

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Filing at a Glance

Company: MedAmerica Insurance Company

Product Name: TRS-336-AR

SERFF Tr Num: MEAM-127754532 State: Arkansas

TOI: H13I Individual Health - Short Term Care

SERFF Status: Closed-Approved-
Closed State Tr Num: 50196

Sub-TOI: H13I.002 Nursing Home

Co Tr Num: TRS-336-AR

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Author: Jamie Vahue

Disposition Date: 11/07/2011

Date Submitted: 11/04/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: TRS-336-AR

Status of Filing in Domicile:

Project Number: TRS-336-AR

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 11/07/2011

State Status Changed: 11/07/2011

Deemer Date:

Created By: Jamie Vahue

Submitted By: Jamie Vahue

Corresponding Filing Tracking Number:

Filing Description:

Please accept this filing for review and approval for use in your state.

Company and Contact

Filing Contact Information

Jamie Vahue, LTC Compliance Analyst

jamie.vahue@medamericaltc.com

165 Court Street

800-544-0327 [Phone] 6782 [Ext]

Rochester, NY 14647

585-238-3675 [FAX]

Filing Company Information

MedAmerica Insurance Company

CoCode: 69515

State of Domicile: Pennsylvania

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR
 165 Court Street Group Code: Company Type: Long Term Care
 Rochester, NY 14647 Group Name: Insurance
 (585) 327-6522 ext. [Phone] FEIN Number: 34-0977231 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$500.00
 Retaliatory? Yes
 Fee Explanation: 10 Forms x \$50 = \$500.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MedAmerica Insurance Company	\$500.00	11/04/2011	53486225

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/07/2011	11/07/2011

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	Rosalind Minor	11/07/2011	11/07/2011	Jamie Vahue	11/07/2011	11/07/2011

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Disposition

Disposition Date: 11/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
MedAmerica Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Redlines 11/7/2011	Approved-Closed	Yes
Form (revised)	Transitions Policy	Approved-Closed	Yes
Form	Transitions Policy	Approved-Closed	Yes
Form	Transitions Rider	Approved-Closed	Yes
Form	Medicare Notice	Approved-Closed	Yes
Form	Conditional Premium Receipt	Approved-Closed	Yes
Form	Replacement Notice	Approved-Closed	Yes
Form	Coverage Change Form within 30	Approved-Closed	Yes
Form	Coverage Change Form after 30	Approved-Closed	Yes
Rate	TRS-336-AR Rates	Approved-Closed	Yes

SERFF Tracking Number: MEAM-127754532 State: Arkansas
Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
Company Tracking Number: TRS-336-AR
TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
Product Name: TRS-336-AR
Project Name/Number: TRS-336-AR/TRS-336-AR

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/07/2011

Submitted Date 11/07/2011

Respond By Date

Dear Jamie Vahue,

This will acknowledge receipt of the captioned filing.

Objection 1

- Transitions Policy, TRS-336-AR (Form)

Comment:

On the face page of the policy, the policy title required by Section 7(A)(1) of Rule and Regulation 18, shall include "Limited Benefit Health Insurance Coverage" as well as the appropriate categories of coverage.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 11/07/2011
 Submitted Date 11/07/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Rosalind,

Per your instruction I have corrected the Policy title to read - Short Term Recovery Care Policy - Limited Benefit Health Insurance Coverage. Thank you for your assistance.

Jamie Vahue

LTC Compliance Analyst

Related Objection 1

Applies To:

- Transitions Policy, TRS-336-AR (Form)

Comment:

On the face page of the policy, the policy title required by Section 7(A)(1) of Rule and Regulation 18, shall include "Limited Benefit Health Insurance Coverage" as well as the appropriate categories of coverage.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redlines 11/7/2011

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Transitions Policy	TRS-336-AR		Policy/Contract/Fraternal Certificate	Initial		0.000	TRS-336-AR.pdf

Previous Version

<i>SERFF Tracking Number:</i>	<i>MEAM-127754532</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>MedAmerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>50196</i>
<i>Company Tracking Number:</i>	<i>TRS-336-AR</i>		
<i>TOI:</i>	<i>H13I Individual Health - Short Term Care</i>	<i>Sub-TOI:</i>	<i>H13I.002 Nursing Home</i>
<i>Product Name:</i>	<i>TRS-336-AR</i>		
<i>Project Name/Number:</i>	<i>TRS-336-AR/TRS-336-AR</i>		
<i>Transitions Policy</i>	<i>TRS-336-AR</i>	<i>Policy/Contract/Fraternal Certificate</i>	<i>Initial 0.000 TRS-336-AR.pdf</i>

No Rate/Rule Schedule items changed.

Sincerely,
 Jamie Vahue

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Form Schedule

Lead Form Number: TRS-336-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/07/2011	TRS-336-AR	Policy/Cont ract/Fratern al Certificate	Transitions Policy	Initial		0.000	TRS-336-AR.pdf
Approved-Closed 11/07/2011	TR-SBIR-AR	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Transitions Rider	Initial		0.000	TR-SBIR-AR.pdf
Approved-Closed 11/07/2011	TR-205	Other	Medicare Notice	Initial		0.000	TR-205.pdf
Approved-Closed 11/07/2011	TR-103	Other	Conditional Premium Receipt	Initial		0.000	TR-103.pdf
Approved-Closed 11/07/2011	TR-RPL	Other	Replacement Notice	Initial		0.000	TR-RPL.pdf
Approved-Closed 11/07/2011	TRS-15830-AR	Other	Coverage Change Form within 30	Initial		0.000	TRS-15830-AR.pdf
Approved-Closed 11/07/2011	TRS-15831-AR	Other	Coverage Change Form after 30	Initial		0.000	TRS-15831-AR.pdf



Short Term Recovery Care Policy - Limited Benefit Health Insurance Coverage

Thank You for selecting MedAmerica Insurance Company, We are pleased to provide You with this Policy. Your coverage, if the first premium is paid, as stated herein, begins at 12:01a.m. Standard time at Your home on the Effective Date of this Policy. It ends on 12:01a.m. Standard time at Your home on the termination date of this Policy.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with short term recovery care incurred by the buyer during the period of coverage. THIS POLICY PROVIDES LIMITED BENEFITS FOR SHORT TERM RECOVERY CARE ONLY. The buyer is advised to review carefully all Policy limitations. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Us.

DISCLAIMER: THIS POLICY IS NOT A LONG TERM CARE INSURANCE POLICY. THIS POLICY IS NOT A MAJOR MEDICAL HEALTH INSURANCE POLICY. THIS POLICY WILL NOT COVER ANY PRE-EXISTING CONDITIONS FOR A PERIOD OF 6 MONTHS AFTER THE EFFECTIVE DATE OF COVERAGE.

SUBROGATION: If You become eligible for Benefits under this Policy as the result of injury or illness for which another party may be responsible, and We pay You Benefits as the result of that injury or illness, We reserve the right to pursue recovery from such third party, whether by judgment, settlement or otherwise, to the extent of the total amount of Benefits paid to You under this Policy, less reasonable and necessary expenditures, including attorneys' fees, incurred in effecting such recovery. Our right to proceed against the third party is independent of any right of action You may have. Failure To Cooperate: If You fail to cooperate with Us in proceeding against the party responsible for Your illness or injury to recover the Benefits We have paid, We will be entitled to be reimbursed for said Benefits from a settlement or judgment You receive from the responsible party.

GUARANTEED RENEWABLE/PREMIUM INCREASES: This Policy is guaranteed renewable. That means Your coverage will continue for life as long as You pay the premiums within the allowable time. We cannot change the provisions of this Policy without Your consent. We can change Your premium with 45 days written notice, but only if We change the premiums for all similar Policies issued in Your state on this Policy form, regardless of where You reside at the time of the premium change. You cannot be singled out for any increase because of a change in Your age or health.

RIGHT TO EXAMINE AND RETURN THIS POLICY: If You feel this Policy does not meet Your needs, You may return it to Your producer or Us within 30 days of Your receipt of this Policy. If You do so: (1) We will return the premium You paid; and (2) We will not provide any Benefits under this Policy.

IMPORTANT NOTICE: Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Us within 10 days if any information shown on it is not correct and/or complete or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

This Policy is signed on Our behalf by Our President.

[William E. Jones, Jr.]
[President]

TABLE OF CONTENTS

SCHEDULE OF POLICY BENEFITS	[3]
DEFINITIONS.....	[4]
PART 1: BENEFITS.....	[9]
PART 2: HOW TO RECEIVE BENEFITS.....	[11]
PART 3: LIMITATIONS OR EXCLUSIONS	[14]
PART 4: PREMIUM.....	[15]
PART 5: GENERAL PROVISIONS.....	[16]

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL)

Each of the following is an Activity of Daily Living:

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair, or wheelchair.

ADULT DAY CARE / ADULT DAY CARE CENTER

This is a facility that provides a daytime program of social and health-related services in a community group setting. An Adult Day Care Center does not provide 24-hour care. It must be established, licensed and operated in accordance with any applicable state or local laws.

APPROVED PROVIDERS

Approved Providers are any of the following:

- Qualified Facility; or
- Hospice Program; or
- Home Health Care Agency; or
- Adult Day Care Center.

ASSESSMENT

An Assessment is an evaluation of Your ability to perform Activities of Daily Living and Your cognitive condition to certify whether You qualify for benefits. A Licensed Health Care Practitioner using recognized and accepted, objective standards of measurement must perform the Assessment. The Assessment must be made at the time You wish to establish Benefit Eligibility.

BENEFITS

Payments described in the "Benefits" section of Your Policy, Your Schedule of Policy Benefits, and Riders attached to Your Policy.

BENEFIT ELIGIBLE or BENEFIT ELIGIBILITY	<p>To be Benefit Eligible or achieve Benefit Eligibility under this Policy, all of the following conditions must be met.</p> <ol style="list-style-type: none"> 1. We have verified You have been certified by a Licensed Health Care Practitioner as: <ol style="list-style-type: none"> a) Being unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) Requiring Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment; and 2. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period).
COVERED CARE	Care or services for which Benefits are payable under this Policy, or would have been payable except for any Elimination Period, that assist with Activities of Daily Living and/or Severe Cognitive Impairment.
DOMESTIC PARTNER	Domestic Partners are persons at least 18 years of age, not related by blood, of the same or opposite sex in an exclusive and committed relationship. They must have lived together for at least 12 months in a common household and have an exclusive mutual commitment, including financial interdependence, similar to that of marriage.
DAILY BENEFIT AMOUNT	This is the maximum amount We will pay for all covered Benefits You receive on any one day as stated in Your Schedule of Policy Benefits. You may only receive one Daily Benefit Amount per day.
ELIMINATION PERIOD	<p>The Elimination Period is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins on the first day of Covered Care.</p> <p>The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Days in an Elimination Period are combined and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.</p> <p>Benefits are not payable during the Elimination period except for Hospice Care, Respite Care and MyCare benefits.</p>
FAMILY; FAMILY MEMBER	Your Spouse or Domestic Partner and anyone who is related to You, Your Spouse or Your Domestic Partner (including adopted, in-law and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.
HOME	Any place where You reside other than a Qualified Facility or hospital.
HOME HEALTH CARE AGENCY	A state or federally licensed, accredited or certified Home Health Care Agency that provides care and services in Your Home.

HOSPICE CARE PROGRAM	<p>A state or federally licensed, accredited or certified program that provides a program of care designed to provide palliative care with the philosophy of alleviating the physical, emotional, and spiritual discomforts of a person who:</p> <ul style="list-style-type: none"> a) Is in the last phases of life due to a terminal disease; and b) Has a physician-certified prognosis of less than six (6) months to live. <p>The program must be administered by an interdisciplinary team that consists of a physician, a registered nurse, clergy or counselors, trained volunteers and other appropriate staff having expertise in meeting the needs of terminal patients.</p> <p>Hospice Care Program services may be provided in a Qualified Facility, or in Your Home. This benefit is not subject to the Elimination Period.</p>
LICENSED HEALTH CARE PRACTITIONER	<p>A Licensed Health Care Practitioner means any of the following other than a family member: a physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.</p>
LIFETIME BENEFIT AMOUNT	<p>This is the total amount of Benefits payable under this Policy as shown in Your Schedule of Policy Benefits. We will deduct from this amount all Benefits paid under this Policy.</p> <p>If Your Schedule of Policy Benefits states that You have a Simple Benefits Increase Rider, Your Lifetime Benefit Amount will increase over time. The initial Lifetime Benefit Amount is determined by the Daily Benefit Amount multiplied by the number of Benefit Days as shown on Your Schedule of Policy Benefits.</p>
MEDICARE	<p>The Health Insurance for Aged Act, Title XVIII of the Social Security Act Amendments of 1965, as Constituted and Later Amended.</p>
POLICY	<p>This is a legal agreement between You and Us. It includes this document, Your application, and any attached riders or endorsements.</p>
POLICY ANNIVERSARY DATE	<p>This is the date each year that coincides with the date Your Policy went into effect. Your first Policy Anniversary Date will be one year from the date Your Policy went into effect.</p>
PRE-EXISTING CONDITION	<p>A Pre-existing Condition means the existence of a health, physical or cognitive condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Licensed Health Care Practitioner within a 6 month period before the Effective Date of this Policy.</p>

QUALIFIED FACILITY

A Qualified Facility is a state or federally regulated, licensed, accredited or certified facility that meets all of the following criteria:

- Provides accommodations to 3 or more unrelated individuals and supervision and personal care services for at least 3 of these individuals; and
- Provides 24-hour-a-day care and services; and
- Has a trained, awake, and ready-to-respond employee on duty in the facility at all times to provide necessary care; and
- Provides 2 meals a day and accommodates special dietary needs; and
- Conducts an assessment of the resident on admission that includes a history and physical by a physician, nurse practitioner, or physician assistant in the last 60 days, the resident's ability to perform both instrumental activities of daily living and activities of daily living, safety evaluation, risk of fall assessment, cognitive assessment, and the resident's ability to manage medication administration; and
- Develops a Plan of Care or service plan for each resident that is customized to the resident and includes both the services provided by or contracted by the residence and identifies services that will be provided by outside agencies directly contracted with the insured including the scope of services, frequency of services and monitoring of services delivered; and
- Reviews the service plan at least every six months or as the resident's needs change.

A Qualified Facility must meet the above criteria for the Benefits to be paid.

A Qualified Facility is NOT:

- A hospital or clinic; or
- A place that operates primarily for the treatment of alcoholism, drug addiction or mental illness;
- An Adult Day Care or similar establishment.

RESPITE CARE

Respite Care services provide temporary care for You while Your regular caregiver in the Home takes time away from providing care.

SEVERE COGNITIVE IMPAIRMENT

Severe Cognitive Impairment means a deterioration or irreversible loss in intellectual capacity that requires Substantial Supervision to assure You and others' safety. The deterioration or loss is established by clinical evidence and standardized tests that reliably measure:

- short-term or long-term memory;
- orientation as to people, place, or time;
- deductive or abstract reasoning; or
- judgement as it relates to safety awareness.

SPOUSE A Spouse is a married policyholder or the person to whom they are married. The marriage must be recognized as legal in accordance with the laws of the state in which this Policy is sold.

SUBSTANTIAL ASSISTANCE There are two types of Substantial Assistance.

1. *Hands-on Assistance*: The physical assistance of another person without which an individual could not perform an Activity of Daily Living, or
2. *Stand-by Assistance*: The presence of another person within arm's reach necessary to prevent, by physical intervention, injury to an individual while they are performing an Activity of Daily Living.

SUBSTANTIAL SUPERVISION This is continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and that is necessary to protect You from threats to Your health or safety.

WE, US, OUR This refers to MedAmerica Insurance Company.

YOU, YOUR, YOURSELF This refers to the person to whom this Policy is issued and whose name appears in the Schedule.

PART 1: BENEFITS

Below are descriptions of the Benefits under this Policy.

Benefits are described in this Policy or the Riders attached to it. Benefit and Rider limits and effective dates are stated on the Schedule of Policy Benefits.

If You meet Benefit Eligibility, We will provide Benefits for the actual charges incurred up to the Daily Benefit Amount and subject to a Lifetime Benefit Amount shown in Your Schedule of Policy Benefits for the following Covered Care:

QUALIFIED FACILITY BENEFITS Confinement in a Qualified Facility for room, board and care services (such care services being nursing care, custodial care or hospice care).

HOME CARE BENEFITS Services provided by a Hospice Care Program, or by an Adult Day Care Center or Home Health Care Agency including:

- nursing services; and/or
- physical, occupational, respiratory and speech therapy; and/or
- home health aide or personal care attendant services including such things as: personal hygiene, performing Activities of Daily Living (ADL) , managing medications, and other related supportive services; and/or
- homemaker services including light work, household tasks, preparing meals, doing laundry and other incidental household tasks that do not require the services of a trained aide or attendant.

OTHER BENEFITS

BED RESERVATION If You leave the Qualified Facility temporarily while We are paying for Benefits and the facility charges You a fee to reserve Your bed, We will pay to reserve Your bed for up to 21 days per calendar year.

We will pay the actual charges to reserve Your bed, up to the Daily Benefit Amount and subject to a Lifetime Benefit Amount shown in Your Schedule of Policy Benefits.

You must continue to meet Benefit Eligibility. Your eventual need to return to the facility where the bed is reserved must be expected and documented by Your physician.

MYCARE PROGRAM If You meet Benefit Eligibility, You may elect to choose to use some of Your Benefits to pay for care management services with a licensed health care professional at 100% of the actual charges incurred up to six (6) times the Daily Benefit Amount shown in Your Schedule of Policy Benefits. This Benefit provides You with the option to seek the consultation services of a licensed health care professional of Your choice.

Such consultation services may provide You with assistance and advice in choosing services and providers. This benefit is not subject to the Elimination Period. Payments made under this Benefit are deducted from you Lifetime Benefit.

OTHER GOODS AND SERVICES

From time to time, We may offer or provide certain goods and services in addition to insurance coverage. We may also arrange for third party vendors to provide goods and services at a discount including without limitation, financial counseling services and discounts to service providers. Though We may make the arrangements, the third party vendors are solely liable for providing the goods and services. We shall not be responsible for providing or failing to provide the goods and services. Further, We shall not be liable for the negligent provision of the goods and services by third party vendors. We reserve the right to discontinue providing additional goods and services at any time.

RESPITE CARE

Respite Care services provide temporary care for You while Your regular caregiver in the Home takes time away from providing care.

If You meet Benefit Eligibility and You are at Home, We will pay Benefits for Covered Care for Respite Care provided in Your Home, or a Qualified Facility.

We will reimburse the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule of Policy Benefits for a maximum Benefit of 14 days per calendar year. Payments made under this Benefit are deducted from Your Lifetime Benefit.

This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

RESTORATION OF LIFETIME BENEFIT AMOUNT

If You have received Benefits under this policy and have used up a portion of the Lifetime Benefit Amount shown in Your Schedule of Policy Benefits, We will restore Your Policy's Lifetime Benefit Amount, once during the lifetime of Your Policy if You meet the following qualifications:

1. Your Policy remains continually in force; and
2. We have verified with an assessment that you are not currently, nor have been in the past 180 days, a) unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) require Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment.

WAIVER OF PREMIUMS

The premiums for this Policy will be waived the first day of Policy paid Benefits. Premiums become due and payable again on the date we determine you are no longer Benefit Eligible.

PART 2: HOW TO RECEIVE BENEFITS

ESTABLISHING BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need Covered Care under this Policy. Please call Our Customer Service Representative at [1-800-544-0327].

To be eligible for Benefits provided by this Policy, We must receive a periodic assessment that verifies You are a person who meets the following conditions:

- You need Substantial Assistance from another person to perform at least two of the Activities of Daily Living (ADL) (Bathing, Dressing, Eating, Toileting, Transferring, Continence); or
- You need Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

We will work with You, Your family and Your physician when We need information about Your condition. We will review the status of Your Activities of Daily Living (ADL) and cognitive function. We will use this information to make an evaluation of Your condition to determine whether You qualify or continue to qualify for Benefits under this Policy. This information may be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our determination.

NOTICE OF CLAIM

When You become Benefit Eligible, written notice of claim must be given to Us within 60 days after the date Your loss starts, or as soon thereafter as is reasonably possible. The notice should include at least Your name, Your Policy Identification Number, and the address to which the claim form is to be sent. Notice must be given by You or on Your behalf to Us at:

[MedAmerica Insurance Company]
[165 Court Street]
[Rochester, NY 14647]

HOW TO FILE A CLAIM

CLAIM FORMS: We will send claim forms to You upon receipt of a written notice of claim. If We do not send such forms within 15 days after receiving notice, You will be deemed to have met the timeliness of claim filing requirements when You do submit, within the time fixed in this Policy for filing proof of loss, a letter describing the occurrence, character and extent of Your loss for which the claim is made.

At a minimum, the description should include Your name and address, Your Policy Identification number, the type of Benefits You are claiming, the names and addresses of Your physicians, the services You required, Your diagnosis, and the periods for which You are claiming Benefits.

WHEN TO FILE A CLAIM

PROOF OF LOSS: Written proof of loss must be received by Us within 90 days after the end of each month for which Benefits may be paid. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

CONDITIONS FOR RECEIVING CLAIM PAYMENT

If You meet Benefit Eligibility, We will pay Benefits subject to the terms, limitations and exclusions described in this Policy. The following conditions also apply:

- Your Policy must be in force when the care is approved and received; and
- You have completed the Elimination Period, if it applies; and
- The service is covered under this Policy; and
- You have not exhausted the Lifetime Benefit Amount shown in Your Schedule of Policy Benefits.

PAYMENT OF CLAIMS: All Benefits will be paid to You or another person or approved Provider upon your written request. You may request in writing no later than the time proof of loss is filed that payment be made to the Approved Provider. Benefits due and unpaid at Your death will be paid to Your estate.

HOW AND WHEN CLAIMS ARE PAID

TIME OF PAYMENT OF CLAIM: Upon receipt of the proper written proof of loss, any Benefits then due will be paid:

1. Monthly, when the loss is expected to result in ongoing Benefits, and
2. Promptly, when Our liability has ended.

Such payment will be made within 30 days after having received the proper written proof of loss.

If We contest a claim or a portion of a claim, You or Your Legal Representative will be notified in writing that the claim is contested or denied within 30 days after We have received Your claim.

The notice that the claim is contested will identify the contested portion of the claim and the reasons for contesting the claim. Upon receiving any additional information requested by Us, the contested claim or portion thereof will be paid or denied within 30 days.

Benefits due and unpaid at Your death will be paid to Your estate or Your Named Payee.

Currency: Benefits will be paid in US currency.

RECOVERY OF OVERPAYMENT

If, due to an error in processing, a claim results in an overpayment, We will explain the overpayment to You. You must return the amount of overpayment within 60 days of Our request. Any overpayment that is not returned to Us within 60 days of Our request will be deducted from future claim payments.

WHEN YOU HAVE CLAIM QUESTIONS

If You would like an explanation of Our claim payment, please call or write to Us.

YOUR APPEAL RIGHTS

If We contest a claim or a portion of a claim, You or Your legal representative will be notified in writing that the claim is contested or denied.

You have a right to appeal Our claims decision. The appeal must be filed in writing with Our office within 3 years of the time the denied claim being appealed was filed. Include the reason for the appeal and any documents You feel are pertinent to the situation.

We will send You a written acknowledgement of Your appeal. If no additional information is needed, the acknowledgement will include an explanation of the denial. If additional information is required, We will explain what is needed. If We do not receive the requested information within 21 days, We will notify You in writing.

Within 60 days of the receipt of required information, We will notify You in writing of the outcome of the reconsideration of Your claim, and the contested claim or portion thereof that will be paid or denied.

PHYSICAL EXAMINATION

We, at Our expense, can have You examined as often as reasonably needed while a claim is pending or active.

TIME LIMIT FOR LEGAL ACTION

You cannot begin legal action before 60 days after written proof of loss has been given to Us. The time limit for legal action is 3 years after the time written proof of loss is furnished.

PART 3: LIMITATIONS AND EXCLUSIONS

EXCLUDED SERVICES

Expenses for the following will not be covered under this Policy:

1. Treatment for illness or medical condition arising out of war or any act of war, declared or undeclared.
2. Services for intentionally self-inflicted injury.
3. Services for Mental or Nervous Disorders without demonstrable organic disease (subject to the other Policy provisions, We will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the Policy);
4. Services for alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician;
5. Due to participation in a felony, riot or insurrection
6. Care or services provided by a member of Your Family or someone who normally lives in Your residence;
7. Services for which You are not liable or for which no charge is normally made in the absence of insurance.
8. Covered Care outside the United States and the District of Columbia.
9. Non-duplication. We will not pay Benefits for Covered Care to the extent that the service is reimbursed, or would be reimbursed but for the application of a deductible or coinsurance amount, under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid).
10. Pre-existing condition. No benefits are payable for any Covered Care that begins within the first six (6) months after the Effective Date of this Policy which is caused by a Pre-existing Condition.

PART 4: PREMIUM

PREMIUM AMOUNT

The initial premium is shown in Your Schedule of Policy Benefits. It will remain the same unless You change Your coverage or We change the premium. If We change the premium, We will notify You at least 45 days in advance. No change will be made to the premium amount unless We change the premium rates for all Policies like Yours that We have issued in the state where this Policy has been approved and, where applicable, Your State Department of Insurance has approved the increase.

PAYMENT

Premiums are due in advance.

GRACE PERIOD

An initial Grace Period of 31 days will be granted for each premium that is unpaid on the date due. After the initial Grace Period of 31 days elapses, a notice will be sent to You explaining that a payment has been missed and that Your Policy risks lapsing. If You have designated an individual to be notified in case of lapse, We will also send notice to the address You provided for that designee. You will have an additional 35 days Grace Period that begins the date We mail the second notice to pay the unpaid premium.

Payment will allow Your Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the second Grace Period will result in the termination of Your Policy as of the premium due date.

Lapse Designee: If You have designated an individual to be notified of lapse, We will provide You the opportunity, no less frequently than every 2 years, to change such designation.

REINSTATEMENT

If Your Policy lapses because You did not pay Your premium within the Grace Period, You may request reinstatement with no break in coverage. If We honor this request, Your Policy will be reinstated back to the termination date. If We do not approve or disapprove Your request within 45 days of receipt of the request and a premium was accepted by Us or one of Our authorized representatives, Your Policy will be reinstated as of the date Your Policy terminated.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

You may request reinstatement up to 5 months after termination, if You did not pay Your premium due to a condition that would qualify You for Benefits. Your condition is subject to verification. An Assessment is required before deciding on reinstatement. If reinstated, You must pay Your premium retroactive to the date Your Policy terminated.

UNEARNED PREMIUM

When We are notified of Your cancellation or death, We will refund any premium paid for the period beyond Your cancellation or death. If You have died, all premiums paid for the period beyond Your death will be refunded to Your Estate. In the event of Your cancellation, premiums paid for the period beyond Your cancellation will be refunded to You.

PART 5: GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES	This Policy document, Your application and any Riders establish the entire contract of insurance between You and Us. Any material change must be approved by one of Our officers and be endorsed on or attached to this Policy. No insurance agent has the authority to change this Policy or to waive any of its provisions.
YOUR BENEFITS	With the exception of a Named Payee or Your estate, only You are eligible for Benefit payments other than returned premiums under this Policy.
WHEN YOUR POLICY COVERAGE BEGINS	The date that Your Policy begins is shown in Your Schedule of Policy Benefits. All time periods begin and end at 12:01 a.m. standard time at Your residence.
WHEN YOUR POLICY COVERAGE ENDS	<p>Your Policy ends on the day after the date one of the following occurs. As of 12:01 a.m. standard time at Your residence, You will no longer be entitled to Benefits under this Policy:</p> <ul style="list-style-type: none">• Nonpayment of premium (subject to the Grace Period); or• Your Lifetime Maximum is exhausted; or• You elect to cancel this Policy; or• Your death.
EXTENSION OF BENEFITS	<p>If, on the date this Policy is cancelled, You are Benefit Eligible, We will continue to pay for Your care without interruption of Benefits until the first of the following dates:</p> <ul style="list-style-type: none">• It is determined that You are no longer eligible for Benefits under this Policy; or• You have used up Your Lifetime Benefit Amount. <p>If You have become a) unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) require Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment, prior to the date the Policy is cancelled and are able to meet Benefit Eligibility, We will pay for Your care without interruption of Benefits until the first of the following date:</p> <ul style="list-style-type: none">• It is determined that You are no longer eligible for Benefits under this Policy; or• You have used up Your Lifetime Benefit Amount. <p>We will not pay for more care than You would have been entitled to receive if Your Policy had not terminated.</p> <p>You will not be entitled to Benefits after termination if the reason Your Policy terminated was due to You reaching Your maximum Lifetime Benefit Amount.</p>

INCONTESTABLE PERIOD

If Your Policy has been in force for less than 6 months, We may rescind Your Policy or deny a claim if it can be shown that a misrepresentation by You was material to Our acceptance of You.

If Your Policy has been in force for at least 6 months but less than 2 years, We may rescind Your Policy or deny a claim if it is shown that a misrepresentation by You both was material to Our acceptance of You and pertained to the condition for which Benefits are sought.

If Your Policy has been in force for 2 years or more, We may rescind Your Policy or deny a claim only if it is shown that You knowingly and intentionally misrepresented relevant facts relating to Your health or due to non-payment of premiums.

These provisions also apply if You provide additional evidence of insurability to purchase additional coverage after Your Policy Effective Date.

CLERICAL ERROR

Clerical error, whether by You or Us, will not void Your insurance if that insurance would otherwise have been in effect. Neither will it extend Your insurance if that insurance would otherwise have ended or been reduced as provided in this Policy.

MISSTATEMENT OF AGE

If Your age was misstated on Your Application, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

Our liability will be limited to a refund of the premiums You have paid for this Policy if You would have been subject to additional evidence of insurability at Your correct age, and You do not provide satisfactory proof to Us of successfully completing the additional evidence of insurability according to our standards in effect for Your correct age at the time of Your original application to Us.

MISSTATEMENT OF FACT

If Your information regarding Your Spouse or Domestic Partner's eligibility was misstated on Your Application, Your premium will be changed retroactively to Your original effective date to correspond to Your Spouse or Domestic Partner's actual eligibility status.

Application misstatements regarding Your Spouse or Domestic Partner eligibility are subject to the provision "Incontestable Period" for purposes of Policy rescission or claim denial.

NON-PARTICIPATING

This Policy does not participate in Our profits or surplus earnings.

**COMMUNICATION THROUGH
ELECTRONIC MEANS**

We reserve the right to designate the form and means of all communications or notices required by Your Policy.
If We agree, You may contact Us about Your Policy using electronic means or technologies.
If You agree, We may contact You regarding Your Policy using electronic means or technologies.

Except where barred by state or federal law, electronic communication is equal to other communication methods. Information exchanged has the same legal effect, validity, and enforceability.

**CONFORMITY WITH FEDERAL
AND STATE STATUTES**

Any provision of this Policy that does not comply with a law to which it is subject is amended to conform to the minimum requirement of such law.

Transitions.

Is a trademark of MedAmerica Insurance Company.
All rights reserved.

5% SIMPLE BENEFIT INCREASE RIDER

Subject to the terms and conditions contained in Your Policy and the payment of the required premium, You are entitled to the Benefits described in this Simple Benefit Increase Rider.

This Rider is a part of Your Policy and is subject to all of its terms and conditions. Terms used in this Rider and not defined here have the meanings given to them in the Definitions section of Your Policy.

SIMPLE BENEFIT INCREASE RIDER

This Rider adds a Benefit to Your Policy that increases Your Daily Benefit Amount and Lifetime Benefit Amount annually. The following provision is added to the Other Benefits section under Part 1: Benefits in Your Policy.

TERMS OF RIDER

Increase Calculation:

1. We will automatically increase Your Daily Benefit Amount and Lifetime Benefit Amount on each Policy Anniversary Date. The first increase will take effect on the Policy Anniversary Date that follows the date this Rider went into effect. The increase will occur even if Benefits are being paid.
2. Premiums will not change due to increases under this Rider.
3. On each Policy Anniversary Date, We will recalculate Your Daily Benefit Amount and Lifetime Benefit Amount as follows:
 - a. Your Daily Benefit Amount will increase by 5% multiplied by the Daily Benefit in effect on the Effective Date of this Rider.
 - b. Your Lifetime Benefit Amount will increase by the same proportion as the increase in Your Daily Benefit Amount.
 - c. We will round the increase to the nearest dollar.

TERMINATION

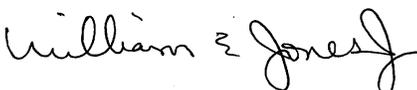
1. This Rider will terminate immediately on the earliest of the following:
 - a. Your Policy lapses for non-payment of premium.
 - b. You send a written request terminating this Rider.
 - c. You exhaust Your Maximum Lifetime Benefit.
2. If Your Policy terminates and is later reinstated, We will make automatic Benefit increases as if Your Policy had remained in effect.
3. If Your Policy lapses for non-payment of premium and coverage continues under a non-forfeiture provision, We will make no increases after the due date of the unpaid premium.

OTHER PROVISIONS

All of the terms and conditions of Your Policy also apply to the Benefits of this Rider, except where specifically changed by this Rider.

This Rider shall not otherwise vary, alter or extend the terms of Your coverage under Your Policy.

This Rider shall not be effective unless signed by the Authorized Officer of [MedAmerica Insurance Company] as set forth below.


[

[William E. Jones, Jr.]
[President]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

Some health care services paid for by Medicare would otherwise trigger the payment of benefits under this policy.

Federal law requires us to inform you that in certain situations Medicare may pay for some care also covered by this policy.

- This insurance provides benefits primarily for short term recovery care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.



[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

CONDITIONAL PREMIUM RECEIPT

This acknowledges receipt of the initial premium in connection with your application for a MedAmerica Insurance Company short term recovery care insurance policy. All premium checks must be made payable to MedAmerica. Do not make check payable to the producer or leave the payee blank.

PAYMENT OF PREMIUM DOES NOT PROVIDE INSURANCE COVERAGE UNTIL THE CONDITIONS SPECIFIED BELOW ARE SATISFIED.

APPLICANT NAME: _____	APPLICATION DATE: _____
PREMIUM RECEIPT DATE: _____	INITIAL PREMIUM*: \$ _____

- * For Monthly EFT: A minimum of 1 month conditional premium is required.
- * For Credit Card: We will debit your card once you are accepted for coverage.

SIGNATURE OF LICENSED AND APPOINTED PRODUCER	Producer Name and Business Address(Please Print)
X _____	_____

The initial and subsequent premiums will differ from the amount submitted if coverage is issued other than as applied for or an anticipated discount does not apply. The premium for coverage applied for is based on medical underwriting guidelines and the premium quoted includes certain assumptions regarding the applicant's health.

If coverage is declined, the full conditional premium will be returned.

CONDITIONS THAT MUST BE SATISFIED BEFORE COVERAGE IS EFFECTIVE

1. THIS RECEIPT IS SIGNED BY THE SAME PRODUCER THAT SIGNED THE APPLICATION;
2. AN AMOUNT EQUAL TO THE PREMIUM NOTED ABOVE HAS BEEN COLLECTED WITH THE APPLICATION; AND
3. MEDAMERICA, UPON INVESTIGATION, IS SATISFIED THAT ON THE EFFECTIVE DATE OF COVERAGE, SUCH PERSON WAS INSURABLE ACCORDING TO THE COMPANY'S RULES AND REGULATIONS.

EFFECTIVE DATE OF COVERAGE

IF THE APPLICANT IS INSURABLE, THE POLICY WILL BECOME EFFECTIVE ON THE LATEST OF THE FOLLOWING DATES:

1. DATE OF COMPLETION OF ALL PARTS OF THE APPLICATION AND SUPPLEMENTS THERETO; OR
2. DATE OF COMPLETION OF ALL REPORTS, MEDICAL EXAMINATIONS OR TESTS, INCLUDING A SECOND MEDICAL EXAMINATION, AS REQUESTED FOR ANY PERSON TO BE INSURED BECAUSE OF AGE, MEDICAL HISTORY, THE PLAN, OR THE AMOUNT OF INSURANCE APPLIED FOR; OR
3. THE DATE AS REQUESTED ON THE APPLICATION, WHICH MAY BE NO GREATER THAN SIXTY DAYS BEYOND THE COMPANY ASSIGNED EFFECTIVE DATE AND NOT EARLIER THAN THE APPLICATION SIGNATURE DATE. IF YOU HAVE SELECTED THIS OPTION, YOU AGREE TO THE FACT THAT YOU MAY BE WAIVING CERTAIN RIGHTS AND GUARANTEES UNDER THE CONDITIONAL RECEIPT.

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE**

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by MedAmerica Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- 1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
- 2) You may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- 3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date

Agent Name (Print)

Applicant's Signature

Agent Signature

Coverage Change Form - BENEFIT CHANGES WITHIN 30 DAYS OF COVERAGE ISSUE DATE	
IDENTIFYING INFORMATION:	Social Security #: _____
Name: _____	Amount Collected: \$ _____
Address: _____	This Amount Represents:
City: _____	<input type="checkbox"/> Premium Payment for the Benefit Change listed or
State: _____ Zip _____	<input type="checkbox"/> Balance of Mode
1) MAXIMUM DAILY BENEFIT AMOUNT	
Current: Daily Benefit Amount \$ _____ per day	Change to: Daily Benefit Amount \$ _____ per day (minimum \$50 – maximum \$300; multiples of \$10)
2) BENEFIT PERIOD	
Current: <input type="checkbox"/> 100 days <input type="checkbox"/> 200 days <input type="checkbox"/> 360 days	Change to: <input type="checkbox"/> 100 days <input type="checkbox"/> 200 days <input type="checkbox"/> 360 days
3) ELIMINATION PERIOD (CALENDAR DAYS)	
Current: <input type="checkbox"/> 20 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days	Change to: <input type="checkbox"/> 20 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days
4) INFLATION OPTIONS	
Current: <input type="checkbox"/> None <input type="checkbox"/> 5% Simple-No Maximum	Change to: <input type="checkbox"/> None <input type="checkbox"/> 5% Simple-No Maximum
Insured Signature: X	Date:
Producer Signature: X	Date:
Print Producer Name:	Writing Number:

Coverage Change Form - BENEFIT CHANGES AFTER 30 DAYS OF COVERAGE ISSUE DATE	
IDENTIFYING INFORMATION:	
Name:	Social Security #: _____
Address:	Amount Collected: \$ _____
City:	This Amount Represents:
State: _____ Zip _____	<input type="checkbox"/> Premium Payment for the Benefit Change listed or
	<input type="checkbox"/> Balance of Mode
1) MAXIMUM DAILY BENEFIT AMOUNT	
Current: Daily Benefit Amount \$ _____ per day	Change to: Daily Benefit Amount \$ _____ per day (minimum \$50 – maximum \$300; multiples of \$10)
2) BENEFIT PERIOD	
Current: <input type="checkbox"/> 100 days <input type="checkbox"/> 200 days <input type="checkbox"/> 360 days	Decrease to: <input type="checkbox"/> 100 days <input type="checkbox"/> 200 days
3) ELIMINATION PERIOD (CALENDAR DAYS)	
Current: <input type="checkbox"/> 20 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days	Increase to: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days
4) INFLATION OPTIONS Any decrease to your inflation will be based on Your age as of Your Original Policy Effective Date.	
Current: <input type="checkbox"/> 5% Simple-No Maximum	Decrease to: <input type="checkbox"/> None
Insured Signature: X _____	Date: _____
Producer Signature: X _____	Date: _____
Print Producer Name: _____	Writing Number: _____

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision: 11/04/2011
Filing Method of Last Filing: N/A

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
MedAmerica Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 11/07/2011	TRS-336-AR Rates	TRS-336-AR	New		Rate Sheet_TRS336_AR_103111.pdf

MedAmerica Insurance Company
Policy Form TRS-336-AR
"Transitions" Short Term Recovery Care Policy
Annual Premium Rates - Single Insureds*
Non-Inflationary - \$10 Daily Benefit Amount

Issue Age	100 BP 20 Day EP	200 BP 20 Day EP	360 BP 20 Day EP	100 BP 30 Day EP	200 BP 30 Day EP	360 BP 30 Day EP	100 BP 60 Day EP	200 BP 60 Day EP	360 BP 60 Day EP
<50	20.40	25.10	31.60	20.08	24.69	31.07	19.25	23.41	29.23
50	21.24	26.59	34.01	20.88	26.13	33.41	19.93	24.68	31.32
51	22.08	28.08	36.42	21.68	27.57	35.75	20.62	25.95	33.41
52	22.92	29.58	38.83	22.47	29.01	38.09	21.30	27.22	35.50
53	23.81	31.09	41.21	23.33	30.47	40.42	22.06	28.53	37.59
54	24.70	32.60	43.60	24.19	31.94	42.74	22.82	29.84	39.69
55	25.59	34.11	45.98	25.05	33.41	45.06	23.58	31.15	41.79
56	26.49	35.62	48.36	25.90	34.87	47.38	24.34	32.47	43.89
57	27.38	37.13	50.75	26.76	36.34	49.71	25.10	33.78	45.98
58	28.76	39.48	54.48	28.09	38.62	53.35	26.28	35.83	49.28
59	30.13	41.83	58.22	29.42	40.91	57.00	27.46	37.88	52.58
60	31.51	44.19	61.95	30.74	43.19	60.64	28.64	39.94	55.87
61	32.89	46.54	65.68	32.07	45.48	64.28	29.82	41.99	59.17
62	34.27	48.89	69.42	33.40	47.76	67.93	31.00	44.04	62.47
63	36.57	52.86	75.77	35.62	51.63	74.14	32.99	47.52	68.10
64	38.88	56.83	82.13	37.85	55.49	80.36	34.98	51.01	73.74
65	41.18	60.80	88.49	40.08	59.36	86.57	36.97	54.49	79.38
66	43.49	64.77	94.85	42.31	63.22	92.78	38.96	57.97	85.02
67	45.80	68.74	101.20	44.54	67.09	99.00	40.94	61.46	90.66
68	49.25	76.15	114.30	47.81	74.26	111.76	43.66	67.73	102.06
69	52.70	83.56	127.39	51.09	81.43	124.52	46.37	74.00	113.46
70	56.15	90.97	140.48	54.36	88.61	137.28	49.09	80.28	124.86
71	59.60	98.38	153.57	57.64	95.78	150.05	51.81	86.55	136.26
72	63.05	105.79	166.67	60.91	102.95	162.81	54.52	92.82	147.67
73	69.63	117.24	185.23	67.32	114.16	181.01	60.29	102.99	164.26
74	76.22	128.70	203.79	73.73	125.37	199.21	66.06	113.15	180.86
75	82.81	140.16	222.35	80.14	136.57	217.41	71.83	123.32	197.45
76	89.40	151.62	240.91	86.55	147.78	235.61	77.60	133.48	214.05
77	95.99	163.08	259.47	92.96	158.99	253.81	83.37	143.65	230.64
78	105.24	178.92	284.47	101.92	174.43	278.21	91.35	157.48	252.58
79	114.50	194.77	309.48	110.89	189.86	302.61	99.33	171.31	274.51
80	123.76	210.62	334.49	119.86	205.30	327.02	107.32	185.14	296.44
81	133.01	226.47	359.49	128.82	220.74	351.42	115.30	198.97	318.38
82	142.27	242.31	384.50	137.79	236.17	375.82	123.29	212.80	340.31
83	153.62	261.73	415.58	148.80	255.14	406.26	133.15	229.91	367.99
84	164.96	281.16	446.66	159.82	274.10	436.70	143.02	247.02	395.66
85	176.31	300.58	477.73	170.84	293.07	467.14	152.89	264.13	423.34

* Married insureds receive a 10% discount.

Modal factors: .515 semi-annual
 .260 quarterly
 .090 monthly

MedAmerica Insurance Company
Policy Form TRS-336-AR with Rider TR-SBIR-AR
"Transitions" Short Term Recovery Care Policy
Annual Premium Rates - Single Insureds*
5% Simple Inflation - \$10 Daily Benefit Amount

Issue Age	100 BP 20 Day EP	200 BP 20 Day EP	360 BP 20 Day EP	100 BP 30 Day EP	200 BP 30 Day EP	360 BP 30 Day EP	100 BP 60 Day EP	200 BP 60 Day EP	360 BP 60 Day EP
<50	30.11	42.15	59.29	29.39	41.24	58.08	27.45	38.22	53.65
50	31.73	45.04	64.00	30.95	44.03	62.67	28.81	40.72	57.79
51	33.35	47.92	68.70	32.50	46.83	67.26	30.17	43.22	61.93
52	34.97	50.81	73.41	34.05	49.63	71.85	31.53	45.72	66.08
53	36.48	53.43	77.64	35.51	52.18	75.99	32.83	48.02	69.85
54	37.99	56.05	81.88	36.97	54.73	80.14	34.13	50.33	73.62
55	39.49	58.66	86.11	38.43	57.28	84.28	35.43	52.63	77.39
56	41.00	61.28	90.35	39.88	59.83	88.42	36.74	54.93	81.16
57	42.51	63.90	94.58	41.34	62.38	92.56	38.04	57.23	84.93
58	44.63	67.59	100.57	43.39	65.98	98.43	39.87	60.49	90.27
59	46.75	71.27	106.56	45.44	69.58	104.29	41.71	63.75	95.62
60	48.86	74.96	112.54	47.49	73.17	110.15	43.55	67.01	100.97
61	50.98	78.65	118.53	49.53	76.77	116.02	45.38	70.26	106.32
62	53.10	82.34	124.52	51.58	80.37	121.88	47.22	73.52	111.67
63	56.36	88.04	133.84	54.75	85.94	131.02	50.07	78.59	120.02
64	59.63	93.75	143.16	57.92	91.52	140.16	52.92	83.65	128.38
65	62.90	99.46	152.48	61.09	97.10	149.30	55.77	88.72	136.74
66	66.16	105.17	161.81	64.26	102.68	158.44	58.62	93.78	145.10
67	69.43	110.88	171.13	67.42	108.25	167.58	61.47	98.85	153.46
68	73.60	119.69	186.81	71.41	116.82	182.92	64.86	106.45	167.30
69	77.77	128.49	202.48	75.40	125.39	198.26	68.25	114.04	181.15
70	81.94	137.30	218.16	79.39	133.95	213.59	71.64	121.64	194.99
71	86.11	146.11	233.84	83.38	142.52	228.93	75.02	129.23	208.83
72	90.28	154.92	249.51	87.37	151.09	244.26	78.41	136.83	222.68
73	97.55	167.66	270.45	94.46	163.58	264.84	84.83	148.22	241.55
74	104.82	180.39	291.38	101.55	176.06	285.41	91.25	159.62	260.42
75	112.09	193.13	312.32	108.64	188.55	305.99	97.67	171.01	279.30
76	119.36	205.87	333.26	115.73	201.04	326.56	104.09	182.41	298.17
77	126.63	218.60	354.19	122.82	213.53	347.14	110.52	193.80	317.05
78	135.97	234.62	379.57	131.88	229.14	371.91	118.59	207.81	339.33
79	145.31	250.64	404.95	140.93	244.75	396.68	126.66	221.81	361.61
80	154.65	266.66	430.32	149.98	260.36	421.45	134.73	235.81	383.89
81	163.99	282.68	455.70	159.04	275.98	446.22	142.80	249.81	406.17
82	173.33	298.70	481.08	168.09	291.59	470.99	150.87	263.82	428.46
83	184.18	317.34	511.20	178.64	309.82	500.55	160.36	280.33	455.46
84	195.03	335.98	541.33	189.19	328.05	530.11	169.85	296.85	482.47
85	205.89	354.62	571.45	199.75	346.27	559.66	179.34	313.36	509.47

* Married insureds receive a 10% discount.

Modal factors: .515 semi-annual
 .260 quarterly
 .090 monthly

SERFF Tracking Number: MEAM-127754532 State: Arkansas
 Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
 Company Tracking Number: TRS-336-AR
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home
 Product Name: TRS-336-AR
 Project Name/Number: TRS-336-AR/TRS-336-AR

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	11/07/2011
Comments:		
Attachment: AR Flesch Score.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	11/07/2011
Comments:		
Attachment: TRS-345-AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	11/07/2011
Comments:		
Attachment: ACTMEM-ShortTermCare-Nationwide-TRS336_AR_103111.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	11/07/2011
Comments:		
Attachment: TRS-151-AR .pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	11/07/2011
Comments:		

SERFF Tracking Number: MEAM-127754532 State: Arkansas
Filing Company: MedAmerica Insurance Company State Tracking Number: 50196
Company Tracking Number: TRS-336-AR
TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home
Product Name: TRS-336-AR
Project Name/Number: TRS-336-AR/TRS-336-AR

Attachment:

AR File Letter.pdf

Satisfied - Item: Redlines 11/7/2011

Comments:

Attachment:

TRS-336-AR Redline 11-7-2011.pdf

Item Status:

Approved-Closed

Status

Date:

11/07/2011

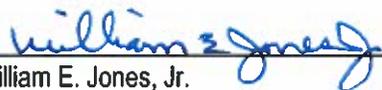
CERTIFICATION

This is to certify that the forms listed below exceed the Flesch Reading Ease test score minimum of 40 in compliance with Arkansas insurance policy readability law:

Short-Term Care Insurance Policy	TRS-336-AR
Policy Schedule Page (Located within the Policy)	TRS-238-AR
5% Simple Benefit Increase Rider	TR-SBIR-AR
Application	TRS-345-AR

This Policy and these forms were scored together.

Certification by:



William E. Jones, Jr.

President _____
Title

[EP/ASSOC. NAME/#:]

I. APPLICANT INFORMATION:									
1. IDENTIFYING INFORMATION:									
Applicant Name (First, MI, Last)				Social Security Number			Email Address		
Legal Residence Street Address (PO Box Not Adequate-Must Provide Street)						Mailing/Delivery Street Address (if different)			
City		State		Zip		City		State Zip	
()	()	/ /		<input type="checkbox"/> Male	<input type="checkbox"/> Married	<input type="checkbox"/> Single with Domestic Partner			
		MM/DD/YYYY		<input type="checkbox"/> Female	<input type="checkbox"/> Single	(Sign Domestic Partner Statement)			
Home Phone	Work Phone	Date of Birth	Age	Sex	Marital Status				
2. SPOUSE / DOMESTIC PARTNER INFORMATION: Complete IF your Spouse/Domestic Partner is applying at this time OR if they have another MedAmerica Policy in force.					3. ALTERNATE BILLING ADDRESS: Address applicant requests billing be mailed to IF different than above.				
					()				
Name (First, MI, Last)				Name (First, MI, Last)			Phone Number		
Social Security Number				Street Address		City		State Zip	
II. INSURABILITY PROFILE-MUST BE COMPLETED BY ALL APPLICANTS (Answer each question, check YES or NO.)									
1. Have you had Diabetes, other than diet controlled, for greater than ten (10) years?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Do you have any complications of Diabetes including peripheral vascular disease, kidney disease, neuropathy, retinopathy, or amputations?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. In the past 3 years have you received Medical Advice, Consultation, or Treatment for any of the following: <ul style="list-style-type: none"> Alzheimer's Disease, Memory Loss, Dementia, Schizophrenia, Manic-Depression, or Mental Retardation Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis or Parkinson's Disease Muscular Dystrophy, Any Chronic Muscular or Connective Tissue Diseases, or Rheumatoid Arthritis 2 or more Joint Replacements, 2 or more Fractures, any Spinal Surgery, or any Narcotic or Epidural pain management Congestive Heart Failure, Cardiomyopathy, Stroke, or Transient Ischemic Attack (TIA) AIDS, Kidney Disease, Liver Cirrhosis, or Hepatitis (Other than Hepatitis A) Cancer (Other than Basal or Squamous Cell Skin Cancer), Organ Transplants, or Bone Marrow Transplants Alcohol abuse, prescription drug abuse, or illegal drug use 								<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. In the past 3 years have you needed assistance or supervision from another person to eat, bathe, dress, get in or out of a bed or chair, use the toilet, or maintain personal hygiene due to incontinence?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
5. In the past 3 years have you used a Wheelchair, Walker, Motorized Scooter, Quad Cane, Dialysis, Catheters, Ventilators, Oxygen, Stairlift, Hospital Bed at Home, or Home Intravenous Medications?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
6. In the past 3 years have you been advised to receive Home Health Care, Adult Day Care services or Rehabilitative Services for a period of 6 months or longer, including Physical or Occupational Therapy?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
7. In the past 3 years have you been confined to or advised to enter a Nursing Home, Assisted Living Facility, or any other type of Long-Term Care Facility?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
8. In the past 3 years have you been advised to be hospitalized or have any surgery that has not yet taken place?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
9. In the past 3 years have you qualified to receive federal, state, or local government assistance in any form, such as, Supplemental Social Security Income, Social Security Disability Income, Medicare premiums paid by the state, Medicare due to disability, or Medicaid OR received Worker's Compensation or Long Term Disability benefits?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
10. In the past 3 years have you been declined for any long term care insurance?								<input type="checkbox"/> YES <input type="checkbox"/> NO	
STOP  Any Yes Response, we cannot offer coverage at this time. <u>Do not submit the application.</u>				OFFICE USE ONLY App. Rec: _____ App Status: _____ UW Date: _____ Init: _____ <input type="checkbox"/> Issued <input type="checkbox"/> Declined Effective Date: _____					

III. POLICY BENEFIT SELECTION:

STEP 1: SELECT DAILY BENEFIT AMOUNT: \$ _____ (\$50 - \$300 in \$10 increments)

STEP 2: SELECT BENEFIT PERIOD: (Choose One) 100 Days 200 Days 360 Days

STEP 3: ELIMINATION PERIOD: (Choose One) 20 Days 30 Days 60 Days

STEP 4: INFLATION: (Choose One) None 5% Simple

IV. INSURANCE HISTORY

1. Do you currently or have had in the last 12 months a nursing home (NH), home health care, long term care insurance policy, rider or certificate or any other accident or health insurance policy in force? **If Lapsed, Provide Termination Date.** If YES, please provide the following information. (Please use extra paper if needed) YES NO

Company Name	Address (Street, City, State, Zip)			Policy Type: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Home Care <input type="checkbox"/> LTC <input type="checkbox"/> Accident <input type="checkbox"/> Health	
In Force <input type="checkbox"/> YES <input type="checkbox"/> NO	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

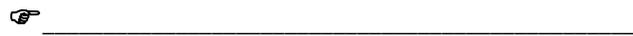
2. Are you allowing any nursing home (NH), home health care, long term care insurance policy, rider or certificate or any other accident or health insurance policy to lapse or do you intend to replace any other nursing home, home health care, long term care insurance policy, rider or certificate or any other accident or health insurance policy in force with this policy? **If Lapsed, Provide Termination Date.** If YES, please provide the following information. (Use extra paper if needed). YES NO

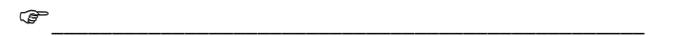
Company Name	Address (Street, City, State, Zip)			Policy Type: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Home Care <input type="checkbox"/> LTC <input type="checkbox"/> Accident <input type="checkbox"/> Health	
In Force <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number	Daily Benefit Amount	Years Coverage	Effective Date	Term Date

V. PREMIUM PAYMENT INFORMATION: All Applicants must CHOOSE ONE method and complete required information.

<p>1. <input type="checkbox"/> DIRECT BILL</p> <p>Select the frequency of your Direct Billing payment</p> <p><input type="checkbox"/> Quarterly</p> <p><input type="checkbox"/> Semi-Annual</p> <p><input type="checkbox"/> Annual</p>	<p>2. <input type="checkbox"/> ELECTRONIC FUNDS TRANSFER (EFT)</p> <p>Select the frequency of your EFT payment. Signature required below.</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly</p> <p><input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual</p> <p>Bank Name _____</p> <p>Bank Account Number _____</p> <p>Routing Number (9 digits) _____</p> <p>Requires Minimum of 1 month Conditional Premium. Attach Voided Check if Requesting EFT from Different Bank Account than Conditional Premium Check.</p>	<p>3. <input type="checkbox"/> CREDIT CARD</p> <p>Select the frequency of your Credit Card payment. Signature required below.</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly</p> <p><input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual</p> <p><input type="checkbox"/> VISA</p> <p><input type="checkbox"/> MASTERCARD]</p> <p>Credit Card Number _____</p> <p>Expiration Date MM/YY _____</p>	<p>4. <input checked="" type="checkbox"/> Payroll Deduction</p> <p>(Must be available through a group program and your employer.) Signature required below.</p> <p>I authorize my employer to deduct the applicable premium from my salary.</p> <p>I authorize MedAmerica Insurance Company to adjust these deductions based on rate changes or changes in coverage to my Policy.</p> <p>I may revoke this authorization at any time by written notice to my employer and to MedAmerica Insurance Company. Please attach Payroll stub.]</p>
--	--	---	---

*Authorization for [EFT, Credit Card and Payroll Deduction]: **Required IF Choosing [EFT OR Credit Card] Payment Method**
 I authorize my financial institution, credit card company [or employer] as indicated above, to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution and MedAmerica Insurance Company in writing.


 Account Holder Signature


 Joint Account Holder Signature (only required for joint accounts)

VI. HIPAA MEDICAL AUTHORIZATION (Uses and Disclosures of Medical Information)
Must be signed by all applicants.

This is a HIPAA compliant authorization. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of medical information about me.

From Me. I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager or other health care provider or health related facility, including but not limited to those identified above, insurance or reinsurance company or employer, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments (including prescriptions and medications), to furnish MedAmerica Insurance Company and/or designated business associates (for example MIB Group, Inc.) acting as insurance support organizations on MedAmerica Insurance Company's behalf any such protected health information, which may include my entire medical record, needed to determine my eligibility for insurance. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES. This authorization does not include psychotherapy notes. Regulations require a separate authorization for psychotherapy notes. We will contact you if we determine that such an authorization is needed.

For 24 Months. I agree that this authorization will be valid for 24 months from the date signed below and that a photocopy shall be as valid as this original. You may revoke this authorization at any time by giving written notice of revocation to the [LTC Privacy Officer, PO Box 41930, Rochester, New York 14604 or LTCPrivacy.Officer@MedAmericaLTC.com]. Revocation will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Your Rights. Although voluntary, this authorization is required to determine your eligibility for enrollment. If you choose not to complete this authorization, we will be unable to determine your eligibility for insurance. By signing this authorization, you acknowledge that if you authorize a person or organization to receive your protected health information that is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

PRINT APPLICANT NAME:

APPLICANT DATE OF BIRTH:

____ / ____ / ____
MM DD YYYY

APPLICANT SOCIAL SECURITY NUMBER:

____ - ____ - ____

 APPLICANT'S SIGNATURE:

DATE:

VII. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

- 1. **FRAUD NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties not to exceed \$5,000, plus the stated value of the claim for each violation, can apply.
- 2. **PROTECTION AGAINST UNINTENDED LAPSE:** I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until **31 days** after a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, I select **one of the following options:**

- I elect **NOT to designate** any person to receive such notice.
- I **designate** the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

Name: _____ Phone Number: _____

Address: _____
Street City State Zip

- 3. **INFLATION PROTECTION OPTION:** I have reviewed the Outline of Coverage and the graph that compare the benefits and premiums of this Policy with and without inflation protection, and
 - I **ACCEPT** inflation protection.
 - I **REJECT** inflation protection.

4. **DECLARATION AND APPLICATION CONDITIONS:**

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use the information contained herein to determine if my application is accepted. I understand that the coverage I am applying for is medically underwritten and that my coverage will begin only when I am notified of the effective date of coverage, or if selected, my alternate effective date. To receive benefits under the policy, I understand I must satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

I acknowledge receipt of the Outline of Coverage and, if over 65, a Medicare Buyer's Guide: "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

I understand the Producer or subsequent assignee, and any managing entities (which may include an affiliate of the Company), may receive compensation, monetary and/or non-monetary, as a result of my purchasing this insurance.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company may have the right to deny benefits or rescind your policy.

I understand that with this signature I am agreeing with all applicable conditions contained in this Section.

Dated at: City _____ State _____ Month _____ Day _____ Year _____

 **APPLICANT SIGNATURE:** _____

VIII. PRODUCER STATEMENT

1. Has the Applicant purchased any other health insurance policy from you during the past five (5) years? *If Yes, provide the following information:*

COMPANY	TYPE OF POLICY	POLICY NUMBER	IN FORCE:
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

2. By my signature on this form I certify that:

- (a) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
- (b) I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
- (c) I am in compliance with the insurance requirements in the state this application was solicited in and signed by the applicant.
- (d) I have delivered the Outline of Coverage, and if over 65, a Medicare Buyer's Guide: "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Soliciting Producer Name *(Please print)* _____ Writing Number _____

Supervising General Agency Name _____

Telephone Number (Best number to reach soliciting producer) : (_____) - _____

SOLICITING PRODUCER SIGNATURE: _____ DATE: _____

3. Are you SPLITTING the Commission Payment? YES NO

If YES, List all producers receiving compensation, their Writing Number(s), and % splits. The first producer listed MUST be the soliciting producer and the producer of record. Case splits must total 100%. (Only Licensed and Appointed Producers/Brokers may receive compensation.)

Soliciting Producer Name: _____	Writing#: _____	_____ %
Please Print First and Last Name		
Co-Producer Name: _____	Writing#: _____	_____ %
Please Print First and Last Name		
Co-Producer Name: _____	Writing#: _____	_____ %
Please Print First and Last Name		
Co-Producer Name: _____	Writing#: _____	_____ %
Please Print First and Last Name		
		TOTAL: 100 %

[Amount of Conditional Premium Check [(attached)]: \$ _____]

[As per the Conditional Receipt, Modal Premium is Required*
*If EFT, 1 month's premium is required]

Special Requests, Remarks, and Instructions: _____

Transitions[™]
Short Term Recovery Care Insurance
OUTLINE OF COVERAGE
Policy Number TRS-336-AR

Caution: The issuance of this Short Term Recovery Care Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, the Company may have the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the Company at the address above.

Notice to Buyer: This Policy may not cover all of the costs associated with Your care that are incurred by You during the period of coverage. You are advised to review carefully all Policy limitations.

1. **POLICY:** This Policy is an individual Policy of insurance.
2. **PURPOSE OF OUTLINE OF COVERAGE:** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You **READ YOUR POLICY CAREFULLY!**
3. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED:**
 - (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means that You have the right, subject to the terms of Your Policy, to continue Your Policy as long as You pay Your premiums on time. MedAmerica Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY CHANGE THE PREMIUM YOU PAY. Where applicable, premium increases must be approved by the State Department of Insurance.
 - (b) **WAIVER OF PREMIUM:** The premiums for this Policy will be waived the day after the date the Elimination Period has elapsed. Premiums become due and payable again on the date We determine You are no longer Benefit Eligible.
4. **TERMS UNDER WHICH PREMIUMS MAY BE CHANGED:** We reserve the right to increase Your premium as of the premium due date; however, any changes in the premium rates must apply to all similar policies issued in Your state on this Policy form. This means We cannot single You out for an increase because of any change in Your age or health. However, Your rates may go up based on the experience of all policyholders with a Policy similar to Yours.
5. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED:** If You feel this Policy does not meet Your insurance needs, return it to us or Your producer within 30 days. If You do so, We will return any premium You may have paid. We also will void Your Policy from its effective date.

6. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE:** If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the insurance company. Neither MedAmerica Insurance Company nor its producers represent Medicare, the federal government, or any state government.

DISCLAIMER: THIS POLICY IS NOT A LONG TERM CARE INSURANCE POLICY. THIS POLICY IS NOT A MAJOR MEDICAL HEALTH INSURANCE POLICY. THIS POLICY WILL NOT COVER ANY PRE-EXISTING CONDITIONS FOR A PERIOD OF 6 MONTHS AFTER THE EFFECTIVE DATE OF COVERAGE.

7. **SHORT TERM RECOVERY CARE COVERAGE:** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. These services must be provided in a setting other than an acute care unit of a hospital, such as a nursing facility, in the community, or in the home.

This Policy provides coverage for 100% of Your actual charges up to the Daily Benefit Amount listed on the Schedule of Policy Benefits page of Your Policy for services by an Approved Provider. Coverage is subject to Policy limitations and an Elimination Period.

8. **BENEFITS AND CONDITIONS FOR ELIGIBILITY:**

Benefits Provided By This Policy: If You are Benefit Eligible, this Policy will pay You 100% of Your actual charges up to Your Daily Benefit Amount for services by an Approved Provider.

Benefit Eligible: This means You will receive Benefits. To be Benefit Eligible or achieve Benefit Eligibility under this Policy all of the following conditions must be met.

1. We have verified You have been certified by a Licensed Health Care Practitioner as:
 - a) Being unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or
 - b) Requiring Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment; and
2. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period).

We will work with You, Your family and Your physician when We need information about Your condition. This information will be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our decision.

Activities of Daily Living: Each of the following is an Activity of Daily Living:

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair, or wheelchair.

Approved Provider: Approved Providers are a Qualified Facility; or Hospice Program; or Home Health Care Agency; or Adult Day Care Center.

Elimination Period: The Elimination Period is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins on the first day of Covered Care. Covered Care is care or services for which Benefits are payable under the Policy, or would have been payable except for any Elimination Period, that assist with Activities of Daily Living and/or Severe Cognitive Impairment.

The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Days in an Elimination Period are combined and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.

Benefits are not payable during the Elimination period except for Hospice Care, Respite Care and MyCare benefits.

OPTIONAL RIDERS UNDER THIS POLICY

You may elect any of the optional Riders listed. Depending on the Rider You select, You may pay an additional premium.

Simple Benefit Increase Rider – Form # TR-SBIR-AR

This Rider adds a Benefit to Your Policy that increases Your Daily Benefit Amount and Lifetime Benefit Amount annually. Your Daily Benefit Amount and current Lifetime Benefit Amount will automatically increase on each Policy Anniversary Date. The first increase will take effect on the Policy Anniversary Date that follows the date this Rider went into effect. The increase will occur even if Benefits are being paid. On each Policy Anniversary Date, We will recalculate Your Daily Benefit Amount and current Lifetime Benefit Amount as follows:

1. Your Daily Benefit Amount will increase by 5% multiplied by the Daily Benefit in effect on the Effective Date of this Rider.
2. Your current Lifetime Benefit Amount will increase by the same proportion as the increase in Your Daily Benefit Amount.
3. We will round the increase to the nearest dollar.

9. LIMITATIONS AND EXCLUSIONS: Expenses for the following will not be covered under this Policy:

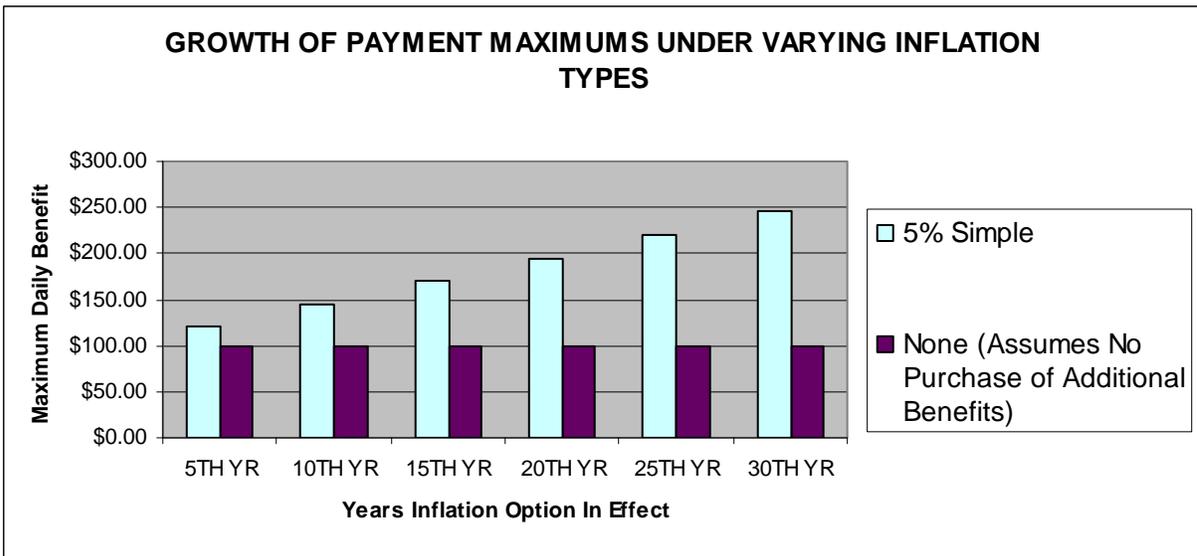
1. Treatment for illness or medical condition arising out of war or any act of war, declared or undeclared.
2. Services for intentionally self-inflicted injury.
3. Services for Mental or Nervous Disorders without demonstrable organic disease (subject to the other Policy provisions, We will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the Policy);
4. Services for alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician;
5. Due to participation in a felony, riot or insurrection
6. Care or services provided by a member of Your Immediate Family or someone who normally lives in Your residence;
7. Services for which You are not liable or for which no charge is normally made in the absence of insurance.
8. Covered Care outside the United States and the District of Columbia.

- 9. Non-duplication. We will not pay Benefits for Covered Care to the extent that the service is reimbursed, or would be but for the application of a deductible or coinsurance amount, under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid).
- 10. Pre-existing condition. No benefits are payable for any Covered Care that begins within the first six (6) months after the Effective Date of this Policy which is caused by a Pre-existing Condition.

10. **RELATIONSHIP OF COST OF CARE AND BENEFITS:**

Because the cost of recovery care services will likely increase over time, You should consider whether and how the benefits of this plan might be adjusted. Neither Your Daily Benefit Amount nor Your Lifetime Benefit will increase over time if You do not purchase inflation protection.

The following is a hypothetical comparison of the levels of a Policy that increases the Daily Benefit over a period of coverage with a Policy that does not increase the Daily Benefit. The comparison shows the effect on Benefits at five (5) year intervals over thirty years for a client purchasing a \$1000 Daily Benefit with a 5% index percentage.



Simple: If You purchase simple indexing, Your Daily Benefit and Lifetime Benefit will increase on every anniversary of the effective date of the Policy. Your Daily Benefit Amount will increase by 5% multiplied by the Daily Benefit in effect on the Effective Date of this Rider. Your Lifetime Benefit Amount will increase by the same proportion as the increase in Your Daily Benefit Amount. We will round the increase to the nearest dollar. This increase will continue for as long as Your Policy is in force without regard to health status or age. Premiums will not change due to increases under this Rider.

None: If You purchase no indexing, Your Daily Benefit Amount and Lifetime Benefit Amount will not increase over time.

- 11. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS:** This Policy provides coverage if You are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses that result in a cognitive impairment.

12. **PREMIUM:**

The total annual premium quoted for Your Policy is shown below. The total premium amount of Your issued Policy is listed on the Premium Information page of Your Schedule of Policy Benefits and may vary from the amount that is identified below due to medical underwriting.

(Producer: Please use the space below to indicate the premium quoted.)

Basic Benefits Annual Premium \$ _____

Optional Riders Modal Premium

Inflation Rider \$ _____

Total Modal Premium for Optional Riders \$ _____

Less any /Affiliation/ Employer Program/ Discounts

Your Total Modal Premium will be: \$ _____ on a _____ basis*.

The Annualized Modal Premium for this Policy is: _____

* You may elect to pay Your premium on other than an annual basis. Please note that payment schedules of less than annual will result in a higher premium amount paid per year.

13. **ADDITIONAL FEATURES:**

- (a) Medical underwriting of Your application is used to determine Your eligibility for short term recovery care insurance.
- (b) Benefits may be available after termination if You are receiving Benefits covered under the Policy. See the "Extension of Benefits" section of Your Policy for specific requirements.
- (c) If Your Policy terminates because of non-payment, You may apply for reinstatement of the Policy.
- (d) No prior hospitalization is required before You can receive coverage under this Policy.

14. **CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING SHORT TERM RECOVERY CARE INSURANCE.**

CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR POLICY.

15. **SENIOR COUNSELING PROGRAMS:** Please refer to *A Shopper's Guide To Long Term Care Insurance* contained in Your enrollment material for the telephone number of the Senior Counseling Program in Your state.

16. **POTENTIAL RATE INCREASE DISCLOSURE**

- 1. **Premium Rate:** Your premium rate that is applicable to You and that will be in effect until a request is made and filed with Your State Department of Insurance for an increase is shown on Your Schedule of Policy Benefits page in Your Policy.
- 2. The premium for this Policy will be shown on the Schedule of Policy Benefits page of Your Policy.

3. **Rate Schedule Adjustments:** If Your rates are changed, the new rates will become effective on the next billing date. The new rates will remain in effect until another request is made and filed with Your State Department of Insurance. You have the right to receive a revised Schedule of Policy Benefits page if the premium rate is changed.
4. **Potential Rate Revision: This Policy is Guaranteed Renewable.** This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to Your age or declining health, but Your rates may go up based on the experience of all insureds with a Policy similar to Yours. If You receive a premium rate increase in the future, You will be notified of the new premium amount and You will be able to exercise at least one of the following options:
 - (a) Pay the increased premium and continue Your coverage in force as is.
 - (b) Reduce Your coverage benefits to a level such that Your premiums will not increase.

MEDAmerica INSURANCE COMPANY

An Excellus Company

Home Office: Pittsburgh, PA

Administrative Office:

165 Court Street
Rochester, NY 14647

Product Filing/Contracts Management

Tel: (800) 544-0327 x 6782

Fax: (585) 238-3642

E-Mail Address: Jamie.Vahue@medamericaltc.com

11/4/2011

Jay Bradford, Commissioner
Arkansas Department of Insurance
1200 West 3rd. Street
Little Rock, Arkansas 72201-1904

RE: **MedAmerica Insurance Company**
Form and Rate Filing – Short-Term Care Insurance
FORM #: TRS-336-AR et al.

NAIC #: 69515 00
FEIN #: 34-0977231

Dear Commissioner Bradford:

The enclosed form and rate filing is submitted for our Short-Term Care Insurance product for your review and approval. The forms submitted under the Forms Schedule tab are new and are not intended to replace any existing forms. The application format may change depending on the medium used for implementation to allow for another method of taking an application; however the content will remain the same.

This product is being filed with an anticipated target date for product availability of 12/18/11.

Thank you for your consideration of this filing. Please do not hesitate to contact me at the number listed above if I can be of any assistance as you complete your review.

Sincerely,

Jamie Vahue

Ms. Jamie Vahue
LTC Compliance Analyst



Short Term Recovery Care Policy - Limited Benefit Health Insurance Coverage

Thank You for selecting MedAmerica Insurance Company, We are pleased to provide You with this Policy. Your coverage, if the first premium is paid, as stated herein, begins at 12:01a.m. Standard time at Your home on the Effective Date of this Policy. It ends on 12:01a.m. Standard time at Your home on the termination date of this Policy.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with short term recovery care incurred by the buyer during the period of coverage. THIS POLICY PROVIDES LIMITED BENEFITS FOR SHORT TERM RECOVERY CARE ONLY. The buyer is advised to review carefully all Policy limitations. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Us.

DISCLAIMER: THIS POLICY IS NOT A LONG TERM CARE INSURANCE POLICY. THIS POLICY IS NOT A MAJOR MEDICAL HEALTH INSURANCE POLICY. THIS POLICY WILL NOT COVER ANY PRE-EXISTING CONDITIONS FOR A PERIOD OF 6 MONTHS AFTER THE EFFECTIVE DATE OF COVERAGE.

SUBROGATION: If You become eligible for Benefits under this Policy as the result of injury or illness for which another party may be responsible, and We pay You Benefits as the result of that injury or illness, We reserve the right to pursue recovery from such third party, whether by judgment, settlement or otherwise, to the extent of the total amount of Benefits paid to You under this Policy, less reasonable and necessary expenditures, including attorneys' fees, incurred in effecting such recovery. Our right to proceed against the third party is independent of any right of action You may have. Failure To Cooperate: If You fail to cooperate with Us in proceeding against the party responsible for Your illness or injury to recover the Benefits We have paid, We will be entitled to be reimbursed for said Benefits from a settlement or judgment You receive from the responsible party.

GUARANTEED RENEWABLE/PREMIUM INCREASES: This Policy is guaranteed renewable. That means Your coverage will continue for life as long as You pay the premiums within the allowable time. We cannot change the provisions of this Policy without Your consent. We can change Your premium with 45 days written notice, but only if We change the premiums for all similar Policies issued in Your state on this Policy form, regardless of where You reside at the time of the premium change. You cannot be singled out for any increase because of a change in Your age or health.

RIGHT TO EXAMINE AND RETURN THIS POLICY: If You feel this Policy does not meet Your needs, You may return it to Your producer or Us within 30 days of Your receipt of this Policy. If You do so: (1) We will return the premium You paid; and (2) We will not provide any Benefits under this Policy.

IMPORTANT NOTICE: Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Us within 10 days if any information shown on it is not correct and/or complete or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

This Policy is signed on Our behalf by Our President.

[William E. Jones, Jr.]
[President]

TABLE OF CONTENTS

SCHEDULE OF POLICY BENEFITS	[3]
DEFINITIONS.....	[4]
PART 1: BENEFITS.....	[9]
PART 2: HOW TO RECEIVE BENEFITS.....	[11]
PART 3: LIMITATIONS OR EXCLUSIONS	[14]
PART 4: PREMIUM.....	[15]
PART 5: GENERAL PROVISIONS.....	[16]

SCHEDULE OF POLICY BENEFITS



Short Term Recovery Care Policy

POLICY NUMBER: TRS-336-AR ORIGINAL POLICY EFFECTIVE DATE: MM/DD/YY
 BILLING ACCOUNT #: [POLICY CHANGE EFFECTIVE DATE: MM/DD/YY]
 POLICYHOLDER ISSUE AGE: [(18-85)]
 PAYMENT MODE:[Monthly, Quarterly, Semi-annually, Annually]
 INSURED NAME: XXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX XXX
 ADDRESS: Line 1
 Line 2
 City, State, ZIP Code

BASE BENEFITS AND PREMIUM INFORMATION

ELIMINATION PERIOD:	[20]; [30]; [60] Calendar Days
DAILY BENEFIT AMOUNT:	[\$50 TO \$300]
LIFETIME BENEFIT AMOUNT:	[[100];[200];[360] X DAILY BENEFIT=\$_____]
BASIC BENEFITS MODAL PREMIUM:	[\$ 99,999.99]
PREMIUM PAYMENT OPTION: <input checked="" type="checkbox"/> Lifetime: Premiums are payable as long as Your Policy is in force.	
OPTIONAL RIDERS MODAL PREMIUM:	[\$ 99,999.99]
[No Inflation, Benefits Remain Level];	
[5% Simple Benefit Increase Rider];	[\$ 9,999.99]
Total Modal Premium Including Optional Riders and Discounts	[\$ 99,999.99]
Total Annualized Premium Including Optional Riders and Discounts	[\$ 99,999.99]

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL)

Each of the following is an Activity of Daily Living:

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair, or wheelchair.

ADULT DAY CARE / ADULT DAY CARE CENTER

This is a facility that provides a daytime program of social and health-related services in a community group setting. An Adult Day Care Center does not provide 24-hour care. It must be established, licensed and operated in accordance with any applicable state or local laws.

APPROVED PROVIDERS

Approved Providers are any of the following:

- Qualified Facility; or
- Hospice Program; or
- Home Health Care Agency; or
- Adult Day Care Center.

ASSESSMENT

An Assessment is an evaluation of Your ability to perform Activities of Daily Living and Your cognitive condition to certify whether You qualify for benefits. A Licensed Health Care Practitioner using recognized and accepted, objective standards of measurement must perform the Assessment. The Assessment must be made at the time You wish to establish Benefit Eligibility.

BENEFITS

Payments described in the "Benefits" section of Your Policy, Your Schedule of Policy Benefits, and Riders attached to Your Policy.

BENEFIT ELIGIBLE or BENEFIT ELIGIBILITY	<p>To be Benefit Eligible or achieve Benefit Eligibility under this Policy, all of the following conditions must be met.</p> <ol style="list-style-type: none"> 1. We have verified You have been certified by a Licensed Health Care Practitioner as: <ol style="list-style-type: none"> a) Being unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) Requiring Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment; and 2. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period).
COVERED CARE	Care or services for which Benefits are payable under this Policy, or would have been payable except for any Elimination Period, that assist with Activities of Daily Living and/or Severe Cognitive Impairment.
DOMESTIC PARTNER	Domestic Partners are persons at least 18 years of age, not related by blood, of the same or opposite sex in an exclusive and committed relationship. They must have lived together for at least 12 months in a common household and have an exclusive mutual commitment, including financial interdependence, similar to that of marriage.
DAILY BENEFIT AMOUNT	This is the maximum amount We will pay for all covered Benefits You receive on any one day as stated in Your Schedule of Policy Benefits. You may only receive one Daily Benefit Amount per day.
ELIMINATION PERIOD	<p>The Elimination Period is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins on the first day of Covered Care.</p> <p>The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Days in an Elimination Period are combined and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.</p> <p>Benefits are not payable during the Elimination period except for Hospice Care, Respite Care and MyCare benefits.</p>
FAMILY; FAMILY MEMBER	Your Spouse or Domestic Partner and anyone who is related to You, Your Spouse or Your Domestic Partner (including adopted, in-law and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.
HOME	Any place where You reside other than a Qualified Facility or hospital.
HOME HEALTH CARE AGENCY	A state or federally licensed, accredited or certified Home Health Care Agency that provides care and services in Your Home.

HOSPICE CARE PROGRAM	<p>A state or federally licensed, accredited or certified program that provides a program of care designed to provide palliative care with the philosophy of alleviating the physical, emotional, and spiritual discomforts of a person who:</p> <ul style="list-style-type: none"> a) Is in the last phases of life due to a terminal disease; and b) Has a physician-certified prognosis of less than six (6) months to live. <p>The program must be administered by an interdisciplinary team that consists of a physician, a registered nurse, clergy or counselors, trained volunteers and other appropriate staff having expertise in meeting the needs of terminal patients.</p> <p>Hospice Care Program services may be provided in a Qualified Facility, or in Your Home. This benefit is not subject to the Elimination Period.</p>
LICENSED HEALTH CARE PRACTITIONER	<p>A Licensed Health Care Practitioner means any of the following other than a family member: a physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.</p>
LIFETIME BENEFIT AMOUNT	<p>This is the total amount of Benefits payable under this Policy as shown in Your Schedule of Policy Benefits. We will deduct from this amount all Benefits paid under this Policy.</p> <p>If Your Schedule of Policy Benefits states that You have a Simple Benefits Increase Rider, Your Lifetime Benefit Amount will increase over time. The initial Lifetime Benefit Amount is determined by the Daily Benefit Amount multiplied by the number of Benefit Days as shown on Your Schedule of Policy Benefits.</p>
MEDICARE	<p>The Health Insurance for Aged Act, Title XVIII of the Social Security Act Amendments of 1965, as Constituted and Later Amended.</p>
POLICY	<p>This is a legal agreement between You and Us. It includes this document, Your application, and any attached riders or endorsements.</p>
POLICY ANNIVERSARY DATE	<p>This is the date each year that coincides with the date Your Policy went into effect. Your first Policy Anniversary Date will be one year from the date Your Policy went into effect.</p>
PRE-EXISTING CONDITION	<p>A Pre-existing Condition means the existence of a health, physical or cognitive condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Licensed Health Care Practitioner within a 6 month period before the Effective Date of this Policy.</p>

QUALIFIED FACILITY

A Qualified Facility is a state or federally regulated, licensed, accredited or certified facility that meets all of the following criteria:

- Provides accommodations to 3 or more unrelated individuals and supervision and personal care services for at least 3 of these individuals; and
- Provides 24-hour-a-day care and services; and
- Has a trained, awake, and ready-to-respond employee on duty in the facility at all times to provide necessary care; and
- Provides 2 meals a day and accommodates special dietary needs; and
- Conducts an assessment of the resident on admission that includes a history and physical by a physician, nurse practitioner, or physician assistant in the last 60 days, the resident's ability to perform both instrumental activities of daily living and activities of daily living, safety evaluation, risk of fall assessment, cognitive assessment, and the resident's ability to manage medication administration; and
- Develops a Plan of Care or service plan for each resident that is customized to the resident and includes both the services provided by or contracted by the residence and identifies services that will be provided by outside agencies directly contracted with the insured including the scope of services, frequency of services and monitoring of services delivered; and
- Reviews the service plan at least every six months or as the resident's needs change.

A Qualified Facility must meet the above criteria for the Benefits to be paid.

A Qualified Facility is NOT:

- A hospital or clinic; or
- A place that operates primarily for the treatment of alcoholism, drug addiction or mental illness;
- An Adult Day Care or similar establishment.

RESPITE CARE

Respite Care services provide temporary care for You while Your regular caregiver in the Home takes time away from providing care.

SEVERE COGNITIVE IMPAIRMENT

Severe Cognitive Impairment means a deterioration or irreversible loss in intellectual capacity that requires Substantial Supervision to assure You and others' safety. The deterioration or loss is established by clinical evidence and standardized tests that reliably measure:

- short-term or long-term memory;
- orientation as to people, place, or time;
- deductive or abstract reasoning; or
- judgement as it relates to safety awareness.

SPOUSE A Spouse is a married policyholder or the person to whom they are married. The marriage must be recognized as legal in accordance with the laws of the state in which this Policy is sold.

SUBSTANTIAL ASSISTANCE There are two types of Substantial Assistance.

1. *Hands-on Assistance*: The physical assistance of another person without which an individual could not perform an Activity of Daily Living, or
2. *Stand-by Assistance*: The presence of another person within arm's reach necessary to prevent, by physical intervention, injury to an individual while they are performing an Activity of Daily Living.

SUBSTANTIAL SUPERVISION This is continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and that is necessary to protect You from threats to Your health or safety.

WE, US, OUR This refers to MedAmerica Insurance Company.

YOU, YOUR, YOURSELF This refers to the person to whom this Policy is issued and whose name appears in the Schedule.

PART 1: BENEFITS

Below are descriptions of the Benefits under this Policy.

Benefits are described in this Policy or the Riders attached to it. Benefit and Rider limits and effective dates are stated on the Schedule of Policy Benefits.

If You meet Benefit Eligibility, We will provide Benefits for the actual charges incurred up to the Daily Benefit Amount and subject to a Lifetime Benefit Amount shown in Your Schedule of Policy Benefits for the following Covered Care:

QUALIFIED FACILITY BENEFITS Confinement in a Qualified Facility for room, board and care services (such care services being nursing care, custodial care or hospice care).

HOME CARE BENEFITS Services provided by a Hospice Care Program, or by an Adult Day Care Center or Home Health Care Agency including:

- nursing services; and/or
- physical, occupational, respiratory and speech therapy; and/or
- home health aide or personal care attendant services including such things as: personal hygiene, performing Activities of Daily Living (ADL) , managing medications, and other related supportive services; and/or
- homemaker services including light work, household tasks, preparing meals, doing laundry and other incidental household tasks that do not require the services of a trained aide or attendant.

OTHER BENEFITS

BED RESERVATION If You leave the Qualified Facility temporarily while We are paying for Benefits and the facility charges You a fee to reserve Your bed, We will pay to reserve Your bed for up to 21 days per calendar year.

We will pay the actual charges to reserve Your bed, up to the Daily Benefit Amount and subject to a Lifetime Benefit Amount shown in Your Schedule of Policy Benefits.

You must continue to meet Benefit Eligibility. Your eventual need to return to the facility where the bed is reserved must be expected and documented by Your physician.

MYCARE PROGRAM If You meet Benefit Eligibility, You may elect to choose to use some of Your Benefits to pay for care management services with a licensed health care professional at 100% of the actual charges incurred up to six (6) times the Daily Benefit Amount shown in Your Schedule of Policy Benefits. This Benefit provides You with the option to seek the consultation services of a licensed health care professional of Your choice.

Such consultation services may provide You with assistance and advice in choosing services and providers. This benefit is not subject to the Elimination Period. Payments made under this Benefit are deducted from you Lifetime Benefit.

OTHER GOODS AND SERVICES

From time to time, We may offer or provide certain goods and services in addition to insurance coverage. We may also arrange for third party vendors to provide goods and services at a discount including without limitation, financial counseling services and discounts to service providers. Though We may make the arrangements, the third party vendors are solely liable for providing the goods and services. We shall not be responsible for providing or failing to provide the goods and services. Further, We shall not be liable for the negligent provision of the goods and services by third party vendors. We reserve the right to discontinue providing additional goods and services at any time.

RESPITE CARE

Respite Care services provide temporary care for You while Your regular caregiver in the Home takes time away from providing care.

If You meet Benefit Eligibility and You are at Home, We will pay Benefits for Covered Care for Respite Care provided in Your Home, or a Qualified Facility.

We will reimburse the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule of Policy Benefits for a maximum Benefit of 14 days per calendar year. Payments made under this Benefit are deducted from Your Lifetime Benefit.

This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

RESTORATION OF LIFETIME BENEFIT AMOUNT

If You have received Benefits under this policy and have used up a portion of the Lifetime Benefit Amount shown in Your Schedule of Policy Benefits, We will restore Your Policy's Lifetime Benefit Amount, once during the lifetime of Your Policy if You meet the following qualifications:

- 1. Your Policy remains continually in force; and
- 2. We have verified with an assessment that you are not currently, nor have been in the past 180 days, a) unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) require Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment.

WAIVER OF PREMIUMS

The premiums for this Policy will be waived the first day of Policy paid Benefits. Premiums become due and payable again on the date we determine you are no longer Benefit Eligible.

PART 2: HOW TO RECEIVE BENEFITS

ESTABLISHING BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need Covered Care under this Policy. Please call Our Customer Service Representative at [1-800-544-0327].

To be eligible for Benefits provided by this Policy, We must receive a periodic assessment that verifies You are a person who meets the following conditions:

- You need Substantial Assistance from another person to perform at least two of the Activities of Daily Living (ADL) (Bathing, Dressing, Eating, Toileting, Transferring, Continence); or
- You need Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

We will work with You, Your family and Your physician when We need information about Your condition. We will review the status of Your Activities of Daily Living (ADL) and cognitive function. We will use this information to make an evaluation of Your condition to determine whether You qualify or continue to qualify for Benefits under this Policy. This information may be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our determination.

NOTICE OF CLAIM

When You become Benefit Eligible, written notice of claim must be given to Us within 60 days after the date Your loss starts, or as soon thereafter as is reasonably possible. The notice should include at least Your name, Your Policy Identification Number, and the address to which the claim form is to be sent. Notice must be given by You or on Your behalf to Us at:

[MedAmerica Insurance Company]
[165 Court Street]
[Rochester, NY 14647]

HOW TO FILE A CLAIM

CLAIM FORMS: We will send claim forms to You upon receipt of a written notice of claim. If We do not send such forms within 15 days after receiving notice, You will be deemed to have met the timeliness of claim filing requirements when You do submit, within the time fixed in this Policy for filing proof of loss, a letter describing the occurrence, character and extent of Your loss for which the claim is made.

At a minimum, the description should include Your name and address, Your Policy Identification number, the type of Benefits You are claiming, the names and addresses of Your physicians, the services You required, Your diagnosis, and the periods for which You are claiming Benefits.

WHEN TO FILE A CLAIM

PROOF OF LOSS: Written proof of loss must be received by Us within 90 days after the end of each month for which Benefits may be paid. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

CONDITIONS FOR RECEIVING CLAIM PAYMENT

If You meet Benefit Eligibility, We will pay Benefits subject to the terms, limitations and exclusions described in this Policy. The following conditions also apply:

- Your Policy must be in force when the care is approved and received; and
- You have completed the Elimination Period, if it applies; and
- The service is covered under this Policy; and
- You have not exhausted the Lifetime Benefit Amount shown in Your Schedule of Policy Benefits.

PAYMENT OF CLAIMS: All Benefits will be paid to You or another person or approved Provider upon your written request. You may request in writing no later than the time proof of loss is filed that payment be made to the Approved Provider. Benefits due and unpaid at Your death will be paid to Your estate.

HOW AND WHEN CLAIMS ARE PAID

TIME OF PAYMENT OF CLAIM: Upon receipt of the proper written proof of loss, any Benefits then due will be paid:

1. Monthly, when the loss is expected to result in ongoing Benefits, and
2. Promptly, when Our liability has ended.

Such payment will be made within 30 days after having received the proper written proof of loss.

If We contest a claim or a portion of a claim, You or Your Legal Representative will be notified in writing that the claim is contested or denied within 30 days after We have received Your claim.

The notice that the claim is contested will identify the contested portion of the claim and the reasons for contesting the claim. Upon receiving any additional information requested by Us, the contested claim or portion thereof will be paid or denied within 30 days.

Benefits due and unpaid at Your death will be paid to Your estate or Your Named Payee.

Currency: Benefits will be paid in US currency.

RECOVERY OF OVERPAYMENT

If, due to an error in processing, a claim results in an overpayment, We will explain the overpayment to You. You must return the amount of overpayment within 60 days of Our request. Any overpayment that is not returned to Us within 60 days of Our request will be deducted from future claim payments.

WHEN YOU HAVE CLAIM QUESTIONS

If You would like an explanation of Our claim payment, please call or write to Us.

YOUR APPEAL RIGHTS

If We contest a claim or a portion of a claim, You or Your legal representative will be notified in writing that the claim is contested or denied.

You have a right to appeal Our claims decision. The appeal must be filed in writing with Our office within 3 years of the time the denied claim being appealed was filed. Include the reason for the appeal and any documents You feel are pertinent to the situation.

We will send You a written acknowledgement of Your appeal. If no additional information is needed, the acknowledgement will include an explanation of the denial. If additional information is required, We will explain what is needed. If We do not receive the requested information within 21 days, We will notify You in writing.

Within 60 days of the receipt of required information, We will notify You in writing of the outcome of the reconsideration of Your claim, and the contested claim or portion thereof that will be paid or denied.

PHYSICAL EXAMINATION

We, at Our expense, can have You examined as often as reasonably needed while a claim is pending or active.

TIME LIMIT FOR LEGAL ACTION

You cannot begin legal action before 60 days after written proof of loss has been given to Us. The time limit for legal action is 3 years after the time written proof of loss is furnished.

PART 3: LIMITATIONS AND EXCLUSIONS

EXCLUDED SERVICES

Expenses for the following will not be covered under this Policy:

1. Treatment for illness or medical condition arising out of war or any act of war, declared or undeclared.
2. Services for intentionally self-inflicted injury.
3. Services for Mental or Nervous Disorders without demonstrable organic disease (subject to the other Policy provisions, We will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the Policy);
4. Services for alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician;
5. Due to participation in a felony, riot or insurrection
6. Care or services provided by a member of Your Family or someone who normally lives in Your residence;
7. Services for which You are not liable or for which no charge is normally made in the absence of insurance.
8. Covered Care outside the United States and the District of Columbia.
9. Non-duplication. We will not pay Benefits for Covered Care to the extent that the service is reimbursed, or would be reimbursed but for the application of a deductible or coinsurance amount, under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid).
10. Pre-existing condition. No benefits are payable for any Covered Care that begins within the first six (6) months after the Effective Date of this Policy which is caused by a Pre-existing Condition.

PART 4: PREMIUM

PREMIUM AMOUNT

The initial premium is shown in Your Schedule of Policy Benefits. It will remain the same unless You change Your coverage or We change the premium. If We change the premium, We will notify You at least 45 days in advance. No change will be made to the premium amount unless We change the premium rates for all Policies like Yours that We have issued in the state where this Policy has been approved and, where applicable, Your State Department of Insurance has approved the increase.

PAYMENT

Premiums are due in advance.

GRACE PERIOD

An initial Grace Period of 31 days will be granted for each premium that is unpaid on the date due. After the initial Grace Period of 31 days elapses, a notice will be sent to You explaining that a payment has been missed and that Your Policy risks lapsing. If You have designated an individual to be notified in case of lapse, We will also send notice to the address You provided for that designee. You will have an additional 35 days Grace Period that begins the date We mail the second notice to pay the unpaid premium.

Payment will allow Your Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the second Grace Period will result in the termination of Your Policy as of the premium due date.

Lapse Designee: If You have designated an individual to be notified of lapse, We will provide You the opportunity, no less frequently than every 2 years, to change such designation.

REINSTATEMENT

If Your Policy lapses because You did not pay Your premium within the Grace Period, You may request reinstatement with no break in coverage. If We honor this request, Your Policy will be reinstated back to the termination date. If We do not approve or disapprove Your request within 45 days of receipt of the request and a premium was accepted by Us or one of Our authorized representatives, Your Policy will be reinstated as of the date Your Policy terminated.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

You may request reinstatement up to 5 months after termination, if You did not pay Your premium due to a condition that would qualify You for Benefits. Your condition is subject to verification. An Assessment is required before deciding on reinstatement. If reinstated, You must pay Your premium retroactive to the date Your Policy terminated.

UNEARNED PREMIUM

When We are notified of Your cancellation or death, We will refund any premium paid for the period beyond Your cancellation or death. If You have died, all premiums paid for the period beyond Your death will be refunded to Your Estate. In the event of Your cancellation, premiums paid for the period beyond Your cancellation will be refunded to You.

PART 5: GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES	This Policy document, Your application and any Riders establish the entire contract of insurance between You and Us. Any material change must be approved by one of Our officers and be endorsed on or attached to this Policy. No insurance agent has the authority to change this Policy or to waive any of its provisions.
YOUR BENEFITS	With the exception of a Named Payee or Your estate, only You are eligible for Benefit payments other than returned premiums under this Policy.
WHEN YOUR POLICY COVERAGE BEGINS	The date that Your Policy begins is shown in Your Schedule of Policy Benefits. All time periods begin and end at 12:01 a.m. standard time at Your residence.
WHEN YOUR POLICY COVERAGE ENDS	<p>Your Policy ends on the day after the date one of the following occurs. As of 12:01 a.m. standard time at Your residence, You will no longer be entitled to Benefits under this Policy:</p> <ul style="list-style-type: none">• Nonpayment of premium (subject to the Grace Period); or• Your Lifetime Maximum is exhausted; or• You elect to cancel this Policy; or• Your death.
EXTENSION OF BENEFITS	<p>If, on the date this Policy is cancelled, You are Benefit Eligible, We will continue to pay for Your care without interruption of Benefits until the first of the following dates:</p> <ul style="list-style-type: none">• It is determined that You are no longer eligible for Benefits under this Policy; or• You have used up Your Lifetime Benefit Amount. <p>If You have become a) unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) require Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment, prior to the date the Policy is cancelled and are able to meet Benefit Eligibility, We will pay for Your care without interruption of Benefits until the first of the following date:</p> <ul style="list-style-type: none">• It is determined that You are no longer eligible for Benefits under this Policy; or• You have used up Your Lifetime Benefit Amount. <p>We will not pay for more care than You would have been entitled to receive if Your Policy had not terminated.</p> <p>You will not be entitled to Benefits after termination if the reason Your Policy terminated was due to You reaching Your maximum Lifetime Benefit Amount.</p>

INCONTESTABLE PERIOD

If Your Policy has been in force for less than 6 months, We may rescind Your Policy or deny a claim if it can be shown that a misrepresentation by You was material to Our acceptance of You.

If Your Policy has been in force for at least 6 months but less than 2 years, We may rescind Your Policy or deny a claim if it is shown that a misrepresentation by You both was material to Our acceptance of You and pertained to the condition for which Benefits are sought.

If Your Policy has been in force for 2 years or more, We may rescind Your Policy or deny a claim only if it is shown that You knowingly and intentionally misrepresented relevant facts relating to Your health or due to non-payment of premiums.

These provisions also apply if You provide additional evidence of insurability to purchase additional coverage after Your Policy Effective Date.

CLERICAL ERROR

Clerical error, whether by You or Us, will not void Your insurance if that insurance would otherwise have been in effect. Neither will it extend Your insurance if that insurance would otherwise have ended or been reduced as provided in this Policy.

MISSTATEMENT OF AGE

If Your age was misstated on Your Application, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

Our liability will be limited to a refund of the premiums You have paid for this Policy if You would have been subject to additional evidence of insurability at Your correct age, and You do not provide satisfactory proof to Us of successfully completing the additional evidence of insurability according to our standards in effect for Your correct age at the time of Your original application to Us.

MISSTATEMENT OF FACT

If Your information regarding Your Spouse or Domestic Partner's eligibility was misstated on Your Application, Your premium will be changed retroactively to Your original effective date to correspond to Your Spouse or Domestic Partner's actual eligibility status.

Application misstatements regarding Your Spouse or Domestic Partner eligibility are subject to the provision "Incontestable Period" for purposes of Policy rescission or claim denial.

NON-PARTICIPATING

This Policy does not participate in Our profits or surplus earnings.

**COMMUNICATION THROUGH
ELECTRONIC MEANS**

We reserve the right to designate the form and means of all communications or notices required by Your Policy.
If We agree, You may contact Us about Your Policy using electronic means or technologies.
If You agree, We may contact You regarding Your Policy using electronic means or technologies.

Except where barred by state or federal law, electronic communication is equal to other communication methods. Information exchanged has the same legal effect, validity, and enforceability.

**CONFORMITY WITH FEDERAL
AND STATE STATUTES**

Any provision of this Policy that does not comply with a law to which it is subject is amended to conform to the minimum requirement of such law.

Transitions.

Is a trademark of MedAmerica Insurance Company.
All rights reserved.

SERFF Tracking Number: MEAM-127754532 *State:* Arkansas
Filing Company: MedAmerica Insurance Company *State Tracking Number:* 50196
Company Tracking Number: TRS-336-AR
TOI: H131 Individual Health - Short Term Care *Sub-TOI:* H131.002 Nursing Home
Product Name: TRS-336-AR
Project Name/Number: TRS-336-AR/TRS-336-AR

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)
10/25/2011	Form	Transitions Policy	11/07/2011	TRS-336-AR.pdf (Superseded)

Transitions
Short Term Recovery Care Policy

Thank You for selecting MedAmerica Insurance Company, We are pleased to provide You with this Policy. Your coverage, if the first premium is paid, as stated herein, begins at 12:01a.m. Standard time at Your home on the Effective Date of this Policy. It ends on 12:01a.m. Standard time at Your home on the termination date of this Policy.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with short term recovery care incurred by the buyer during the period of coverage. THIS POLICY PROVIDES LIMITED BENEFITS FOR SHORT TERM RECOVERY CARE ONLY. The buyer is advised to review carefully all Policy limitations. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Us.

DISCLAIMER: THIS POLICY IS NOT A LONG TERM CARE INSURANCE POLICY. THIS POLICY IS NOT A MAJOR MEDICAL HEALTH INSURANCE POLICY. THIS POLICY WILL NOT COVER ANY PRE-EXISTING CONDITIONS FOR A PERIOD OF 6 MONTHS AFTER THE EFFECTIVE DATE OF COVERAGE.

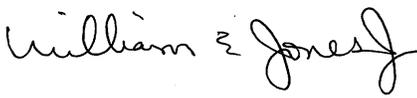
SUBROGATION: If You become eligible for Benefits under this Policy as the result of injury or illness for which another party may be responsible, and We pay You Benefits as the result of that injury or illness, We reserve the right to pursue recovery from such third party, whether by judgment, settlement or otherwise, to the extent of the total amount of Benefits paid to You under this Policy, less reasonable and necessary expenditures, including attorneys' fees, incurred in effecting such recovery. Our right to proceed against the third party is independent of any right of action You may have. Failure To Cooperate: If You fail to cooperate with Us in proceeding against the party responsible for Your illness or injury to recover the Benefits We have paid, We will be entitled to be reimbursed for said Benefits from a settlement or judgment You receive from the responsible party.

GUARANTEED RENEWABLE/PREMIUM INCREASES: This Policy is guaranteed renewable. That means Your coverage will continue for life as long as You pay the premiums within the allowable time. We cannot change the provisions of this Policy without Your consent. We can change Your premium with 45 days written notice, but only if We change the premiums for all similar Policies issued in Your state on this Policy form, regardless of where You reside at the time of the premium change. You cannot be singled out for any increase because of a change in Your age or health.

RIGHT TO EXAMINE AND RETURN THIS POLICY: If You feel this Policy does not meet Your needs, You may return it to Your producer or Us within 30 days of Your receipt of this Policy. If You do so: (1) We will return the premium You paid; and (2) We will not provide any Benefits under this Policy.

IMPORTANT NOTICE: Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Us within 10 days if any information shown on it is not correct and/or complete or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

This Policy is signed on Our behalf by Our President.



[William E. Jones, Jr.]
[President]

TABLE OF CONTENTS

SCHEDULE OF POLICY BENEFITS	[3]
DEFINITIONS.....	[4]
PART 1: BENEFITS.....	[9]
PART 2: HOW TO RECEIVE BENEFITS.....	[11]
PART 3: LIMITATIONS OR EXCLUSIONS	[14]
PART 4: PREMIUM.....	[15]
PART 5: GENERAL PROVISIONS.....	[16]

SCHEDULE OF POLICY BENEFITS



Short Term Recovery Care Policy

POLICY NUMBER: TRS-336-AR

ORIGINAL POLICY EFFECTIVE DATE: MM/DD/YY

BILLING ACCOUNT #:

[POLICY CHANGE EFFECTIVE DATE: MM/DD/YY]

POLICYHOLDER ISSUE AGE: [(18-85)]

PAYMENT MODE:[Monthly, Quarterly, Semi-annually, Annually]

INSURED NAME: XXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX XXX

ADDRESS: Line 1

Line 2

City, State, ZIP Code

BASE BENEFITS AND PREMIUM INFORMATION

ELIMINATION PERIOD:	[20]; [30]; [60] Calendar Days
DAILY BENEFIT AMOUNT:	[\$50 TO \$300]
LIFETIME BENEFIT AMOUNT:	[[100];[200];[360] X DAILY BENEFIT=\$_____]
BASIC BENEFITS MODAL PREMIUM:	[\$ 99,999.99]
PREMIUM PAYMENT OPTION: <input checked="" type="checkbox"/> Lifetime: Premiums are payable as long as Your Policy is in force.	
OPTIONAL RIDERS MODAL PREMIUM:	[\$ 99,999.99]
[No Inflation, Benefits Remain Level];	
[5% Simple Benefit Increase Rider];	[\$ 9,999.99]
Total Modal Premium Including Optional Riders and Discounts	[\$ 99,999.99]
Total Annualized Premium Including Optional Riders and Discounts	[\$ 99,999.99]

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL)

Each of the following is an Activity of Daily Living:

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair, or wheelchair.

ADULT DAY CARE / ADULT DAY CARE CENTER

This is a facility that provides a daytime program of social and health-related services in a community group setting. An Adult Day Care Center does not provide 24-hour care. It must be established, licensed and operated in accordance with any applicable state or local laws.

APPROVED PROVIDERS

Approved Providers are any of the following:

- Qualified Facility; or
- Hospice Program; or
- Home Health Care Agency; or
- Adult Day Care Center.

ASSESSMENT

An Assessment is an evaluation of Your ability to perform Activities of Daily Living and Your cognitive condition to certify whether You qualify for benefits. A Licensed Health Care Practitioner using recognized and accepted, objective standards of measurement must perform the Assessment. The Assessment must be made at the time You wish to establish Benefit Eligibility.

BENEFITS

Payments described in the "Benefits" section of Your Policy, Your Schedule of Policy Benefits, and Riders attached to Your Policy.

BENEFIT ELIGIBLE or BENEFIT ELIGIBILITY	<p>To be Benefit Eligible or achieve Benefit Eligibility under this Policy, all of the following conditions must be met.</p> <ol style="list-style-type: none"> 1. We have verified You have been certified by a Licensed Health Care Practitioner as: <ol style="list-style-type: none"> a) Being unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) Requiring Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment; and 2. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period).
COVERED CARE	Care or services for which Benefits are payable under this Policy, or would have been payable except for any Elimination Period, that assist with Activities of Daily Living and/or Severe Cognitive Impairment.
DOMESTIC PARTNER	Domestic Partners are persons at least 18 years of age, not related by blood, of the same or opposite sex in an exclusive and committed relationship. They must have lived together for at least 12 months in a common household and have an exclusive mutual commitment, including financial interdependence, similar to that of marriage.
DAILY BENEFIT AMOUNT	This is the maximum amount We will pay for all covered Benefits You receive on any one day as stated in Your Schedule of Policy Benefits. You may only receive one Daily Benefit Amount per day.
ELIMINATION PERIOD	<p>The Elimination Period is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins on the first day of Covered Care.</p> <p>The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Days in an Elimination Period are combined and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.</p> <p>Benefits are not payable during the Elimination period except for Hospice Care, Respite Care and MyCare benefits.</p>
FAMILY; FAMILY MEMBER	Your Spouse or Domestic Partner and anyone who is related to You, Your Spouse or Your Domestic Partner (including adopted, in-law and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.
HOME	Any place where You reside other than a Qualified Facility or hospital.
HOME HEALTH CARE AGENCY	A state or federally licensed, accredited or certified Home Health Care Agency that provides care and services in Your Home.

HOSPICE CARE PROGRAM

A state or federally licensed, accredited or certified program that provides a program of care designed to provide palliative care with the philosophy of alleviating the physical, emotional, and spiritual discomforts of a person who:
a) Is in the last phases of life due to a terminal disease; and
b) Has a physician-certified prognosis of less than six (6) months to live.

The program must be administered by an interdisciplinary team that consists of a physician, a registered nurse, clergy or counselors, trained volunteers and other appropriate staff having expertise in meeting the needs of terminal patients.

Hospice Care Program services may be provided in a Qualified Facility, or in Your Home. This benefit is not subject to the Elimination Period.

LICENSED HEALTH CARE PRACTITIONER

A Licensed Health Care Practitioner means any of the following other than a family member: a physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.

LIFETIME BENEFIT AMOUNT

This is the total amount of Benefits payable under this Policy as shown in Your Schedule of Policy Benefits. We will deduct from this amount all Benefits paid under this Policy.

If Your Schedule of Policy Benefits states that You have a Simple Benefits Increase Rider, Your Lifetime Benefit Amount will increase over time. The initial Lifetime Benefit Amount is determined by the Daily Benefit Amount multiplied by the number of Benefit Days as shown on Your Schedule of Policy Benefits.

MEDICARE

The Health Insurance for Aged Act, Title XVIII of the Social Security Act Amendments of 1965, as Constituted and Later Amended.

POLICY

This is a legal agreement between You and Us. It includes this document, Your application, and any attached riders or endorsements.

POLICY ANNIVERSARY DATE

This is the date each year that coincides with the date Your Policy went into effect. Your first Policy Anniversary Date will be one year from the date Your Policy went into effect.

PRE-EXISTING CONDITION

A Pre-existing Condition means the existence of a health, physical or cognitive condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Licensed Health Care Practitioner within a 6 month period before the Effective Date of this Policy.

QUALIFIED FACILITY

A Qualified Facility is a state or federally regulated, licensed, accredited or certified facility that meets all of the following criteria:

- Provides accommodations to 3 or more unrelated individuals and supervision and personal care services for at least 3 of these individuals; and
- Provides 24-hour-a-day care and services; and
- Has a trained, awake, and ready-to-respond employee on duty in the facility at all times to provide necessary care; and
- Provides 2 meals a day and accommodates special dietary needs; and
- Conducts an assessment of the resident on admission that includes a history and physical by a physician, nurse practitioner, or physician assistant in the last 60 days, the resident's ability to perform both instrumental activities of daily living and activities of daily living, safety evaluation, risk of fall assessment, cognitive assessment, and the resident's ability to manage medication administration; and
- Develops a Plan of Care or service plan for each resident that is customized to the resident and includes both the services provided by or contracted by the residence and identifies services that will be provided by outside agencies directly contracted with the insured including the scope of services, frequency of services and monitoring of services delivered; and
- Reviews the service plan at least every six months or as the resident's needs change.

A Qualified Facility must meet the above criteria for the Benefits to be paid.

A Qualified Facility is NOT:

- A hospital or clinic; or
- A place that operates primarily for the treatment of alcoholism, drug addiction or mental illness;
- An Adult Day Care or similar establishment.

RESPITE CARE

Respite Care services provide temporary care for You while Your regular caregiver in the Home takes time away from providing care.

SEVERE COGNITIVE IMPAIRMENT

Severe Cognitive Impairment means a deterioration or irreversible loss in intellectual capacity that requires Substantial Supervision to assure You and others' safety. The deterioration or loss is established by clinical evidence and standardized tests that reliably measure:

- short-term or long-term memory;
- orientation as to people, place, or time;
- deductive or abstract reasoning; or
- judgement as it relates to safety awareness.

SPOUSE A Spouse is a married policyholder or the person to whom they are married. The marriage must be recognized as legal in accordance with the laws of the state in which this Policy is sold.

SUBSTANTIAL ASSISTANCE There are two types of Substantial Assistance.

1. *Hands-on Assistance*: The physical assistance of another person without which an individual could not perform an Activity of Daily Living, or
2. *Stand-by Assistance*: The presence of another person within arm's reach necessary to prevent, by physical intervention, injury to an individual while they are performing an Activity of Daily Living.

SUBSTANTIAL SUPERVISION This is continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and that is necessary to protect You from threats to Your health or safety.

WE, US, OUR This refers to MedAmerica Insurance Company.

YOU, YOUR, YOURSELF This refers to the person to whom this Policy is issued and whose name appears in the Schedule.

PART 1: BENEFITS

Below are descriptions of the Benefits under this Policy.

Benefits are described in this Policy or the Riders attached to it. Benefit and Rider limits and effective dates are stated on the Schedule of Policy Benefits.

If You meet Benefit Eligibility, We will provide Benefits for the actual charges incurred up to the Daily Benefit Amount and subject to a Lifetime Benefit Amount shown in Your Schedule of Policy Benefits for the following Covered Care:

QUALIFIED FACILITY BENEFITS Confinement in a Qualified Facility for room, board and care services (such care services being nursing care, custodial care or hospice care).

HOME CARE BENEFITS Services provided by a Hospice Care Program, or by an Adult Day Care Center or Home Health Care Agency including:

- nursing services; and/or
- physical, occupational, respiratory and speech therapy; and/or
- home health aide or personal care attendant services including such things as: personal hygiene, performing Activities of Daily Living (ADL) , managing medications, and other related supportive services; and/or
- homemaker services including light work, household tasks, preparing meals, doing laundry and other incidental household tasks that do not require the services of a trained aide or attendant.

OTHER BENEFITS

BED RESERVATION If You leave the Qualified Facility temporarily while We are paying for Benefits and the facility charges You a fee to reserve Your bed, We will pay to reserve Your bed for up to 21 days per calendar year.

We will pay the actual charges to reserve Your bed, up to the Daily Benefit Amount and subject to a Lifetime Benefit Amount shown in Your Schedule of Policy Benefits.

You must continue to meet Benefit Eligibility. Your eventual need to return to the facility where the bed is reserved must be expected and documented by Your physician.

MYCARE PROGRAM If You meet Benefit Eligibility, You may elect to choose to use some of Your Benefits to pay for care management services with a licensed health care professional at 100% of the actual charges incurred up to six (6) times the Daily Benefit Amount shown in Your Schedule of Policy Benefits. This Benefit provides You with the option to seek the consultation services of a licensed health care professional of Your choice.

Such consultation services may provide You with assistance and advice in choosing services and providers. This benefit is not subject to the Elimination Period. Payments made under this Benefit are deducted from you Lifetime Benefit.

OTHER GOODS AND SERVICES

From time to time, We may offer or provide certain goods and services in addition to insurance coverage. We may also arrange for third party vendors to provide goods and services at a discount including without limitation, financial counseling services and discounts to service providers. Though We may make the arrangements, the third party vendors are solely liable for providing the goods and services. We shall not be responsible for providing or failing to provide the goods and services. Further, We shall not be liable for the negligent provision of the goods and services by third party vendors. We reserve the right to discontinue providing additional goods and services at any time.

RESPITE CARE

Respite Care services provide temporary care for You while Your regular caregiver in the Home takes time away from providing care.

If You meet Benefit Eligibility and You are at Home, We will pay Benefits for Covered Care for Respite Care provided in Your Home, or a Qualified Facility.

We will reimburse the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule of Policy Benefits for a maximum Benefit of 14 days per calendar year. Payments made under this Benefit are deducted from Your Lifetime Benefit.

This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

RESTORATION OF LIFETIME BENEFIT AMOUNT

If You have received Benefits under this policy and have used up a portion of the Lifetime Benefit Amount shown in Your Schedule of Policy Benefits, We will restore Your Policy's Lifetime Benefit Amount, once during the lifetime of Your Policy if You meet the following qualifications:

- 1. Your Policy remains continually in force; and
- 2. We have verified with an assessment that you are not currently, nor have been in the past 180 days, a) unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) require Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment.

WAIVER OF PREMIUMS

The premiums for this Policy will be waived the first day of Policy paid Benefits. Premiums become due and payable again on the date we determine you are no longer Benefit Eligible.

PART 2: HOW TO RECEIVE BENEFITS

ESTABLISHING BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need Covered Care under this Policy. Please call Our Customer Service Representative at [1-800-544-0327].

To be eligible for Benefits provided by this Policy, We must receive a periodic assessment that verifies You are a person who meets the following conditions:

- You need Substantial Assistance from another person to perform at least two of the Activities of Daily Living (ADL) (Bathing, Dressing, Eating, Toileting, Transferring, Continence); or
- You need Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

We will work with You, Your family and Your physician when We need information about Your condition. We will review the status of Your Activities of Daily Living (ADL) and cognitive function. We will use this information to make an evaluation of Your condition to determine whether You qualify or continue to qualify for Benefits under this Policy. This information may be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our determination.

NOTICE OF CLAIM

When You become Benefit Eligible, written notice of claim must be given to Us within 60 days after the date Your loss starts, or as soon thereafter as is reasonably possible. The notice should include at least Your name, Your Policy Identification Number, and the address to which the claim form is to be sent. Notice must be given by You or on Your behalf to Us at:

[MedAmerica Insurance Company]
[165 Court Street]
[Rochester, NY 14647]

HOW TO FILE A CLAIM

CLAIM FORMS: We will send claim forms to You upon receipt of a written notice of claim. If We do not send such forms within 15 days after receiving notice, You will be deemed to have met the timeliness of claim filing requirements when You do submit, within the time fixed in this Policy for filing proof of loss, a letter describing the occurrence, character and extent of Your loss for which the claim is made.

At a minimum, the description should include Your name and address, Your Policy Identification number, the type of Benefits You are claiming, the names and addresses of Your physicians, the services You required, Your diagnosis, and the periods for which You are claiming Benefits.

WHEN TO FILE A CLAIM

PROOF OF LOSS: Written proof of loss must be received by Us within 90 days after the end of each month for which Benefits may be paid. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

CONDITIONS FOR RECEIVING CLAIM PAYMENT

If You meet Benefit Eligibility, We will pay Benefits subject to the terms, limitations and exclusions described in this Policy. The following conditions also apply:

- Your Policy must be in force when the care is approved and received; and
- You have completed the Elimination Period, if it applies; and
- The service is covered under this Policy; and
- You have not exhausted the Lifetime Benefit Amount shown in Your Schedule of Policy Benefits.

PAYMENT OF CLAIMS: All Benefits will be paid to You or another person or approved Provider upon your written request. You may request in writing no later than the time proof of loss is filed that payment be made to the Approved Provider. Benefits due and unpaid at Your death will be paid to Your estate.

HOW AND WHEN CLAIMS ARE PAID

TIME OF PAYMENT OF CLAIM: Upon receipt of the proper written proof of loss, any Benefits then due will be paid:

1. Monthly, when the loss is expected to result in ongoing Benefits, and
2. Promptly, when Our liability has ended.

Such payment will be made within 30 days after having received the proper written proof of loss.

If We contest a claim or a portion of a claim, You or Your Legal Representative will be notified in writing that the claim is contested or denied within 30 days after We have received Your claim.

The notice that the claim is contested will identify the contested portion of the claim and the reasons for contesting the claim. Upon receiving any additional information requested by Us, the contested claim or portion thereof will be paid or denied within 30 days.

Benefits due and unpaid at Your death will be paid to Your estate or Your Named Payee.

Currency: Benefits will be paid in US currency.

RECOVERY OF OVERPAYMENT

If, due to an error in processing, a claim results in an overpayment, We will explain the overpayment to You. You must return the amount of overpayment within 60 days of Our request. Any overpayment that is not returned to Us within 60 days of Our request will be deducted from future claim payments.

WHEN YOU HAVE CLAIM QUESTIONS

If You would like an explanation of Our claim payment, please call or write to Us.

YOUR APPEAL RIGHTS

If We contest a claim or a portion of a claim, You or Your legal representative will be notified in writing that the claim is contested or denied.

You have a right to appeal Our claims decision. The appeal must be filed in writing with Our office within 3 years of the time the denied claim being appealed was filed. Include the reason for the appeal and any documents You feel are pertinent to the situation.

We will send You a written acknowledgement of Your appeal. If no additional information is needed, the acknowledgement will include an explanation of the denial. If additional information is required, We will explain what is needed. If We do not receive the requested information within 21 days, We will notify You in writing.

Within 60 days of the receipt of required information, We will notify You in writing of the outcome of the reconsideration of Your claim, and the contested claim or portion thereof that will be paid or denied.

PHYSICAL EXAMINATION

We, at Our expense, can have You examined as often as reasonably needed while a claim is pending or active.

TIME LIMIT FOR LEGAL ACTION

You cannot begin legal action before 60 days after written proof of loss has been given to Us. The time limit for legal action is 3 years after the time written proof of loss is furnished.

PART 3: LIMITATIONS AND EXCLUSIONS

EXCLUDED SERVICES

Expenses for the following will not be covered under this Policy:

1. Treatment for illness or medical condition arising out of war or any act of war, declared or undeclared.
2. Services for intentionally self-inflicted injury.
3. Services for Mental or Nervous Disorders without demonstrable organic disease (subject to the other Policy provisions, We will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the Policy);
4. Services for alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician;
5. Due to participation in a felony, riot or insurrection
6. Care or services provided by a member of Your Family or someone who normally lives in Your residence;
7. Services for which You are not liable or for which no charge is normally made in the absence of insurance.
8. Covered Care outside the United States and the District of Columbia.
9. Non-duplication. We will not pay Benefits for Covered Care to the extent that the service is reimbursed, or would be reimbursed but for the application of a deductible or coinsurance amount, under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid).
10. Pre-existing condition. No benefits are payable for any Covered Care that begins within the first six (6) months after the Effective Date of this Policy which is caused by a Pre-existing Condition.

PART 4: PREMIUM

PREMIUM AMOUNT

The initial premium is shown in Your Schedule of Policy Benefits. It will remain the same unless You change Your coverage or We change the premium. If We change the premium, We will notify You at least 45 days in advance. No change will be made to the premium amount unless We change the premium rates for all Policies like Yours that We have issued in the state where this Policy has been approved and, where applicable, Your State Department of Insurance has approved the increase.

PAYMENT

Premiums are due in advance.

GRACE PERIOD

An initial Grace Period of 31 days will be granted for each premium that is unpaid on the date due. After the initial Grace Period of 31 days elapses, a notice will be sent to You explaining that a payment has been missed and that Your Policy risks lapsing. If You have designated an individual to be notified in case of lapse, We will also send notice to the address You provided for that designee. You will have an additional 35 days Grace Period that begins the date We mail the second notice to pay the unpaid premium.

Payment will allow Your Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the second Grace Period will result in the termination of Your Policy as of the premium due date.

Lapse Designee: If You have designated an individual to be notified of lapse, We will provide You the opportunity, no less frequently than every 2 years, to change such designation.

REINSTATEMENT

If Your Policy lapses because You did not pay Your premium within the Grace Period, You may request reinstatement with no break in coverage. If We honor this request, Your Policy will be reinstated back to the termination date. If We do not approve or disapprove Your request within 45 days of receipt of the request and a premium was accepted by Us or one of Our authorized representatives, Your Policy will be reinstated as of the date Your Policy terminated.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

You may request reinstatement up to 5 months after termination, if You did not pay Your premium due to a condition that would qualify You for Benefits. Your condition is subject to verification. An Assessment is required before deciding on reinstatement. If reinstated, You must pay Your premium retroactive to the date Your Policy terminated.

UNEARNED PREMIUM

When We are notified of Your cancellation or death, We will refund any premium paid for the period beyond Your cancellation or death. If You have died, all premiums paid for the period beyond Your death will be refunded to Your Estate. In the event of Your cancellation, premiums paid for the period beyond Your cancellation will be refunded to You.

PART 5: GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES	This Policy document, Your application and any Riders establish the entire contract of insurance between You and Us. Any material change must be approved by one of Our officers and be endorsed on or attached to this Policy. No insurance agent has the authority to change this Policy or to waive any of its provisions.
YOUR BENEFITS	With the exception of a Named Payee or Your estate, only You are eligible for Benefit payments other than returned premiums under this Policy.
WHEN YOUR POLICY COVERAGE BEGINS	The date that Your Policy begins is shown in Your Schedule of Policy Benefits. All time periods begin and end at 12:01 a.m. standard time at Your residence.
WHEN YOUR POLICY COVERAGE ENDS	<p>Your Policy ends on the day after the date one of the following occurs. As of 12:01 a.m. standard time at Your residence, You will no longer be entitled to Benefits under this Policy:</p> <ul style="list-style-type: none">• Nonpayment of premium (subject to the Grace Period); or• Your Lifetime Maximum is exhausted; or• You elect to cancel this Policy; or• Your death.
EXTENSION OF BENEFITS	<p>If, on the date this Policy is cancelled, You are Benefit Eligible, We will continue to pay for Your care without interruption of Benefits until the first of the following dates:</p> <ul style="list-style-type: none">• It is determined that You are no longer eligible for Benefits under this Policy; or• You have used up Your Lifetime Benefit Amount. <p>If You have become a) unable to perform, without Substantial Assistance from another Individual, at least two Activities of Daily Living; or b) require Substantial Supervision for protection from threats to health and safety due to Severe Cognitive Impairment, prior to the date the Policy is cancelled and are able to meet Benefit Eligibility, We will pay for Your care without interruption of Benefits until the first of the following date:</p> <ul style="list-style-type: none">• It is determined that You are no longer eligible for Benefits under this Policy; or• You have used up Your Lifetime Benefit Amount. <p>We will not pay for more care than You would have been entitled to receive if Your Policy had not terminated.</p> <p>You will not be entitled to Benefits after termination if the reason Your Policy terminated was due to You reaching Your maximum Lifetime Benefit Amount.</p>

INCONTESTABLE PERIOD

If Your Policy has been in force for less than 6 months, We may rescind Your Policy or deny a claim if it can be shown that a misrepresentation by You was material to Our acceptance of You.

If Your Policy has been in force for at least 6 months but less than 2 years, We may rescind Your Policy or deny a claim if it is shown that a misrepresentation by You both was material to Our acceptance of You and pertained to the condition for which Benefits are sought.

If Your Policy has been in force for 2 years or more, We may rescind Your Policy or deny a claim only if it is shown that You knowingly and intentionally misrepresented relevant facts relating to Your health or due to non-payment of premiums.

These provisions also apply if You provide additional evidence of insurability to purchase additional coverage after Your Policy Effective Date.

CLERICAL ERROR

Clerical error, whether by You or Us, will not void Your insurance if that insurance would otherwise have been in effect. Neither will it extend Your insurance if that insurance would otherwise have ended or been reduced as provided in this Policy.

MISSTATEMENT OF AGE

If Your age was misstated on Your Application, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

Our liability will be limited to a refund of the premiums You have paid for this Policy if You would have been subject to additional evidence of insurability at Your correct age, and You do not provide satisfactory proof to Us of successfully completing the additional evidence of insurability according to our standards in effect for Your correct age at the time of Your original application to Us.

MISSTATEMENT OF FACT

If Your information regarding Your Spouse or Domestic Partner's eligibility was misstated on Your Application, Your premium will be changed retroactively to Your original effective date to correspond to Your Spouse or Domestic Partner's actual eligibility status.

Application misstatements regarding Your Spouse or Domestic Partner eligibility are subject to the provision "Incontestable Period" for purposes of Policy rescission or claim denial.

NON-PARTICIPATING

This Policy does not participate in Our profits or surplus earnings.

**COMMUNICATION THROUGH
ELECTRONIC MEANS**

We reserve the right to designate the form and means of all communications or notices required by Your Policy.
If We agree, You may contact Us about Your Policy using electronic means or technologies.
If You agree, We may contact You regarding Your Policy using electronic means or technologies.

Except where barred by state or federal law, electronic communication is equal to other communication methods. Information exchanged has the same legal effect, validity, and enforceability.

**CONFORMITY WITH FEDERAL
AND STATE STATUTES**

Any provision of this Policy that does not comply with a law to which it is subject is amended to conform to the minimum requirement of such law.

Transitions.

Is a trademark of MedAmerica Insurance Company.
All rights reserved.