

# PENN TREATY NETWORK AMERICA INSURANCE COMPANY

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



## POST-ACUTE RECOVERY<sup>SM</sup> POLICY

**THIS POLICY PROVIDES BENEFITS FOR RECUPERATIVE STAYS  
IN NURSING FACILITIES & ASSISTED LIVING FACILITIES.**

### **GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is guaranteed renewable for the rest of Your life and may be kept in force by the timely payment of premiums. We cannot refuse to renew this Policy as long as You pay the premiums when due. We cannot change the premiums of this Policy due to a change in Your age or health. We can change the premiums only 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 change in premiums will be sent at least thirty-one (31) days in advance.

(Payment of the renewal premium will not restore or replenish the benefits available under this Policy. Please refer to the Policy's **Restoration of Benefits** provision on Page 10 to learn how benefits may be restored.)

### **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, if You purchased this from an 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. 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 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 3440 LEHIGH STREET, PO BOX 7066, ALLENTOWN, PA 18105-7066.**

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# POLICY SCHEDULE

POLICY NUMBER

EFFECTIVE DATE

INSURED

FIRST RENEWAL DATE

AGE

INITIAL PREMIUM  
\$

POLICY FEE  
\$

RENEWAL PREMIUM  
\$

## PREMIUMS

ANNUAL \$	SEMI-ANNUAL \$	QUARTERLY \$	MONTHLY \$	AUTOMATIC BANK WITHDRAWAL (MONTHLY) \$
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## BENEFITS

MAXIMUM DAILY BENEFIT	\$ _____
MAXIMUM LIFETIME BENEFIT	_____ DAYS
ADULT DAY CARE DAILY BENEFIT Fifty percent (50%) of the Maximum Daily Benefit	\$ _____
ELIMINATION PERIOD	_____ DAYS
BED RESERVATION BENEFIT	<u>10</u> DAYS
RESTORATION OF BENEFITS	<u>INCLUDED</u>

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

**RIDERS ISSUED ON THE SAME DATE AS THIS POLICY**

**SPECIMEN**

# SECTION I: POLICY BENEFIT PROVISIONS

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

Benefits are available for **Assisted Living Facilities, Nursing Facilities** and **Adult Day Care Facilities**. What follows is an explanation of each of these benefits, including definitions of important words and terms, which will help You understand these benefits. Throughout the 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 **Assisted Living Facility Conditions of Eligibility**, We will pay the lesser of:

- 1) the **Assisted Living Facility Daily Fee**; or
- 2) the **Maximum Daily Benefit** listed in the Policy Schedule; or
- 3) the reasonable and customary charge for similar services rendered in a similar facility in the same geographic area.

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

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

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

(Please refer to the definitions of **Activities of Daily Living** and **Cognitive Impairment** on page 5.)

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

An **Assisted Living Facility** may sometimes be called a Residential Care Facility, Adult Congregate Living Facility, Personal Care Facility or Sheltered Living Facility. Any facility, or section thereof, known by one (1) of these names, or any other name, will be considered eligible if it meets this Policy definition of an **Assisted Living Facility**.

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

## **ASSISTED LIVING FACILITY BENEFITS CONDITIONS OF ELIGIBILITY**

You become eligible to receive the **Assisted Living Facility Benefits** when:

- 1) You are unable to perform two (2) or more of the **Activities of Daily Living** without human assistance or continual supervision. Human assistance includes hands-on physical aid or support, as well as stand-by assistance, reminders and verbal cueing.

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

- 1) Eating is reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.
- 2) Bathing is cleaning the body using a tub, shower, or sponge bath, including getting a basin of water; managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.
- 3) Dressing is putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.
- 4) Ambulating is walking or moving around inside or outside of Your home, whether or not the use of a cane, crutches, braces, walker or wheelchair is required.
- 5) Transferring is moving from one sitting or lying position to another sitting or lying position; for example, from bed to a wheelchair or sofa; coming to a standing position; or repositioning to promote circulation and prevent skin breakdown.
- 6) Toileting is getting on and off a toilet or commode and emptying a commode; managing clothing and wiping and cleaning the body after toileting; and using and emptying a bedpan and urinal.
- 7) Continence is the ability to control bowel and bladder, as well as use ostomy or catheter receptacles, and apply diapers and/or disposable barrier pads.

**OR**

2) You are afflicted with **Cognitive Impairment**.

**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 supervision to maintain Your safety and/or the safety of others.

The 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.

OR

3) Your confinement is certified by Your **Physician** as essential to Your health, safety and welfare and this certification is in accordance with the usual standards of medical practice for your injury or sickness. (This is sometimes referred to as the confinement being "Medically Necessary".)

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

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

# NURSING FACILITY BENEFITS

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

- 1) the **Nursing Facility Daily Fee**; or
- 2) the **Maximum Daily Benefit** listed in the Policy Schedule; or
- 3) the reasonable and customary charge for similar services rendered in a similar facility 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, 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.

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

A **Nursing Facility** may sometimes be called a Skilled Nursing Facility, Intermediate Care Facility or Custodial Care Facility. Any facility, or section thereof, known by one (1) of these names, or any other name, will be considered eligible if it meets this Policy definition of a **Nursing Facility**.

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

## NURSING FACILITY BENEFITS CONDITIONS OF ELIGIBILITY

The **Nursing Facility Conditions of Eligibility** are identical to the **Assisted Living Facility Conditions of Eligibility**. (Please refer to Page 5 for the **Assisted Living Facility Conditions of Eligibility**.)

## ADULT DAY CARE BENEFITS

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

- 1) the actual charge incurred; or
- 2) the **Adult Day Care Daily Benefit** listed in the Policy Schedule; or
- 3) the reasonable and customary charge for similar services provided in the same geographic area.

**Adult Day Care** is medical or non-medical care provided on a less than twenty-four (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.

### ADULT DAY CARE BENEFITS CONDITIONS OF ELIGIBILITY

The **Adult Day Care Conditions of Eligibility** are identical to the **Assisted Living Facility Conditions of Eligibility**. (Please refer to Page 5 for the **Assisted Living Facility Conditions of Eligibility**.)

# HOSPICE CARE BENEFITS

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

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

**Hospice Care** means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement to: (a) individuals who have no reasonable prospect of cure as estimated by a physician; and (b) the immediate families or family caregivers of those individuals described in section (a).

**Terminally Ill** means a medical prognosis given by a physician that your life expectancy is six (6) months or less.

This policy will pay **Hospice Care Benefits** for:

- a.) A maximum lifetime benefit of 30 days of inpatient hospice care;
- b.) Part-time nursing care by or supervised by a registered graduate nurse;
- c.) Counseling, including dietary counseling, for the terminally ill insured;
- d.) Family counseling for the immediate family and the family caregiver before the death of the terminally ill insured;
- e.) Bereavement counseling for the immediate family and the family caregiver of the insured for at least the six (6) month period following the insured's death or fifteen (15) visits, whichever comes first.
- f.) Respite care annual benefit for 14 days (with any one inpatient stay for respite care limited to five (5) consecutive days);
- g.) Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill insured.

**Family caregiver** means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill insured.

**Family counseling** means counseling given to the immediate family or family caregiver of the terminally ill insured for the purpose of learning to care for the insured and to adjust to the death of the insured.

**Respite Care** means temporary care provided to the terminally ill insured to relieve the family caregiver from the daily care of the insured.

## **HOSPICE CARE BENEFITS CONDITIONS OF ELIGIBILITY**

The **Hospice Care Conditions of Eligibility** are identical to the **Assisted Living Facility Conditions of Eligibility**. (Please refer to Page 5 for the **Assisted Living Facility Conditions of Eligibility**.)

**SPECIMEN**

## SECTION II: BENEFIT LIMITATIONS

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

### MAXIMUM DAILY BENEFIT

The **Maximum Daily Benefit** is the maximum amount in benefits We will pay under any one (1) benefit, or combination of benefits, for care/services received during the same calendar day. The **Maximum Daily Benefit** is listed in the Policy Schedule.

### MAXIMUM LIFETIME BENEFIT

The **Maximum Lifetime Benefit** is the maximum number of days in benefits We will pay during Your lifetime under this Policy, unless benefits are restored as described in the **Restoration of Benefits** provision on Page 10. Each day You are eligible for and receive the **Assisted Living Facility Benefits, Nursing Facility Benefits or Hospice Care Benefits** will count as one (1) full day of the **Maximum Lifetime Benefit**. Each day You are eligible for and receive the **Adult Day Care Benefits** will count as one-half (1/2) day of the **Maximum Lifetime Benefit**. Your Policy's **Maximum Lifetime Benefit** is listed in the Policy Schedule.

### ELIMINATION PERIOD

The **Elimination Period** serves as a deductible that must be satisfied before benefits will be available. Specifically, it is the number of days You must receive care/services before You will be eligible for benefits. For each day of care/services to be applied towards the satisfaction of the **Elimination Period**, the care/services 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**.

Each day of confinement to an **Assisted Living Facility** and/or **Nursing Facility** shall count as one (1) full day toward the satisfaction of the **Elimination Period**. Each day of **Hospice Care** will count as one (1) full day toward the satisfaction of the **Elimination Period**. Each day of **Adult Day Care** shall count as one-half (1/2) day toward the satisfaction of the **Elimination Period**.)

The **Elimination Period** must be satisfied only once, unless benefits are restored in accordance with the **Restoration of Benefits** provision on Page 10, and applies to all of the benefits available under this Policy on a combined basis. (e.g., If You satisfy the **Elimination Period** for confinement to an **Assisted Living Facility** and then would need to enter a **Nursing Facility**, it will not be necessary for You to satisfy the **Elimination Period** again.) The **Elimination Period** is listed in the Policy Schedule.

### PRE-EXISTING CONDITIONS LIMITATION

**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 Effective Date as shown in the Policy Schedule.

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

## SECTION III: ADDITIONAL BENEFITS

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

### RESTORATION OF BENEFITS

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

- 1) You have not been confined to an **Assisted Living Facility** or **Nursing Facility** and You have not received **Adult Day Care** or **Home Health Care** for a period of one hundred and eighty (180) consecutive days; and
- 2) Your **Physician** certifies that You recovered sufficiently to not require, and You were not advised, to be confined to an **Assisted Living Facility** or **Nursing Facility** or to receive **Adult Day Care** or **Home Health Care** during the same one hundred eighty (180) day period.

**Home Health Care** is skilled nursing services and/or assistance with the **Activities of Daily Living** provided by a nurse, certified nurse's aide, home health aide or any other caregiver, whether skilled or unskilled.

There is no limit to the number of times the **Maximum Lifetime Benefit** will restore as long as You meet the above requirements. The **Elimination Period** of the Policy must be satisfied each time benefits are restored. (Please refer to Page 9 for the Policy's **Elimination Period**.)

### BED RESERVATION BENEFITS

We will pay a **Bed Reservation Benefit** when You are charged to hold Your room in an **Assisted Living Facility** or **Nursing Facility** when hospitalized during the course of an **Assisted Living Facility** or **Nursing Facility** confinement. The amount payable per day under the **Bed Reservation Benefit** shall be equal to the **Assisted Living Facility Benefit** and/or **Nursing Facility Benefit** payable on the day prior to the hospitalization. This benefit will be limited to ten (10) days per Calendar Year on a combined basis. Any days not used in a Calendar Year cannot be carried over to any subsequent year.

## **PROHIBITED PRACTITIONER REFERRAL**

We will exclude payment for any claim, bill or demand for payment when a health care practitioner refers You for health care services determined to be furnished as a result of a referral prohibited by Section 1-302 of Maryland's Health Occupation Article.

**SPECIMEN**

## SECTION IV: EXCLUSIONS

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

Exclusions: The Policy will not pay benefits for:

- 1) Care/services that are provided while this Policy is not in force.
- 2) Care/services provided by a **Family Member**, or in a facility owned or operated by You or a **Family Member**.
- 3) Care/services that You would not be legally obligated to pay for in the absence of this insurance.
- 4) Care/services provided outside of the United States or its possessions.
- 5) Care/services that are payable under any Worker's Compensation or Occupational Disease Law.
- 6) Care/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).**
- 7) Care/services that are required as a result of war, or an act of war, whether declared or not.
- 8) Care/services that are required as a result of attempted suicide or intentionally self-inflicted injuries.
- 9) Care/services that are required as a result of Your being intoxicated or under the influence of a non-**Physician** prescribed narcotic.
- 10) Care/services that are required as a result of Your commission of a felony or Your being engaged in an illegal occupation.
- 11) Care/services paid for by Medicare. If any portion of the charges for such care/services are not paid by Medicare, they will be covered, subject to the terms of this Policy.

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

## SECTION V: GENERAL CONTRACT PROVISIONS

Your Post-Acute Recovery 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 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.

**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 issuance of Your policy, 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, at Your residence, 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 (1) 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.

**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. Pre-existing conditions which manifested prior to the reinstatement will be covered if the pre-existing limitation was previously satisfied prior to the lapse in coverage. Pre-existing conditions will be covered after the six month pre-existing limitation. If the pre-existing limitation was not satisfied prior to the lapse in coverage, the time you were an active insured member will be credited to the reinstated policy.

**Conformity with State Statutes:** Any provision of the Policy, which, on its Effective Date, conflicts with the statutes of Your state on such date, is amended to conform to its minimum requirements.

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## CLAIMS UNDER THIS POLICY:

### **WHAT YOU SHOULD DO WHEN YOU HAVE A CLAIM:**

Included with Your Policy are the claim forms that need to be completed so We can consider Your claim. Please follow the instructions on these forms as they will tell You precisely what You have to do. Following these instructions and submitting the information required will help us expedite the processing of Your claim. If You have any questions, or if You need claim forms, Please call Us at (800) 362-0700.

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

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

**Time of Payment of Claims:** Benefits payable under the Policy for any loss incurred will be paid within thirty (30) days after receipt of written proof of loss. Any balance remaining unpaid at the end of Our liability will be paid immediately upon receipt of written proof.

**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 that 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.

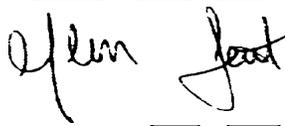
**Time Limit on Certain Defenses:** No claim for care/assistance which begins after six (6) months from the Effective Date of coverage will be reduced or denied because a physical condition had existed before the Effective Date of coverage, (please refer to the Pre-Existing Conditions Limitation on Page 11), unless this Policy is voided due to a material misstatement made in the application. If Your Policy has been in force for more than six (6) months but less than two (2) years, we may rescind your policy or deny an otherwise valid claim upon a showing of a misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought. 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. No claim for care/assistance commencing after six (6) months from the Effective Date of coverage will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of this Policy.

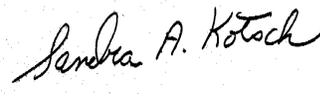
**Legal Actions:** No legal or equitable action shall be brought to recover on the policy sooner than sixty (60) days after written proof of loss has been furnished. No action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**Misstatement of Age:** If Your age has been misstated at the time You applied for this Policy, all amounts payable shall be such as the premium paid would have purchased given the correct age.

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

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

  
President

  
Secretary