SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Filing at a Glance

Company: Penn Treaty Network America Insurance Company

Product Name: 2600/6500 Amendatory Rider	SERFF Tr Num: PNTX-126417565	State: Arkansas
TOI: LTC05I Individual Long Term Care - Nursing Home & Home Health Care	SERFF Status: Closed-Approved	State Tr Num: 44337
Sub-TOI: LTC05I.003 Other	Co Tr Num: LTCAR0018310F01	State Status: Closed
Filing Type: Form		Reviewer(s): Marie Bennett
	Author: SPI PennTreatyNetwork	Disposition Date: 04/05/2010
	Date Submitted: 12/11/2009	Disposition Status: Approved
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: 2600/6500 Amendatory Rider	Status of Filing in Domicile:
Project Number: LTCAR0018310F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/05/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/05/2010
Deemer Date:	Created By: SPI PennTreatyNetwork
Submitted By: SPI PennTreatyNetwork	Corresponding Filing Tracking Number:

Filing Description:

RE: NAIC Number: 63282 / Penn Treaty Network America Insurance Company
Submission
Amendatory Rider, Form Number 2600-AMEND(Rev)
Amendatory Rider, Form Number 6500-AMEND(Rev)

Attached please find the above-captioned Amendatory Riders for the Department's review and approval. Also attached are the required filing forms and fees.

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Amendatory Rider, forms 2600-AMEND(Rev) and 6500-AMEND(Rev), will amend the following Comprehensive Long-Term Care Policies:

PF2600(AR)-N approved on May 15, 1997
FPF2600(AR)-N approved on May 15, 1997
LTCTP-6500-N approved on July 22, 1997
FLTCTP-6500-N approved on July 22, 1997

For your convenience, a copy of each approved policy and relevant, prior amendatory riders are provided with changed language highlighted by underlining. (We did not, however, provide copies of the franchise policy forms as the language we are seeking to amend within the franchise forms is identical to the forms attached.) We marketed these policy forms from 1997 to 2001; thus, it is a closed block of business.

These riders update the definitions found in each policy by revising the definition of Home and Care Management as well as adding definitions for Care Coordinator and, for product form series 2600, Plan of Care. In addition, the rider revises the policy provisions for Waiver of Premium and Proof of Loss and adds the Right of Subrogation provision. Upon approval, this rider will be mailed to all in-force policyholders, which number 79 and 58 to-date, respectively.

Our Company appreciates the Department's time and consideration. Should you have any questions or concerns, please do not hesitate to contact me directly.

Company and Contact

Filing Contact Information

Anita Small, Analyst	asmall@penntreaty.com	
3440 Lehigh St	610-965-2222 [Phone] 6645 [Ext]	
Allentown, PA 18103	484-232-6638 [FAX]	

Filing Company Information

Penn Treaty Network America Insurance Company	CoCode: 63282	State of Domicile: Pennsylvania
3440 Lehigh St	Group Code: 810	Company Type:
Allentown, PA 18103	Group Name: Penn Treaty	State ID Number:
(610) 965-2222 ext. [Phone]	FEIN Number: 23-2603386	

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Penn Treaty Network America Insurance Company	$40.00	12/11/2009	32729006

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	04/05/2010	04/05/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Marie Bennett	04/01/2010	04/01/2010	SPI PennTreatyNetwork	04/05/2010	04/05/2010
Pending Industry Response	Marie Bennett	03/03/2010	03/03/2010	SPI PennTreatyNetwork	03/09/2010	03/09/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Amendatory Rider	SPI PennTreatyNetwork	01/28/2010	01/28/2010
Form	Amendatory Rider	SPI PennTreatyNetwork	01/28/2010	01/28/2010
Form	Amendatory Rider	SPI PennTreatyNetwork	12/15/2009	12/15/2009

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Status of Review	Note To Reviewer	SPI PennTreatyNetwork	02/12/2010	02/12/2010

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Disposition

Disposition Date: 04/05/2010
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Flesch Certification		Yes
Supporting Document	Approved Policy Forms 2600 and 6500 - highlighted	Accepted for Informational Purposes	Yes
Form *(revised)*	Amendatory Rider	Approved	Yes
Form	Amendatory Rider	Replaced	Yes
Form	Amendatory Rider	Replaced	Yes
Form *(revised)*	Amendatory Rider	Approved	Yes
Form	Amendatory Rider	Replaced	Yes
Form	Amendatory Rider	Replaced	Yes
Form	Amendatory Rider	Replaced	Yes

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	04/01/2010
Submitted Date	04/01/2010
Respond By Date	05/01/2010

Dear Anita Small,

This will acknowledge receipt of the captioned filing.

Objection 1

- Amendatory Rider, 2600-AMEND(Rev) (Form)
- Amendatory Rider, 6500-AMEND(Rev) (Form)

Comment:
Anita:

The Department will not approve the referenced riders to be attached to and made part of an existing policy with the Subrogation language. We will approve, if you wish, for use with new issue only policy forms.

Riders without a Subrogation clause would be approved for use with existing policyholders.

Please feel free to contact me if you have questions.
Sincerely,
Marie Bennett

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	04/05/2010
Submitted Date	04/05/2010

Dear Marie Bennett,

Comments:
This responds to the Objection Letter of April 1, 2010.

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Response 1

Comments: In light of the Department's view that the Right of Subrogation provision must be removed from the riders, attached please find revised riders with this change.

Related Objection 1

Applies To:

- Amendatory Rider, 2600-AMEND(Rev) (Form)
- Amendatory Rider, 6500-AMEND(Rev) (Form)

Comment:

Anita:

The Department will not approve the referenced riders to be attached to and made part of an existing policy with the Subrogation language. We will approve, if you wish, for use with new issue only policy forms.

Riders without a Subrogation clause would be approved for use with existing policyholders.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Amendatory Rider	2600-AMEND(Rev)(AR)		Other	Revised		42.500	2600-AMEND(Rev)(AR).PDF
Previous Version							
Amendatory Rider	*2600-AMEND(Rev)*		*Other*	*Initial*		*42.500*	2600-AMEND(Rev).PDF
Amendatory Rider	*2600-*		*Other*	*Initial*		*42.500*	2600-

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*		
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*		
Company Tracking Number:	*LTCAR0018310F01*				
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*		
Product Name:	*2600/6500 Amendatory Rider*				
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*				

	AMEND(Rev)				AMEND(Rev).PDF
Amendatory Rider	6500-AMEND(Rev)(AR)	Other	Revised	42.500	6500-AMEND(Rev)(AR).PDF

Previous Version

Amendatory Rider	*6500-AMEND(Rev)*	*Other*	*Initial*	*42.500*	6500-AMEND(Rev).PDF
Amendatory Rider	*6500-AMEND(Rev)*	*Other*	*Initial*	*42.500*	6500-AMEND(Rev).PDF
Amendatory Rider	*6500-AMEND(Rev)*	*Other*	*Initial*	*42.500*	6500-AMEND(Rev).PDF

No Rate/Rule Schedule items changed.

Our Company appreciates your time and consideration in this matter and looks foward to your approval of the forms shortly.

Sincerely,
SPI PennTreatyNetwork

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/03/2010
Submitted Date	03/03/2010
Respond By Date	04/05/2010

Dear Anita Small,

This will acknowledge receipt of the captioned filing.

Objection 1

- Amendatory Rider, 2600-AMEND(Rev) (Form)
- Amendatory Rider, 6500-AMEND(Rev) (Form)

Comment: The Department objects to adding a "Right of Subrogation" provision to an issued policy. Do you want to refile the Rider without the provision?

Please feel free to contact me if you have questions.
Sincerely,
Marie Bennett

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/09/2010
Submitted Date	03/09/2010

Dear Marie Bennett,

Comments:
This letter is filed in response to the Objection Letter of March 3, 2010.

Response 1

Comments: Our Company is not aware of any Arkansas law or regulation that would prohibit or restrict inclusion of a Right to Subrogation clause in the policies. This common legal provision for contracts will not alter or reduce policy benefits, services, or rates to the insured. As such, we believe it is not precluded by the guaranteed renewable nature of the policies. We respectfully ask the Department to reconsider its position and approve the riders.

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Related Objection 1

Applies To:

- Amendatory Rider, 2600-AMEND(Rev) (Form)
- Amendatory Rider, 6500-AMEND(Rev) (Form)

Comment:

The Department objects to adding a "Right of Subrogation" provision to an issued policy. Do you want to refile the Rider without the provision?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We appreciate the Department's time and consideration in this matter.

Sincerely,
SPI PennTreatyNetwork

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Note To Reviewer

Created By:
SPI PennTreatyNetwork on 02/12/2010 03:27 PM
Last Edited By:
Marie Bennett
Submitted On:
04/05/2010 12:30 PM
Subject:
Status of Review
Comments:
Dear Mr. Shearer,

Please let me know the status of this filing. May we expect your approval soon?

Thank you.
Anita Small
800-222-3469 ext 6645

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Amendment Letter

Submitted Date: 01/28/2010

Comments:

This Filing Amendment is being made to update the Amendatory Riders that are pending your approval.

We found it necessary to remove the revised definition of "Home" from each of the riders as this language is more restrictive than intended. Please substitute these updated Amendatory Riders for the forms submitted previously.

Our Company appreciates the Department's time and consideration. Should you have any questions or concerns, please do not hesitate to contact me directly.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
2600-AMEND(Rev)	Other	Amendatory Rider	Initial				42.500	2600-AMEND(Rev).PDF
6500-AMEND(Rev)	Other	Amendatory Rider	Initial				42.500	6500-AMEND(Rev).PDF

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Amendment Letter

Submitted Date: 12/15/2009

Comments:

This Filing Amendment is being made to correct Amendatory Rider form 6500-AMEND(Rev). In the definition of "Home" on page 1 of the form, the internal page reference should be made to page 7 instead of pages 8 and 9. This is the only change being made to this rider.

Please substitute this corrected Amendatory Rider for the form submitted initially. Please let me know if you have any questions. Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
6500-AMEND(Rev)	Other	Amendatory Rider	Initial				42.500	6500-AMEND(Rev).PDF

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Form Schedule

Lead Form Number: 2600-AMEND(Rev)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 04/05/2010	2600-AMEND(Rev)(AR)	Other	Amendatory Rider	Revised	Replaced Form #: Previous Filing #:	42.500	2600-AMEND(Rev)(AR).PDF
Approved 04/05/2010	6500-AMEND(Rev)(AR)	Other	Amendatory Rider	Revised	Replaced Form #: Previous Filing #:	42.500	6500-AMEND(Rev)(AR).PDF

PENN TREATY℠

tel 800.362.0700
www.penntreaty.com

AMENDATORY RIDER

This Amendatory Rider shall amend Policy Form Series PF2600 as follows:

1) The definition of **Care Management** is revised as follows:

   Care Management is provided through a **Care Coordinator** qualified to perform a comprehensive, individualized, assessment of your needs. The **Care Coordinator** will develop a written **Plan of Care** designed to meet your individual needs.

2) The definition of **Care Coordinator** is added as follows:

   Care Coordinator is a health care professional, usually a Registered Nurse, we employ or contract with to provide our Policyholders the **Care Management** described above.

3) The definition of **Plan of Care** is added as follows:

   Plan of Care is an outline of services identifying the type of care/assistance, number of days per week, and the number of hours per day you require. The **Plan of Care** is developed and modified periodically based on your care needs.

4) The "**Waiver of Premium**" provision of your Policy is revised as follows:

   Once you have received benefits for ninety (90) consecutive days under the **Assisted Living Facility Benefit** or **Nursing Facility Benefit,** or have received benefits for ninety (90) continuous days or more on a regular basis for **Homemaker/Companion Care** or **Home Health Care**, (a regular basis is five (5) days or more per week), we will waive the payment of premiums coming due for this Policy and any riders attached to this Policy. To continue to qualify for the **Waiver of Premium Benefit**, you must continue to be eligible for benefits and continue to receive benefits. For **Homemaker/Companion Care** or **Home Health Care**, you must continuously receive benefits on a regular basis (a regular basis is five (5) days or more per week) to maintain waiver of premium. We will refund any premium paid beyond the date you become eligible for the benefit. Premiums will become payable immediately when you are no longer eligible for the **Waiver of Premium Benefit**.

(If you accepted amendatory rider form number WOP-AMEND, the "**Waiver of Premium**" revision does not apply to your Policy.)

5) The "**Proof of Loss**" provision is revised as follows:

You must give us written proof of loss, including all required claim forms, within ninety (90) days from the date you start receiving services. Written proof of loss may include copies of paid invoices for covered services, copies of internet banking transactions showing payment to an eligible provider(s) for covered services, or cancelled checks made payable to eligible provider(s) for covered services. If you have good reason for not doing so, we will not contest your right to file a claim. However, you must give us proof of loss no later than one (1) year from the time normally required unless legally incapable.

Signed for Us at Allentown, Pennsylvania.

Secretary

PENN TREATY℠

tel 800.362.0700
www.penntreaty.com

AMENDATORY RIDER

This Amendatory Rider shall amend Policy Form Series LTCTP-6500 as follows:

1) The definition of **Care Management** is revised as follows:

   Care Management is provided through a **Care Coordinator** qualified to perform a comprehensive, individualized, assessment of your needs. The **Care Coordinator** will develop a written **Plan of Care** designed to meet your individual needs.

2) The definition of **Care Coordinator** is added as follows:

   Care Coordinator is a health care professional, usually a Registered Nurse, we employ or contract with to provide our Policyholders the **Care Management** described above.

3) The "Waiver of Premium" provision of your Policy is revised as follows:

   Once you have received benefits for ninety (90) consecutive days under the **Assisted Living Facility Benefit** or **Nursing Facility Benefit,** or have received benefits for ninety (90) continuous days or more on a regular basis for **Homemaker Care** or **Home Health Care**, (a regular basis is five (5) days or more per week), we will waive the payment of premiums coming due for this Policy and any riders attached to this Policy. To continue to qualify for the **Waiver of Premium Benefit**, you must continue to be eligible for benefits and continue to receive benefits. For **Homemaker Care** or **Home Health Care**, you must continuously receive benefits on a regular basis (a regular basis is five (5) days or more per week) to maintain waiver of premium. Premiums that have been paid for coverage after the date you become eligible for the **Waiver of Premium Benefit** will be held by Penn Treaty Network America Insurance Company and applied to any premiums due once you are no longer eligible for the **Waiver of Premium Benefit.** If you die while eligible for this benefit the waived premiums will be refunded to your estate.

(If you accepted amendatory rider form number WOP-AMEND, the "**Waiver of Premium**" revision does not apply to your Policy.)

4) The "**Proof of Loss**" provision is revised as follows:

You must give us written proof of loss, including all required claim forms, within ninety (90) days from the date you start receiving services. Written proof of loss may include copies of paid invoices for covered services, copies of internet banking transactions showing payment to an eligible provider(s) for covered services, or cancelled checks made payable to eligible provider(s) for covered services. If you have good reason for not doing so, we will not contest your right to file a claim. However, you must give us proof of loss no later than one (1) year from the time normally required unless legally incapable.

Signed for Us at Allentown, Pennsylvania.

Secretary

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A
Comments:

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: N/A
Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage
Bypass Reason: N/A
Comments:

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Readability Certification.PDF

Item Status:	**Status Date:**
Accepted for Informational Purposes	04/05/2010

Satisfied - Item: Approved Policy Forms 2600 and 6500 - highlighted
Comments:

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Attachments:

Approved Policy 2600 - highlighted.PDF

Approved Policy Form 6500 - highlighted.PDF

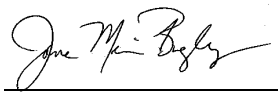
STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Penn Treaty Network America Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
2600-AMEND(Rev)	42.5
6500-AMEND(Rev)	42.5

Signed: 

Name: Jane Bagley

Title: Senior Vice President and Corporate Counsel

Date: 12/11/09

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

PERSONAL FREEDOM[SM] POLICY

THIS POLICY PROVIDES BENEFITS FOR LONG-TERM CARE AND HOME HEALTH CARE

This Long Term Care Policy is not intended to be a Tax-Qualified Long Term Care Policy, as defined by the Health Insurance Portability and Accountability Act of 1996. This policy is not a Tax-Qualified policy specifically because it includes benefit triggers that are more comprehensive than those permitted in a Tax-Qualified policy. Consequently, it may be easier to qualify for benefits under this policy than under a Tax-Qualified policy.

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

TABLE OF CONTENTS

POLICY SCHEDULE PAGE

AGENT:
ADDRESS:
TELEPHONE NUMBER:

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	***$_____***	
MAXIMUM LIFETIME BENEFIT	***$_____***	
ADULT DAY CARE DAILY BENEFIT ***Fifty percent (50%) of the Maximum Daily Benefit***	***$_____***	
HOSPICE CARE DAILY BENEFIT ***Fifty percent (50%) of the Maximum Daily Benefit***	***$_____***	
RESPITE CARE DAILY BENEFIT ***Fifty percent (50%) of the Maximum Daily Benefit***	***$_____***	
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 **Homemaker/Companion Care, Home Health Care, Assisted Living Facilities, Nursing Home Facilities, Adult Day Care, Hospice Care** and **Respite Care.** What follows is an explanation of each of these benefits, the conditions of eligibility that explain how You qualify to receive each of the 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.
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.

HOMEMAKER/COMPANION CARE BENEFITS

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

1.) 80% of the actual charge incurred; or
2.) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3.) 80% of the reasonable and customary charge for similar services rendered in the same geographic area.

Please refer to the **100% Care Management Benefit** on Page 7 to learn how You can qualify to receive up to 100% of the **Maximum Daily Benefit** for **Homemaker/Companion Care**.

Homemaker/Companion Care is assistance with the **Instrumental Activities of Daily Living. Homemaker/Companion Care** may be provided by anyone reasonably qualified, whether skilled or unskilled, and capable of helping You perform these activities and/or actually performing these activities for You.

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

1.) Meal Preparation is Your ability to prepare meals, including cooking.
2.) Shopping/Travel is Your ability to utilize public or private transportation to get to a store and shop for groceries, to pick up prescriptions and to get to medical appointments.
3.) Light Housekeeping is Your ability to maintain a safe and clean home living environment. Light Housekeeping does not include any type of home construction or maintenance, lawn care, snow removal, maintenance of a vehicle, or any other service provided outside the home.
4.) Laundry is Your ability to wash and dry Your clothes, bed linens, etc.
5.) Telephoning is Your ability to make telephone calls.
6.) Handling Money/Bill Paying is Your ability to deposit and/or withdraw funds at a financial institution, write a check to pay bills, etc.

Home is Your personal residence, whether it be in a private dwelling, a home for the retired or aged or an **Assisted Living Facility.** It does not include a hospital, sanatorium or **Nursing Facility.** (Please refer to Page 8 for the definition of **Assisted Living Facility** and Page 9 for the definition of **Nursing Facility**.)

HOMEMAKER/COMPANION CARE CONDITIONS OF ELIGIBILITY

You become eligible to receive the **Homemaker/Companion Benefits** if:

1.) Your **Physician** certifies that the care/services are **Medically Necessary**.

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

Medically Necessary means recommended by Your **Physician** as necessary and in accordance with the usual standards of medical practice for Your injury or sickness.

OR

2.) You are unable to perform one (1) 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 reminders and verbal cueing.

The ***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.) Ambulating is Your ability to move from place to place.
5.) Transferring is Your ability to get into and out of bed or chair.
6.) Toileting is Your ability to transfer to toilet and complete hygienic measures such that Your health is not compromised.
7.) 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.

OR

3.) You are unable to perform two (2) or more of the **Instrumental Activities of Daily Living.** (Please refer to Page 4 for the definition of **Instrumental Activities of Daily Living**).

OR

4.) 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 twenty-four (24) hour a day 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.

HOME HEALTH CARE BENEFITS

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

1.) 80% of the actual charge incurred; or
2.) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3.) 80% of the reasonable and customary charge for similar services rendered in the same geographic area.

Please refer to the **100% Care Management Benefit** on Page 7 to learn how You can qualify to receive up to 100% of the **Maximum Daily Benefit** for **Home Health Care**.

Home Health Care is skilled nursing services or other medical services performed in Your **Home** by a licensed registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), chemotherapy specialist, enterostomal specialist, total parental nutrition specialist, physical therapist, speech therapist or occupational therapist.

Home Health Care also includes assistance with the **Activities of Daily Living** and may be provided by a home health aide or certified nurse's assistant. A **Home Health Care** provider not named here may also be used as long as they are qualified through education, training or experience, and are pre-approved by Us.

HOME HEALTH CARE CONDITIONS OF ELIGIBILITY

You become eligible to receive the **Home Health Care Benefits** if:

1.) Your **Physician** certifies that the care/services are **Medically Necessary** (Please refer to Page 5 for the definitions of **Physician** and **Medically Necessary**);

OR

2.) You are unable to perform one 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 reminders and verbal cueing. (Please refer to Page 5 for the definition of **Activities of Daily Living**.)

OR

3.) You are afflicted with **Cognitive Impairment.** (Please refer to Page 5 for the definition of **Cognitive Impairment**.)

100% CARE MANAGEMENT BENEFIT

If You otherwise qualify for the **Homemaker/Companion Benefits** and/or **Home Health Care Benefits**, and utilize Our **Care Management** service, We will pay the lesser of:

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

To utilize Our **Care Management** service, You simply have to call Us at (800) 865-8722 within 15 calendar days of the care/services beginning and notify Us You are receiving, or will be receiving, care/services covered by this Policy.

Care Management is provided through an independent agency or entity designated by Us and qualified to perform a comprehensive, individualized, face-to-face assessment of Your needs. The **Care Management** service will develop a written plan of care designed to meet Your individual needs and, if You so desire, will also arrange for the actual delivery of the **Homemaker/Companion Care** and/or **Home Health Care**.

FAMILY MEMBER BENEFITS

FAMILY MEMBER AS CAREGIVER

Neither **Homemaker/Companion Care** nor **Home Health Care** services may be provided by a **Family Member** or someone already living at Your address prior to the inception of, or need for, the care/services. A **Family Member** can, however, provide care/services covered by this Policy if pre-approved by Us. To request that a **Family Member,** other than a spouse or someone living with You prior to the inception of, or need for, care/services, provide care and be eligible for benefits, You simply have to call Us at (800) 865-8722 or write to Us at Our Home Office within fifteen (15) calendar days of the care/services beginning.

FAMILY MEMBER TRAINING BENEFIT

If the **Family Member** requires training to provide the care/services You need at Home, We will provide a **Family Member Training Benefit** for reimbursement of this training. The training must be for the purpose of preparing the **Family Member** to provide for Your care and be pre-approved by Us.

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

MEALS ON WHEELS BENEFIT

When this service is included as part of the plan of care developed by Our **Care Management** service, We will pay the charge incurred, subject to a maximum of $25.00 per day, for **Meals on Wheels** to be delivered to Your **Home**.

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

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.) 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*** means 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:

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.

Assisted Living Facility Daily Fee means 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.**

ASSISTED LIVING FACILITY CONDITIONS OF ELIGIBILITY

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

1.) Your **Physician** certifies Your confinement to be **Medically Necessary**. (Please refer to Page 5 for definitions of **Physician** and **Medically Necessary**.)

OR

2.) 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 reminders and verbal cueing. (Please refer to Page 5 for definition of **Activities of Daily Living.**)

OR

3.) You are afflicted with **Cognitive Impairment**. (Please refer to Page 5 for definition of **Cognitive Impairment**.)

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 **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:

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.

NURSING FACILITY CONDITIONS OF ELIGIBILITY

The **Nursing Facility Conditions of Eligibility** are identical to the **Assisted Living Facility Conditions of Eligibility.** (Please refer to Page 9 for the **Assisted Living Facility Conditions of Eligibility**.)

ADULT DAY CARE BENEFITS

For each day You receive **Adult Day Care** in an **Adult Day Care Center** and meet the **Adult Day Care 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 a community group setting 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.

ADULT DAY CARE CONDITIONS OF ELIGIBILITY

The **Conditions of Eligibility for Adult Day Care** are identical to the **Assisted Living Facility Conditions of Eligibility.** (Please refer to Page 9 for **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 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.

HOSPICE CARE CONDITIONS OF ELIGIBILITY

The **Conditions of Eligibility for Hospice Care** are identical to the **Conditions of Eligibility for Assisted Living Facility** benefits. (Please refer to Page 9 for the **Assisted Facility Living Conditions of Eligibility**.)

RESPITE CARE BENEFITS

For each day You receive **Respite Care** and meet the **Respite Care 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 means **Home Health Care, Homemaker/Companion 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.

RESPITE CARE CONDITIONS OF ELIGIBILITY

The **Conditions of Eligibility for Respite Care** are identical to the **Assisted Living Facility Conditions of Eligibility.** (Please refer to Page 9 for the **Assisted Living Facility Conditions of Eligibility**.)

This benefit is payable for a maximum of fifteen (15) days per Calendar Year and is not subject to the **Elimination Period**. Any days not used in a Calendar Year cannot be carried over to any subsequent years. (Please refer to Page 13 for the definition of **Elimination Period**.)

SECTION II: ADDITIONAL BENEFITS AND DEFINITIONS

ALTERNATIVE PLAN OF CARE BENEFIT

If You would otherwise qualify for benefits for a confinement in an **Assisted Living Facility** or **Nursing 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 Lifetime Benefit** listed in the Policy Schedule and will, correspondingly, reduce the benefits available for the other forms of care/services covered by this Policy. (Please refer to Page 13 for the definition of **Maximum Lifetime Benefit**.)

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 received care/services for a period of 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 to receive **Home Health Care, Homemaker/Companion Care, Adult Day Care** or **Hospice Care**, during the one hundred eighty (180) day period.

There is no limit to the number of times the **Maximum Lifetime Benefit** will restore as long as You meet the above requirements.

WAIVER OF PREMIUM BENEFIT

Once You have received benefits for ninety (90) consecutive days under the **Assisted Living Facility Benefit** or **Nursing Facility Benefit,** or have received benefits for ninety (90) continuous days or more on a regular basis for **Homemaker/Companion Care** or **Home Health Care**, (a regular basis is five (5) days or more per week), 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 the benefits. We will refund any premium paid beyond the date You become eligible for the benefit. Premiums will become payable immediately when You are no longer eligible for the **Waiver of Premium Benefit**.

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**, 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 III: 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 cancelled 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 IV: 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 LIFETIME BENEFIT

The ***Maximum Lifetime Benefit*** is the maximum aggregate amount We will pay during Your lifetime under this Policy, unless benefits are restored as described in the **Restoration of Benefits** provision. The **Maximum Lifetime Benefit** applies to all of the benefits available under this Policy on a combined basis. This means each dollar in benefits paid under this Policy will reduce the remaining amount available for all benefits by an equal amount. The **Maximum Lifetime Benefit** is listed in the Policy Schedule.

ELIMINATION PERIOD

The ***Elimination Period*** listed in the Policy Schedule is the number of days when care/services first begin, but for which no benefits will be paid. 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**. The **Elimination Period** must be satisfied only once during the lifetime of this Policy and, with the exception of **Respite Care**, applies to all of the benefits available under this Policy on a combined basis. (e.g., If You satisfy the **Elimination Period** for **Nursing Facility** care and would require the services of a **Homemaker/Companion**, it will not be necessary for You to satisfy the **Elimination Period** again.)

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 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 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 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 V: 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.

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: Indemnities payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due 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.

Appealing a Denial of Benefits: You, or someone acting on Your behalf, will have the right to appeal any denial of benefits. Your appeal should be in writing and explain Your reasons why You disagree with Our decision. You may include any documentation, or request that We contact Your Physician or other provider of services, which supports Your appeal of the denial. Upon receipt of Your appeal, We will review Our decision and advise You in writing within thirty (30) days of Our receipt of Your appeal of Our decision, along with a full explanation.

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.

Should You have any questions pertaining to this policy, You may contact Our Policyholder Service Department at:

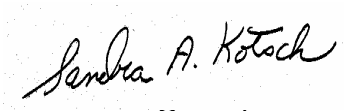
Penn Treaty Network America Insurance Company
3440 Lehigh Street
P. O. Box 7066
Allentown, PA 18103
(800) 628-3417

In the event that You would need to contact the Arkansas Insurance Department for any reason, they may be reached at:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2600 or
(800) 282-9134

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

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

AMENDATORY RIDER

This Amendatory Rider is part of the Policy Form PF2600(AR)-N and FPF2600(AR)-N, and shall amend the Policy as follows:

- The Family Member As Caregiver benefit, located under the Family Member Benefits section of your Policy, located on page 7, is replaced in its entirety with the following:

FAMILY MEMBER AS CAREGIVER
Homemaker/Companion Care and/or **Home Health Care** provided by anyone already living at Your address prior to the inception of, or need for, the care/assistance, or by a **Family Member** is not covered by this Policy.

A **Family Member** can provide care/services that will be covered by this Policy and be eligible for benefits only if You obtain pre-approval from Us. To request pre-approval, call Our Claims Department at (800) 362-0700 to inform Us that You need care/services covered by this Policy and that You would like a **Family Member** to provide a portion or all of the care/services. We will then ask for information pertaining to Your needs, the **Family Member** and the schedule of the care/services to be provided by the **Family Member**. (Spouses and individuals, whether **Family Members** or not, living with You prior to the inception of, or need for, care/services are not covered and will not be considered under any circumstances.)

We will then conduct an assessment, which is usually performed by a Registered Nurse over the telephone or through a face-to-face visit. This assessment will help us determine whether You meet the Policy's **Conditions of Eligibility** and what type of care/services You need.

We will also send You a form that the proposed **Family Member** will need to complete in order to be considered for pre-approval. If the proposed **Family Member** is approved, We will notify You in writing. If pre-approval of a **Family Member** is not obtained, no benefits will be payable for the care/assistance provided by that caregiver.

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

President

Secretary

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

TAX QUALIFIED COMPREHENSIVE LONG-TERM CARE INSURANCE POLICY

This Policy Provides Benefits For Long-Term Care Facilities and Home Health Care.

This Policy is a Qualified Long-Term Care Insurance Policy as defined 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 deductible 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 carefully review 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, standard time, at Your residence on the Effective Date shown in the Policy Schedule. It ends at twelve o'clock noon, standard time, on the first renewal date.

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 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 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

TABLE OF CONTENTS

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	***$*** _____	
MAXIMUM LIFETIME BENEFIT	***$*** _____	
ADULT DAY CARE DAILY BENEFIT ***Fifty percent (50%) of the Maximum Daily Benefit***	***$*** _____	
HOSPICE CARE DAILY BENEFIT ***Fifty percent (50%) of the Maximum Daily Benefit***	***$*** _____	
RESPITE CARE DAILY BENEFIT ***Fifty percent (50%) of the Maximum Daily Benefit***	***$*** _____	
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 **Homemaker Care, Home Health Care, Assisted Living Facilities, Nursing Home Facilities, Adult Day Care, Hospice Care** and **Respite Care.** What follows is an explanation of each of these benefits, the conditions of eligibility that explain how You qualify to receive each of these benefits, and 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.

HOMEMAKER CARE BENEFITS

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

1.) 80% of the actual charge incurred; or
2.) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3.) 80% of the reasonable and customary charge for similar services rendered in the same geographic area.

Please refer to the **100% Care Management Benefit** on Page 5 to learn how You can qualify to receive up to 100% of the **Maximum Daily Benefit** for **Homemaker Care**.

Homemaker Care is assistance with the **Instrumental Activities of Daily Living. Homemaker Care** may be provided by anyone reasonably qualified, whether skilled or unskilled, and capable of helping You perform these activities and/or actually performing these activities for You.

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

1.) Meal Preparation is Your ability to prepare meals, including cooking.
2.) Shopping/Travel is Your ability to utilize public or private transportation to get to a store and shop for groceries, to pick up prescriptions and to get to medical appointments.
3.) Light Housekeeping is Your ability to maintain a safe and clean home living environment. Light Housekeeping does not include any type of home construction or maintenance, lawn care, snow removal, maintenance of a vehicle, or any other service provided outside the home.
4.) Laundry is Your ability to wash and dry Your clothes, bed linens, etc.
5.) Telephoning is Your ability to make telephone calls.
6.) Handling Money/Bill Paying is Your ability to deposit and/or withdraw funds at a financial institution, write a check to pay bills, etc.
7.) Medication Management is Your ability to safely control, dispense and/or administer a controlled substance prescribed by a Physician.

Home is Your personal residence, whether it be in a private dwelling, a home for the retired or aged or an **Assisted Living Facility.** It does not include a hospital, sanitarium or **Nursing Facility.** (Please refer to Page 7 for the definitions of **Assisted Living Facility** and **Nursing Facility**.)

HOME HEALTH CARE BENEFITS

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

1.) 80% of the actual charge incurred; or
2.) 80% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3.) 80% of the reasonable and customary charge for similar services rendered in the same geographic area.

Please refer to the **100% Care Management Benefit** on Page 5 to learn how You can qualify to receive up to 100% of the **Maximum Daily Benefit** for **Home Health Care**.

Home Health Care is skilled nursing services or other medical services performed in Your **Home** by a licensed registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), chemotherapy specialist, enterostomal specialist, total parental nutrition specialist, physical therapist, speech therapist or occupational therapist.

Home Health Care also includes assistance with the **Activities of Daily Living** and may be provided by a home health aide or certified nurse's assistant. A **Home Health Care** provider not named here may also be used as long as they are qualified through education, training or experience, and are pre-approved by Us.

100% CARE MANAGEMENT BENEFIT

If You otherwise qualify for the **Homemaker Care Benefits** and/or **Home Health Care Benefits**, and utilize Our **Care Management** service, We will pay the lesser of:

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

To utilize Our **Care Management** service, You simply have to call Us at (800) 865-8722 within fifteen (15) calendar days of the care/services beginning and notify Us You are receiving, or will be receiving, care/services covered by this Policy.

Care Management is provided through an independent agency or entity designated by Us and qualified to perform a comprehensive face-to-face assessment of Your needs. The **Care Management** service will develop a written Plan of Care designed to meet Your individual needs and, if You so desire, will also arrange for the actual delivery of the **Homemaker Care** and/or **Home Health Care**.

Use of our **Care Management** Service is not mandatory in order to access benefits for **Homemaker Care** or **Home Health Care** under this Policy. This service is provided, free of charge, to assist You in obtaining the care and services You require.

FAMILY MEMBER BENEFIT

FAMILY MEMBER AS CAREGIVER

Neither **Homemaker Care** nor **Home Health Care** services may be provided by a **Family Member** or someone already living at Your address prior to the inception of, or need for, the care/services. A **Family Member** can, however, provide care/services covered by this Policy if pre-approved by Us.

To request that a **Family Member,** other than a spouse or someone living with You prior to the inception of, or need for, care/services, provide care and be eligible for benefits, You simply have to call Us at (800) 865-8722 or write to Us at Our Home Office within fifteen (15) calendar days of the care/services beginning. (Care provided by Your spouse or someone living at Your residence prior to the need for, or inception of, care/services shall not be eligible for reimbursement under the Family Member Benefit of this Policy.)

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.

FAMILY MEMBER TRAINING BENEFIT

If the **Family Member** requires training to provide the care/services You need at Your **Home**, We will provide a **Family Member Training Benefit** for reimbursement of this training. The training must be for the purpose of preparing the **Family Member** to provide for Your care and be pre-approved by Us.

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

MEALS ON WHEELS BENEFIT

When this service is included as part of the Plan of Care developed by Our **Care Management** service, We will pay the charge incurred, subject to a maximum of $25.00 per day, for **Meals on Wheels** to be delivered to Your **Home**.

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

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 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 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 means 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:

1.) 100% of the **Nursing Facility Daily Fee**; or
2.) the **Maximum Daily Benefit** listed in the Policy Schedule Page.
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, 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.

Nursing Facility Daily Fee means 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**.

ADULT DAY CARE BENEFITS

For each day You receive **Adult Day Care** in an **Adult Day Care Center** 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 means **Home Health Care, Homemaker 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.

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 means 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**.

Chronically Ill Individual means 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 means hands-on physical aid or support from an individual, as well as supervision, reminders and verbal cueing.

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 Your bowel or bladder or, if not able to control Your bowel or bladder, Your ability to complete hygienic measures such that Your health is not compromised

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**. (Please refer to page 6 for the definition of **Family Member**)

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 LIFETIME BENEFIT

The ***Maximum Lifetime Benefit*** is the maximum aggregate amount We will pay during Your lifetime under this Policy, unless benefits are restored as described in the **Restoration of Benefits** provision. The **Maximum Lifetime Benefit** applies to all of the benefits available under this Policy on a combined basis. This means each dollar in benefits paid under this Policy will reduce the remaining amount available for all benefits by an equal amount. The **Maximum Lifetime Benefit** is listed in the Policy Schedule.

ELIMINATION PERIOD

The ***Elimination Period*** listed in the Policy Schedule is the number of days when care/services first begin, but for which no benefits will be paid. 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**. The **Elimination Period** must be satisfied only once during the lifetime of this Policy and, with the exception of **Respite Care**, applies to all of the benefits available under this Policy on a combined basis. (e.g., If You satisfy the **Elimination Period** for **Nursing Facility** care and would require the services of a **Homemaker**, it will not be necessary for You to satisfy the **Elimination Period** again.)

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 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

If You would otherwise qualify for benefits for a confinement in an **Assisted Living Facility** or **Nursing Facility**, We may pay for services provided under a written **Alternative Plan of Care**, if such plan is a medically acceptable option. A written description of the proposed **Alternative Plan of Care** must be submitted in advance and must be agreed upon by all parties before benefits will be payable. Benefits extended under the **Alternative Plan of Care** will be deducted from the **Maximum Lifetime Benefit** listed in the Policy Schedule and will, correspondingly, reduce the benefits available for the other forms of care/services covered by this Policy. (Please refer to Page 10 for the definition of **Maximum Lifetime Benefit**.)

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 a **Nursing Facility** or **Assisted Living Facility** or received **Home Health Care, Homemaker Care, Adult Day Care** or **Hospice Care**, during the past one hundred eighty (180) day period; 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 to receive **Home Health Care, Homemaker Care, Adult Day Care** or **Hospice Care**, during the one hundred eighty (180) day period.

There is no limit to the number of times the **Maximum Lifetime Benefit** will restore as long as You meet the above requirements.

WAIVER OF PREMIUM BENEFIT

Once You have received benefits for ninety (90) consecutive days under the **Assisted Living Facility Benefit** or **Nursing Facility Benefit,** or have received benefits for ninety (90) continuous days or more on a regular basis for **Homemaker Care** or **Home Health Care**, (a regular basis is five (5) days or more per week), 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 the benefits. Premiums that have been paid for coverage after the date You become eligible for the **Waiver of Premium Benefit** will be held by Penn Treaty Network America Insurance Company and applied to any premiums due once you are no longer eligible for the **Waiver of Premium Benefit.** If You die while eligible for this benefit the waived premiums will be refunded 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 Daily Fee**, and for a **Nursing Facility** confinement, shall be equal to the **Nursing Facility Daily Fee** payable for the calendar day immediately preceding the date of hospitalization. This benefit will be limited to thirty (30) days per Calendar Year on a combined basis. Any days not used in a Calendar Year cannot be carried over to any subsequent year.

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.

REINSTATEMENT 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

Upon termination of Your Policy benefits will continue to be payable for a claim if such claim began while the Policy was in force and continues without interruption after termination. This extension of benefits beyond the period the Policy is in force is limited to the benefits remaining in the **Maximum Lifetime Benefit**..

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.

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 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.

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: Indemnities payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due 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.

Should You have any questions pertaining to this policy, You may contact Our Policyholder Service Department at:

Penn Treaty Network America Insurance Company
3440 Lehigh Street
P. O. Box 7066
Allentown, PA 18103
(800) 362-0700

In the event that You would need to contact the Arkansas Insurance Department for any reason, they may be reached at:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2600 or (800) 282-9134

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

PENN TREATY℠

tel 800.362.0700
www.penntreaty.com

AMENDATORY RIDER

This Amendatory Rider shall amend the **EXCLUSIONS** section of your Tax Qualified Policy by replacing the exclusion regarding Medicare with the following:

Charges for care or services that are reimbursable by Medicare, including amounts that would otherwise be reimbursable by Medicare but for the application of a deductible, co-payment or coinsurance amount. This exclusion will not apply to expenses that are reimbursable by Medicare where Medicare is the secondary payor.

Signed for Us at Allentown, Pennsylvania.

Secretary

SERFF Tracking Number:	*PNTX-126417565*	*State:*	*Arkansas*
Filing Company:	*Penn Treaty Network America Insurance Company*	*State Tracking Number:*	*44337*
Company Tracking Number:	*LTCAR0018310F01*		
TOI:	*LTC05I Individual Long Term Care - Nursing Home & Home Health Care*	*Sub-TOI:*	*LTC05I.003 Other*
Product Name:	*2600/6500 Amendatory Rider*		
Project Name/Number:	*2600/6500 Amendatory Rider/LTCAR0018310F01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/28/2010	Form	Amendatory Rider	04/05/2010	2600-AMEND(Rev).PDF (Superceded)
12/11/2009	Form	Amendatory Rider	01/28/2010	2600-AMEND(Rev).PDF (Superceded)
01/28/2010	Form	Amendatory Rider	04/05/2010	6500-AMEND(Rev).PDF (Superceded)
12/15/2009	Form	Amendatory Rider	01/28/2010	6500-AMEND(Rev).PDF (Superceded)
12/11/2009	Form	Amendatory Rider	12/15/2009	6500-AMEND(Rev).PDF (Superceded)

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AMENDATORY RIDER

This Amendatory Rider shall amend Policy Form Series PF2600 as follows:

1) The definition of **Care Management** is revised as follows:

   Care Management is provided through a **Care Coordinator** qualified to perform a comprehensive, individualized, assessment of your needs. The **Care Coordinator** will develop a written **Plan of Care** designed to meet your individual needs.

2) The definition of **Care Coordinator** is added as follows:

   Care Coordinator is a health care professional, usually a Registered Nurse, we employ or contract with to provide our Policyholders the **Care Management** described above.

3) The definition of **Plan of Care** is added as follows:

   Plan of Care is an outline of services identifying the type of care/assistance, number of days per week, and the number of hours per day you require. The **Plan of Care** is developed and modified periodically based on your care needs.

4) The "**Waiver of Premium**" provision of your Policy is revised as follows:

   Once you have received benefits for ninety (90) consecutive days under the **Assisted Living Facility Benefit** or **Nursing Facility Benefit,** or have received benefits for ninety (90) continuous days or more on a regular basis for **Homemaker/Companion Care** or **Home Health Care**, (a regular basis is five (5) days or more per week), we will waive the payment of premiums coming due for this Policy and any riders attached to this Policy. To continue to qualify for the **Waiver of Premium Benefit**, you must continue to be eligible for benefits and continue to receive benefits. For **Homemaker/Companion Care** or **Home Health Care**, you must continuously receive benefits on a regular basis (a regular basis is five (5) days or more per week) to maintain waiver of premium. We will refund any premium paid beyond the date you become eligible for the benefit. Premiums will become payable immediately when you are no longer eligible for the **Waiver of Premium Benefit**.

(If you accepted amendatory rider form number WOP-AMEND, the "**Waiver of Premium**" revision does not apply to your Policy.)

5) The "**Proof of Loss**" provision is revised as follows:

You must give us written proof of loss, including all required claim forms, within ninety (90) days from the date you start receiving services. Written proof of loss may include copies of paid invoices for covered services, copies of internet banking transactions showing payment to an eligible provider(s) for covered services, or cancelled checks made payable to eligible provider(s) for covered services. If you have good reason for not doing so, we will not contest your right to file a claim. However, you must give us proof of loss no later than one (1) year from the time normally required unless legally incapable.

6) The "**Right of Subrogation**" provision is added to your policy as follows:

If you or someone acting on your behalf is a claimant in any action or proceeding in which payment is received from any third party as a result of a court judgment, verdict, arbitration award, compromised settlement, etc, to compensate you for losses sustained, we shall have a Right of Subrogation or reimbursement for any benefits paid under your Policy. We shall not be responsible for any attorney's fees or court costs incurred or associated with the recovery of such payment from any third party unless otherwise specifically provided by law.

Signed for Us at Allentown, Pennsylvania.

Secretary

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AMENDATORY RIDER

This Amendatory Rider shall amend Policy Form Series PF2600 as follows:

1) The definition of **Home** is revised as follows:

   Home is your personal residence, which you must own or lease. It includes a home for the retired or aged or an **Assisted Living Facility**. It does not include a hospital, sanitarium or **Nursing Facility**. (Please refer to Page 8 for the definition of **Assisted Living Facility** and Page 9 for the definition of **Nursing Facility**.)

2) The definition of **Care Management** is revised as follows:

   Care Management is provided through a **Care Coordinator** qualified to perform a comprehensive, individualized, assessment of your needs. The **Care Coordinator** will develop a written **Plan of Care** designed to meet your individual needs.

3) The definition of **Care Coordinator** is added as follows:

   Care Coordinator is a health care professional, usually a Registered Nurse, we employ or contract with to provide our Policyholders the **Care Management** described above.

4) The definition of **Plan of Care** is added as follows:

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(If you accepted amendatory rider form number WOP-AMEND, the "**Waiver of Premium**" revision does not apply to your Policy.)

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7) The "**Right of Subrogation**" provision is added to your policy as follows:

If you or someone acting on your behalf is a claimant in any action or proceeding in which payment is received from any third party as a result of a court judgment, verdict, arbitration award, compromised settlement, etc, to compensate you for losses sustained, we shall have a Right of Subrogation or reimbursement for any benefits paid under your Policy. We shall not be responsible for any attorney's fees or court costs incurred or associated with the recovery of such payment from any third party unless otherwise specifically provided by law.

Signed for Us at Allentown, Pennsylvania.

Secretary

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AMENDATORY RIDER

This Amendatory Rider shall amend Policy Form Series LTCTP-6500 as follows:

1) The definition of **Care Management** is revised as follows:

   Care Management is provided through a **Care Coordinator** qualified to perform a comprehensive, individualized, assessment of your needs. The **Care Coordinator** will develop a written **Plan of Care** designed to meet your individual needs.

2) The definition of **Care Coordinator** is added as follows:

   Care Coordinator is a health care professional, usually a Registered Nurse, we employ or contract with to provide our Policyholders the **Care Management** described above.

3) The "Waiver of Premium" provision of your Policy is revised as follows:

   Once you have received benefits for ninety (90) consecutive days under the **Assisted Living Facility Benefit** or **Nursing Facility Benefit,** or have received benefits for ninety (90) continuous days or more on a regular basis for **Homemaker Care** or **Home Health Care**, (a regular basis is five (5) days or more per week), we will waive the payment of premiums coming due for this Policy and any riders attached to this Policy. To continue to qualify for the **Waiver of Premium Benefit**, you must continue to be eligible for benefits and continue to receive benefits. For **Homemaker Care** or **Home Health Care**, you must continuously receive benefits on a regular basis (a regular basis is five (5) days or more per week) to maintain waiver of premium. Premiums that have been paid for coverage after the date you become eligible for the **Waiver of Premium Benefit** will be held by Penn Treaty Network America Insurance Company and applied to any premiums due once you are no longer eligible for the **Waiver of Premium Benefit.** If you die while eligible for this benefit the waived premiums will be refunded to your estate.

(If you accepted amendatory rider form number WOP-AMEND, the "**Waiver of Premium**" revision does not apply to your Policy.)

4) The "**Proof of Loss**" provision is revised as follows:

You must give us written proof of loss, including all required claim forms, within ninety (90) days from the date you start receiving services. Written proof of loss may include copies of paid invoices for covered services, copies of internet banking transactions showing payment to an eligible provider(s) for covered services, or cancelled checks made payable to eligible provider(s) for covered services. If you have good reason for not doing so, we will not contest your right to file a claim. However, you must give us proof of loss no later than one (1) year from the time normally required unless legally incapable.

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Signed for Us at Allentown, Pennsylvania.

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This Amendatory Rider shall amend Policy Form Series LTCTP-6500 as follows:

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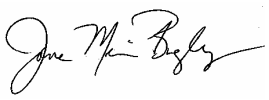
Signed for Us at Allentown, Pennsylvania.



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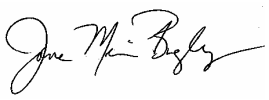
Signed for Us at Allentown, Pennsylvania.



Secretary