sections 221.20 and 221.21 and the clear holding of the Pennsylvania

Supreme Court's controlling decision in *Warrantech*. Thus, the Plan's proposal for an Uncovered Benefits Trust is improper and contrary to law.

3. Claims For The Uncovered Benefits Under The Plan Cannot Be Paid With Assets Of The Companies Under Pennsylvania Law.

Under the Plan, the Uncovered Benefits are claims that exceed the per-policy coverage limits of the Guaranty Associations' governing statutes. See Plan § IV.M.[1] Since the Guaranty Association coverage caps will certainly be enough to cover any claims that accrue during the first 30 days of the liquidation, and all claims for which payment is due prior to the liquidation date will be paid, the Uncovered Benefits are benefits that will accrue and be claimed only after the date that is 30 days after the liquidation order. As such, the Uncovered Benefits are barred by Sections 221.20 and 221.21 of the Act. As a matter of law, policyholders in Company B do not have allowable claims where such claims accrue by virtue of healthcare services provided after the 30th day following the liquidation order. Therefore, using the Companies' assets to satisfy such claims for Uncovered Benefits violates Sections 221.20 and 221.21 of the Act.

As in *Warrantech*, there is no basis for a determination that the claims for the Uncovered Benefits are "triggered" before the 30-day cut-off date. Under the

[1] Assets allocated to the Uncovered Benefits Trust will be used to purchase coverage from a third party carrier or, more likely, to fund the Trust that will provide the Uncovered Benefits. *Id.* Whether the assets are used to purchase third party coverage or the Trust provides the Uncovered Benefits does not impact the application of Sections 221.20 and 221.21.

Companies' policies, policyholders have a claim for payment of benefits only if they meet the specific conditions for eligibility set forth in their policy. For example, one class of the Companies' policies provides that a policyholder has a claim if (1) the care is received while the policy is in force, and (2) the policyholder meets certain eligibility requirements.[2] *See* policy form LTCTP-6000-N, attached hereto as Exhibit 1 ("You become eligible to receive benefits available under Section I of this policy if the care is received while coverage is in force under this policy, and a Licensed Health Care Practitioner certifies that Qualified Long-Term Care Services are required because you are a Chronically Ill Individual"). Satisfying these two conditions constitutes the "triggering event" for coverage under the Companies' policies. Under the standard set forth by the Pennsylvania Supreme Court in *Warrantech*, unless the triggering event for coverage under a policy has occurred prior to the termination of coverage under Section 221.21 (i.e., the 30th day after the liquidation order), there can be no claim against the Companies' estates under that policy. *See Warrantech*, 96 A.3d at 357.

This Court previously reached the same conclusion in this case, relying on Pennsylvania precedent that preceded *Warrantech*. As this Court noted in the May 2012 Order, two decades before *Warrantech*, in a case arising out of the Colonial

[2] These eligibility requirements vary, but generally a policyholder must be unable to perform certain activities of daily living for a specified period of time or otherwise prove medical necessity.

Assurance Company liquidation, the Commonwealth Court found that because the triggering event under the policy had not occurred before coverage had lapsed as a result of Section 221.21, the liquidator properly valued the policyholder's claim at zero. *See* May 2012 Order at 445-46 (citing *Foster v. Colonial Assurance Co.*, 668 A.2d 174, 184 (Pa. Commw. Ct. 1995), *aff'd sub. nom.*, *Kaiser v. Colonial Assurance Co.*, 673 A.2d 922 (Pa. 1996)); *see also* May 2012 Order at 378 ("In a liquidation, all policyholders will have their policies cancelled in 30 days. At that point the guaranty fund in the state where a particular policyholder resides will offer some kind of replacement coverage.") *see id.* at n.7 ("Of course, policyholder claims against an insolvent insurer estate may be filed after the insurer is liquidated. However, the claim must be one for a loss that occurred while the policy was in existence, *i.e.,* before the liquidation.").

This Court noted that the Insurance Department has continued to take this position in other insurance company estates, including, for example, the Legion Insurance Company liquidation. May 2012 Order at 378, 446 n.51. The Insurance Department again took this position in *Warrantech* and the Supreme Court agreed.

The statute is not discretionary. The Rehabilitator does not have the option to decline to apply Sections 221.20 and 221.21 in a particular liquidation. It applies as a matter of law, as the Insurance Department has argued previously. Contrary to the controlling decision in *Warrantech*, the statements in this Court's

May 2012 Order, and the Insurance Department's prior position in other receivership cases, the Plan allocates assets to the Uncovered Benefits Trust on the basis of claims that will first accrue under policies long after they have terminated by operation of law. This aspect of the proposed Plan fails as a matter of law.

B. The Plan Also Violates The Best Interest Of Creditors Test As A Result Of The Uncovered Benefits Trust And The Payment of Uncovered Benefits.

Section A above establishes that the proposed plan for payment of Uncovered Benefits violates Sections 221.20 and 221.21 of the Act and the Pennsylvania Supreme Court's binding decisions construing those sections. In their Formal Comment on the proposed Plan, the Health Insurers also asserted that the Plan violates the best interest of creditors test, as set forth in *Neblett v. Carpenter*, 305 U.S. 297 (1938), and *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 614 A.2d 1086, 1093 (Pa. 1992), *affirming sub nom., remanding in part, Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 572 A.2d 798 (Pa. Commw. Ct. 1990). *See* Health Insurers' Formal Comment on the Proposed Second Amended Plan of Rehabilitation filed on February 13, 2015 § II.A at 16-22. As argued above, the Health Insurers believe the Uncovered Benefits Trust and the payment of Uncovered Benefits must be eliminated from the Plan because they violate the Act and the holding in *Warrantech*. In addition, even if that were not the case, these features of the Plan also violate the best interest of the creditors test. Thus, if

the proposal for paying the Uncovered Benefits is not eliminated as a matter of law in advance of the confirmation hearing, the Health Insurers reserve their rights to contest these features of the Plan under the best interest of creditors test at trial on confirmation of the Plan.

CONCLUSION

For the reasons set forth above, the Health Insurers respectfully request that the Court enter an order finding that:

(1) The assets of PTNA and ANIC may not be used for the payment of Company B policyholder claims that accrue more than thirty days following the order of liquidation of Company B; and

(2) The proposed Second Amended Plan of Rehabilitation for the Companies cannot be approved unless it is modified to eliminate the "Uncovered Benefits Trust" or any other use of the Companies' assets to provide coverage for "Uncovered Benefits" resulting from claims accruing more than thirty days following the order of liquidation of Company B.

Respectfully submitted,

Dated: April 2, 2015

MORGAN, LEWIS & BOCKIUS LLP

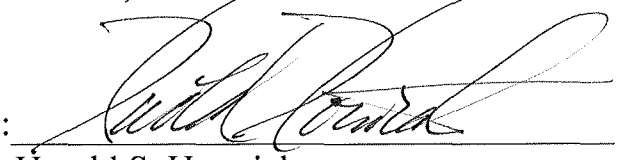
By: 

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EXHIBIT 1

PENN TREATY NETWORK AMERICA INSURANCE COMPANY

3440 Lehigh Street, P.O. Box 7066
Allentown, PA 18105-7066
(800) 362-0700

QUALIFIED LONG TERM CARE INSURANCE POLICY

This Policy Provides Benefits For Long-Term Care Facilities And May Qualify For Income Tax Deductions

This policy is a Qualified Long-Term Care Insurance Policy under Title III, Subtitle C of the Health Care Portability and Accountability Act of 1996, as then constituted and later amended.

PREMIUMS MAY BE TAX DEDUCTIBLE

All or part of the premium which You pay for this Policy during a taxable year may be deducted 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 any given taxable year. (Consult Your accountant or income tax preparer to determine if You are eligible to take this tax deduction and the amount of this deduction.)

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

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 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

Evidence of insurability is required before the coverage is provided. Upon approval of Your application, coverage will begin at twelve o'clock noon (12:00 p.m.), standard time, at Your residence on the Effective Date shown in the Policy Schedule. It ends at twelve o'clock noon (12:00 p.m.), standard time, on the first renewal date.

RENEWABILITY

GUARANTEED RENEWABLE - 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 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 LONG-TERM CARE 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.

THIS IS A NON-PARTICIPATING POLICY

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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)
$

MAXIMUM DAILY BENEFIT AMOUNT	$ _____	
MAXIMUM BENEFIT PERIOD	_____	DAYS
ADULT DAY CARE DAILY BENEFIT AMOUNT (Fifty percent (50%) of the Maximum Daily Benefit Amount)	$ _____	
HOSPICE CARE DAILY BENEFIT AMOUNT (Fifty percent (50%) of the Maximum Daily Benefit Amount	$ _____	
ADULT DAY CARE/HOSPICE CARE MAXIMUM BENEFIT PERIOD (Fifty percent (50%) of the Maximum Benefit Period)	_____	DAYS
RESPITE CARE DAILY BENEFIT AMOUNT	$ _____	
RESPITE CARE BENEFIT PERIOD (Per Calendar Year)	15	DAYS
ELIMINATION PERIOD	_____	DAYS
ALTERNATIVE PLAN OF CARE	INCLUDED	
BED RESERVATION	30	DAYS
RESTORATION OF BENEFITS	INCLUDED	
WAIVER OF PREMIUM	INCLUDED	

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 long-term care services covered by this Policy. Benefits are available for **Assisted Living Facilities, Nursing Facilities, Adult Day Care, Hospice Care** and **Respite Care.** What follows is an explanation of each of these benefits, an explanation of how You qualify to receive benefits and definitions of important words and terms which will help You understand these benefits. Throughout this Policy, important words and terms appear in **bold print.** 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.

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 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.

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

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

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

An **Assisted Living Facility** may sometimes be called a Residential Care Facility, Sheltered Living 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.

Assisted Living Facility Daily Fee is the facility's 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 **Maximum Daily Benefit** shown in the Policy Schedule.

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

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

ADULT DAY CARE BENEFITS

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

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

Adult Day Care is a program for two (2) or more individuals of social and health-related services provided during the day in an Adult Day Care Center for the purpose of supporting frail, impaired elderly or other adults with a disability who can benefit from care in a group setting outside of the home.

Adult Day Care Center is a facility that:

1.) is established and operated in accordance with any applicable state or local laws that are required in order to provide **Adult Day Care**;
2.) operates at least five (5) days per week for a minimum of five (5) hours per day, but is not an overnight facility;
3.) maintains a written record of medical services given to each client; and
4.) has established procedures for obtaining appropriate aid in the event of a medical emergency.

HOSPICE CARE BENEFITS

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

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

Hospice Care means outpatient services that are 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 to provide supportive care to the primary care-giver and the family.

RESPITE CARE BENEFITS

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

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

Respite Care may consist of **Home Health Care, Hospice Care,** or care provided in a **Nursing Facility,** an **Assisted Living Facility** or an **Adult Day Care Center,** to temporarily relieve a **Family Member** providing care.

Home Health Care is skilled nursing services or other medical services performed in Your home by a home health aide, certified nurse assistant, medical social worker, occupational therapist, speech therapist, physical therapist, total parental nutrition specialist, enterostomal specialist, chemotherapy specialist, licensed visiting nurse, licensed vocational nurse (LVN), licensed practical nurse (LPN), or a licensed graduate nurse (RN).

SECTION II: CONDITIONS OF ELIGIBILITY

You become eligible to receive the benefits available under Section I of this policy if the care is received while coverage is in force under this policy, and a **Licensed Health Care Practitioner** certifies that **Qualified Long-Term Care Services** are required because you are a **Chronically Ill Individual.**

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/her license who is other than You or a **Family Member**.

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

Qualified Long-Term Care Services means any necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and 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**.

Plan of Care means a written individualized 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 need substantial human assistance due to Your being a **Chronically Ill Individual**. Certification of Your condition may be required periodically, but not more than once every thirty-one (31) days.

Chronically Ill Individual means an individual who has been certified by a **Licensed Health Care Practitioner** at any time within the preceding 12-month period as: (a) being unable to perform (without substantial assistance from another individual) at least two (2) **Activities of Daily Living** for a period of at least ninety (90) days due to a loss of functional capacity; or, having a level of disability similar to the level of disability described in (a); or, (b) requiring substantial supervision to protect such individual from threats to health and safety due to severe **Cognitive Impairment**.

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

1.) **Eating** is Your ability to get food from Your plate into Your mouth.
2.) **Bathing** is Your ability to get into or out of a tub or shower, and/or wash parts of Your body with a sponge or washcloth.
3.) **Dressing** is Your ability to dress appropriately for personal health and safety.
4.) **Transferring** is Your ability to get into and out of bed or chair.
5.) **Toileting** is Your ability to transfer to toilet and complete hygienic measures such that Your health is not compromised.
6.) **Continence** is Your ability to control urination and defecation or, if not able to control urination or defecation, Your ability to complete hygienic measures such that Your health is not compromised.

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. **Cognitive Impairment** must result in Your requiring substantial 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.

SECTION III: BENEFIT LIMITATIONS

MAXIMUM DAILY BENEFIT

The ***Maximum Daily Benefit*** is the maximum amount We will pay under any one benefit, or combination of benefits, during any one calendar day. The **Maximum Daily Benefit** is listed in the Policy Schedule.

MAXIMUM BENEFIT PERIOD

The **Maximum Benefit Period**, shown in the Policy Schedule, is the maximum number of days of benefits available for a confinement in a Nursing Facility and/or Assisted Living Facility or any combination of Nursing Facility and Assisted Living confinements, during Your lifetime, unless benefits are restored in accordance with the **Restoration of Benefits** provision (described on page 7). Each day benefits are paid, whether it be for a confinement in a **Nursing Facility** or confinement in an **Assisted Living Facility**, will count as one (1) full day of the **Maximum Benefit Period.**

ADULT DAY CARE / HOSPICE CARE MAXIMUM BENEFIT PERIOD

The **Adult Day Care / Hospice Care Maximum Benefit Period**, shown in the Policy Schedule, is the maximum number of days in benefits available for **Adult Day Care** and/or **Hospice Care**, during Your lifetime, unless benefits are restored in accordance with the **Restoration of Benefits** provision. Each day benefits are paid, whether it be for **Adult Day Care** or **Hospice Care**, will count as one (1) full day of the **Adult Day Care / Hospice Care Maximum Benefit Period.**

ELIMINATION PERIOD

The ***Elimination Period*** listed in the Policy Schedule is the number of days at the beginning of **Nursing Facility** or **Assisted Living Facility** confinement for which no benefits will be paid. For each day of confinement to be applied towards the satisfaction of the **Elimination Period**, the day of confinement 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.

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 and/or services begin six (6) months or more after the Effective Date shown in the Policy Schedule.

SECTION IV: ADDITIONAL BENEFITS AND DEFINITIONS

ALTERNATIVE PLAN OF CARE BENEFIT

If You would otherwise qualify for benefits for a confinement in a **Nursing Facility** or **Assisted Living Facility**, We may pay for services provided under a written **Alternative Plan of Care**, if such plan is a medically acceptable option. This **Alternative Plan of Care** must be agreed on in advance by You, Your Physician and Us. The **Alternative Plan of Care** can be at Your suggestion, but must be developed and approved by health professionals. Benefits extended under the **Alternative Plan of Care** will be deducted from the **Maximum Benefit Period** and thus, reduce the benefits available for a confinement to a **Nursing Facility** and/or **Assisted Living Facility**.

RESTORATION OF BENEFITS

We will restore the **Maximum Benefit Period** and **Adult Day Care/Hospice Care Maximum Benefit Period** of this Policy to the full original amounts listed in the Policy Schedule when:

1.) You have not been confined in a **Nursing Facility** or **Assisted Living Facility** and have not received **Adult Day Care**, **Respite Care**, **Hospice Care**, **Home Health Care** or **Homemaker/Companion Care** for one hundred and eighty (180) consecutive days; and
2.) Your **Physician** certifies that You did not require and have not been advised to be confined to a **Nursing Facility** or **Assisted Living Facility** or receive **Adult Day Care**, **Respite Care, Hospice Care, Home Health Care** or **Homemaker/Companion Care** during the one hundred eighty (180) day period.

There is no limit to the number of times the **Maximum Benefit Period** and **Adult Day Care/ Hospice Care Maximum Benefit Period** will restore as long as You meet the above requirements.

Homemaker/Companion Care is assistance with the basic functional activities required to remain in your home. This assistance may be with meal preparation, shopping/travel, light housekeeping, laundry, telephoning, handling money/bill paying .

WAIVER OF PREMIUM BENEFIT

Once You have received benefits for ninety (90) consecutive days for confinement to an **Assisted Living Facility** or **Nursing Facility,** We will waive the payment of premiums coming due for this Policy and any riders attached to this Policy while You continue to be eligible for these benefits. We will apply any premium paid beyond the date You become eligible for these benefits to the next premium payment coming due and reduce it accordingly. Should you die while eligible for the **Waiver of Premium Benefit**, the premium paid beyond the date you became eligible for this benefit will be refunded and paid to Your estate.

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** for an **Assisted Living Facility** confinement shall be equal to the **Assisted Living Facility Benefit** payable for the day immediately prior to the hospitalization date, and for a **Nursing Facility** confinement shall be equal to the **Maximum Daily Benefit** listed in the Policy Schedule. 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.

SECTION V: 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 **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 VI: 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 a confinement, use of a facility, services, supplies and care 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 that are required as a result of war, or an act of war, whether declared or not.
8.) 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).**
9.) Charges for care or services that are required as a result of attempted suicide or intentionally self-inflicted injuries.
10.) Charges for care or services that are required as a result of Your being intoxicated or under the influence of a non-**Physician** prescribed narcotic.
11.) Charges for care or services that are required as a result of Your commission of a felony or Your being engaged in an illegal occupation.
12.) 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.

SECTION VII: 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.

GENERAL CONTRACT PROVISIONS CONTINUED

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.

Notice of Claim: We must receive written notice of claim within twenty (20) 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 under the policy for any loss incurred will be paid within thirty (30) days after receipt of written proof of loss. Any balance remaining unpaid at the end of Our liability will be paid immediately upon receipt of written proof.

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.

Sandra A. Kotsch
Secretary

David Levin
President

CERTIFICATE OF SERVICE

I certify that on April 2, 2015, I caused a true and correct copy of the foregoing document to be served on the following persons by email at the email addresses indicated below:

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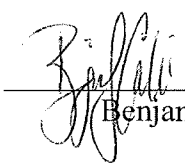

Benjamin J. Cordiano