

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA**

**JAMES J. DONELON
IN HIS OFFICIAL CAPACITY
AS COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA**

CIVIL ACTION:

JUDGE:

MAGISTRATE:

VERSUS

**JESSICA K. ALTMAN,
INSURANCE COMMISSIONER OF THE
COMMONWEALTH OF PENNSYLVANIA,
IN HER CAPACITY AS STATUTORY REHABILITATOR
OF SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**

**COMPLAINT FOR DECLARATORY RELIEF
AND PERMANENT INJUNCTION**

The complaint of James J. Donelon, in his official capacity as Commissioner of Insurance for the State of Louisiana respectfully represents and alleges:

PARTIES

1.

Plaintiff, James J. Donelon, in his official capacity as Commissioner of Insurance for the State of Louisiana (the “Commissioner”), is the duly elected Commissioner of Insurance for the Department of Insurance of the State of Louisiana. The Commissioner is domiciled in the State of Louisiana, and the principal place of business of the Louisiana Department of Insurance, a state agency of the State of Louisiana, is in Baton Rouge, Louisiana.

2.

The Defendant is Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory Rehabilitator (the “Rehabilitator”) of Senior Health

Insurance Company of Pennsylvania (“SHIP”). Upon information and belief, the principal place of business of the Rehabilitator is in Harrisburg, Pennsylvania and, upon information and belief, the Rehabilitator is domiciled in the Commonwealth of Pennsylvania.

3.

SHIP is a life and health insurance company organized pursuant to the laws of the Commonwealth of Pennsylvania and has its principal place of business in the State of Indiana. SHIP is currently under rehabilitation in the Commonwealth Court of Pennsylvania, and, under the provisions of PA ST 40 P.S. § 221.14 *et seq.*, the Rehabilitator stands in the shoes of SHIP’s officers and directors in the conduct of SHIP’s affairs while the rehabilitation is pending.

JURISDICTION

4.

This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 because this matter arises under Article IV, Section 1 of the United States Constitution, 15 U.S.C. § 1011, and 15 U.S.C. § 6701 *et seq.*

5.

Additionally, or alternatively, subject matter jurisdiction is provided by 28 U.S.C. § 1332 in that there exists complete diversity of citizenship between the two parties, namely the Commissioner, on behalf of a state agency that is a citizen of the State of Louisiana, and the Rehabilitator, in her representative capacity of SHIP, is a citizen of the State of Pennsylvania, and the Commissioner asserts in good faith that the matter in controversy exceeds the value of \$75,000, exclusive of interest and costs.

VENUE

6.

Venue is proper in this Court pursuant 28 U.S.C. § 1391 because the Rehabilitator has proposed a rehabilitation plan for SHIP that attempts to alter the rates paid by and benefits provided to SHIP policyholders who are domiciled in Louisiana and who were issued such policies while domiciled in Louisiana. Therefore, a substantial part of the events or omissions giving rise to this action occurred in the State of Louisiana.

INTRODUCTION

7.

SHIP, facing numerous and serious financial challenges, has been placed in rehabilitation in the Commonwealth Court of Pennsylvania pursuant to the provisions of Pennsylvania law. SHIP was formerly an insurance company that issued long term care (“LTC”) insurance policies in forty-six states and other jurisdictions. However, upon information and belief, SHIP has not issued any new policies since at least July 2003.

8.

In an attempt to resolve SHIP’s financial distress, the Rehabilitator has filed a proposed plan of rehabilitation that proposes a menu of policy changes for all its policyholders, any of which would materially alter the rates charged to and paid by SHIP policyholders and/or the benefits accorded to the policyholders under their respective existing policies.

9.

Ignoring longstanding principles of state regulation of insurance, the Rehabilitator seeks to impose its plan without the approval of any of the departments of insurance in the states and other jurisdictions with SHIP policyholders and without regard to whether the plan violates the laws of

the respective states and jurisdictions. For Louisiana policyholders, the Rehabilitator does not intend to comply with Louisiana laws and regulations designed to protect the contractual rights of policyholders of LTC policies and assure the actuarial soundness of the financial projections of an insurer. The Commissioner therefore seeks a declaratory judgment that the SHIP rehabilitation plan cannot alter rates charged to SHIP policyholders and/or the benefits accorded to the policyholders in Louisiana unless approved by the Commissioner in accordance with all applicable Louisiana laws and regulations, and a permanent injunction prohibiting the imposition on Louisiana policyholders of SHIP policies of any plan approved by the Commonwealth Court that has provisions that are violative of Louisiana laws and regulations.

FACTUAL ALLEGATIONS

The Rehabilitation Proceeding and Plan of Rehabilitation

10.

LTC insurance is designed to cover long-term services and support for individuals, including personal and custodial care in a variety of settings such as a person's home, community organization, or other facility. LTC policies reimburse policyholders a daily amount (up to a pre-selected limit) for services to assist them with activities of daily living such as bathing, dressing, or eating. The policyholder can select a menu or range of care options and benefits. The cost of an LTC policy is based on a number of factors, including the insured's age at time of issuance, the maximum amount that a policy will pay per day, the maximum number of days (or years) that a policy will pay, the maximum amount per day times the number of days determines the lifetime maximum amount that the policy will pay, and any optional benefits that may be selected, such as benefits that increase with inflation.

11.

As of January 29, 2020, SHIP was an operating company that issued LTC policies in forty-six states and additional jurisdictions. As of November 30, 2019, SHIP reported that it had 48,477 policies in force with annual premium payments of \$62 million.

12.

SHIP is qualified to do business in Louisiana and has issued insurance policies to citizens of Louisiana. As of December 31, 2019, SHIP had 373 policies in force in Louisiana with annual premiums amounting to \$413,911. SHIP is thus subject to Louisiana laws and regulations regarding insurance.

13.

On January 29, 2020, upon the application of Jessica K. Altman in her capacity as Insurance Commissioner for the Commonwealth of Pennsylvania, the Commonwealth Court of Pennsylvania, in suit number 1 SHP 2020 (the “Rehabilitation Proceeding”) entered an Order of Rehabilitation placing SHIP into rehabilitation in accordance with the provisions of Pennsylvania law. A true and correct copy of the application is attached as Exhibit 1, and a true and correct copy of the Order of Rehabilitation entered by the Commonwealth Court on January 29, 2020 is attached as Exhibit 2.

14.

According to SHIP’s 2018 Annual Statement, SHIP is licensed in every state except Connecticut, New York, Rhode Island, and Vermont, and it is also licensed in the District of Columbia and the U.S. Virgin Islands. Prior to the filing of the Rehabilitation Proceeding, SHIP’s business consisted exclusively of closed blocks of LTC policies including more than 70 distinct

policy forms with many state variations for each form. SHIP's policy forms include home health care, nursing home, and comprehensive plans. Upon information and belief, each of those policy forms and the premiums charged to policyholders were submitted by SHIP for approval by the insurance regulator in each state that they were issued if the laws and regulations of such states required such approval.

15.

SHIP's 2018 Annual Statement stated that the company had negative (deficit) capital and surplus of more than \$466 million dollars. SHIP did not prepare a 2018 Annual Statement, but upon information and belief SHIP's negative (deficit) capital and surplus as of December 31, 2019 significantly exceeded its 2018 amount.

16.

The Order of Rehabilitation appointed Defendant Altman and her successors in office as statutory rehabilitator of SHIP pursuant to the provisions of 40 P.S. § 221.14, *et seq.* Further, among other provisions, the order required the Rehabilitator to prepare a plan of rehabilitation in accordance with Pennsylvania law.

17.

On April 22, 2020 the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP (the "SHIP Plan"). A true and correct copy of the SHIP Plan is attached as Exhibit 3.

18.

The SHIP Plan is complex in its detail. The following is a summary description contained in the plan:

Recognizing that SHIP faces a substantial Funding Gap...the aim of the Plan is to increase revenues and reduce liabilities so as to narrow or eliminate that

gap through a combination of Policy Modifications for most of the approximately 45,000 policies in force as of the filing of the Plan. Although the Plan has certain default provisions that apply when policyholders fail to make effective choices, it is structured to maximize policyholder choice, based on each person's individual circumstances and preferences. In structuring the Plan, the Rehabilitator recognizes that many policyholders have costly policies that provide far more coverage than the policyholders are reasonably likely to require. Accordingly, a key element of the Plan is to enable policyholders to remove coverages that are not essential or even necessary, thereby helping to narrow the Funding Gap and potentially reducing their own premium, or at least avoiding part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. Phase One, commencing immediately following final approval, is the principal phase and will strive to reduce substantially or eliminate the Funding Gap. In this phase it will be determined which policies require modification because their Current Premium is below the "*If Knew Premium*" for the benefits offered by the policy. The If Knew Premium is a widely accepted methodology for setting premiums for LTCI policies, more fully explained at page 16. Policyholders with Current Premium (see page 92) below the If Knew Premium will have to increase their premiums or reduce their benefits so that the premium will be adequate on an If Knew Premium basis. Policyholders whose Current Premium is at or above the If Knew Premium will not be required to modify their policies (increase their premiums or reduce their benefits) but may choose to make some such modifications if they prefer to do so[.] (SHIP Plan, p. 6, emphasis added.)

19.

Simply stated, the SHIP Plan proposes to impose universal changes to premiums paid by all SHIP policyholders and/or benefits contractually accorded to policyholders regardless of their consent, bypassing the Commissioner's regulatory authority over SHIP policies issued to Louisiana citizens, as well as the regulatory authority of insurance regulators in each state and jurisdiction with SHIP policyholders.

20.

The SHIP Plan further states and admits as follows:

Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. This is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no

approval from individual states, modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating “subsidies” by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of state-by-state rate approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate. [SHIP Plan, p. 22.] [Emphasis added.]

....
 The Rehabilitator believes that the provisions of the Plan can be implemented with approval of the Commonwealth Court without the need that insurance regulators in every state approve the plan, including premium rate increases implemented under the Plan. However, regulators in other states may conclude that their approval is required. The Rehabilitator cannot provide an assurance that approval from other regulators will not ultimately be deemed necessary. Neither can the Rehabilitator provide assurances that if such other states approvals are necessary they can be obtained consistent with the timing and substance of the Plan. [SHIP Plan, p. 86 – 87.] [Emphasis added.]

....
 The Plan depends on implementation of a complex restructure of SHIP’s insurance business for which there is no precedent and which depends on legal provisions that may be difficult to implement. Failure to implement these provisions may have a material effect on the success of the Plan. (SHIP Plan, p. 87).

The State-Based Regulatory Structure of the Business of Insurance and Louisiana’s Laws

21.

In 1945, Congress enacted the McCarran-Ferguson Act, 15 U.S.C. § 1011, by which Congress stated the following as a declaration of policy: “Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.” Section 1012(a) of the McCarran-Ferguson Act provides that “[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”

22.

The empowerment of each state with respect to the business of insurance was reinforced by Congress in 1999 with the enactment of the Gramm-Leach-Bliley Act, 15 U.S.C. § 6701 *et seq.* In that Act, Congress stated that the McCarran-Ferguson Act “remains the law of the United States” and that “the insurance activities of any person...shall be functionally regulated by the States.”

23.

Regulation of the insolvencies of insurance companies is also indirectly delegated to the states by virtue of the inability of insurance companies to seek bankruptcy relief under the United States Bankruptcy Code. See 11 U.S.C. 109(b) and (d) (providing that a “domestic insurance company” may not be a debtor under Chapter 7 or 11 bankruptcies). Thus, there is no Federal law or regulation that governs the rehabilitation of insurance companies or that allows the imposition of the SHIP Plan on Louisiana policyholders absent approval by the Commissioner in accordance the laws and regulations of the State of Louisiana.

24.

Under Louisiana law applicable to insurance (the “Louisiana Insurance Code,” found in Title 22 of the Louisiana Revised Statutes), insurance is deemed an industry affected with the public interest and the purpose of the Louisiana laws on insurance are to regulate that industry in all its phases. La. R.S. 22:2A(1). Regulations have been adopted to supplement provisions of the Louisiana Insurance Code. Louisiana Administrative Code (“LAC”) Title 37.

25.

The Commissioner is charged with the duty to administer the provisions of the Louisiana Insurance Code, La. R.S. 22:2A(1), and make reasonable rules and regulations not inconsistent with law. La. R.S. 22:2E.

26.

Louisiana has comprehensive statutes and regulations governing LTC policies. *See* La. R.S. 22:1181–1191, and LAC 37:46.19.1901 *et seq.*

27.

Under Louisiana law, “no person shall be authorized to transact or shall transact a business of insurance in this state without complying with the provisions” of the Louisiana Insurance Code. La. R.S. 22:12. Further, “[e]very health insurance issuer shall file with the department [of insurance] every proposed rate to be used in connection with all of its particular products ... All proposed rate filings may be reviewed for compliance with R.S.22:1095 and with other provisions of law governing rates in the individual market and the small group market. A review of rates made pursuant to this Subpart shall not constitute a determination under the Administrative Procedure Act, R.S. 49:950 *et seq.*, nor shall such a review of rates be subject to other administrative or judicial relief.” La. R.S. 22:1092(A) and (D). Further, the forms for LTC policies issued in Louisiana are required to be approved by the Commissioner. LAC 37:46.19.1913 *et seq.*

28.

There is no provision of Pennsylvania law that permits a statutory rehabilitator or court to unilaterally impose modifications to premium rates or contractual policy benefits of policyholders residing in another state.

COUNT 1: DECLARATORY JUDGMENT

29.

The allegations of all preceding paragraphs are incorporated in this Count as if set forth herein.

30.

Pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1011 and the Gramm-Leach-Bliley Act, 15 U.S.C. § 6701 *et seq.*, the insurance activities of SHIP are functionally regulated by each individual state in which SHIP operates.

31.

Article IV, Section 1 of the United States Constitution provides that full faith and credit shall be given in each State to the public Acts, Records, and judicial proceedings of every other State.

32.

Full faith and credit does not require or compel a state to substitute the statutes of other states for its own statutes dealing with a subject matter concerning which it is competent to legislate.

33.

Louisiana is competent and has the jurisdictional authority to legislate the regulation of insurers licensed to do business in Louisiana. See McCarran-Ferguson Act, 15 U.S.C. § 1011 and the Gramm-Leach-Bliley Act, 15 U.S.C. § 6701 *et seq.*

34.

Louisiana's laws and regulations governing LTC policies are set forth at La. R.S. 22:1181–1191, and the LAC.

35.

Under Louisiana's laws and regulations governing LTC policies, the Commissioner has the authority and duty to review policy forms for compliance with applicable Louisiana law and regulations, and the authority and duty to conduct an actuarial review of all proposed policy rates.

36.

There is no law or regulation under Federal or Pennsylvania law that permits the Rehabilitator to bypass the aforementioned Louisiana statutory requirements for approval of rate increases and changes in policy terms and conditions.

37.

The Commissioner and insurance regulators in other states have expressed to the Rehabilitator their opposition to the SHIP Plan to the extent it bypasses the laws and regulations of states with SHIP policyholders. Notwithstanding such opposition, as of the date of the filing of this complaint the Rehabilitator has not altered the SHIP Plan to address these concerns and has not indicated any intention to do so.

38.

The Commissioner thus seeks a declaratory judgment that the SHIP Plan is (1) unconstitutional under Article IV, Section 1 of the United States Constitution, (2) unlawful under the McCarran-Ferguson Act, the Gramm-Leach-Bliley Act, and applicable Louisiana law, and (3) without effect insofar as it seeks to impose rate and/or policy modifications to policies held by

Louisiana SHIP policyholders without compliance with all applicable provisions of Louisiana law and regulations.

39.

A declaratory judgment will clarify and settle the legal dispute at issue, namely, whether the rehabilitator of a financially troubled insurer in one state may unilaterally impose insurance rate and benefit modifications on another state without complying with the non-domiciliary state's applicable laws and regulations.

40.

Further, a declaratory judgment will terminate and afford the Commissioner and the Rehabilitator relief from the uncertainty, insecurity, and controversy arising out SHIP's rehabilitation proceeding regarding the rights of insurance regulators as set forth in this complaint.

COUNT 2: - PERMANENT INJUNCTION

41.

The allegations of all preceding paragraphs are incorporated in this Count as if set forth herein.

42.

In addition to the declaratory relief sought herein, the Commissioner also seeks a permanent injunction enjoining the Rehabilitator from attempting to enforce against any Louisiana policyholders of SHIP any plan adopted at the request of the Rehabilitator in the Commonwealth Court of Pennsylvania that affects the rates paid by or benefits accorded to Louisiana policyholders of SHIP without compliance with all applicable provisions of Louisiana law and regulations

43.

The party seeking a permanent injunction must establish (1) success on the merits; (2) that a failure to grant the injunction will result in irreparable injury; (3) that said injury outweighs any damage that the injunction will cause the opposing party; and (4) that the injunction will not disserve the public interest.

44.

The Commissioner will succeed on the merits for the reasons set forth in this Complaint.

45.

Failure to grant the injunction will result in irreparable injury to the Commissioner and the SHIP policyholders in Louisiana. Without an injunction, the Rehabilitator will seek to unlawfully alter the premiums paid and benefits as currently contracted under SHIP policies held by Louisiana policyholders without proper review or actuarial or other analysis under Louisiana law.

46.

The injunction will not cause any injury to the Rehabilitator.

47.

The injunction will serve the public interest by maintaining well-established constitutional principles of comity in the regulation of insurance, as well as uphold the state sovereignty of the State of Louisiana.

WHEREFORE, James J. Donelon, in his official capacity as Commissioner of Insurance for the State of Louisiana requests entry of an order and judgment against Defendant Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania as follows:

1. On Count 1, that it be declared by this Court that no provision of the SHIP Plan can affect the rates paid by or benefits accorded to Louisiana policyholders of SHIP without compliance with all applicable provisions of Louisiana law and regulations;
2. On Count 2, for a permanent injunction enjoining the Rehabilitator from attempting to enforce against any Louisiana policyholders of SHIP any plan adopted at the request of the Rehabilitator in the Commonwealth Court of Pennsylvania that affects the rates paid by or benefits accorded to Louisiana policyholders of SHIP without compliance with all applicable provisions of Louisiana law and regulations; and
3. For such further relief as allowed by law and that the Court deems just, equitable and proper.

Respectfully Submitted:

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capacity as Commissioner of Insurance for the
State of Louisiana**

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Jessica K. Altman,
Insurance Commissioner of the
Commonwealth of Pennsylvania,

Plaintiff

v.

Senior Health Insurance Company of
Pennsylvania
550 Congressional Boulevard, Suite
200, Carmel, IN 46032,
NAIC Company Code 76325

Defendant

Docket No. 1 SHP 2020

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RECEIVED
COMMONWEALTH COURT
OF PENNSYLVANIA

**APPLICATION FOR ORDER PLACING SENIOR
HEALTH INSURANCE COMPANY OF PENNSYLVANIA
IN REHABILITATION**

INTRODUCTION

Pursuant to Article V of the Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *as amended*. (“Article V”), 40 P.S. §§ 221.1-221.63, and Rule 3774(c) of the Pennsylvania Rules of Appellate Procedure, Pa.R.A.P. 3774(c), Plaintiff, Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, files this Application for Order Placing Senior Health Insurance Company of Pennsylvania (“SHIP”) in Rehabilitation (the “Application”) seeking entry of an order directing her to rehabilitate SHIP, and in support thereof respectfully avers as follows:

SHIP has committed one or more acts which constitute grounds for rehabilitation as set forth in 40 P.S. § 221.14 (applicable to a petition for rehabilitation under 40 P.S. § 221.15). Specifically, SHIP's most recent annual statement demonstrates that the company is statutorily insolvent as defined in 40 P.S. § 221.3. Additionally, SHIP's most recent risk-based capital ("RBC") report indicates that the company's total adjusted capital is substantially below its mandatory control level RBC, thereby triggering a "mandatory control level event" as defined in 40 P.S. § 221.1-A. Finally, the Trustees of the Senior Health Care Oversight Trust ("Oversight Trust") and SHIP's directors have consented in a signed writing to the company being placed in rehabilitation and have waived the hearing contemplated by 40 P.S. § 221.15.

JURISDICTION

Jurisdiction over this case is founded upon 42 Pa.C.S. § 761(a) and Section 504(d) of Article V, 40 P.S. § 221.4(d).

PARTIES

1. Plaintiff is Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania ("Commissioner" or "Plaintiff"), acting in her official capacity. Plaintiff has her principal office at 1326 Strawberry Square, Harrisburg State Office Building No. 1, Harrisburg, Pennsylvania 17120.

2. Plaintiff is charged with the execution of the laws of the Commonwealth of Pennsylvania relating to insurance for the protection of policyholders, creditors, and the public generally.

3. Defendant, SHIP, is a domestic life and health insurance company organized pursuant to the laws of the Commonwealth of Pennsylvania and has its principal place of business at 550 Congressional Boulevard, Suite 200, Carmel, IN 46032.

4. SHIP was established to run off a closed block of long-term care insurance previously indirectly owned and administered by Conseco, Inc. Pursuant to an Order dated November 12, 2008 issued by then Insurance Commissioner Joel Ario, SHIP became wholly owned by the Oversight Trust.

5. The Oversight Trust is a Pennsylvania business trust designed and created with input and assistance from the Pennsylvania Insurance Department (the "Department") to provide, along with the Department, certain oversight of the runoff of SHIP business, as well as certain other activities specified in the Trust Agreement (as amended). The Oversight Trust is governed by a Board of Trustees ("Trustees") approved by the Department and is comprised of former insurance regulators and financial experts who also serve as members of the board of directors of SHIP.

6. At the time SHIP was transferred to the Oversight Trust, SHIP had approximately 165,000 policyholders and approximately \$3.2 billion in assets.

Presently, SHIP has approximately 51,000 policyholders and approximately \$2.2 billion in assets.

7. SHIP is the 100% owner and sole shareholder of Fuzion Analytics, Inc. ("Fuzion"), a Delaware Corporation that performs SHIP's operating functions, employs all the staff utilized by SHIP, and owns and operates all of the equipment and infrastructure through which SHIP operates.

8. SHIP is authorized to write the accident and health line of business under the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, *as amended*, Section 202(c)(2), 40 P.S. § 382(c)(2). Specifically, SHIP has written long-term care insurance policies, including nursing home and assisted living facility stays and stand-alone home health care products, primarily for senior citizens. SHIP is, and at all material times has been, engaged solely in the long-term care line of insurance business. SHIP has not written any new insurance business since at least July 2003.

9. SHIP is, and at all material times has been, subject to examination by and to the jurisdiction of the Commissioner.

BACKGROUND

10. Paragraphs 1 through 9 above are incorporated herein by reference.

11. SHIP is required to file annual statements of its financial condition with the Commissioner. Annual statements are due March 1 of each year as to the prior year. *See* 40 P.S. § 443(a). On or about March 1, 2019, SHIP filed with the Commissioner

its 2018 Annual Statement. *See* Exhibit 1 - A true and correct copy of SHIP's annual financial statement for the year ended December 31, 2018 ("2018 Annual Statement") is attached as Ex. 1 to this Application and incorporated herein by reference. This Annual Statement reports that SHIP was insolvent by \$466,872,975 on assets of \$2,186,058,273 and liabilities, including capital stock, of \$2,652,931,248 as of December 31, 2018.

12. SHIP's officers personally attested that its 2018 Annual Statement was a "full and true statement" of "all of the assets and liabilities and of the condition and affairs" of SHIP. *See* Ex. 1 at p. 1.

13. SHIP is required to file a Risk-Based Capital ("RBC") report with the Commissioner by March 1 of each year as to the preceding calendar year. On or about February 27, 2019, SHIP filed an RBC report with the Commissioner for the year ended December 31, 2018 (the "2018 RBC Report"). *See* Exhibit 2 - A true and correct copy of SHIP's 2018 RBC Report is attached as Ex. 2 to this Application and incorporated herein by reference. This report stated that at the time SHIP's required authorized control level Risk-Based Capital was \$51,352,310. Capital of 70% or less of this amount (\$35,946,617) would have placed SHIP in "mandatory control level." SHIP's actual total adjusted capital at the time was -\$466,814,972, leaving SHIP far below mandatory control level.

14. On July 30, 2019 a majority of the Oversight Trust's Board of Trustees voted to give consent to the rehabilitation of SHIP and to waive the hearing contemplated by 40 P.S. § 221.15. *See Exhibit 3* - A true and correct copy of the Lead Trustee's Certificate attaching resolutions adopted by the Board of Trustees of the Oversight Trust is attached as Ex. 3 to this Application and incorporated herein by reference.

15. On July 30, 2019, of SHIP's directors (which includes all of the Trustees of the Oversight Trust), a majority voted to give consent to the rehabilitation of SHIP and to waive the hearing contemplated by 40 P.S. § 221.15. *See Exhibit 4* - A true and correct copy of the Secretary's Certificate attaching resolutions adopted by the Board of Directors of SHIP is attached as Ex. 4 to this Application and incorporated herein by reference.

FIRST GROUND FOR REHABILITATION: INSOLVENCY

16. Paragraphs 1 through 15 above are incorporated herein by reference.

17. Under 40 P.S. §§ 221.14, and 221.15, an order of rehabilitation may be entered if the insurer is insolvent. *See* 40 P.S. § 221.14(1) (order of rehabilitation may be issued based upon insurer's insolvency).

18. Under Section 503 of Article V, 40 P.S. § 221.3, an insurer is insolvent if its admitted assets do not exceed its liabilities plus the greater of its capital and surplus

required by law or its authorized and issued capital stock. *See* 40 P.S. § 221.3 (definition of “insolvency”).

19. SHIP’s minimum required capital and surplus is \$1,000,000. *See* 40 P.S. § 386(a).

20. SHIP’s authorized and issued capital stock is valued at \$7,500,005, which amount is greater than its statutorily required capital and surplus. *See* Ex. 1, p. 3, lines 29 and 30; *see also* 40 P.S. § 221.3 (definition of “insolvency”); 40 P.S. § 386(a) (minimum capital stock and financial requirements to do business).

21. Based on actuarial projections of the longtail claim exposures, as of December 31, 2018, SHIP’s liabilities, plus its authorized and issued capital stock, exceeded its admitted assets by more than \$474 million:

	2018 Annual Statement
Admitted Assets	\$ 2,186,058,273
Liabilities	\$ 2,652,931,248
Authorized and Issued Capital Stock	\$ 7,500,005
Liabilities + Authorized and Issued Capital Stock	\$ 2,660,431,253
Total Insolvency (line 1 – line 4) (Admitted Assets minus sum of Liabilities plus Authorized and Issued Capital Stock)	(\$ 474,372,980)

22. Under Section 503 of Article V, SHIP is statutorily insolvent because, as it has reported in its 2018 Annual Statement, SHIP's admitted assets do not exceed its liabilities plus the greater of any capital and surplus required by law or its authorized and issued capital stock. *See* 40 P.S. § 221.3 (definition of "insolvency").

**SECOND GROUND FOR REHABILITATION: MANDATORY
CONTROL LEVEL EVENT**

23. Paragraphs 1 through 22 above are incorporated herein by reference.

24. RBC is a tool developed by the National Association of Insurance Commissioners to assist state insurance regulators in identifying insurers in a weak or deteriorating capital position and to authorize regulatory action based solely on RBC results to avoid or minimize the impact of insolvencies.

25. Under 40 P.S. § 221.2-A, every domestic insurer must submit to the Commissioner a report of its RBC levels, as of the end of the immediately preceding calendar year, on or before March 1 of each year.

26. Under 40 P.S. § 221.9-A(2), the filing of an RBC report that indicates that an insurer's total adjusted capital is less than its mandatory control level RBC provides an independent and sufficient basis for the entry of an order of liquidation. 40 P.S. § 221.1-A (definition of "mandatory control level event"); 40 P.S. § 221.9-A(2) (mandatory control level event "shall be deemed sufficient grounds" for entry of order of rehabilitation under 40 P.S. § 221.14).

27. On or about February 27, 2019, SHIP filed an RBC report with the Department for the year ending December 31, 2018 ("2018 RBC Report"). *See* Exhibit 2.

28. SHIP's officers personally represented that its 2018 RBC Report was a "true and fair representation of the company's affairs and has been completed in accordance with the [National Association of Insurance Commissioners ("NAIC")] instruction according to the best of their information, knowledge and belief." *See* Ex. 2, p. LR001.

29. SHIP's 2018 RBC Report indicated that its total adjusted capital of -\$466,814,972 was less than its mandatory control level RBC of \$35,946,617, thereby triggering the occurrence of a mandatory control level event. *See* Ex. 2, p. LR033, ln. 1, 5; LR034, ln. 12.

30. SHIP has not provided the Commissioner a corrective action plan that restores the company's RBC above mandatory control level, let alone above company action level, which would be 43% higher.

THIRD GROUND FOR REHABILITATION: CONSENT

31. Paragraphs 1 through 30 above are incorporated herein by reference.

32. As documented in Exhibits 3 and 4, a majority of the Trustees of the Oversight Trust and SHIP's directors have consented to the placement of SHIP in rehabilitation and to waiving the hearing contemplated in 40 P.S. § 221.15.

REHABILITATION

33. SHIP's financial condition is dire. The Commissioner's staff and consultants have spent some time working with the Trustees and SHIP management to obtain as accurate as possible a financial picture of SHIP's affairs. They have advised the Commissioner that it may be possible to devise and implement a plan for the rehabilitation of SHIP that would produce for policyholders a result no less beneficial than would be produced by a liquidation, and perhaps materially better than that.

34. Because of the gravity of SHIP's financial difficulties, there can be no assurance that the rehabilitation efforts will be successful. Nonetheless, in cooperation with SHIP's staff, the Trustees, and consultants, the Commissioner's representatives have begun the development of a plan for addressing the Company's financial difficulties that can only be implemented with the assistance of this Court in the context of court-ordered rehabilitation under Article V.

35. It is probable that the plan, when implemented, will require modification of existing contracts, premium rate increases, and other measures that in combination will reduce or eliminate SHIP's deficit.

36. To that end, the Commissioner requests that this Court enter an Order placing SHIP in rehabilitation, enabling her to develop a rehabilitation plan for this Court's approval, modification, or rejection after notice and hearing, and providing her the tools necessary for the development of that plan.

CONCLUSION

37. Under 40 P.S. § 221.14, SHIP's insolvency, by itself, is sufficient grounds for the Commissioner's requested relief. There is no good faith dispute that SHIP is insolvent.

38. Under 40 P.S. § 221.9-A(2), SHIP's RBC ratio is below the mandatory control level, which by itself, is sufficient grounds for the Commissioner's requested relief. There is no good faith dispute that SHIP's RBC ratio is below the mandatory control level.

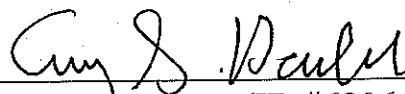
39. Under 40 P.S. § 221.14, SHIP's consent, by itself, is sufficient grounds for the Commissioner's requested relief. The consent of the Oversight Trust's Trustees and SHIP's directors is documented in Exhibits 3 and 4.

40. It is evident that ample grounds exist to place SHIP in rehabilitation or liquidation. By this application, the Commissioner seeks to enlist the aid of this Court in attempting to salvage SHIP's business as much as possible and to avoid its liquidation.

RELIEF

WHEREFORE, Plaintiff Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, respectfully requests that this Court enter the attached Order of Rehabilitation.

Respectfully submitted,



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DATED: January 23, 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance :
Company of Pennsylvania :
In Rehabilitation : No. 1 SHP 2020

ORDER OF REHABILITATION

AND NOW, this 29th day of January, 2020, upon consideration of the Application for Order Placing Senior Health Insurance Company of Pennsylvania in Rehabilitation (Petition for Rehabilitation) filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, it is hereby ORDERED as follows:

1. The Petition for Rehabilitation is GRANTED, and effective January 29, 2020, Senior Health Insurance Company of Pennsylvania (SHIP) is placed into rehabilitation in accordance with the provisions of Article V of The Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *as amended*, 40 P.S. §§221.1-221.63, on the ground that rehabilitation has been requested by and consented to by SHIP's board of directors and the trustees of the Senior Health Care Oversight Trust.

2. Insurance Commissioner Jessica K. Altman and her successors in office are hereby appointed Rehabilitator of SHIP and invested with the full powers and authority of a rehabilitator as set forth in Section 516 of The Insurance Department Act of 1921, 40 P.S. §221.16.

3. The Rehabilitator is hereby directed to rehabilitate the business of SHIP; to take possession of the assets of SHIP; and to administer the SHIP assets in accordance with the orders of this Court. Specifically, the Rehabilitator is directed to:

- (a) Inform all banks, investment banks, and other financial institutions or persons with custody of SHIP assets to identify and report these assets to the Rehabilitator and advise these institutions not to disburse, transfer, hypothecate or encumber such assets without the prior written consent of the Rehabilitator.
- (b) Inform all banks and other financial institutions with SHIP accounts that checks or other payments that have been processed and transmitted may be honored without prejudice to the ability of the Rehabilitator to recover said amounts from the recipient or payee in accordance with applicable law.
- (c) Inform all insurance producers, agents, managing general agents, brokers or other persons who have collected premiums on behalf of SHIP to account for all earned and unearned premiums and commissions to the Rehabilitator at the offices of SHIP within thirty (30) days of the date of this Order and that premium monies owed to SHIP must be remitted to the Rehabilitator.
- (d) Inform all attorneys employed or retained by SHIP that within thirty (30) days of this Order they must report to the Rehabilitator the name of the case or claim they are handling; the claim or docket number, if one is assigned; the status of each such case; and, further, that the Rehabilitator will not make payment for any unsolicited reports.

- (e) Inform all vendors providing claims or data processing services to SHIP that they shall continue such services unless and until instructed to the contrary by the Rehabilitator.
- (f) Inform all vendors with custody or control of any data processing information and electronic records belonging to SHIP to preserve these electronic files and information and to transfer the data to the control of the Rehabilitator upon request.

4. The filing or recording of this Order with the Prothonotary of the Commonwealth Court shall impart the same notice as is imparted by any deed, bill of sale or other evidence of title duly filed or recorded.

5. The Rehabilitator shall take such actions as are necessary to correct the condition that prompted SHIP's board of directors and the Senior Health Care Oversight Trust to request and consent to the rehabilitation of SHIP.

6. The Rehabilitator shall authorize, where appropriate and necessary, the payment of expenses, including employee compensation, incurred in the ordinary course of SHIP's business, as well as the actual, reasonable, and necessary costs of preserving or recovering the assets of SHIP.

7. The Rehabilitator shall prepare a plan of rehabilitation, which may include a consolidation, merger or other transformation of SHIP and to that end may retain accountants, actuaries, attorneys and other consultants at the expense of SHIP.

8. In the event this Court should determine that a rehabilitation of SHIP is not feasible and a liquidation of SHIP is ordered, the actual, reasonable and necessary costs of goods or services provided to and approved by the Rehabilitator during the period of rehabilitation will be treated as costs and

expenses of administration for purposes of Section 544 of The Insurance Department Act of 1921, 40 P.S. §221.44.

9. The Rehabilitator may, in her discretion, pay claims, in whole or in part, arising under SHIP's contracts of insurance; provided, however, that the Rehabilitator may not pay bad faith claims or claims for extra-contractual charges or damages.

10. The Rehabilitator may, in her discretion, write new and renewal policies or may cancel or refuse to renew existing policies, as she deems appropriate.

11. In accordance with Section 515 of The Insurance Department Act of 1921, 40 P.S. §221.15(c), the Rehabilitator is authorized to take possession of the statutory deposits held by any state or territory and to do all things necessary to manage and apply the deposits in accordance with the application agreements; provided, however, the Rehabilitator shall not post additional statutory security deposits in any state or territory on behalf of SHIP.

12. All court actions, arbitrations and mediations currently or hereafter pending against SHIP in the Commonwealth of Pennsylvania are stayed for ninety (90) days from the effective date of this Order and such additional time as the Rehabilitator may request, to allow the Rehabilitator an opportunity to review litigation and where appropriate retain new counsel.

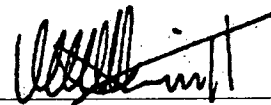
13. The Rehabilitator is directed to review all litigation pending outside the courts of the Commonwealth of Pennsylvania and petition these other courts or tribunals for a ninety (90) day stay of litigation where necessary to protect the estate of SHIP.

14. The Rehabilitator may appoint a Special Deputy Rehabilitator to be compensated from SHIP's assets, and such Special Deputy Rehabilitator shall have all the same rights and authority under this Order and applicable law as the Rehabilitator, subject to oversight and supervision by the Rehabilitator and this Court.

15. This Order is not, and shall not be considered, a finding or declaration of insolvency that can activate the provisions of the Pennsylvania Life and Health Insurance Guaranty Act, *as added by* the Act of Dec. 18, 1992, P.L. 1519, 40 P.S. §§991.1701-991.1718, or the provisions of similar acts of any other state or territory.

16. On or before April 22, 2020, the Rehabilitator shall file a preliminary plan of rehabilitation with the Court, which shall include a timeline for the preparation of a final plan of rehabilitation.

17. This Court shall retain jurisdiction of this proceeding to the full extent necessary to enforce the terms of this Order and to issue such other orders that may be required in the course of the rehabilitation.



MARY HANNAH LEAVITT, Judge

Certified from the Record

JAN 29 2020

And Order Exit

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance : No. 1 SHP 2020
Company of Pennsylvania :
In Rehabilitation :

**APPLICATION FOR APPROVAL
OF THE PLAN OF REHABILITATION FOR
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (“SHIP”), hereby applies to this Court for approval of a plan of rehabilitation for SHIP, and in support thereof, avers the following:

1. In the exercise of her discretion as statutory Rehabilitator and pursuant to 40 P.S. § 221.16(d), and pursuant to the January 29, 2020 Order of this Court that the Rehabilitator develop and submit a preliminary plan of rehabilitation for SHIP, the Rehabilitator has developed a Plan of Rehabilitation for SHIP (the “Plan”), which is set forth and submitted herewith as Exhibit A.

2. Consistent with the purposes of Article V of The Insurance Department Act of 1921, Act of May 17, 1921, P.L. 789, *as amended*, 40 P.S.

§§ 221.1 – 221.63 the Plan endeavors to protect the interests of insureds, creditors, and the public by proposing corrective action to restore SHIP to a financially self-sustaining long-term care insurance company. Key features of the Plan include equitable apportionment of unavoidable loss and lessening the problems of interstate rehabilitation.

3. In addition to the definitions set forth in this Application, the Rehabilitator incorporates by reference the definitions set forth in the Plan with respect to the capitalized terms in this Application.

4. Significant features of the Plan (as further described therein) include the following:

- a) reduction of the Funding Gap by appropriately increasing, maintaining and, in some instances, reducing premium rates to more accurately reflect the cost of benefits;
- b) allowing policyholders to elect to maintain or reduce the level of benefits from their policy;
- c) allowing policyholders to choose between Option One, Option Two, Option Three and Option Four relating to the premium paid and level of benefit received;
- d) implementation of the corrective action in three distinct phases;
- e) the suspension of payments of commissions to Agents;
- f) investigation and analysis of the past operations and business dealings of the Company; and

- g) a streamlined process nationally implemented under the supervision of this Court.

5. The attached Plan provides the facts that demonstrate the need for the corrective action recommended by the Plan. The Court is directed to the following Sections of the Plan:

VI. OTHER MATTERS

- A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**
- B. LONG-TERM CARE INSURANCE**
- C. FINANCIAL CONDITION**
- D. REHABILITATION PROCEEDING**
- E. SENIOR HEALTHCARE OVERSIGHT TRUST**
- F. FUZION ANALYTICS**
- G. LTCG, INC.**
- L. REINSURANCE**
- M. COMMISSIONS**

Attached is a verification executed by Special Deputy Rehabilitator Patrick Cantilo certifying that the facts contained in these Sections are true and correct to the best of his knowledge, information, and belief.

6. By this Application, the Rehabilitator seeks approval of the terms, conditions, and provisions of the Plan.

7. The Rehabilitator reserves the right to amend or supplement the Plan and this Application and to proffer additional evidence and arguments in support of the Plan at any hearing thereon or by written submission.

8. Approval should issue only after due notice, opportunity to object, and a hearing on the Plan. A separate Application for Approval of a Form and Distribution of Notice of this Application and for Scheduling Order is being filed by the Rehabilitator.

9. The Plan satisfies the requirements of Article V of the Insurance Department Act of 1921, as amended, and represents a sound exercise of the Rehabilitator's broad discretion.

WHEREFORE, the Rehabilitator respectfully requests that the Court, in accordance with 40 P.S. § 221.16(d), enter an order approving and confirming the Plan.

Respectfully submitted,

/s/James R. Potts
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and

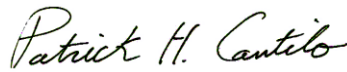
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Counsel for Applicant,
JESSICA K. ALTMAN, Insurance
Commissioner of the Commonwealth of
Pennsylvania as Rehabilitator of
SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

VERIFICATION

I, Patrick H. Cantilo, hereby state that I am the Special Deputy Rehabilitator for Senior Health Insurance Company of Pennsylvania, and I am authorized to make this Verification on behalf of the Court Appointed Rehabilitator. I hereby verify that the facts set forth in the foregoing application are true and correct to the best of my knowledge, information, and belief.

I understand that this Verification is made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.

A handwritten signature in cursive script that reads "Patrick H. Cantilo".

Patrick H. Cantilo
Special Deputy Rehabilitator

Dated: April 22, 2020

EXHIBIT A

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

IN RE: Senior Health Insurance : No. 1 SHP 2020
Company of Pennsylvania in :
Rehabilitation :

REHABILITATION PLAN
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA, IN REHABILITATION

Wednesday, April 22, 2020

TABLE OF CONTENTS

HOW TO PROVIDE COMMENTS AND OBJECTIONS	1
IMPORTANT NOTICE	2
I. BASIC INFORMATION ABOUT THE PLAN.....	5
A. SUMMARY DESCRIPTION OF THE PLAN	6
1. GOAL AND PHASES OF THE PLAN	6
2. POLICYHOLDER ELECTIONS	7
B. KEY CONSIDERATIONS FOR POLICYHOLDERS	9
C. TIMELINE	10
D. RATIONALE FOR THE PLAN.....	10
II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION .	11
A. PLAN PHASES	12
B. POLICYHOLDER CATEGORIES	12
C. POLICYHOLDER OPTIONS	12
D. CLAIM STATUS	15
E. PREMIUM RATE DETERMINATIONS	15
TABLE 1: ASSET ALLOCATION	17
TABLE 2: DIFFERENTIAL PREMIUM	19
F. PREMIUM WAIVERS	19

SHIP REHABILITATION PLAN

G.	CERTAIN “NON-CORE” POLICY BENEFITS	21
H.	RATE APPROVALS	22
I.	NFOs AND PAID-UP POLICIES	22
J.	PARTNERSHIP-QUALIFIED POLICIES	23
K.	PLAN TIMING	23
	TABLE 3: PLAN SEQUENCE	23
L.	POLICYHOLDER INFORMATION	26
M.	CALCULATION NOTES	27
N.	DRAFTING NOTES	29
III.	DETAILS OF PHASE ONE OF THE PLAN	29
A.	ACTIVE LIVES PAYING PREMIUM (<i>ACTIVE - PAYING</i>) ...	29
1.	OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.....	29
	TABLE 4: IS DOWNGRADE NECESSARY?	30
	TABLE 5: DOWNGRADE PROCESS	35
2.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT CORRESPONDING IF KNEW PREMIUM.	35
3.	OPTION THREE - NFO.	37
4.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM.	38
B.	ACTIVE LIVES NOT PAYING PREMIUM (<i>ACTIVE - WAIVER</i>)	38
1.	LIFETIME WAIVER	38
a.	OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.	38
b.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM	39
c.	OPTION THREE - NFO.....	39
d.	OPTION FOUR - KEEP THE CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.	39
2.	DUAL WAIVER	39
a.	OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.	40

SHIP REHABILITATION PLAN

b.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.....	40
c.	OPTION THREE - NFO.	41
d.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM	41
C.	DISABLED LIVES PAYING PREMIUM (<i>ON CLAIM - PAYING</i>)	
	41
1.	OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.....	41
2.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW PREMIUM.	42
3.	OPTION THREE - NFO.	43
4.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM.....	43
D.	DISABLED LIVES NOT PAYING PREMIUM (<i>ON CLAIM - WAIVER</i>)	43
1.	OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.	43
2.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.....	44
3.	OPTION THREE - NFO.	45
4.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.	45
IV.	DETAILS OF PHASE TWO OF THE PLAN	45
A.	APPLICATION	45
B.	ACTIVE LIVES PAYING PREMIUM (<i>ACTIVE - PAYING</i>) ...	46
1.	OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.....	46
2.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.	46
3.	OPTION THREE - NFO.	47
4.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.	47

SHIP REHABILITATION PLAN

C.	ACTIVE LIVES NOT PAYING PREMIUM (<i>ACTIVE - WAIVER</i>)	47
1.	LIFETIME WAIVER	47
a.	OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.	47
b.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.	48
c.	OPTION THREE - NFO.	48
d.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.	48
2.	DUAL WAIVER	48
a.	OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.	48
b.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.	49
c.	OPTION THREE - NFO.	49
d.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.	49
D.	DISABLED LIVES PAYING PREMIUM (<i>ON CLAIM - PAYING</i>)	50
a.	OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.	50
b.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.	50
c.	OPTION THREE - NFO.	51
d.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.	51
E.	DISABLED LIVES NOT PAYING PREMIUM (<i>ON CLAIM - WAIVER</i>)	51
1.	OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.	51

SHIP REHABILITATION PLAN

2.	OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.....	52
3.	OPTION THREE - NFO.	52
4.	OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.....	52
	TABLE 6: POLICYHOLDER OPTIONS.....	53

POLICY ILLUSTRATIONS.....	54
----------------------------------	-----------

V. PHASE THREE	67
-----------------------------	-----------

VI. OTHER MATTERS.....	67
A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	67
B. LONG-TERM CARE INSURANCE	68
C. FINANCIAL CONDITION.....	72
TABLE 8: FINANCIAL CONDITION (IN DOLLARS)	
.....	72
D. REHABILITATION PROCEEDING	75
E. SENIOR HEALTH CARE OVERSIGHT TRUST.....	75
F. FUZION ANALYTICS	76
G. LTCG, INC.	77
H. POLICY RESTRUCTURING	77
I. GAUGING PLAN PERFORMANCE	77
J. GUARANTY ASSOCIATIONS	78
K. JURISDICTION OF COMMONWEALTH COURT	80
L. REINSURANCE.....	81
M. COMMISSIONS	83
N. OPT OUT	83
O. STATE DEPOSITS	84
P. TAX MATTERS.....	84
Q. PRINCIPLES AND FAIRNESS OF THE PLAN.....	85
R. RISK FACTORS	86
S. DISCLAIMERS AND SOURCES OF INFORMATION.....	87

VII. GLOSSARY	89
----------------------------	-----------

SHIP REHABILITATION PLAN



**SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA, *IN REHABILITATION*
REHABILITATION PLAN**

JESSICA K. ALTMAN, REHABILITATOR

PATRICK H. CANTILO, SPECIAL DEPUTY REHABILITATOR

HOW TO PROVIDE COMMENTS AND OBJECTIONS

Comments may be addressed to Patrick H. Cantilo, Special Deputy Rehabilitator, at Senior Health Insurance Company of Pennsylvania, In Rehabilitation, 550 Congressional Blvd., Suite 200, Carmel, IN 46032, or by electronic mail to plan.comments@shipltc.com.

Formal objections must be made in compliance with the Order of the Commonwealth Court of Pennsylvania, which will be available at www.shipltc.com when the Court enters the Order.

THIS PLAN DOCUMENT PROVIDES DETAILS ABOUT THE PLAN PROPOSED FOR THE REHABILITATION OF SHIP. IT DESCRIBES IN DETAIL THE OPTIONS FROM AMONG WHICH SHIP POLICYHOLDERS CAN CHOOSE UNDER THE PLAN. EACH LONG-TERM CARE (“LTC”) POLICYHOLDER WILL RECEIVE PERSONALIZED INFORMATION BEFORE HE OR SHE IS ASKED TO CHOOSE AN OPTION UNDER THE PLAN. THIS INFORMATION WILL BE PROVIDED, IN A SIMPLIFIED FORMAT, AFTER A FINAL VERSION OF THE PLAN IS APPROVED BY THE COURT.

SHIP REHABILITATION PLAN

IMPORTANT NOTICE

THE PLAN DESCRIBED BELOW, IF APPROVED BY THE COURT, WILL AFFECT SUBSTANTIALLY THE RIGHTS AND BENEFITS OF SHIP'S POLICYHOLDERS, CREDITORS AND OTHERS. NOTHING IN THE PLAN OR RELATED DOCUMENTS CONSTITUTES, IS INTENDED AS, OR SHOULD BE TAKEN AS, LEGAL, TAX, OR OTHER ADVICE FROM THE REHABILITATOR, HER REPRESENTATIVES, OR HER CONSULTANTS. ALL PERSONS INTERESTED IN SHIP'S REHABILITATION SHOULD READ THE PLAN DOCUMENT CAREFULLY AND CONSULT WITH THEIR OWN LEGAL, BUSINESS, FINANCIAL, TAX AND OTHER ADVISORS AS TO MATTERS CONCERNING THE PLAN DOCUMENT.

THE PLAN PROPOSES THE IDENTIFICATION OF THOSE POLICIES OF LONG TERM CARE INSURANCE ISSUED OR ASSUMED BY SHIP THAT ARE ACTUARIALLY PROJECTED TO BE UNDERPRICED IN PHASE ONE AND NON-SELF-SUSTAINING IN PHASE TWO, AS DEFINED IN THE PLAN DOCUMENT, AND THE METHODOLOGY BY WHICH POLICYHOLDERS WHO HAVE SUCH LONG TERM CARE POLICIES MAY ELECT FROM AMONG SEVERAL OPTIONS TO MAKE SUCH POLICIES APPROPRIATELY PRICED OR SELF-SUSTAINING.

SOME POLICYHOLDERS WILL BE FOUND TO HAVE POLICIES THAT ARE PROPERLY PRICED OR SELF-SUSTAINING. THESE POLICYHOLDERS WILL NOT BE REQUIRED TO MODIFY THEIR POLICIES BUT WILL HAVE THE OPTION TO DO SO IF THEY SO CHOOSE. FOR POLICYHOLDERS WHO ARE REQUIRED TO MAKE SUCH ELECTIONS BUT FAIL TO DO SO, THE PLAN INCLUDES AUTOMATIC DEFAULT OPTIONS.

SHIP REHABILITATION PLAN

THESE MODIFICATIONS TO MAKE LTC POLICIES PROPERLY PRICED OR SELF-SUSTAINING MAY INCLUDE PERMANENT REDUCTIONS IN THE BENEFITS AVAILABLE UNDER SUCH POLICIES, PERMANENT INCREASES IN THE PREMIUM RATES THAT MUST BE PAID TO MAINTAIN SUCH POLICIES IN FORCE, OR A COMBINATION OF PERMANENT BENEFIT REDUCTIONS AND RATE INCREASES. THE PLAN DOCUMENT DESCRIBES THE METHODOLOGY FOR SUCH MODIFICATIONS IN DETAIL BUT DOES NOT CONTAIN SPECIFIC INFORMATION ABOUT HOW THEY WOULD AFFECT ANY PARTICULAR POLICYHOLDER. THE SPECIFIC MANNER IN WHICH THE PLAN WOULD IMPACT A PARTICULAR POLICY CAN ONLY BE DETERMINED AFTER CALCULATIONS THAT WILL BE MADE DURING THE PERIOD AFTER THE PLAN IS APPROVED BY THE COURT AND BEFORE THE PLAN IS IMPLEMENTED, AND WILL DEPEND IN PART ON WHETHER AND TO WHAT EXTENT THE PLAN IS MODIFIED. ONCE THE CALCULATIONS ARE MADE, EACH LTC POLICYHOLDER WILL RECEIVE PERSONALIZED INFORMATION FOR PURPOSES OF MAKING ELECTIONS PERMITTED UNDER THE PLAN.

THE PLAN DOCUMENT DESCRIBES THE DETAILED PROCESS FOR DOWNGRADING POLICIES WHEN OPTION ONE IS ELECTED AND CHANGING BENEFITS WHEN OPTIONS TWO OR THREE ARE ELECTED. ALTHOUGH THESE CONSTRUCTS ARE THE PRODUCT OF EXTENSIVE ANALYSIS, THEIR EVALUATION CONTINUES AND IT IS POSSIBLE THAT THEY MAY BE FURTHER REFINED BEFORE THE PLAN IS IMPLEMENTED. IN ANY EVENT, BEFORE BEING REQUIRED TO ELECT FROM AMONG THE PLAN OPTIONS, EACH POLICYHOLDER WILL RECEIVE INDIVIDUALIZED DETAILED DATA ABOUT EACH OPTION AVAILABLE TO HIM OR HER.

SHIP REHABILITATION PLAN

THE PLAN IS DESIGNED TO REDUCE OR ELIMINATE THE SHORTFALL BETWEEN SHIP'S PROJECTED LIABILITIES AND THE ASSETS PROJECTED TO BE AVAILABLE TO FUND SUCH LIABILITIES. THERE CAN BE NO ASSURANCE THAT THE PLAN WILL SUCCEED IN THIS GOAL. IF THE PLAN FAILS IN THIS RESPECT, IT IS LIKELY THAT SHIP WILL BE PLACED IN LIQUIDATION.

IN THAT EVENT, THERE CAN BE NO ASSURANCE THAT SHIP WILL BE ABLE TO FULFILL THE CONTRACTUAL OBLIGATIONS ENTAILED IN LTC POLICIES MODIFIED UNDER THE PLAN TO THE EXTENT THAT SUCH OBLIGATIONS INCLUDE UNCOVERED BENEFITS AS DEFINED IN THE PLAN DOCUMENT.

THE PLAN DOCUMENT STRIVES TO PROVIDE A COMPLETE EXPLANATION OF EVERY SIGNIFICANT ELEMENT OF THE PROPOSED REHABILITATION. NONETHELESS, IT IS LIKELY THAT ISSUES WILL ARISE THAT HAVE NOT BEEN ENVISIONED IN THIS PLAN DOCUMENT, AND THAT CHANGES AND EVENTS OCCURRING AFTER THIS PLAN DOCUMENT IS FILED WITH THE COURT WILL REQUIRE ADDITIONAL ADJUSTMENTS TO THE PLAN. THE REHABILITATOR ANTICIPATES SEEKING FROM THE COURT AUTHORITY TO MAKE SUCH CHANGES, OR TAKE SUCH ADDITIONAL STEPS, IN IMPLEMENTING THE PLAN AS SHE CONCLUDES ARE NECESSARY TO GIVE EFFECT TO THE SPIRIT OF THE COURT'S ORDER APPROVING OR MODIFYING THE PLAN. THE FINAL PLAN AS IMPLEMENTED MAY THEREFORE VARY IN SOME MEASURE FROM THE DESCRIPTION IN THIS PLAN DOCUMENT.

SHIP REHABILITATION PLAN

REHABILITATION PLAN DOCUMENT

I. BASIC INFORMATION ABOUT THE PLAN

As more fully detailed below, after reporting a very large deficit in capital and surplus, and having submitted no plan to restore required surplus, on January 29, 2020, Senior Health Insurance Company of Pennsylvania (“SHIP” or the “Company”) was placed in rehabilitation by order of the Commonwealth Court of Pennsylvania. The Court appointed Pennsylvania Insurance Commissioner, Jessica K. Altman, as Rehabilitator. Under the Court’s order and the applicable statutes, Commissioner Altman, as Rehabilitator, has broad authority to take remedial steps to address SHIP’s financial challenges. She has engaged a Special Deputy Rehabilitator and a group of consultants who have developed this rehabilitation plan for the protection of SHIP’s policyholders and creditors.

This document (“Plan Document”) is intended to provide a sufficient description of the proposed rehabilitation plan (the “Plan”) to:

1. Enable policyholders and interested parties to understand, provide meaningful comments about, and formal objections if any to, the Plan, and
2. Enable the Commonwealth Court to determine whether to approve, modify and approve, or disapprove the Plan.

Necessarily, many of the details of the Plan will have to be resolved during the implementation period. It is not possible to anticipate all of the implications of every aspect of the Plan before it is put in place. Nonetheless, this Plan Document provides a detailed description of how the Plan, if approved as proposed, is expected to be implemented.

The actual choices for, and projected impact upon, each policyholder will not be known until after the Plan is finalized and its provisions are calculated by the Company’s systems. Those calculations produce materially different results depending on the passage of time and changes in both general and policyholder-specific circumstances. The cost and delay attendant to making the calculations for every policyholder in advance of approval are not justified given that the results will be too inaccurate to be meaningful. However, at page 54 are presented illustrations of Plan options for several representative policyholders. This Plan Document therefore provides relative and directional guidance about Plan options rather than precise details for each one.

SHIP REHABILITATION PLAN

A. SUMMARY DESCRIPTION OF THE PLAN

The following description of the Plan is intended to provide policyholders the basic information required for them to make the required election(s) if the Plan is implemented as proposed. To that extent, it should also enable policyholders to decide what if any comments or formal objections they may offer in response to the request for approval of the Plan. Much more detail about the Plan and related matters is provided in the sections that follow.

1. GOAL AND PHASES OF THE PLAN

Recognizing that SHIP faces a substantial Funding Gap (described on page 72), the aim of the Plan is to increase revenues and reduce liabilities so as to narrow or eliminate that gap through a combination of Policy Modifications for most of the approximately 45,000 policies in force as of the filing of the Plan. Although the Plan has certain default provisions that apply when policyholders fail to make effective choices, it is structured to maximize policyholder choice, based on each person's individual circumstances and preferences. In structuring the Plan, the Rehabilitator recognizes that many policyholders have costly policies that provide far more coverage than the policyholders are reasonably likely to require. Accordingly, a key element of the Plan is to enable policyholders to remove coverages that are not essential or even necessary, thereby helping to narrow the Funding Gap and potentially reducing their own premium, or at least avoiding part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. Phase One, commencing immediately following final approval, is the principal phase and will strive to reduce substantially or eliminate the Funding Gap. In this phase it will be determined which policies require modification because their Current Premium is below the "***If Knew Premium***" for the benefits offered by the policy. The If Knew Premium is a widely accepted methodology for setting premiums for LTCI policies, more fully explained at page 16. Policyholders with Current Premium (see page 92) below the If Knew Premium will have to increase their premiums or reduce their benefits so that the premium will be adequate on an If Knew Premium basis. Policyholders whose Current Premium is at or above the If Knew Premium will not be required to modify their policies (increase their premiums or reduce their benefits) but may choose to make some such modifications if they prefer to do so, as explained below.

In Phase Two, the results of Phase One will be evaluated and additional Policy Modifications may be necessary for certain policies. Modifications in Phase Two will be based on Self-sustaining Premiums as explained at page 16. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies whose premiums are not already Self-sustaining, which are not ***Fully Covered*** (i.e., they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 93), and which have not selected Option Two or Option Three (described below) in Phase One, may be modified in Phase Two.

SHIP REHABILITATION PLAN

In Phase Three, the Company will complete the run-off of the LTCI business in force. If there are sufficient funds to do so, in Phase Three the Plan will also provide additional benefits to policyholders and make payments to unpaid creditors.

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 12. In Phase One every policyholder whose Current Premium is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium is at or above the If Knew Premium may keep their current policies without premium increases or may elect Option Two or Option Three, described below.

- a. Option One will be to continue paying the Current Premium but (if it is less than the If Knew Premium) have benefits reduced so that the premium for the reduced benefits on an If Knew Premium basis is equal to the Current Premium. The benefit reductions will be selected automatically by the Plan.
- b. Option Two will be to select certain policy endorsements that in most cases provide greater benefits than Option One but at a lower premium than Option Four. This Option, of which an enhanced version will also be available, will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. This Option is designed to provide reasonable coverage at reasonable premium rates.
- c. Option Three will be a ***Non-forfeiture Option*** through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will be charged. Under the Plan, this Option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30 month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.
- d. Option Four will be to retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the Current Premium that the policyholder is paying). For many policyholders this may require a very large increase in premiums.

Policyholders paying premium at or above the If Knew Premium may elect to make no changes (or make no election at all and leave their policies unchanged) or may elect Option Two or Three if preferable for their individual circumstances. Options One and Four would not result in any changes for such policyholders.

SHIP REHABILITATION PLAN

Before being required to make an election, each policyholder will receive information detailing the premiums and benefits of each option. Special rules apply to policyholders who are not currently paying premium due to a Premium Waiver provision in their or their spouses' policies. These are explained fully beginning at page 19. Generally, such policyholders who elect Option Two or Option Four and whose Current Premium (the premium they would be paying but for the waiver) is lower than the If Knew Premium, will be required to pay a Differential Premium. The Differential Premium consists of the difference between (1) the premium they would be paying if there were not a waiver in effect (the Current Premium), and (2) the If Knew Premium corresponding to the policy. See Section II.E.6, page 18. If the Premium Waiver terminates, such policyholders will be required to pay the full applicable If Knew Premium (or Self-sustaining Premium if in Phase Two). Substantially the same options will be offered to policyholders on claim.

Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to the applicable Guaranty Association limits but no more than the current policy benefits. For every policyholder Option Two will do that and for many policyholders other options will do that as well. In that respect, the Plan is designed to place policyholders in no worse a position than they would face in a liquidation of SHIP.

For every policyholder whose Current Premium is below the If Knew Premium, there will be a Default Option that will be identified in the election materials (and is illustrated on page 53). In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements - see Section III.A.2.d, page 36) will be the Default Option. The Default Option will apply if the policyholder fails to make an election by the applicable deadline or submits an election form that does not clearly identify the policyholder's election (for example because two or more options is elected). For a policyholder whose Current Premium is equal to, or higher than, the If Knew Premium, no Default Option will apply and no changes will be made to the policy unless specifically elected, even if the policyholder does not submit a proper completed election form. The Rehabilitator believes that there are a substantial number of policyholders in these circumstances.

Similar options as those offered in Phase One will be offered to policyholders in Phase Two of the Plan, but the premium modification will be based on attaining Self-sustaining Premiums. It is important to note that policyholders who elect Option One or Option Four in Phase One, and whose policies after Phase One are not Self-sustaining or Fully Covered (*i.e.*, within Guaranty Association limits), may face additional premium rate increases or benefit reductions (sometimes substantial) in Phase Two. Policyholders who elect Option Two or Option Three will NOT face additional rate increases or benefit reductions in Phase Two of the Plan. In addition, policyholders who select Option Three will never pay any more premiums.

SHIP REHABILITATION PLAN

B. KEY CONSIDERATIONS FOR POLICYHOLDERS

For every policyholder there will always be two competing considerations: the anticipated need for LTC benefits and the cost of maintaining coverage for those benefits. As is true of many similar LTCI blocks in the market, many of SHIP's policies have historically been substantially underpriced and policyholders have not been asked to pay the premium that would be necessary to assure that those benefits will be available when needed. Obviously, this is not a sustainable model and is a key contributor to SHIP's present financial challenge. The Plan aims to enable policyholders to balance these competing considerations in the context of their individual circumstances. Put simply, not every policyholder will need the same level of benefits in the future and not every policyholder will be in a position to pay an appropriate premium for the most generous combinations of LTC benefits.

In determining which option to elect, each policyholder should endeavor to identify what is a reasonable level of benefits to be provided by his or her policy given his or her likely future needs, and the ability of the policyholder to pay for such benefits. For example, there is a very material difference in the cost of a policy that provides 5% Inflation Protection when compared to one that provides 2% Inflation Protection and one that provides no Inflation Protection at all. Similarly, there is a material difference between the cost of a policy with lifetime benefits, one with a five-year benefit period, and one with a two-year benefit period. Moreover, features like Premium Waivers, Restoration of Benefits, Return of Premium, short Elimination Periods, indemnity vs. reimbursement, and "traditional" benefit triggers can all add materially to the cost of a policy but may not be indispensable to every policyholder.

The Plan is constructed to offer policyholders an array of options that can be responsive to the widely divergent circumstances of SHIP's policyholders. For example, for policyholders who cannot afford any premium rate increases, Option One (maintaining Current Premium and reducing benefits) may be the best Option for those policyholders in that it eliminates rate increases in Phase One of the Plan. However, for some of those policyholders, the reduction in benefits necessary to achieve that goal may leave the policy with benefits deemed insufficient by the policyholders. Moreover, policyholders who select Option One may face additional rate increases or benefit reductions in Phase Two of the Plan. For such policyholders Options Two or Three may be preferable. Option Two is designed to provide a reasonable combination of benefits at a reasonable premium. For many policyholders it is likely that the premium required for Option Two will be less than what would be required for Option Four to maintain the current policy benefits. On the other hand for these policyholders, the benefits offered in Option Two may be more acceptable than those provided by Option One. An advantage of Option Two is that it would not present the possibility of rate increases or benefit reductions in Phase Two of the Plan. For other policyholders, Option Three (the Non-forfeiture Option) may be optimal. That would be a policy with modest benefits but for which no more premium would ever be required, even if the Company were placed in liquidation.

SHIP REHABILITATION PLAN

For those fortunate policyholders who can afford any rate increase, Option Four might be attractive in that it would enable them to retain the most generous benefits, even at very high premium rates. But many of these policyholders would face very large rate increases when selecting Option Four, sometimes as much as or more than ten-fold. This is because, in many cases, the premiums for those policies began below where they should have been and were never raised to adequate levels. Thus, such policies now have years, even decades, of underpricing embedded in their current premium rates. Moreover, policyholders selecting Option Four would face the possibility of additional substantial rate increases or benefit reductions in Phase Two of the Plan.

There will also be a number of policyholders whose Current Premiums are already appropriate. For these policyholders, selecting Option One or Option Four would be meaningless because neither their premiums nor benefits would change in either case. Such policyholders will not be required to make any election. However, they will be given the opportunity to select Option Two or Option Three if that would be better for their circumstances.

It is not practical to offer enough options to precisely meet every policyholder's expectations or preferences. Doing so would make the Plan too complicated and costly. The Special Deputy Rehabilitator has led a team that has devoted intense efforts to the development of a manageable number of options that recognize the major differences in policyholders' circumstances. While no one option may be ideal for a particular policyholder, the differences among the options are such that it is hoped that every policyholder will find at least one option that will enable that policyholder to emerge from SHIP's rehabilitation with adequate long-term care protection at reasonable premiums.

C. TIMELINE

The order placing SHIP in rehabilitation requires the Rehabilitator to submit to the Court a preliminary plan for SHIP's rehabilitation by April 22, 2020. At page 23 is a preliminary sequence of expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity, the Rehabilitator expects that policyholders and other interested parties will be afforded an opportunity to comment on the Plan within the next few months. Because of the extraordinary circumstances facing our nation, the Rehabilitator will ask the Court to provide policyholders and others a prolonged period of time to review the Plan before such comments are due. Depending on the nature of such comments, and whether formal objections to the Plan are filed with the Court, a hearing on the Plan may occur as early as late summer or early fall of 2020. Depending on the outcome of that hearing, implementation of the Plan might commence in the fall of 2020. In that event, policyholders may be asked to make their elections before or shortly after year-end.

D. RATIONALE FOR THE PLAN

The Plan hinges on two essential assumptions: (1) in order to maximize policyholder

SHIP REHABILITATION PLAN

protection, the Plan must strive to reduce the Funding Gap by increasing revenue or reducing liabilities; and (2) while premium rate increases can increase revenue by some increment, elimination by policyholders of long-term care coverage they may not truly need or be able to afford will go much further in remedying the Company's dire financial situation. The Rehabilitator believes that the Plan structure, which is the product of extended analysis by industry experts, offers a reasonable prospect of success based on sound principles.

1. The Plan gives policyholders more control over their fates, allowing each to elect the path best suited to his or her circumstances.
2. All policyholders will have at least one option for preserving their current coverage and at least one option for preserving their Current Premium.
3. Target premiums under the Plan take rate increase history and product differences into account, improving the equity of the premium rate structure. Generally, policyholders whose policies were issued in states that have approved comparatively more rate increases over preceding years will face lower premium increases or benefit reductions under the Plan.
4. In every case, unless their policies are already below Guaranty Association limits, policyholders will have at least one option (Option Two) calibrated to Guaranty Association limits to provide outcomes no less favorable than liquidation.
5. The revenue from rate increases under the Plan will go to pay claims and expenses of implementing the Plan whereas, in liquidation, Guaranty Association rate increases are used to reduce assessment burdens for member insurers and not to increase the ability to pay claims.
6. Though certainly not guaranteed, the Plan structure inherently creates the possibility of greatly reducing, if not eliminating, the Company's deficit.



II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION

This Section of the Plan Document provides detailed and technical explanations of proposed Rehabilitation Plan provisions for modification of long-term care insurance policies issued or assumed or reinsured by Senior Health Insurance Company of Pennsylvania. As modeling and analysis continue, additional refinements are possible. However, the fundamental Plan structure is unlikely to change unless the Court requires it. The following notes may aid in understanding this structure.

SHIP REHABILITATION PLAN

A. PLAN PHASES

The Plan is contemplated to occur in three phases. In **Phase One**, all LTC policies that are not in Non-forfeiture Option status will be evaluated and their holders offered options to modify premiums or benefits, or some combination of the two. The results of this phase for the Company can vary materially depending on Policyholder Elections. They will be monitored and evaluated after Phase One becomes effective to gauge the results. In due course a decision will be made as to whether and, if so, how to implement Phase Two. **Phase Two** will be aimed at narrowing or eliminating any remaining deficit and its timing will depend on the results achieved in Phase One. Under the terms of the Plan, in Phase Two only policies which have not selected Option Two (Basic Policy Endorsements - see section III.A.2.d) or Option Three (Non-forfeiture Option - see Section III.A.3), that are not Self-sustaining in that they are notionally projected to create unfunded liability, and which would not be Fully Covered by Guaranty Associations, will be affected. Holders of these remaining policies will again be asked to “right-size” them by modifying premiums or benefits, or a combination of the two. For that purpose, they will be offered options very similar to those offered in Phase One. Depending on the results of Phase One, Phase Two may also include additional remedial measures. In **Phase Three** SHIP will conclude the run-off of its business in force, as modified by the Plan. The Plan is not designed to create a surplus for SHIP. However, in the unlikely event that the Plan actually does generate a surplus, in Phase Three that surplus will be distributed to policyholders, Agents and other creditors.

B. POLICYHOLDER CATEGORIES

1. For Plan implementation purposes, policyholders are sorted into eight main categories, four each in Phase One and in Phase Two:
 - (1) Active - premium paying;
 - (2) Active - not premium paying (further segregated between lifetime or dual Premium Waiver);
 - (3) Disabled - premium paying; and
 - (4) Disabled - not premium paying.
2. There may be some policyholders who do not fit neatly into the Plan’s defined policyholder categories in each Phase, though none have yet been identified. If so, those will be addressed on an *ad hoc* basis.

C. POLICYHOLDER OPTIONS

1. In each category, policyholders whose Current Premiums are below the If Knew Premium for their policies will have four options, including the option to take a Non-forfeiture Option (NFO) on which no additional premium will be due. No other cash-out or buy-back option will be included. Generally, the options provided by the Plan will be:

SHIP REHABILITATION PLAN

- a. **Option One** - Keep the Current Premium (or Premium Waiver) and downgrade to specified reduced benefits in a manner determined automatically by the Plan. The **Downgrade Process** is explained beginning at page 30. This will be solely a benefit reduction option;
 - b. **Option Two** - Elect **Basic Policy Endorsements** (making the policy one designed to provide reasonable benefits and premiums - see Section III.A.2.d, page 36) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. This option may entail both premium increases and benefit reductions for many policyholders, but premium increases will always be lower than under Option Four. For some policyholders it may entail a premium reduction. Policyholders will be offered two variations of this option, a standard version and an enhanced alternative. As explained below, policyholders who select this option in Phase One will not be asked to make Policy Modifications in Phase Two;
 - c. **Option Three** - Elect a Non-forfeiture Option on which no additional premium will ever be paid (see Section III.A.3, page 37); or
 - d. **Option Four** - Keep the current policy benefits and accept a premium increase. The new premium will be (as defined below) the **Phase One Premium** in Phase One and the **Self-sustaining Premium** in Phase Two. This will be solely a premium increase option.
2. Thus, policyholders whose Current Premiums are below the If Knew Premium for their policies will be able to: (a) keep their current premium with downgraded benefits, (b) choose Basic Policy Endorsements, (c) take a NFO, or (d) to keep their current benefits and pay additional premium.
- a. The Basic Policy Endorsements modify the existing policy to one with generally more affordable premiums than would be charged for the current policy benefits on an If Knew basis and more limited benefits when compared to the current policy, but generally richer than those in Option One, the downgrade. Details of its provisions are laid out in Section III.A.2.d, page 36, below. As noted, to maximize policyholder choice, two variations of this option will be offered, standard and enhanced.
 - b. The NFO is a reduced paid up policy more fully described in Section III.A.3, page 37, below. No more premium is ever due on the NFO and it will never lapse.
3. These will be the only options available under the Plan. Other options that are sometimes available in particular states in response to approved rate increases are not offered under the Plan.

SHIP REHABILITATION PLAN

4. In Phase One, policyholders whose Current Premium on the Determination Date (see page 92) is at or above the If Knew Premium for the benefits offered by their policies need not modify their policies, and their policies would not be changed by selecting Option One or Option Four. Such policyholders may do nothing or they may select Option Two or Option Three if they wish to do so to accommodate their individual circumstances, for example to reduce their premiums or to avoid the possibility of a Phase Two rate increase. The Default Option for these policyholders will be that their policies remain unchanged.
5. Subject to the orders of the Commonwealth Court of Pennsylvania (*Commonwealth Court* - which is the rehabilitation court), the Plan contemplates that Basic Policy Endorsements elected in Phase One (Option Two) will be immune from Phase Two changes unless the Company is placed in liquidation. Policyholders who elect this option in Phase One generally will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.
6. However, certain policyholders paying the lower *Phase One Differential Premium* or *If Knew Differential Premium* due to a Premium Waiver may be required to begin paying the full Phase One Premium or If Knew Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). Similarly, in Phase Two certain policyholders paying the *Self-sustaining Differential Premium* due to a Premium Waiver may be required to begin paying the full Self-sustaining Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). See Section III.A.2.c, page 35.
7. Non-forfeiture Options elected in Phase One will not be subject to change thereafter, including in Phase Two or if the Company is placed in liquidation.
8. It is important to note, and policyholders will be advised before making such elections, that policies for which Options One or Option Four are chosen in Phase One may be subject to additional modifications in Phase Two. Moreover, the timing and details of the modifications that may be required in Phase Two will not be known to policyholders when they make their Phase One elections. In particular, policyholders will be advised that options to retain benefits that generate low premium rate increases in Phase One may result in premium rate increases or benefit reductions in Phase Two due to differences in the methodologies used to calculate premium rates in each phase.
9. The exceptions to this possibility of changes in Phase Two are the election of Basic Policy Endorsements or NFO (Options Two and Three, respectively) in Phase One. As noted below (see Section III.A.2.c, page 35), so long as the Plan remains in effect, and unless the Commonwealth Court orders otherwise, the Basic Policy Endorsements elected in Phase One will be immune from Phase Two changes except that (as explained above in Section II.C.5)

SHIP REHABILITATION PLAN

certain policyholders on claim (or their spouses) may be required to pay full Phase One Premium or If Knew Premium when they recover. The NFO is expected to remain permanent through policy termination.

10. The approximately 10,500 policyholders who have already chosen to replace their policies with Non-forfeiture Options before the Plan is implemented will not be asked, or have the ability, to make any changes to their policies as part of the Plan.
11. Beginning on the applicable Effective Date and while the Rehabilitation Plan is in effect, policyholders who fail to pay their premiums when due, or who otherwise terminate or lapse their policies voluntarily, will receive a notice that, as of the date on which the unpaid premium was due, or as of the date of their termination request or lapse notice, their policies will be converted to Non-forfeiture Options. However, they may request in writing that their policies be fully terminated. This would not apply to policyholders who have converted their policies to NFOs, from whom no premium is due.

D. CLAIM STATUS

For purposes of Policyholder Elections:

1. After the Plan is approved, a policyholder will be deemed to be on claim if he or she is receiving health care services that would be reimbursable by the Company were it not for an ***Elimination Period*** (EP) that has not been satisfied. Such a policyholder will be expected to begin receiving indemnity or reimbursement payments as soon as the EP is satisfied.
2. The Company may also determine that a policyholder has been on claim as of an earlier date when that policyholder has been receiving health care services reimbursable by the Company but has not reported such services to the Company. Such a policyholder is expected to be reimbursed for prior covered services when they are reported to the Company, subject to policy terms and conditions and applicable law.

E. PREMIUM RATE DETERMINATIONS

1. The Plan contemplates using different target premium rates in each phase. In the first phase, the target premium will be the Phase One Premium (a variation of If Knew Premium that can be no less than the Current Premium) for policyholders electing Option Four (retain their current benefits). Since in Option One, the premium remains the same, benefits are reduced to what that premium would “buy” at If Knew Premium rates as explained on page 29. For policyholders selecting Option One (retain Current Premium) or Option Two (Basic Policy Endorsements), the target premium will be the If Knew Premium. In Phase Two the target premium will be the Self-sustaining Premium.

SHIP REHABILITATION PLAN

2. The **If Knew Premium** rate is the rate that, if charged from inception, would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, this will be assumed to be 60%. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past.
3. For each policy for which the Current Premium is more than the If Knew Premium, the Current Premium will be the Phase One Premium required to maintain the current benefits. In short, that policyholder can (but is not required to) retain the current policy at Current Premium without change in Phase One. Correspondingly, for policies with a Phase One Premium higher than the Current Premium (which in this case would be the same as the If Knew Premium), the downgrade required to maintain the Current Premium will be a reduction in benefits to a level that produces an If Knew Premium equal to the Current Premium as explained beginning on page 29.
4. **Self-sustaining Premium** is the premium calculated by determining the amount of premium required to eliminate a policy's **Shortfall Amount**.
 - a. The Shortfall Amount is the difference between its **Projected Benefit Amount** (PBA) and its **Projected Credit Amount** (PCA) where the difference is more than zero. The Shortfall Amount can also be expressed as a policy's **Gross Premium Reserve** (GPR) less its **Allocated Assets**. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.
 - b. The PBA is the present value as of the valuation date of the sum of (1) unpaid expected policy benefits and (2) unpaid expected policy expenses. For purposes of this determination "expected" consists of best estimate assumptions.
 - c. The PCA is the sum of (1) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (2) the assets allocated to that policy as described below in subparagraph II.E.4.e, page 17. Again, for purposes of this determination "expected" consists of best estimate assumptions.
 - d. **Total Allocable Assets** is a notional determination consisting of the Company's invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority. **Active Allocable Assets** is a notional determination consisting of the Company's Total Allocable Assets less the amount required to fund fully the Claims Reserves for Disabled Lives under the Plan. For the purpose of these calculations, NFO policies will be treated as Disabled Lives and their GPR will be included with Claims Reserves for Disabled Lives. **Disabled Allocable Assets** is a notional allocation consisting of the product of the Active Asset Premium Ratio

SHIP REHABILITATION PLAN

times the Accumulated Premium for Disabled lives. The **Active Asset Premium Ratio** is the ratio of Active Allocable Assets to the aggregate Accumulated Premiums for all Active Lives. For purposes of this calculation, policyholders who have selected an NFO will not be considered Active Lives. **Accumulated Premium** is the total Gross Premiums paid, and premiums waived, under a policy or group of policies from inception until the valuation date. This approach is designed to allocate assets equitably between active and disabled policyholders solely for the purpose of calculating Phase Two premiums.

- e. **Allocated Assets** are the portion of the Company's Allocable Assets notionally allocated to a particular policy in accordance with the terms of, and solely for the purposes of calculations described in, the Plan. Such asset allocations are nominal and do not give a policyholder a right to any Allocated Assets or any particular sum of money. Allocated Assets are determined separately for active lives and disabled lives.
- (1) For each Active Policy, Allocated Assets is the portion of Active Allocable Assets equal to the percentage of total Accumulated Premium for active lives represented by that policy's Accumulated Premium.
 - (2) For a policy on claim, the Allocated Assets is the portion of Disabled Allocable Assets equal to the percentage of total Accumulated Premium for policies on claim represented by that policy's Accumulated Premium.

TABLE 1: ASSET ALLOCATION		
1	Total Invested Assets	\$2,500,000,000
2	Reserve for Costs of Administration	\$200,000,000
3	Contingencies	\$10,000,000
4	Priority Debts	\$50,000,000
5	Total Allocable Assets (L1 - (L2...L4))	\$2,240,000,000
6	Claims Reserves for Disabled Lives under the Plan	\$900,000,000
7	Active Allocable Assets (L5 - L6)	\$1,340,000,000
8	Accumulated Premium - All Active Lives	\$4,500,000,000
9	Accumulated Premium - All Disabled Lives	\$480,000,000
10	Accumulated Premium Hypothetical Active Policy	\$40,000

SHIP REHABILITATION PLAN

11	Accumulated Premium Hypothetical Disabled Policy	\$50,000
12	Active Asset Premium Ratio (L7/L8)	30%
13	Disabled Allocable Assets (L9 X L12)	\$142,933,333
14	Allocated Assets Hypothetical Active Policy (L7 X (L10/L8))	\$11,911
15	Allocated Assets Hypothetical Disabled Policy (L13 X (L11/L9))	\$14,889

5. For policyholders on claim in Phase Two, the Self-sustaining Premium will be determined as if they were not on claim. For this purpose, assets will be allocated notionally to policies on claim as explained above.
6. In certain instances the Plan uses a **Differential Premium**, which in each case is the difference between the target rate (Phase One Premium, If Knew Premium, or Self-sustaining Premium, depending on the option elected and whether this occurs in Phase One or Phase Two) and the Current Premium the policyholder would be paying if not on waiver. Differential Premium can never be less than zero. In cases in which the Current Premium is higher than the target rate, there would be no Differential Premium.
 - a. Thus, in Phase One the Plan requires policyholders not paying premium, who elected Option Four (retain current benefits), to pay the Phase One Differential Premium consisting of the Phase One Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).
 - b. Policyholders not paying premium who chose Option Two (Basic Policy Endorsements) in Phase One and whose current (waived) premium before making that election was lower than the If Knew Premium for the Basic Policy Endorsements will be required to pay the If Knew Differential Premium. This is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect.
 - c. Similarly, in Phase Two the Plan requires policyholders not paying premium who selected Option Two (Basic Policy Endorsements) or Option Four (retain current benefits) to pay the Self-sustaining Differential Premium consisting of the Self-sustaining Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).

SHIP REHABILITATION PLAN

TABLE 2: DIFFERENTIAL PREMIUM			
		CASE 1	CASE 2
1	CURRENT PREMIUM	\$2,300	\$3,200
2	IF KNEW PREMIUM	\$2,250	\$3,500
3	IF KNEW DIFFERENTIAL PREMIUM (L2-L1, BUT NOT <0)	\$0	\$300
4	PHASE ONE PREMIUM	\$2,300	\$3,500
5	PHASE ONE DIFFERENTIAL PREMIUM (L4-L1, BUT NOT <0)	\$0	\$300
6	SELF-SUSTAINING PREMIUMS	\$3,100	\$5,000
7	SELF-SUSTAINING DIFFERENTIAL PREMIUM (L6-L1, BUT NOT <0)	\$800	\$1,800

F. PREMIUM WAIVERS

1. SHIP LTC policies may contain one or more **Premium Waiver** provisions under which a policyholder is permitted to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.
 - a. Under a **Claim Waiver of Premium** (WOP) provision, a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to recommence paying premiums in order to keep the policy in force.
 - b. Under a **Dual Waiver of Premium** (DWOP) provision, also called "Spousal Waiver of Premium", a policyholder may suspend premium payments during the time that a spouse qualifies for waiver of premium.
 - c. The **Lifetime Waiver of Premium** provision permits suspension of premium payments upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years). The Lifetime Waiver of Premium provision, as the name implies, is permanent.
2. The Plan affects these Waiver of Premium provisions in specific ways. Policyholders who took a Non-forfeiture Option before the Plan became effective, or who do so under the Plan, do not pay premium and are not affected by Waiver of Premium provisions.
 - a. **Claim Waiver of Premium.** Policyholders on Claim Waiver of Premium on the

SHIP REHABILITATION PLAN

Policyholder Election Date will be treated as if that waiver continues with respect to the premium in effect at that time (the Current Premium).

- (1) If such policyholders elect Option One, which does not entail a premium increase, the Current Premium remains waived and no Differential Premium is applicable. If such policyholders recover, their Current Premium must again be paid but their policies will remain downgraded.
- (2) If such policyholders make an election under the Plan that increases their premiums (Option Two or Option Four, see page 12), the waiver does not apply to the increase and they will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under the elected Plan Option. When such policyholders recover and the Claim Waiver of Premium terminates, they must begin paying the full Plan premium. If such policyholders go on claim again following a specified period of recovery and their policy retains the Claim Waiver of Premium provision, the full **Plan Premium** (Phase One Premium, If Knew Premium, or Self-Sustaining Premium, depending on the circumstances) is waived while they are on claim.
- (3) Policyholders who elect Option Three, the NFO, are unaffected by Premium Waiver provisions because they do not pay premium.

b. **Dual Waiver of Premium.** Policyholders whose premiums are waived under a Dual Waiver of Premium (DWOP) provision will be treated in the same way as policyholders under a Claim Waiver of Premium. However, it is the status of the spouse on claim that determines whether they pay the Differential Premium or the full Plan premium when they select Option Two or Option Four.

- (1) If a policyholder has selected Option One, is not paying any premium due to the waiver, and his or her spouse recovers, he or she must begin paying the Current Premium but his or her policy will remain downgraded.
- (2) If a policyholder has selected Option Two, is paying only the If Knew Differential Premium due to the waiver, and his or her spouse recovers, such a policyholder must begin paying the full If Knew Premium. Of course, if the If Knew Differential Premium for that policyholder is zero, he or she need not pay any additional premium.
- (3) If a policyholder has selected Option Four, is paying only the Phase One Differential Premium due to the waiver, and his or her spouse recovers, such policyholder must begin paying the full Phase One Premium.

SHIP REHABILITATION PLAN

- (4) If a policyholder is on Dual Waiver, has a policy with Claim Waiver of Premium, selects Option Two or Option Four, is paying Phase One Differential Premium or If Knew Differential Premium, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim, even if the spouse recovers during that period. Once the policyholder recovers, he or she will be required to resume paying the Differential Premium if the spouse remains on claim and the dual waiver of premium is still effective. If the spouse has also recovered or the dual waiver of premium is otherwise no longer effective, the policyholder will be required to pay the full Phase One Premium or If Knew Premium upon recovery. If both policies with Dual Waiver select Option Four, and one goes on claim after the Effective Date, the full Phase One Premium for both policies would be waived.

- c. **Lifetime Waiver of Premium.** Policyholders who are on Lifetime Waiver of Premium on the Policyholder Election Date will retain that waiver after the Plan Effective Date.

- (1) If such a policyholder makes an election under the Plan that increases his or her premiums (Option Two or Option Four), the Lifetime Waiver of Premium does not apply to the increased portion of the premium and he or she will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under the elected Plan Option.
- (2) If a policyholder is on lifetime waiver, has a policy with Claim Waiver of Premium benefit, selects Option Four, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim.

G. CERTAIN “NON-CORE” POLICY BENEFITS

Many SHIP LTC policies provide one or more “Non-core” benefits such as:

1. Bed Reservation Benefit,
2. Respite Care,
3. Caregiver Training,
4. Medic Alert,
5. Prescription Drug Benefit,
6. Homemaker Services,

SHIP REHABILITATION PLAN

7. Personal Needs Benefit,
8. Accidental Death Benefit,
9. Helping Hands Benefit,
10. Adult Foster Care,
11. Ambulance Services,
12. Transportation Benefit,
13. Home Delivered Meals,
14. Assistive Equipment, and
15. Remodeling.

The Plan is not intended to affect these benefits and they will continue once the Plan becomes effective unless the policyholder elects Option Three, the Non-forfeiture Option.

H. RATE APPROVALS

1. Rate increases and Policy Modifications will be submitted to Commonwealth Court of Pennsylvania for approval as part of the Plan. The Rehabilitator will not seek separate approval of rate increases or Benefit reductions.
2. The rate increases will not necessarily be limited by, or adhere to, filed rate cards. Rate cards are issued by insurers and approved by regulators to describe the premium rates applicable under specified circumstances or for specific types of coverage. They are inapplicable to the Plan.
3. Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. This is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no approval from individual states, modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating "subsidies" by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of state-by-state rate approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate.

I. NFOs AND PAID-UP POLICIES

The Plan will not affect the approximately 10,500 policyholders who have already taken NFOs. Their policies will never pay premium and their benefits will not be reduced further by the Plan. The Plan also will not affect paid-up policies for which only a specified number of premium payments were required, including those for which some of those payments remain to be made.

SHIP REHABILITATION PLAN

NFOs selected under the Plan (Option Three) will differ materially from pre-Plan NFOs, principally by providing longer benefit periods.

J. PARTNERSHIP-QUALIFIED POLICIES

Under the Deficit Reduction Act of 2006, certain LTC insurance policies called ***“Partnership-Qualified”*** (PQ), entitle the policyholder to a dollar of asset disregard or spend-down credit with respect to Medicaid eligibility for every dollar of benefit received under the LTC policy. The provisions of PQ policies vary from state to state but many require a minimum amount of cost of living adjustment (COLA) or Inflation Protection. The Plan will not reduce COLA or inflation protection features for PQ policies below those required for PQ status.

K. PLAN TIMING

1. The Plan is designed for implementation of Phase One as rapidly as possible, with more time available for implementation of Phase Two. At the conclusion of Phase One and continuously thereafter its results will be evaluated and, in due course, a determination will be made as to whether and, if so how, Phase Two should be implemented.
2. The anticipated timeline provides for a fair opportunity for policyholders and interested parties to evaluate and object to, or comment upon, the Plan if they choose to do so. The Rehabilitator may suggest modifications of the Plan as a result of those comments and objections, if any. Illustration 4 provides a high-level sequence for the Plan.

TABLE 3: PLAN SEQUENCE	
1.	Filing of Proposed Rehabilitation Plan and request for approval of notice
2.	Notice to Policyholders and Interested Parties
3.	Deadline for Objections and Comments
4.	Hearing on Rehabilitation Plan, if necessary
5.	Order Approving, Modifying or Disapproving Plan
6.	Final Approval Date (assuming approval)
7.	Plan Preparation Period
8.	Determination Date
9.	Policyholder Election Package

SHIP REHABILITATION PLAN

10.	Policyholder Election Deadline
11.	Begin Policyholder Transition Period
12.	Evaluation of Policyholder Elections
13.	End Policyholder Transition Period
14.	Initial Plan Effective Date
15.	Supplemental Policyholder Election Package
16.	Supplemental Policyholder Election Date
17.	Supplemental Plan Effective Date
18.	Evaluation of Phase One
19.	Decision on Phase Two
20.	Phase Two Policyholder Election Package
21.	Phase Two Policyholder Election Deadline
22.	Phase Two Effective Date
23.	Evaluation of Plan performance
24.	Phase Three, if justified.

- a. The Plan will be submitted to the Commonwealth Court for approval, modification, or disapproval. Policyholders and interested parties will have an opportunity to offer comments about, or object to, the Plan. The Commonwealth Court may then hold a hearing on the Plan. Following the hearing, the Court will approve, modify or disapprove the proposed Plan. If the Plan is approved (with or without modification), the date upon which such approval becomes final (including exhaustion of appeals, if any) will be the ***Final Approval Date***. It will commence the ***Plan Preparation Period***, which will end with the ***Initial Plan Effective Date***. During the Plan Preparation Period:
- (1) The Company will make all the determinations and perform the calculations required to construct the options available to each policyholder. All determinations will be made as of a ***Determination Date*** which may vary from policyholder to policyholder but which will always be before the Policyholder Election Date defined below.
 - (2) The ***Policyholder Election Package*** (containing the information required for

SHIP REHABILITATION PLAN

policyholders to make their elections) and the ***Policyholder Election Forms*** (upon which they will do so) will be prepared and distributed.

- (3) Except as noted below in Section II.K.3, page 25, the Policyholder Elections must be made by the ***Policyholder Election Date*** and will be collected and evaluated by the Company as received.
 - (4) On the ***Initial Plan Effective Date*** all the Policyholder Elections, other than those addressed in Section II.K.3.c, below, will be implemented and the premium and policy changes will take effect.
 - (5) The Initial Plan Effective Date may vary from policyholder to policyholder. For each policyholder the Initial Plan Effective Date will be the policy's ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 95 and 97.
- b. The Plan Preparation Period may be several months long in order to provide time for the calculations and other steps necessary to implement the Plan. This includes the period necessary to advise policyholders of their options and to enable them to make the necessary elections.
3. Changes in policyholder circumstances occurring between the Policyholder Election Date and the Initial Plan Effective Date (the ***Policyholder Transition Period***) will not affect policyholders' elections except as follows:
 - a. Policyholders who have qualified for a Premium Waiver which has not yet become effective as of the Policyholder Election Date due to a waiting period or premium paying modal factor will be treated as if they were not paying premium on the ***Policyholder Election Date*** and will be required to elect from among the options available to policyholders not paying premiums. If their policies have ***Dual Waiver of Premium*** (DWOP) the same will be true for their spouses. If such policyholders (or their spouses eligible for DWOP) elect Option Two (Basic Policy Endorsements - see Section II.C.1.b, page 13), or Option Four (retain current benefits at Phase One Premium - see Section II.C.1.d, page 13), they will be required to pay the full Phase One Premium or If Knew Premium, respectively, until the waiver becomes effective and to pay the Phase One Differential Premium or If Knew Differential Premium, respectively, thereafter.
 - b. Policyholders who have been deemed eligible for benefits, but the benefits are pending and they have therefore not yet gone on claim, will be treated as if they were on claim and be required to elect from among the options available to policyholders on claim, including the availability of Premium Waiver. Note that during the

SHIP REHABILITATION PLAN

Policyholder Transition Period, when policyholders whose policies contain DWOP are deemed eligible for benefits, are pending and have not yet gone on claim, and are treated as if on claim, their spouses will also be treated as if on Dual Waiver of Premium.

- c. Policyholders who, during the Policyholder Transition Period,
- (1) discontinue paying premium due to the activation of a Premium Waiver other than those described in subparagraph (a), above), or
 - (2) go on claim (other than those described in subparagraph (b), above), or
 - (3) recover and cease being on claim, or
 - (4) commence paying premium due to the deactivation of a Premium Waiver, and
 - (5) the DWOP spouses of such policyholders

will all be required to elect new options from among those available to policyholders in their new circumstances. They will be provided new Policyholder Election Forms after the Policyholder Election Date, will have an opportunity to make new elections from among options applicable to policyholders in their new circumstances, and will have those elections implemented on a ***Supplemental Plan Effective Date***.

L. POLICYHOLDER INFORMATION

1. Phase One - Before being required to make an election in Phase One of the Plan, each eligible policyholder will receive a ***Policyholder Election Package*** that includes notice and details of the Plan, including a detailed description of Phase One and preliminary descriptions of Phase Two and Phase Three. As to Phase One, these details will include the premium amount and/or benefit reductions that will apply to the policyholder's specific policy under each applicable option in Phase One of the Plan. The notice will make clear that whether or not Phase Two will be implemented, and if so its exact details, may be subject to change depending on the circumstances following Phase One. It will also note that the entire Plan is subject to the orders of the Commonwealth Court and that, if the Company is placed in liquidation, some or all of the Plan's provisions may be changed in accordance with the law applicable to liquidations. Policyholders with more than one policy will be advised that they are required to make independent elections for each policy.
2. Phase Two - Before being required to make any elections in Phase Two of the Plan, each policyholder eligible to make elections in this Phase will receive a ***Phase Two Policyholder Election Package*** that includes notice and details of Phase Two of the Plan. These details will include the premium amount and/or benefit reductions that will apply to the policyholder's specific policy under each applicable option of the Plan in Phase Two.

SHIP REHABILITATION PLAN

M. CALCULATION NOTES

1. The assets allocated on an Accumulated Premium basis for determination of Self-sustaining Premium will be those remaining after provision is made for administrative costs and contingencies as more fully explained above at Section II.E.4.d, page 16.
2. Whenever the Plan calls for adjustment of the *Maximum Benefit Period* (MBP) it will be calculated in increments of whole days.
3. Whenever the Plan calls for matching an existing premium rate, it may be by rounding the premium to the nearest dollar.
4. In calculating the Phase One Premium, the If Knew Premium, and other Plan provisions, periods on claim (including those followed by recovery) prior to the Initial Plan Effective Date will be taken into account and reduce the remaining benefit period. The operative benefit period for the policy will be what remains on the Determination Date. Thus, a policyholder whose initial Maximum Benefit Period was eight years when the policy was issued, but who has used five years of benefits (whether in one or more periods on claim) that were not restored or eligible for restoration and therefore has three years remaining as of the Determination Date, will be deemed to have a Maximum Benefit Period of three years for Plan calculation purposes. The Phase One Premium and If Knew Premium will be calculated using the remaining benefit period without regard to prior periods on claim. Thus, for this hypothetical policyholder the premium will be calculated for a policy with a three year MBP.
5. In calculating reductions of the Maximum Benefit Period, for policies with two different pools of money, one (typically of two years) for Home Health Care and one (typically longer, part of which may have been utilized) for Assisted Living Facility Care or Nursing Home Care:
 - a. The Plan will treat the policy as having a single benefit period equal to the longer of those provided by the pools. The benefit periods provided by the pools will not be aggregated. Thus, the Maximum Benefit Period for Assisted Living Facility Care cannot be increased by adding the unused benefit period for Home Health or *vice versa*.
 - b. Benefits paid under the policy regardless of site of care, will reduce the new single benefit period.
 - c. Pools shorter than four years will not be adjusted by the Plan. If benefits have reduced the benefit period below four years as of the Effective Date, it will remain at that level for Plan calculation purposes.

SHIP REHABILITATION PLAN

6. Policies that share a pool of benefits before the Policyholder Election Date, so that a policyholder whose benefit period is exhausted may continue receiving benefits under the shared pool until it is exhausted, will be treated for purposes of calculating premiums under the Plan as having a benefit period equal to the sum of the policy's benefit period and half of the shared pool's benefit period. Such policies will continue sharing a pool after the Plan and elections made under the Plan will affect only the policy's benefit period, not the value of the shared pool. When such a policyholder goes on claim after the applicable Plan Effective Date, the claim will reduce the policy's benefit period first and then the shared pool. Policyholders sharing a pool need not make the same elections under the Plan.
 - a. For a policyholder who elects Option One, the downgrade will affect only the policy's benefit period (which cannot be reduced below four years unless it is already below that) and not the shared pool.
 - b. For a policyholder who elects Option Two, the policy's benefit period may be reduced but it will retain the possibility of benefits under the shared pool.
 - c. Thus, the premium for such a policyholder who elects Option Four will be calculated as if the policy had a benefit period equal to the sum of the policy's current benefit period plus half of the shared pool.
7. A policy with an unlimited benefit period will be deemed to have an unlimited **Maximum Policy Value** (MPV - the product of a policy's **Maximum Benefit Period** times its **Maximum Daily Benefit** - MDB).
8. The Plan contemplates that the minimum premium for Basic Policy Endorsements in Phase Two will be 110% of the If Knew Premium to discourage delaying the selection of Basic Policy Endorsements to Phase Two. See Sections IV.B.2.c, IV.C.1.b, IV.C.2.b.(4), IV.E.2.b, and IV.D.1.b.
9. Premium paying modalities (*i.e.*, monthly or quarterly payments) in effect before the Plan will be unchanged by the Plan unless necessary to give effect to a policyholder's election. If a policyholder is not paying premium prior to the applicable Plan Effective Date due to a waiver, and under the Plan he or she must begin paying a premium (such as a differential premium), the premium modality in effect prior to the waiver becoming effective will apply to the premium under the Plan.
10. Fees charged before commencement of the rehabilitation to premium payments based on modality (such as additional fees for monthly premiums) will continue to apply to premiums paid under the Plan on the same basis.

SHIP REHABILITATION PLAN

N. DRAFTING NOTES

1. As endorsements are drafted to implement policy changes, provisions not intended to be substantively affected will be left unchanged unless editing is necessary to implement the modifications selected.
2. As a result, for example, if a policy has an unlimited benefit period and a Restoration of Benefit provision, shortening the benefit period will not remove the Restoration of Benefit provision. However, the Restoration of Benefits provision cannot extend the benefit period beyond the newly shortened Maximum Benefit Period. Similarly, policies with limits in terms of days-of-care will remain so and not be converted to pool-of-money policies except by operation of the Downgrade Process or if the Basic Policy Endorsement is elected.
3. Replacement language to implement modifications will strive to eliminate ambiguities and add clarity.
4. If the language of the current policy does not differentiate clearly between Nursing Home and Assisted Living Facilities (ALF) coverage so that SHIP is now covering ALF care within the Nursing Home provision in those policies, electing the Basic Policy Endorsements will not eliminate ALF coverage but Maximum Daily Benefits for ALF care will be limited to 75% of the policy's MDB.

III. DETAILS OF PHASE ONE OF THE PLAN

A. ACTIVE LIVES PAYING PREMIUM (*ACTIVE - PAYING*)

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.
 - a. Policyholders can keep their Current Premium but will have policy benefits reduced if the Current Premium is less than the If Knew Premium for their policy benefits.
 - b. The target premium for this Option is the Phase One Premium, which is the higher of the Current Premium and the If Knew Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the target premium and Options One and Four will produce the same result - no change in their policies. For other policyholders (those whose Current Premiums are lower than the If Knew Premium for their current policies), the benefit reductions applied to each policyholder who elects this option will be calibrated to produce benefits for which the premium on an If Knew Premium basis will be within 2% of the Current Premium, determined as follows:

SHIP REHABILITATION PLAN

- (1) The Downgrade Process, as described below at Section III.A.1.c, page 30, will reduce benefits so that the downgraded benefits will produce a premium on an If Knew Premium basis within 2% of the Current Premium, *i.e.*, no lower than 98% nor higher than 102% of the Current Premium.

TABLE 4: IS DOWNGRADE NECESSARY?

IF:	CASE 1	CASE 2
1. THE CURRENT PREMIUM IS	\$3,000	\$3,200
and		
2. THE IF KNEW PREMIUM FOR THE CURRENT BENEFITS IS	\$2,800	\$5,000
THEN:		
IN CASE 1, SINCE THE IF KNEW PREMIUM IS LOWER THAN THE CURRENT PREMIUM, THERE WILL BE NO BENEFIT REDUCTIONS.		
IN CASE 2, SINCE THE IF KNEW PREMIUM IS MORE THAN THE CURRENT PREMIUM, BENEFITS WILL BE REDUCED 36% TO THE CURRENT PREMIUM.		

- c. DOWNGRADE PROCESS: A single combination of one or more of the benefit reductions described in Section III.A.1.f, page 32 below, will be selected by the Rehabilitator in accordance with the Plan provisions to reduce the policy's benefits to a combination with an If Knew Premium within 2% of the Current Premium. Policyholders will not have the option of electing specific benefit reductions.
- (1) Not all of the benefit reductions on the list below will be applicable to all policies. For example, eliminating inflation protection features would not be applicable to a policy that has no such benefits. Similarly, shortening the Maximum Benefit Period would not be applicable to a policy with a benefit period that does not exceed four years. Thus, the list of potentially applicable benefit reductions may vary from policy to policy.
- (2) Each benefit reduction option is expected to have a materially different effect on premiums, some reducing the If Knew Premium more than others. The result of a particular benefit reduction may vary among different policies. Benefit reductions will be selected sequentially, beginning with the first potentially applicable benefit reduction for the policy in question. However, in some cases the Rehabilitator may skip over one or more possible benefit reductions (for example, because they are inapplicable, produce too large a reduction, or are non-scalable) in order to produce the If Knew Premium closest to the Current Premium.

SHIP REHABILITATION PLAN

- (3) The Rehabilitator may also scale a potentially applicable scalable benefit reduction up or down to simplify the process, for example by enabling fewer benefit reductions to be effected to achieve the desired premium level. For the sake of simplicity, efforts will be made to minimize the number of benefit reductions effected.
 - (4) Benefits will not be scaled above or below Plan Limits (a range of four to six years for MBP and \$300 to \$600 for MDB) unless current benefits already fall short of or exceed these limits.
- d. The default mode will be to evaluate the potentially applicable benefit reductions in the order in which they are included in the Plan.
 - (1) If the first potentially applicable benefit reduction produces an If Knew Premium that is higher than 98% of the Current Premium it will be selected. If it produces a premium lower than 98% of the Current Premium, it would implement too deep a benefit reduction and would not be selected.
 - (a) If that first potentially applicable benefit reduction produces an If Knew Premium that is between 98% and 102% of the Current Premium, that will be the only benefit reduction and downgrade necessary for the policy in order to implement Option One.
 - (b) If the benefit reduction produces an If Knew Premium above 102 % of the Current Premium, is scalable, and can be scaled down sufficiently to produce an If Knew Premium no higher than 102% of the Current Premium without going below Plan Limits for MDB and MBP, then it will be scaled down sufficiently to achieve that result and that will be the only benefit reduction for the policy.
 - (2) If the first potentially applicable benefit reduction will not suffice (with or without scaling, if applicable) to reach an If Knew Premium within 2% of the Current Premium, the next potentially applicable benefit reduction will then be evaluated in the same manner, taking into account the effect of the previously selected potentially applicable benefit reduction.
 - (3) If the result is still an If Knew Premium that is higher than 102% of the Current Premium, that reduction will also be selected and the next potentially applicable benefit reduction will then be evaluated, again taking into account the effects of the previously selected potentially applicable benefit reductions.
 - (4) This process will continue until the resulting If Knew Premium is within 2%

SHIP REHABILITATION PLAN

of the Current Premium. If it is within 2% of the Current Premium the process is complete and the potentially applicable benefit reductions selected will constitute the downgrade option for that policy.

- (5) If the benefit reductions selected, in combination, produce an If Knew Premium that is lower than 98% of the Current Premium, the policy's MDB and MBP can be increased (subject to Plan Limits) to produce (in combination with previously selected benefit reductions) an If Knew Premium within 2% of the Current Premium. If raising the MBP and MDB (in combination with previously selected benefit reductions) still does not produce an If Knew Premium within 2% of the Current Premium, the policy's premium can be reduced so that the resulting If Knew Premium is within 2% of the Current Premium.
 - (6) If all of the benefit reductions selected in combination produce an If Knew Premium that is higher than 102% of the Current Premium, then in addition, the Maximum Benefit Period will be shortened (but not below Plan Limits) to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.
 - (7) If the resulting If Knew Premium is still higher than 102% of the Current Premium, then the Maximum Daily Benefit will be reduced (but not below Plan Limits) to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.
 - (8) In the unlikely event that after all these steps the If Knew Premium for the reduced benefits remains higher than 102% of the Current Premium, there will be no further reductions and those will be the downgraded benefits and the premium charged for those benefits will be the Current Premium.
- e. Each policyholder will only receive one downgrade option, calculated as described in this Section. The Rehabilitator may develop algorithms, tables or other tools that will facilitate implementation of this process through classification of the existing policies. Policy provisions not identified in this Section will not be affected by the Downgrade unless necessary to implement the specified option.
- f. ***Possible Active Benefit Reductions:***
- (1) ***Benefit Reduction One:*** Adjustment of the "recovery period" for Restoration of Benefits provisions so that to be eligible for the benefit period restoration the policyholder must not be eligible for health benefits during a continuous and uninterrupted period of not less than six months. This is a binary and

SHIP REHABILITATION PLAN

non-scalable benefit reduction.

- (2) ***Benefit Reduction Two:*** For policies with less restrictive triggers, adoption of the TQ Trigger. See Section III.A.2.d.(8), page 36. This is a binary and non-scalable benefit reduction.
- (3) ***Benefit Reduction Three:*** Elimination of Return of Premium (ROP) provisions. However, accrued ROP benefits, for policies which provide that they accrue over several years and are then paid, will not be lost and will be calculated as of the applicable Plan Effective Date and repaid within a reasonable time after that date or when due. This is a binary and non-scalable benefit reduction.
- (4) ***Benefit Reduction Four:*** Removal of inflation and “locking” of MDB at their current levels. This is a scalable benefit reduction because the MDB can be increased or decreased within Plan Limits as necessary.
- (5) ***Benefit Reduction Five:*** Conversion of indemnity to reimbursement. See Section VI.B.1.f, page 71. This is a binary and non-scalable benefit reduction.
- (6) ***Benefit Reduction Six:*** Reduction of MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years it will not be modified. As long as the resulting MBP is above the lesser of (a) the current period, or (b) four years, this is a scalable benefit reduction.
- (7) ***Benefit Reduction Seven:*** Extension of the EP to 90 days. If the current EP is 90 days or more it will not be modified. The EP will apply to each period of care. This will be treated as a binary and non-scalable benefit reduction.
- (8) ***Benefit Reduction Eight:*** Reduction of the policy’s MDB to \$300. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits. For comprehensive policies, this benefit reduction will also reduce the MDB available for Assisted Living Facilities to 75%, and for Home Health Care to 50% of the nominal MDB.
- (9) ***Benefit Reduction Nine:*** Elimination of all Waiver of Premium provisions. For purposes of the Plan this is a binary and non-scalable benefit reduction. The Plan will not allow elimination of fewer than all available Premium Waiver provisions.

SHIP REHABILITATION PLAN

- (10) ***Benefit Reduction Ten:*** Elimination of Restoration of Benefits (ROB) provisions. This is a binary and non-scalable benefit reduction.
 - (11) ***Benefit Reduction Eleven:*** Removal of Alternative Plan of Care (APOC) provisions. This is a binary and non-scalable benefit reduction.
 - (12) ***Benefit Reduction Twelve:*** Convert to pool of money and reduce maximum benefit amount to amount required to achieve the Current Premium subject to Plan Limits.
- g. The Downgrade is generally the Default Option for policyholders on Premium Waiver. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than the benefits offered by the NFO, the NFO will be the Default Option.

SHIP REHABILITATION PLAN**TABLE 5: DOWNGRADE PROCESS**

Assume that the policy at issue has a current annual premium of \$2,000 but that the If Knew Premium for the benefits it provides would be \$3,200. Because it is more than the Current Premium, benefits will be downgraded so that the If Knew Premium for such benefits is within 2% of the Current Premium. Reduction to the Current Premium requires a target benefit reduction of 37.5% (\$2,000/\$3,200). Furthermore, assume that the policy has Inflation Protection, is Tax Qualified, has a recovery period of six months, and reimbursement, not indemnity benefits. The following illustrates the Downgrade Process for this hypothetical policy. Each potentially applicable benefit reduction would be evaluated as follows:

1. Hypothetically, Benefit reductions One, Two and Three (BR1, BR2, and BR3) are inapplicable because the policy already has a recovery period of six months, TQ Triggers, and no ROP benefits. Benefit reduction Four (BR4) - Removal of inflation and "locking" of MDB at current level - hypothetically produces an If Knew Premium of \$2,720, a 15% reduction. The If Knew Premium is still above \$2,040, 102% of the Current Premium. This benefit reduction would be selected.
2. BR5 would be inapplicable because this is already a reimbursement policy. Benefit reduction Six (BR6) - reduction of MBP to no more than four years (from the Plan Effective Date) - is evaluated in combination with previously selected BR4 and the result of reducing the MBP to four years is hypothetically an If Knew Premium of \$2,144 (a combined 33% reduction). The If Knew Premium remains above \$2,040, 102% of the Current Premium. BR6 would also be selected and BR7 would be the next to be evaluated.
4. Benefit reduction Seven (BR7) - Extension of the EP to not less than 90 days - is then evaluated in combination with BR4 and BR6, and the result of extending the EP to 90 days (in combination with BR4 and BR6) is hypothetically an If Knew Premium of \$1,920 (a combined reduction of 40%). This reduces the premium below the target of 37.5%.
5. BR4 is then scaled up by increasing the MDB (but not above \$600) to the point at which the If Knew Premium is \$2,000, equal to the Current Premium, amounting to a 4% increase in the If Knew Premium of \$1,920 produced by BR4, BR6, and BR7.

2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT CORRESPONDING IF KNEW PREMIUM.**
 - a. Policyholders will have the option to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy.
 - b. The new premium for the policy will be the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
 - c. **THIS OPTION WILL BE IMMUNE FROM PHASE TWO CHANGES. Policyholders who elect this option will not face premium rate increases or**

SHIP REHABILITATION PLAN

benefit reductions in Phase Two of the Plan. However, under certain circumstances a policyholder who is paying the If Knew Differential Premium for the Basic Policy Endorsements because he or she is on Premium Waiver may be required to pay the full If Knew Premium if the waiver ceases to apply, for example due to recovery of the policyholder on claim.

d. Key provisions of the Basic Policy Endorsements are:

- (1) MBP equal to the lesser of (a) the current benefit period, and (b) four years (beginning on the applicable Plan Effective Date);
- (2) Minimum EP equal to the longer of (a) 90 calendar days, or (b) the current EP;
- (3) Minimum 6-month Recovery Period;
- (4) Removal of Return of Premium (ROP) benefit. However, accrued ROP benefits, for policies which provide that it accrues over several years and is then paid, will not be lost and will be calculated as of the applicable Plan Effective Date and repaid within a reasonable time after that date or when due.
- (5) Reduction of Inflation to 1.5% for policies with inflation above that level;
- (6) Initial MDB set at lesser of 80% of current level or \$300;
- (7) Adjusting MDB by site of care: 100% of MDB available for Nursing Home Care, 75% of MDB available for Assisted Living Facility Care, and 50% of MDB available for Home Health Care;
- (8) Adopting ***Tax Qualified*** (TQ) Triggers. Tax Qualified or TQ Triggers require that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (ADL - eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care;
- (9) Conversion of reimbursement policies to indemnity;
- (10) Removal of Restoration of Benefits (ROB) provisions;

SHIP REHABILITATION PLAN

- (11) Conversion of “Days of Care” policies to “Pool of Money;” and
 - (12) Elimination of all Premium Waivers.
- e. This will be the Default Option for policyholders in this category (active, paying premium) whose Current Premium is lower than the If Knew Premium.
 - f. Unless the benefits of their current policies are lower, policyholders will also be offered an “Enhanced Basic Policy Endorsement” with the terms described above but caps at a five-year benefit period and 2% inflation at higher If Knew Premium. In Phase Two the premium for the Enhanced Basic Policy Endorsements will be at Self-sustaining Premium rates. For a policyholder whose current policy has a Maximum Benefit Period of less than five years but inflation above 2%, the Enhanced Basic Policy Endorsements will only affect the inflation benefit. For a policyholder whose current policy has a inflation below 2% but a Maximum Benefit Period of more than five years, the Enhanced Basic Policy Endorsements will only affect the Maximum Benefit Period.
 - g. With the exception of the change from reimbursement to indemnity, benefits in the Basic Policy Endorsements (even in the Enhanced Basic Policy Endorsements) cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy’s corresponding provision, that provision of the current policy will not be modified by endorsement. Thus, for example, if the MBP of the current policy is three years, the Basic Policy Endorsements for that policy will incorporate a Maximum Benefit Period of three, not four or five years.
 - h. For those policies with an MPV that is currently above their applicable Guaranty Association (GA) limits, the endorsed policy’s MPV will be adjusted so that it is at least equal to the applicable GA limit. The adjustment will be made by lengthening the MBP.
3. OPTION THREE - NFO.
- a. Policyholders can elect a Non-forfeiture option (NFO) policy under which the MBP will be the lesser of 2.5 years and the policy’s current MBP. Like the Basic Policy Endorsements, this will be an indemnity policy (not reimbursement) with no ROP or ROB benefits, a minimum 90-day EP, and TQ triggers. The policy will not have an inflation protection feature and the MDB will be set at the lesser of 80% of the current level or \$300. The MDB will be adjusted by site of care at 100% of MDB available for Nursing Home Care, 75% of MDB available for Assisted Living Facility Care, and 50% of MDB available for Home Health Care.

SHIP REHABILITATION PLAN

- b. No additional premiums will be due for this policy and it will never lapse.
 - c. This policy is much more generous than traditional NFOs. It cannot be upgraded later.
 - d. The selection of indemnity, rather than reimbursement, modality for Options Two and Three is expected to be of significant value to policyholders.
4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM.
- a. Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. See Section II.E.1, page 15, above. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. For those policyholders, this option, like Option One, does not result in any change.
 - b. Policyholders selecting this option may also face substantial rate increases or Benefit reductions in Phase Two.

B. ACTIVE LIVES NOT PAYING PREMIUM (*ACTIVE - WAIVER*)

1. LIFETIME WAIVER - Policyholders not paying premium due to Lifetime Waiver of Premium (because of the death of a spouse) will have essentially the same four options as premium paying active lives (see Section, III.A, page 29) with the following modifications:
- a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. If the Current (waived) Premium is equal to or greater than the If Knew Premium, there will be no downgrade and Options One and Four will produce the same result - no change in their policies. If the Current Premium is less than the If Knew Premium the policy will be downgraded as follows.
 - (1) Due to the Premium Waiver the policyholder will continue not paying premium.
 - (2) The Downgrade Process will be the same as for premium-paying active lives (see Section III.A.1.c, page 30, above).
 - (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 32, above.
 - (4) The benefit reductions will be calibrated to the Current Premium as explained

SHIP REHABILITATION PLAN

in Section III.A.1.b, page 29.

- (5) This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process in Option One are lower than those offered by the NFO, the NFO will be the Default Option.
 - b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM (rather than the If Knew Premium).**
 - (1) The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.
 - (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 37.
 - (3) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.
 - (4) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.
 - c. **OPTION THREE - NFO (see Section III.A.3, page 37).**
 - d. **OPTION FOUR - KEEP THE CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.**
 - (1) The If Knew Differential Premium for this option is the difference between the If Knew Premium and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium.
 - (2) Policyholders who elect this Option may also face substantial rate increases in Phase Two.
2. **DUAL WAIVER - The options for a policyholder not on claim but not paying premium due**

SHIP REHABILITATION PLAN

to a Dual Waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a Lifetime Waiver except that the premium he or she must pay will be determined in part by the spouse's claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, Option Three, the NFO, will be the Default Option.

- a. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.** The policyholder will retain the Current Premium Waiver. If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium the policy will not be downgraded. If the If Knew Premium is greater than the Current Premium the policyholder would be paying in the absence of waiver, the policy will be downgraded as follows:
 - (1) The Downgrade Process will be as described in Section III.A.1.c, page 30 subject to the following provisions.
 - (2) The Possible Active Benefit Reductions will apply, as described in Section III.A.1.f, page 32. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29). However, because of the waiver, the policyholder will not be required to pay any premium.
 - (3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but if the policy has been downgraded it will remain downgraded.
- b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.**
 - (1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 36). The policyholder will be required to pay the If Knew Differential Premium. The If Knew Differential Premium for this Option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

SHIP REHABILITATION PLAN

- (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 37.
 - (3) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.
 - (4) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan, except as noted below.
 - (5) If the disabled spouse recovers, the active spouse will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
- c. OPTION THREE - NFO.
- (1) The policyholder can select a NFO. See Section III.A.3.
- d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM: The policyholder will retain the current policy benefits and pay the Phase One Differential Premium (see Section II.E.6.b, page 18). However, if the disabled spouse recovers, the active spouse will be required to begin paying the full Phase One Premium. As noted, if the Current Premium is equal to or greater than the If Knew Premium, the policyholder will not be required to pay a Differential Premium.

C. DISABLED LIVES PAYING PREMIUM (*ON CLAIM - PAYING*)

Policyholders on claim, who are paying premiums, will have the same options as active lives paying premiums (see Section III.A, page 29), subject to the following conditions:

- 1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.
 - a. Policyholders will preserve their Current Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the target premium and Options One and Four will produce the same result - no change in their policies. However, if the Current Premium is less than the If Knew Premium, the policy will be downgraded using the Downgrade Process described in Section III.A.1.c, page 30, above, subject to the following provisions.
 - b. The following *Possible on Claim Benefit Reductions* will apply instead of the Possible Active Benefit Reductions:

SHIP REHABILITATION PLAN

- (1) **Benefit Reduction One:** Removal of inflation and locking of MDB at current level. This reduction will be implemented as describe in Section III.A.1.f.(4), page 33, above.
 - (2) **Benefit Reduction Two:** Conversion of indemnity policies to reimbursement policies.
 - (3) **Benefit Reduction Three:** Reduction of MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years, the policy will retain its current MBP.
 - (4) **Benefit Reduction Four:** Elimination of Restoration of Benefits provision.
 - (5) **Benefit Reduction Five:** Reduction of the policy's MDB to \$300 if it is above \$300. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits.
- c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29).
 - d. Note that the Downgrade Process does not change the premium being paid prior to the downgrade.
 - e. If the policyholder regains active status, for future periods of care:
 - (1) The EP will be no less than 90 days. If the current EP is more than 90 days the policy will retain the current EP;
 - (2) The EP will apply to each period of care; and
 - (3) TQ triggers will apply. See Section III.A.2.d.(8), page 36.
2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW PREMIUM.** The policy will be endorsed as described in Section III.A.2.d, page 36, at If Knew Premium.
 - a. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
 - b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 37.

SHIP REHABILITATION PLAN

- c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery. This will be the default for these policyholders if their Current Premium is lower than the If Knew Premium.
3. OPTION THREE - NFO. See Section III.A.3.
4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM. Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. Policyholders who elect this Option may also face substantial rate increases in Phase Two.
5. In some cases, options like the downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election. It is also possible that the If Knew Premium for the Basic Policy Endorsements will be lower than the policyholder's Current Premium.

D. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.
 - a. These policyholders will preserve their Premium Waiver but, if the Current Premium they would be paying in the absence of waiver is less than the If Knew Premium, the policies will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 30, but the Possible on Claim Benefit Reductions described in Section III.C.1.b, page 41 will apply.
 - b. This is the Default Option for policyholders on claim with waiver of premium in Phase One. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 29). However, because of the waiver, the policyholder will not be required to pay any premium.
 - d. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process does not change the premium being paid prior to the downgrade.

SHIP REHABILITATION PLAN

- e. If the policyholder regains active status, for future periods of care:
 - (1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;
 - (2) The EP will apply to each period of care; and
 - (3) TQ Triggers will apply. See Section III.A.2.d.(8), page 36.
- 2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.
 - a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36, above.
 - b. Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 37.
 - c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - d. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.
 - e. If the Current Premium the policyholder would be paying but for the waiver is less than the If Knew Premium for this policy, the policyholder must begin paying the If Knew Differential Premium. The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the current premium for the policy, both of which are set as if the policyholder did not have a premium waiver in effect. As noted, if the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.
 - f. If the disabled policyholder recovers, the waiver of premium benefit will no longer be applicable or available in the future, and he or she will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements, even if it is lower than the current waived premium.
 - g. Except upon recovery, policyholders who elect this option in Phase One will not face

SHIP REHABILITATION PLAN

premium rate increases or additional benefit reductions in Phase Two of the Plan.

- h. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
- 3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option (NFO). See Section III.A.3.
- 4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM. If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium, the policyholder will not be required to pay a Differential Premium.
 - a. Policyholders on claim with Premium Waiver can keep their current policy benefits.
 - b. Their Premium Waiver (including Lifetime and Dual) will apply only to the Current Premium they would be paying absent the waiver. If the Current Premium the policyholders would be paying but for the waiver is less than the If Knew Premium for this policy, they will be required to begin paying the corresponding Phase One Differential Premium, if any. (See Section II.E.6.b, page 18).
 - c. If the policyholders recover, they will be required to begin paying the full Phase One Premium.

IV. DETAILS OF PHASE TWO OF THE PLAN

A. APPLICATION

- 1. Throughout the period that follows implementation of Phase One the Company's financial condition will be monitored with emphasis on projected changes in the Company's deficit.
- 2. The evaluation of the Company's condition will include a determination of the magnitude of additional remedial measures required to eliminate any projected remaining deficit. The evaluation will include projections of the effect of Phase One over time.
- 3. A decision will then be made as to whether, when, and how Phase Two should be implemented.
- 4. Phase Two adjustments will only be made to policies that:
 - a. Are not Fully Covered by the applicable Guaranty Association limits (*i.e.*, have

SHIP REHABILITATION PLAN

Uncovered Benefits),

- b. Are not Self-sustaining (because the sum of projected benefits and expenses exceeds the sum of allocated assets and projected premium), and
 - c. Did not elect Option Two (Basic Policy Endorsements) or Option Three (NFO) in Phase One.
5. Phase Two adjustments will be calculated after the results of Phase One adjustments have been incorporated.

B. ACTIVE LIVES PAYING PREMIUM (*ACTIVE - PAYING*)

- 1. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.**
 - a. Policyholders not on claim paying premium can elect in Phase Two to keep the premium rate resulting from Phase One and reduce benefits to eliminate the policy shortfall.
 - b. The benefit reduction process and options will be the same as in Phase One (see Section III.A.1.c page 30) but the current benefits will be reduced so that they produce a Self-sustaining Premium that is within 2% of the policyholder's Current Premium.
 - c. As in Phase One, each policyholder will only receive one downgrade option, calculated as described in Section III.A.1.c.
- 2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.**
 - a. Policyholders can choose to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36.
 - b. This is the Default Option for premium paying active lives in Phase Two.
 - c. Premiums will be set to the corresponding Self-sustaining Premium level. The premium for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - d. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

SHIP REHABILITATION PLAN

- e. With the exception of the change from reimbursement to indemnity, post-endorsement benefits cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy's corresponding provision, that provision of the current policy will not be modified by endorsement.
 - f. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
- 3. **OPTION THREE - NFO.** Policyholders can elect a Non-forfeiture Option. See Section III.A.3.
 - 4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.**
 - a. The policyholder can elect to maintain the current policy benefits but will be required to pay Self-sustaining Premiums.
 - b. The *Self-sustaining Premium* is the premium calculated to eliminate any shortfall in the policy. The shortfall is the excess of the sum of projected benefits and expenses (the PBA) over the sum of projected premiums and assets allocated on an accumulated premium basis (the PCA). See Section II.E.4, page 16, above.

C. ACTIVE LIVES NOT PAYING PREMIUM (*ACTIVE - WAIVER*)

- 1. **LIFETIME WAIVER** - Policyholders on lifetime waiver (due to the death of a spouse) will have essentially the same four options as premium paying policyholders not on claim (See Section IV.B, page 46) with the following modifications:
 - a. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.** This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - (1) Due to the Premium Waiver the policyholder will continue not paying premium.
 - (2) The Downgrade Process will be the same as for premium-paying active lives in Phase One (see Section III.A.1.c, page 30, above).

SHIP REHABILITATION PLAN

- (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 32, above,
 - (4) In this case the benefit reductions will be calibrated such that the projected benefits and expenses (the PBA) is equal to the assets allocated to the policy on an accumulated premium basis (the PCA).
 - b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.** The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.
 - (1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement”. See Section III.A.2.f, page 37 at higher Self-sustaining Premiums.
 - c. **OPTION THREE - NFO** (see Section III.A.3, page 37).
 - d. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.** The new premium will be the Self-sustaining Differential Premium described in the next paragraph.
 - e. The ***Self-sustaining Differential Premium*** is the difference between (1) the corresponding Self Sustaining Premium set as if the policyholder were not on claim and (2) the Current Premium the policyholder would be paying if he or she were not on Premium Waiver. Because these policies are not Self-sustaining the Self-sustaining Differential Premium will never be less than zero.
2. **DUAL WAIVER** - The options for a policyholder not on claim but not paying premium due to a dual waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a lifetime waiver except that the premium he or she must pay will be determined in part by the spouse’s claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - a. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.** The policyholder will retain the Current Premium Waiver but the policy

SHIP REHABILITATION PLAN

will be downgraded.

- (1) The Downgrade Process will be as described in Section III.A.1.c, page 30 subject to the following provisions.
- (2) The Possible Active Benefit Reductions will apply, as described in Section III.A.1.f, page 32. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce a Self-sustaining Premium equal to the premium the policyholder would be paying if not on waiver. However, because of the waiver, the policyholder will not be required to pay any premium.
- (3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but the policy will remain downgraded.

b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.**

- (1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 36). The policyholder will be required to pay the Self-sustaining Differential Premium.
- (2) The Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 37.
- (3) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.
- (4) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy, reflecting the cost of delay in making this election in Phase Two
- (5) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-Sustaining Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.

c. **OPTION THREE - NFO.** The policyholders can elect a Non-forfeiture Option. See Section III.A.3.

d. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.** The policyholder will retain the current policy

SHIP REHABILITATION PLAN

benefits and pay the Self-sustaining Differential Premium (see Section IV.C.1.e, page 48).

- (1) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-sustaining Premium.
- (2) Because these policies are not Self-sustaining, the Current Premium will always be lower than the Self-sustaining Premium and the Self-sustaining Differential Premium will always be greater than zero.

D. DISABLED LIVES PAYING PREMIUM (*ON CLAIM - PAYING*)

1. Policyholders on claim who are paying premiums will have the same options as active lives paying premiums (see Section IV.B, page 46) subject to the following conditions:
 - a. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.** Keep the Current Premium rates but accept specified downgrades. The Downgrade process will be as described in Section III.A.1.c, page 30. The Possible on Claim Benefit Reductions described in Section III.C.1.b, page 41 will apply, but the benefits will be reduced so that they produce a Self-Sustaining Premium within 2% of the Current Premium.
 - b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.** The policy will be endorsed as described in Section III.A.2.d, page 36, at Self-sustaining Premium
 - (1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - (2) Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - (3) For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable GA limits. The adjustment will be made by lengthening the MBP.
 - (4) This will be the default for these policyholders.
 - (5) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.

SHIP REHABILITATION PLAN

- c. OPTION THREE - NFO. See Section III.A.3.
 - d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM. The Self-sustaining Premium will be set as if the policyholder were not on claim. However, in so doing assets will be allocated to the policyholders according to the method previously described for Disabled Lives.
2. In some cases, options like the downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election.

E. DISABLED LIVES NOT PAYING PREMIUM (*ON CLAIM - WAIVER*)

1. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.
- a. This is the Default Option for policyholders on claim with Premium Waiver in Phase Two. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - b. Policyholders may preserve their Premium Waiver and the policy will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 30. The Possible on Claim Benefit Reductions will apply as explained in Section III.D.1, page 41 but benefits will be reduced so that they produce a Self-sustaining premium that is within 2% of the Current Premium.
 - c. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process made that premium equal to the Self-sustaining Premium for the downgraded policy at the time of implementation of Phase Two.
 - d. If the policyholder regains active status, for future periods of care:
 - (1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;
 - (2) The EP will apply to each period of care; and
 - (3) TQ Triggers will apply. See Section III.A.2.d.(8), page 36.

SHIP REHABILITATION PLAN

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.
 - a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 36.
 - b. The policyholder must begin paying the Self-sustaining Differential Premium corresponding to the Self-sustaining premium for the Basic Policy Endorsements set as if the policyholder were not on claim. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.
 - c. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.
 - d. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. The adjustment will be made by lengthening the MBP.
 - e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 37.
 - f. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - g. If he or she recovers, the policyholder will be required to begin paying the full Self-sustaining Premium.
3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option. See Section III.A.3.
4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.
 - a. A policyholder on claim with Premium Waiver can keep the current policy benefits.
 - b. The Premium Waiver (including lifetime and dual) will apply only to the Current Premium. The policyholder will be required to begin paying the corresponding Self-sustaining Differential Premium (see Section IV.C.1.e, page 48). If the policyholder recovers he or she will be required to begin paying the full Self-sustaining Premium.

SHIP REHABILITATION PLAN

TABLE 6: POLICYHOLDER OPTIONS

	PHASE ONE	PHASE TWO
ACTIVE PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM* 3. NFO 4. KEEP BENEFITS - SELF-SUSTAINING PREMIUM
ACTIVE WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM† DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS
ON CLAIM PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM*† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING PREMIUM†
ON CLAIM WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM	1. - DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF-SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM†
*Default Option. †Self-sustaining premium calculated as if policyholder not on claim. ‡If the NFO provides greater benefits, that will be the Default Option. In Phase One, policyholders whose Current Premium is not less than the If Knew Premium need not change premiums or benefits.		

SHIP REHABILITATION PLAN

POLICY ILLUSTRATIONS

The following twelve examples illustrate how these options work for some representative policies. The policies selected are actual in-force SHIP policies. The SHIP SAMPLE POLICY TABLE describes the key attributes of each of the twelve sample policies, enabling the reader to locate easily the samples most similar to a particular policy. They were selected to provide a representative variety of policy features. Reviewing sample policies resembling a particular policy will provide an indication of how the Plan will result in modifications to that policy. Because of the differences among the features in the sample policies, it may be helpful to review several sample policies to see how particular features are affected by the Plan.

SHIP SAMPLE POLICY TABLE

ILLUSTRATION	1	2	3	4	5	6	7	8	9	10	11	12
Gender	F	F	F	F	F	M	M	F	F	F	M	F
Issue Age	56	56	63	67	62	64	64	64	57	64	65	60
Issue Year	1992	1988	1997	1999	1996	1997	1994	1995	1988	2001	1993	1991
Attained Age	84	88	86	88	86	87	90	89	89	83	92	89
State Resident	IN	TX	IL	TX	PA	OK	NE	OH	PA	FL	SD	TX
State Issue	IN	TX	IL	TX	PA	OK	NE	OH	PA	PA	SD	OK
Guaranty Association Coverage Limit	300K	300K	300K	300K	300K	300K	300K	300K	300K	300K	300K	300K
Premium Paying Status	PP	PP	PP	LW	PP	PP	CW	PP	PP	PP	LW	PP
Disability Status	Active	Active	Active	Active	Active	Active	Disabled	Active	Active	Active	Disabled	Active
CODE	32324	37446	12220	19570	09746	13538	33210	05000	00002	03255	01285	00561
Nursing Home: Reimbursement Method	I	I	I	R	I	I	I	I	N/A	R	I	I
Nursing Home: Benefit Period (years)	U	4.0	3.0	3.0	3.0	5.0	U	3.0	N/A	4.0	5.0	U
Nursing Home: Current Maximum Daily Benefit ¹	\$212	\$80	\$234	\$60	\$307	\$205	\$203	\$323	N/A	\$246	\$159	\$133
Nursing Home: Elimination Period ² (days)	N/A	0	100	0	0	0	0	0	N/A	0	0	100
Home Health Care: Reimbursement Method	N/A	N/A	N/A	R	R	R	N/A	N/A	R	R	R	R
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	3.0	3.0	5.0	N/A	N/A	2.0	4.0	5.0	U
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	\$60	\$307	\$205	N/A	N/A	\$160	\$246	\$159	\$133
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	0	0	0	N/A	N/A	0	0	0	100
Assisted Living Facility: Reimbursement Method	N/A	N/A	R	R	R	R	N/A	R	N/A	N/A	R	R
Assisted Living Facility: Benefit Period (years)	N/A	N/A	3	3.0	3.0	5.0	N/A	3	N/A	N/A	5.0	U
Assisted Living Facility: Current Maximum Daily Benefit	N/A	N/A	\$234	\$60	\$307	\$205	N/A	\$323	N/A	N/A	\$159	\$133
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	100	0	0	0	N/A	0	N/A	N/A	0	100
Daily Benefit Annual Inflation	0.0%	0.0%	5.0%	0.0%	5.0%	5.0%	5.0%	5.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	Yes	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	Yes	Yes	Yes	No	No	No	No	Yes	Yes
Return of Premium Coverage ³	No	No	No	No	No	No	No	Yes	No	No	Yes	Yes
Benefit Trigger	TQ	TQ	TQ	NTQ	TQ	NTQ	TQ	TQ	TQ	TQ	TQ	TQ
Maximum Policy Value ⁴	U	117K	256K	65,700	336K	374K	U	353K	117K	357K	291K	U
Annual Premium ⁵	3,089	1,198	2,216	0	2,642	2,995	0	6,306	529	2,614	0	4,116
Active Life Reserve (if applicable)	101K	26,142	61,244	16,972	78,126	45,601	N/A	112K	25,553	79,383	N/A	67,820

PP = Premium paying
I = Indemnity
U = Unlimited

TQ = Tax Qualified
R = Reimbursement
LW = Lifetime waiver

NTQ = Not Tax Qualified
CW = Claim waiver
\$ OMITTED

ILLUSTRATION NO. 1

Gender	F
Issue Age	56
Issue Year	1992
Attained Age	84
State Resident	IN
State Issue	IN
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 32324)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity Unlimited	Reimbursement 4.0	Indemnity 4.0	Indemnity 5.0	Indemnity 2.5	Indemnity Unlimited
Nursing Home: Benefit Period (years)	\$212	\$261	\$170	\$170	\$170	\$212
Nursing Home: Current Maximum Daily Benefit ¹	0	0	90	90	90	0
Nursing Home: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ¹	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	Unlimited	\$381,060	\$247,931	\$309,914	\$154,957	Unlimited
Annual Premium ⁵	\$3,089	\$3,089	\$1,431	\$1,537	\$0	\$3,967

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 2

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Gender	F
Issue Age	56
Issue Year	1988
Attained Age	88
State Resident	TX
State Issue	TX
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

Plan features and premium (CODE 37446)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Nursing Home: Current Maximum Daily Benefit ¹	\$80	\$80	\$64	\$64	\$64	\$80
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$116,800	\$116,800	\$93,440	\$93,440	\$58,400	\$116,800
Annual Premium ⁵	\$1,198	\$1,198	\$508	\$508	\$0	\$1,198

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 3

Gender	F
Issue Age	63
Issue Year	1997
Attained Age	86
State Resident	IL
State Issue	IL
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 12220)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$234	\$234	\$187	\$187	\$187	\$234
Nursing Home: Elimination Period ² (days)	100	100	100	100	100	100
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$234	\$176	\$187	\$187	\$187	\$234
Assisted Living Facility: Elimination Period ² (days)	100	100	100	100	100	100
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$256,274	\$256,230	\$205,019	\$205,019	\$170,849	\$256,274
Annual Premium ⁵	\$2,216	\$2,216	\$2,102	\$2,137	\$0	\$3,029

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 4

Gender	F
Issue Age	67
Issue Year	1999
Attained Age	88
State Resident	TX
State Issue	TX
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Lifetime waiver
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 19570)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$60	\$60	\$48	\$48	\$48	\$60
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Home Health Care: Current Maximum Daily Benefit ¹	\$60	\$60	\$48	\$48	\$48	\$60
Home Health Care: Elimination Period ² (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$60	\$60	\$48	\$48	\$48	\$60
Assisted Living Facility: Elimination Period ² (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Non Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified
Maximum Policy Value ⁴	\$65,700	\$65,700	\$52,560	\$52,560	\$43,800	\$65,700
Annual Premium ⁵	\$0	\$0	\$0	\$0	\$0	\$0

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 5

Gender	F
Issue Age	62
Issue Year	1996
Attained Age	86
State Resident	PA
State Issue	PA
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 09746)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$307	\$312	\$246	\$246	\$246	\$307
Nursing Home: Elimination Period ² (days)	0	90	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Home Health Care: Current Maximum Daily Benefit ¹	\$307	\$312	\$150	\$150	\$150	\$307
Home Health Care: Elimination Period ² (days)	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.0	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$307	\$312	\$225	\$225	\$225	\$307
Assisted Living Facility: Elimination Period ² (days)	0	90	90	90	90	0
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$336,340	\$341,640	\$269,072	\$269,072	\$224,227	\$336,340
Annual Premium ⁵	\$2,642	\$2,642	\$1,934	\$1,965	\$0	\$3,799

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 6

Gender	M
Issue Age	64
Issue Year	1997
Attained Age	87
State Resident	OK
State Issue	OK
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 13538)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Nursing Home: Current Maximum Daily Benefit ¹	\$205	\$205	\$164	\$164	\$164	\$205
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Home Health Care: Current Maximum Daily Benefit ¹	\$205	\$205	\$150	\$150	\$150	\$205
Home Health Care: Elimination Period ² (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	5.0	5.0	4.0	5.0	2.5	5.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$205	\$205	\$164	\$164	\$164	\$205
Assisted Living Facility: Elimination Period ² (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Non Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified
Maximum Policy Value ⁴	\$373,724	\$374,125	\$239,183	\$298,979	\$149,489	\$373,724
Annual Premium ⁵	\$2,995	\$2,995	\$1,171	\$1,232	\$0	\$2,995

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 7

Gender	M
Issue Age	64
Issue Year	1994
Attained Age	90
State Resident	NE
State Issue	NE
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Claim waiver
Disability Status	Disabled

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 33210)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity Unlimited	Indemnity Unlimited	Indemnity 4.0	Indemnity 5.0	Indemnity 2.5	Indemnity Unlimited
Nursing Home: Benefit Period (years)						
Nursing Home: Current Maximum Daily Benefit ¹	\$203	\$212	\$163	\$163	\$163	\$203
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	Unlimited	Unlimited	\$237,314	\$296,643	\$148,321	Unlimited
Annual Premium ⁵	\$0	\$0	\$0	\$0	\$0	\$0

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 8

Gender	F
Issue Age	64
Issue Year	1995
Attained Age	89
State Resident	OH
State Issue	OH
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 05000)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	3.0	3.1	3.0	3.0	2.5	3.0
Nursing Home: Current Maximum Daily Benefit ¹	\$323	\$600	\$258	\$258	\$258	\$323
Nursing Home: Elimination Period ² (days)	0	90	90	90	90	0
Home Health Care: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	3.0	3.1	3.0	3.0	2.5	3.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$323	\$450	\$225	\$225	\$225	\$323
Assisted Living Facility: Elimination Period ² (days)	0	90	90	90	90	0
Daily Benefit Annual Inflation	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	Yes	No	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$353,148	\$679,800	\$282,519	\$282,519	\$235,432	\$353,148
Annual Premium ⁵	\$6,306	\$6,306	\$2,988	\$3,012	\$0	\$11,166

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 9

Gender	F
Issue Age	57
Issue Year	1988
Attained Age	89
State Resident	PA
State Issue	PA
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 00002)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Home: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Home: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Home: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	2.0	2.0	2.0	2.0	2.0	2.0
Home Health Care: Current Maximum Daily Benefit ¹	\$160	\$80	\$128	\$128	\$128	\$160
Home Health Care: Elimination Period ² (days)	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	No	No	No	No	No	No
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ¹	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$116,800	\$58,400	\$93,440	\$93,440	\$93,440	\$116,800
Annual Premium ⁵	\$529	\$529	\$593	\$593	\$0	\$761

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 10

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Gender	F
Issue Age	64
Issue Year	2001
Attained Age	83
State Resident	FL
State Issue	PA
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

Plan features and premium (CODE 03255)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Nursing Home: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Nursing Home: Current Maximum Daily Benefit ¹	\$246	\$246	\$197	\$197	\$197	\$246
Nursing Home: Elimination Period ² (days)	0	90	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	4.0	4.0	4.0	4.0	2.5	4.0
Home Health Care: Current Maximum Daily Benefit ¹	\$246	\$150	\$150	\$150	\$150	\$246
Home Health Care: Elimination Period ² (days)	0	90	90	90	90	0
Assisted Living Facility: Reimbursement Method	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Benefit Period (years)	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Current Maximum Daily Benefit ¹	N/A	N/A	N/A	N/A	N/A	N/A
Assisted Living Facility: Elimination Period ² (days)	N/A	N/A	N/A	N/A	N/A	N/A
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No
Return of Premium Coverage ³	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$356,829	\$357,192	\$285,463	\$285,463	\$179,398	\$356,829
Annual Premium ⁵	\$2,614	\$2,614	\$3,031	\$3,031	\$0	\$6,208

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 11

Gender	M
Issue Age	65
Issue Year	1993
Attained Age	92
State Resident	SD
State Issue	SD
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Lifetime waiver
Disability Status	Disabled

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Plan features and premium (CODE 01285)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Nursing Home: Current Maximum Daily Benefit ¹	\$159	\$159	\$127	\$127	\$127	\$159
Nursing Home: Elimination Period ² (days)	0	0	90	90	90	0
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Home Health Care: Current Maximum Daily Benefit ¹	\$159	\$159	\$127	\$127	\$127	\$159
Home Health Care: Elimination Period ² (days)	0	0	90	90	90	0
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	5.0	4.0	4.0	5.0	2.5	5.0
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$159	\$159	\$127	\$127	\$127	\$159
Assisted Living Facility: Elimination Period ² (days)	0	0	90	90	90	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	Yes	No	No	No	Yes
Return of Premium Coverage ³	Yes	Yes	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	\$290,522	\$232,140	\$185,934	\$232,417	\$116,209	\$290,522
Annual Premium ⁵	\$0	\$0	\$0	\$0	\$0	\$2,183

¹ Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

² Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

³ The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

⁴ Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

⁵ Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

ILLUSTRATION NO. 12

THIS ILLUSTRATION IS PROVIDED SOLELY FOR THE PURPOSE OF DEMONSTRATING HOW PREMIUMS AND BENEFITS UNDER EACH OPTION IN THE PROPOSED REHABILITATION PLAN COMPARE TO EACH OTHER. EVERY POLICY IS DIFFERENT AND PRODUCES DIFFERENT RESULTS

Gender	F
Issue Age	60
Issue Year	1991
Attained Age	89
State Resident	TX
State Issue	OK
Guaranty Association Coverage Limit	\$300,000
Premium Paying Status	Premium paying
Disability Status	Active

Plan features and premium (CODE 00561)

Option Number	N/A	1	2	2a	3	4
Option Name	Current	Downgrade	Basic Policy Endorsement (Standard)	Basic Policy Endorsement (Enhanced)	NFO	Phase I premium
Nursing Home: Reimbursement Method	Indemnity	Reimbursement	Indemnity	Indemnity	Indemnity	Indemnity
Nursing Home: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Nursing Home: Current Maximum Daily Benefit ¹	\$133	\$467	\$106	\$106	\$106	\$133
Nursing Home: Elimination Period ² (days)	100	100	100	100	100	100
Home Health Care: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Home Health Care: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Home Health Care: Current Maximum Daily Benefit ¹	\$133	\$234	\$106	\$106	\$106	\$133
Home Health Care: Elimination Period ² (days)	100	100	100	100	100	100
Assisted Living Facility: Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Indemnity	Reimbursement
Assisted Living Facility: Benefit Period (years)	Unlimited	4.0	4.0	5.0	2.5	Unlimited
Assisted Living Facility: Current Maximum Daily Benefit ¹	\$133	\$350	\$106	\$106	\$106	\$133
Assisted Living Facility: Elimination Period ² (days)	100	100	100	100	100	100
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	Yes	No	No	No	No	Yes
Return of Premium Coverage ³	Yes	No	No	No	No	Yes
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Maximum Policy Value ⁴	Unlimited	\$681,820	\$154,959	\$193,698	\$96,849	Unlimited
Annual Premium ⁵	\$4,116	\$4,116	\$1,172	\$1,242	\$0	\$7,269

1 Current Maximum Daily Benefits reflects inflation (if applicable) through 11/30/2019

2 Elimination Period does not account for claim status (requirements may have already been met) and different period may be applicable for waiver of premium benefits

3 The actuarial present value of accrued ROP benefits will be returned to policyholders electing an option that may remove their ROP benefits (Option 1, 2, 2a, and 3)

4 Maximum Policy Value is as of 11/30/2019. Maximum Policy Value will increase for policies with inflation provisions

5 Differential premium is shown for policies on premium waiver under Options 2, 2a, and 4

SHIP REHABILITATION PLAN

V. PHASE THREE

Following implementation of Phase One and Phase Two, SHIP will continue managing its LTCI in a run-off mode. If the company has improved to the point of having excess assets, the Plan provides for distributions to policyholders and creditors. While some aspects of Phase Three will be developed in the future, one component will be distributions to policyholders on account of benefits they eliminated through Policy Modifications under the Plan. As more fully explained at Section VI.H, page 77, as part of the Plan some of SHIP's policies will be restructured in a way that identifies these eliminated benefits separately. These amounts, called *Unfunded Benefit Liabilities* (UBL), will be tracked by the Rehabilitator. To the extent assets are available in Phase Three, they will be applied to the UBL along with other unpaid liabilities, such as agent commissions. It is possible that in Phase Three SHIP will not be able to pay off all remaining liabilities in full. In that event, it is likely that it will then be placed in Liquidation in accordance with Article V. To the extent that at that time some policy benefits may remain unfunded, the Guaranty Associations may be triggered to assist in the resolution of those remaining policy liabilities. See Section VI.J, page 78.

VI. OTHER MATTERS**A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**

SHIP commenced business on July 5, 1887, as the Home Beneficial Society. It underwent many transactions and transformations in the ensuing century, culminating in the adoption of the current name in October 2008, when it was transferred by its then owner, Consecro, to the newly formed, nonprofit, *Senior Health Care Oversight Trust* (the "Trust" - see page 75) so it could continue running off its long-term care insurance ("LTCI") business independently. At the time, SHIP had 152,000 policies in force. As of year-end 2019 that number was down to close to 45,000. It is a Pennsylvania life and health insurance company. Prior to Rehabilitation, SHIP was licensed in 46 states (excluding Connecticut, New York, Rhode Island, and Vermont), the District of Columbia, and the U.S. Virgin Islands. Since SHIP's creation in 2008, it has utilized an outsourcing model for select functions, specifically: Long Term Care Group ("LTCG") for lower-level claims administration functions; Milliman for rate increase analyses and valuations; Conning (and recently now New England Asset Management) for investment services; KPMG for tax services; and external law firms for specific legal issues. Beginning in 2018, the Company engaged Ernst & Young for internal audit services.

Table 7 summarizes the Company's corporate history.

SHIP REHABILITATION PLAN**TABLE 7****B. LONG-TERM CARE INSURANCE**

At the time this proposed Rehabilitation Plan is filed, the insurance business of SHIP consists entirely of LTCI, much of it issued many decades ago, and none issued any later than 2003, when the Company ceased writing new business. Of approximately 645,000 LTCI policies sold by SHIP and its predecessors since the late 1970s, fewer than 50,000 remain in force. The key characteristic of this remaining "legacy" block of LTCI policies as a group is that the premiums being paid, when added to the Company's assets, are projected to be grossly insufficient to pay the benefits expected to be due under those policies. This anticipated "Funding Gap" led to the Company being placed in Rehabilitation on January 29, 2020, and is the key challenge sought to be addressed by the Plan.

SHIP REHABILITATION PLAN

SHIP's long-term care insurance policies cover long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care for individuals who meet specified requirements. These requirements vary among the Company's policies but typically include things like the policyholder requiring care for at least 90 days, and being unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby).

The Company's business is comprised of both LTCI policies written by the Company and assumed reinsurance. For the policies written by the Company, average LTC policyholder age is 86 and the average claimant is 89 years old. SHIP's policies are approximately 13% Home Health Care coverage, 18% Facility Care coverage (nursing home and/or assisted living facility), and 69% Comprehensive coverage covering multiple levels of care. The following paragraphs provide a general description of certain terms and features that are included in many of the Company's LTC Policies:

- a. Tax Qualified v. Non-Tax Qualified - In order to trigger coverage under a policy, the policyholder generally must satisfy certain needs-based tests that vary depending on whether the policy is Tax Qualified or Non-Tax Qualified. Under Section 213 of the Internal Revenue Code ("IRC"), premiums paid for a Tax Qualified LTC policy are deductible medical expenses. According to Section 7702B of the IRC, a Tax Qualified policy is one that:
 - (1) provides insurance coverage only for qualified LTC services;
 - (2) does not pay or reimburse expenses that are reimbursable under Medicare;
 - (3) is guaranteed renewable;
 - (4) does not provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed;
 - (5) provides that all refunds of premiums (other than refunds on the death of the insured or on a complete surrender or cancellation of the policy, which cannot exceed the aggregate premiums paid under the policy) and the policyholder dividends, or similar amounts, are applied as a reduction of future premiums or to increase future benefits; and
 - (6) satisfies certain consumer protection requirements as well as disclosure and nonforfeitability requirements.
- b. "Qualified long-term care services" are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and other rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. A "chronically ill individual" is defined as one who has been

SHIP REHABILITATION PLAN

certified within the previous twelve (12) months by a licensed health care provider as:

- (1) being unable to perform (without substantial assistance from another individual) at least two (2) Activities of Daily Living (eating, toileting, transferring, bathing, dressing and continence) for a period of at least 90 days due to a loss of functional capacity;
 - (2) having a level of disability similar to the level of disability described in the clause above, as determined by the Internal Revenue Service in consultation with the Department of Health and Human Services; or
 - (3) requiring substantial supervision to protect such an individual from threats to health and safety due to severe cognitive impairment.
- c. A Non-Tax Qualified Policy generally contains eligibility standards, such a Medical Necessity, which is a lower threshold to trigger coverage. For example, some policy forms contain the following conditions for eligibility:
- (1) Your Physician certifies Your care to be Medically Necessary; or
 - (2) You are unable to perform two (2) or more Activities of Daily Living without assistance or supervision; or
 - (3) You are afflicted with Cognitive Impairment.

Approximately 85% of the Company's policies are Non-Tax Qualified policies, and approximately 66% of the in-force policies are eligible to qualify for care through the Medical Necessity provision.

- d. **Daily Benefit Amount** - The Company's LTC policies are subject to a Maximum Daily Benefit that was selected by the policyholder when he or she purchased the coverage. The Maximum Daily Benefit available ranged from \$10 to \$300 per day, with many policies subject to annual percentage increases. Some policies, known as "indemnity", pay the full Maximum Daily Benefit, regardless of actual expenses incurred. With the annual percentage increases, in some cases the Maximum Daily Benefit has accumulated to over \$700. The Company's average Maximum Daily Benefit for in-force policyholders is \$173.
- e. **Inflation Benefit** - Some of the Company's LTC policies were issued with an inflation benefit (referred to as "Inflation Protection"). Inflation Protection may increase a policy's Maximum Daily Benefit by a fixed percentage, often 3% or 5% each year, and inflate the Maximum Lifetime Benefit or Benefit Account Value proportionately. The inflation may be simple (increase by the fixed percentage of the original benefit each year) or compound (increase by the fixed percentage of the current benefit each year). The duration of the inflation may be limited to 20 years, or until a policyholder attained age of 85, but many policies have Inflation Protection

SHIP REHABILITATION PLAN

for the life of the policy. Approximately 32% of the in-force policyholders have lifetime 5% compound inflation.

- f. Indemnification - Indemnity and reimbursement denote the method by which the Maximum Daily Benefit will be paid out. Some policies provide coverage for the actual expenses of care (reimbursement), while others pay the full daily benefit amount regardless of actual expenses incurred (indemnity) much like disability insurance policies. The payment method can vary on comprehensive policies, between Assisted Living Facility Care or Home Health Services. Approximately 63% of in-force policyholders have the indemnity benefit for their main coverage.
- g. Benefit Period - Most of the Company's LTC policies are subject to a Maximum Benefit Period. The Maximum Benefit Periods range from one year to six years. Some policies, however, have an unlimited benefit period ("lifetime policies") while others are subject to a maximum dollar amount. Approximately 72% of the in-force policyholders have a limited benefit period while approximately 29% of policyholders have lifetime policies.
- h. Elimination Period - Some of the Company's LTC policies have an Elimination Period, which is a period of time during which the Company is not required to pay benefits to an otherwise eligible policyholder receiving covered care or services. Some policies were issued with a zero-day Elimination Period. Approximately 66% of the in-force policyholders have a zero-day Elimination Period.
- i. Waiver of Premium - Approximately 99% of the Company's LTC policies provide that a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to recommence paying premiums. Approximately 14% of policyholders who otherwise would pay premiums are currently receiving the Waiver of Premium benefit.
- j. Restoration of Benefits - The Restoration of Benefits ("ROB") provision provides that the policy's Maximum Benefit Period will restore to the original Maximum Benefit after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time such as 180 days. In most instances, partial benefits were utilized prior to the restoration period. Some policies may restore an unlimited number of times, while others are restricted in the number of times the policy can be restored. Approximately 76% of the in-force policyholders have a ROB benefit.
- k. Return of Premium - Approximately 5% of the Company's LTC policies were issued with a Return of Premium ("ROP") benefit. This benefit provides for the return of a percentage of premium paid by the policyholder if the policyholder does not have

SHIP REHABILITATION PLAN

a claim or has a limited amount of benefits paid under the policy. The ROP typically occurs upon termination or upon ten-year incremental anniversaries. Since 2011, over \$53 million has been returned through the ROP benefit.

C. FINANCIAL CONDITION

The Company has been in a declining financial condition for many years. Its reported surplus is reflected in the following table:

TABLE 8: FINANCIAL CONDITION (IN DOLLARS)

YEAR	ASSETS	LIABILITIES	CAPITAL & SURPLUS/ (DEFICIT)
2009	3,251,994,962	3,058,545,856	193,449,106
2010	3,317,023,144	3,139,706,226	177,314,918
2011	3,161,093,979	3,046,696,672	114,397,307
2012	3,080,745,346	2,975,278,318	105,467,028
2013	2,985,938,782	2,887,736,889	98,201,892
2014	2,906,965,242	2,826,959,318	80,005,924
2015	2,879,794,716	2,824,037,145	55,757,570
2016	2,744,535,287	2,716,512,099	28,023,187
2017	2,688,468,510	2,675,819,343	12,649,166
2018	2,186,058,273	2,652,931,248	(466,814,972)
2019	1,907,181,137	2,823,279,366	(915,731,212)

It is estimated that SHIP's Funding Gap is between \$500 million and \$1 billion. That is to say, based on Current Premium payments and the current value of SHIP's assets, in the absence of rehabilitation, by the time all of SHIP's policies terminate about twenty to twenty-five years from now, it will have incurred liability for covered benefits costing between \$500 million and \$1 billion more than the money that will be available to pay for those benefits. It is important to note that these are estimates or projections for events that will occur over a long period of time. Any of a multitude of factors can change during that time affecting materially the accuracy of those projections.

There are many reasons that SHIP finds itself in this dilemma, some understood better than others. The Rehabilitator will be conducting thorough and exhaustive investigations and analyses

SHIP REHABILITATION PLAN

of the reasons for SHIP's current financial condition. The areas of investigation and analysis will include, but not be limited to, industry wide challenges, common industry practices, volatility in the financial markets and the conduct of SHIP's management, business partners, consultants and other service providers. The Rehabilitator, in consultation with her advisors and experts, will determine how these forces may have contributed to SHIP's current financial condition. Actions will be taken as appropriate.

Industry wide challenges may have played a role. The LTCI industry or line of insurance business is relatively young, significant numbers of such policies being sold for the first time in the late 1970s and early 1980s. When the products were first designed, there did not exist a robust data base of historical LTCI experience of the type on which actuaries rely to calculate what benefits will cost, how the policies will "behave" over time, and what level of premium will be required to make them financially safe. There was insufficient historical data on which to base expectations about benefit costs and required premiums. The industry therefore referred to experience in other lines of insurance, such as life and disability, to make such projections. Soon, the industry came to understand that the characteristics of LTCI policies are materially different in key respects from those in other lines of insurance. For example, many fewer policyholders voluntarily surrender their LTCI policies before expiration than is true of other types of insurance. Similarly, the length of time during which LTCI policyholders will require benefits is materially longer than had been projected. In short, many factors affecting projected liabilities turned out materially different from what had been assumed when the policies were first issued and premium rates set for them.

This problem was compounded by a decision by the industry to structure these policies as level-premium guaranteed-renewable contracts. In summary, this meant that, as long as the policyholders paid their premiums, the policies could not be cancelled despite changes in age, health condition, and other circumstances. Moreover, the premiums could only be increased if they were increased by the same percentage for all policyholders who had the same type of policy, and then only if the state insurance regulator approved the increase. Over time, a large percentage of these policies were found to be substantially underpriced in that the premiums paid for a given group of such policies could be projected to fall far short of what the company would need for the benefits due under the policies for that group. Obtaining the required approval for rate increases from state regulators proved difficult over time, resulting in two key problems. First, for many LTCI companies, the entire block of such policies were projected to create liabilities far in excess of what the companies would be able to pay. In fact, for many companies like SHIP, this became a serious threat or contributing cause of insolvency. Second, because of differences in the responses by different states to requests for authorization to increase premium rates, over time there emerged wide divergence in the premiums policyholders holding similar policies would pay in different states. Some critics characterized this phenomenon as resulting in policyholders in rate-increase-approving states subsidizing those in states that rejected such requests. All of this can be contrasted with typical health insurance policies that generally last only a year or less, and the premiums for which are adjusted at least annually.

SHIP REHABILITATION PLAN

Adding to these challenges were material changes in the economic environment in which these policies were required to perform. For example, when early LTCI policies were sold, there did not exist a robust assisted living facility (“ALF”) or continuing care retirement center (“CCRC”) industry. When one became incapable of caring for oneself, the principal choices were internment in a nursing home, widely viewed as undesirable unless absolutely necessary, or (at much lower cost) having family or hired help care for one at home. However, as LTCI policies began becoming more popular and provided a funding source for other alternatives, there emerged a vibrant industry of desirable retirement homes providing varying level of care, but typically in much more enticing surroundings and with attractive amenities. These ALFs and CCRCs increased the cost of caring for those who qualified for long-term care benefits but preferred not to remain at home to be cared for by their families or hired care-givers. In many other ways, the cost of caring for those who could not fend for themselves also increased beyond what had been projected by some companies and their consultants when early LTCI policies were priced.

Another major development affected a different key source of funding for future benefits. LTCI policies are designed to generate far more premium than needed to pay benefits in their early years, with those amounts to be invested and generate a material investment income that will be added to the premium and be used in later years when benefit costs are expected to exceed premiums being collected at that later time. In short, the notion is that the company will build-up a fund of premium and investment income that will suffice to pay the large claims expected in the future. In addition to premium being inadequately low when first set, and claims costing more than expected, income earned on the invested premium has also turned out to be much less than anticipated. Changes in the capital market and the broader economy, especially the “great recession” of 2008, dramatically suppressed investment returns below expectations. Current economic circumstances are exacerbating this problem. Many LTCI insurers have amassed billions of dollars in invested premiums. A decline of 1% in yield on each \$1 billion of invested premium amounts to a loss every year of \$10 million in funds to be reinvested and be available for future claims. It is not hard to see how a decline in market yields of even just 3% for five years for a company with \$2 billion in invested assets could be a major event. That would entail a loss of at least \$300 million! This is the nature of lost investment income experienced by SHIP and the rest of the LTCI industry, but on more invested assets for many more years. As a point of reference, the Wall Street Journal Prime Rate was at: 8.25% on March 5, 1975; **17.25%** on March 4, 1980; 10% on January 8, 1990; 9% on March 22, 2000; 5.75% on March 22, 2005; 3.25% on December 16, 2008; 5.50% on December 20, 2018; and back down to 3.25% on April 10, 2020.

These and other challenges faced by SHIP over the eleven years since it was separated from Consecro have combined to create the Funding Gap described above. The purpose of the Plan is to narrow or eliminate that Funding Gap by a combination of an increase in revenue through rate increases and a reduction in liabilities through benefit modifications.

SHIP REHABILITATION PLAN**D. REHABILITATION PROCEEDING**

Since the fall of 2008, SHIP has been owned and overseen by the Senior Health Care Oversight Trust (“Trust” - see paragraph VI.E, page 75) and its Trustees. As SHIP’s domiciliary regulator, the Pennsylvania Insurance Department (“PID”) regulates SHIP’s affairs and monitors its financial condition. On May 7, 2015, the PID concluded a financial examination of SHIP for the five-year period ending on December 31, 2013. The results were detailed in the Report of Examination dated as of that date, which concluded that, as of December 31, 2013, SHIP had capital & surplus of \$98,201,892 and made no recommendations.

As surplus continued to decline (see Table 7, at page 72, above), the PID became substantially concerned about SHIP’s financial situation. The Department engaged in an intense regulatory focus aimed in part at encouraging management and the Trustees to review and revise the actuarial and other assumptions on which they were basing their financial projections and reports of SHIP’s financial condition. In 2017 the PID commenced a limited examination of SHIP’s affairs and engaged an independent consulting actuary to assist, especially, in evaluation of the adequacy of the Company’s reserves. This work, though continuing, revealed a number of areas of concern and the PID appointed a Special Representative to work with SHIP management, the Trustees, and consultant for both the Company and the PID, to ascertain SHIP’s financial condition and to determine whether it would be able to fulfill the contractual promises inherent in the LTCI block the Company was running off. As this work progressed it became evident that SHIP was in a more hazardous financial condition even than suggested by the 2017 statutory annual statement filed in March 2018, which reported a decline in surplus to just over \$12.6 million from over \$28 million a year earlier and almost twice that the year before.

SHIP and its consultants, in communication with the PID and its representatives and advisors, re-evaluated their underlying assumptions, and, in early 2019, SHIP completed an annual statement for 2018 that reported a \$467 million deficit. Management was provided an opportunity to develop a corrective action plan to eliminate this deficit and restore the Company’s surplus to acceptable levels but failed to do so. On January 29, 2020, at the request of Pennsylvania Insurance Commissioner Jessica K. Altman, and with the consent of a majority of the Trustees and SHIP’s directors, the Commonwealth Court of Pennsylvania entered an order (the “Rehabilitation Order”) placing SHIP in rehabilitation and appointing Commissioner Altman as Rehabilitator. The order directed the Rehabilitator to file a preliminary plan for SHIP’s rehabilitation on or before April 22, 2020. Commissioner Altman appointed Patrick H. Cantilo as Special Deputy Rehabilitator (SDR) to comply with the Court’s requirement. This Plan Document is the plan required by the Court.

E. SENIOR HEALTH CARE OVERSIGHT TRUST

As mentioned above, SHIP had been a subsidiary of Consecro, Inc. (“Consecro”) until 2008 when it agreed with PID’s approval to transfer it to a newly created independent nonprofit trust. For that purpose the Senior Health Care Oversight Trust (the Trust) was formed as a Pennsylvania

SHIP REHABILITATION PLAN

business trust and the following served as its trustees (the “Trustees”) as of the date the Company was placed in Rehabilitation and for at least seven years before that date:

1. Julianne Marie Bowler (Chair), since 2009 the Chief Underwriting Officer, and also the Chief Compliance and Administrative Officer, of Narragansett Bay Insurance Company. Ms. Bowler had served as the Massachusetts Insurance Commissioner from 2002 to 2007;
2. Cecil Dale Bykerk, President of CDBykerk Consulting, LLC, a life and health insurance consulting actuary;
3. Thomas Edward Hampton, Senior Advisor to Dentons US LLP, a Certified Public Accountant and former commissioner of the District of Columbia Department of Insurance, Securities, and Banking;
4. John Martin Morrison, senior Partner at Morrison, Sherwood, Wilson, Deola, PLLP, and former Montana State Auditor and Insurance Commissioner; and
5. Gregory Vincent Serio, Partner and Managing Director of New York lobbying firm Park Strategies, and former New York Superintendent of Insurance.

The transaction transferring SHIP to the Trust was memorialized in an August 1, 2008, Transfer Agreement between Conseco and the Trust. The Trust has been (and continues to be) governed by the board of trustees identified above, who have also served as directors of SHIP and Fuzion, along with certain senior officers of the companies. Their authority to oversee the Company has been effectively suspended by the rehabilitation proceedings.

F. FUZION ANALYTICS

Fuzion Analytics, Inc. (“Fuzion”), is a Delaware corporation formed in 2012 as a subsidiary of the Senior Health Care Oversight Trust ostensibly to provide LTCI data mining, analytical and other services to long-term care insurers, including SHIP. Beginning in 2012, SHIP entered into several agreements with Fuzion under which, over time, it paid Fuzion millions of dollars. In 2014, SHIP conveyed essentially all of its infrastructure to Fuzion in exchange for agreed-upon cash consideration consisting initially of a payment of \$367,806. In due course, Fuzion began providing SHIP all of the services necessary to administer SHIP’s affairs, other than those being performed by other vendors. Since that conveyance, SHIP has had no facilities or employees, relying instead on Fuzion to perform all of the functions necessary to run-off SHIP’s LTCI business. On August 20, 2019, the Senior Health Care Oversight Trust conveyed all of its interest in Fuzion to SHIP as a capital contribution, so that Fuzion is now a wholly owned subsidiary of SHIP. In addition to the services provided to SHIP, Fuzion continues to provide Fraud Waste and Abuse and other services to customers in the long-term care industry.

SHIP REHABILITATION PLAN

G. LTCG, INC.

In 2008 SHIP entered into a Master Services Agreement with Univita for a broad array of claims and administrative services, excluding complaints. Univita has since become the Long Term Group (“LTCG”) and continues providing these services to SHIP.

H. POLICY RESTRUCTURING

Before the Effective Date and potentially again after Phase One, the Rehabilitator will determine which of SHIP’s policies are Impaired Policies (under priced and/or Non-self-sustaining). For purposes of implementing the Plan, the Rehabilitator will request that the Court deem SHIP’s Impaired Policies to have been restructured first as of the Effective Date and before giving effect to Policyholder Elections or modifications under the Plan, and potentially again between Phase One and Phase Two. However, these restructurings will not affect the elections available to or made by policyholders. The restructuring will be for the purpose of separating the liabilities arising under those policies that SHIP is projected to have sufficient assets to fund from those that it is projected to be unable to fund in the absence of the Plan. This initial restructuring will consist of reducing the liability arising under each such policy (equal to its GPR) to its Initial Funded Restructured Policy Value (IFRPV), being the amount of that liability that the Company can be reasonably expected to fund before it is further modified under the Plan. The Company will retain indebtedness to the policyholders for the amount by which the liabilities have been reduced, *i.e.*, the Unfunded Benefit Liability (UBL). It is possible that realization by SHIP of additional assets could reduce its aggregate UBL. In any case, as explained below, the Rehabilitator will take steps so that the portion of SHIP’s UBL that it will not be able to fund will be discharged as part of the Plan.

Allocated Assets and premiums paid as to each policy determined under the Plan as described in Section II.E.4.e, page 17, will suffice to enable the Company to fund its IFRPV. As a result, after the Effective Date SHIP will have assets at least equal to the funded liabilities (or IFRPVs) remaining under the Restructured Policies. Further, SHIP will also have indebtedness to policyholders for the UBL created by the restructuring process described in this Section. The modification of Impaired Policies under the Plan will result in contractual changes to eliminate liabilities that had been converted to UBL in the initial restructuring. That UBL will be equal to the difference between the policy’s GPR before modification and its GPR after such modification. SHIP will retain indebtedness to the policyholder equal to that UBL. In due course, however, that UBL will be paid or be discharged by the Court. Because SHIP is unable to fund the UBL, the Rehabilitator will request that, in due course, the Court’s Order approving the Plan discharge SHIP’s liability for any unpaid UBL.

I. GAUGING PLAN PERFORMANCE

During the pendency of the Plan, the Company’s financial condition will be monitored closely with emphasis on changes in the projected deficit. Elections by policyholders to increase

SHIP REHABILITATION PLAN

premiums and reduce benefits in the aggregate are expected to have a material effect on that projected deficit. Various aspects of the Plan are also expected to have material effects on key trends such as average claim cost, claim incidence, claim duration and policy terminations. Most of these are heavily dependent on policyholder behavior that is difficult to predict with certainty. As time passes following implementation of each phase of the Plan, however, changes in these key trends will become more evident and the effects of the Plan as a whole will be more susceptible of quantification.

J. GUARANTY ASSOCIATIONS

This is a general summary of the state Guaranty Association system. Readers must review the individual state laws to understand how individual Guaranty Associations operate in each jurisdiction and the protections they afford. The Plan does not contemplate involvement by Guaranty Associations in the Plan's operations. This information is provided solely in the interest of addressing anticipated questions.

All U.S. states and the District of Columbia have legislatively established entities, commonly referred to as "Insurance Guaranty Associations," which protect policyholders of licensed insurance companies in the event their insurance company fails. These Guaranty Associations generally are required to provide for the continuation of the life and health insurance coverage provided by the failed insurer, in most cases up to statutory maximum coverage amounts and subject to specified conditions.

Virtually all of SHIP's LTC insurance policies would be covered under the state Guaranty Association system, subject to individual state statutory maxima and conditions, if SHIP were placed into liquidation with a finding that it is insolvent. Policies held by residents of countries other than the U.S. may not be covered by Guaranty Associations.

In most states, Guaranty Association benefits can be "triggered" in one of several ways. Some "triggers" are permissive, authorizing the Guaranty Association to guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered contractual obligations arising under the insurer's policies or contracts (or to provide loans or other assistance). Other "triggers" are mandatory, requiring the Guaranty Association to take such measures. When triggered, the Guaranty Associations generally provide such protections to the residents of their states, though the contracts may have been issued in other states. In most states, the permissive trigger can be used when an insurer is deemed "impaired" but has not been found insolvent or ordered liquidated. As the term implies permissive triggers are optional with the Guaranty Associations and very rarely used.

Mandatory triggers generally include an insurer not paying claims on time and being placed in liquidation with a finding of insolvency. These provisions vary somewhat among the several states. The Rehabilitator has concluded that SHIP does not now qualify for mandatory triggers

SHIP REHABILITATION PLAN

largely because there has not been an order of liquidation with a finding of insolvency and it is currently paying claims on time. However, though SHIP is currently paying claims on time as required by the Rehabilitation Order, its financial condition is so dire that it is a virtual certainty that it cannot continue paying claims in full and on time for as long as required by its LTC insurance contracts without remedial measures. In the absence of a rehabilitation plan, the continuation of full benefit payments to current claimants virtually assures that policyholders who go on claim in the future will not be able to receive full, or in some cases any, benefits from SHIP.

Generally, if a policyholder is entitled to receive benefits from the Guaranty Association of his or her state of residence no further inquiry is necessary to determine which Guaranty Association is responsible for his or her policy. However, when that is not the case, it may be necessary to determine whether the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA) may be required to provide such benefits because SHIP is domiciled in Pennsylvania. It is important to note that the conditions and limits of Guaranty Association protection typically apply to each policyholder, not to each policy. Thus, in a state in which such benefits are limited to \$300,000 (the majority of states), that limit will apply to all of a policyholder's policies issued by the same Company combined. The laws of each specific jurisdiction should be reviewed carefully to determine how these conditions and limits apply in particular cases.

It is important to note that the amount of statutorily promulgated Guaranty Association coverage limits is not directly comparable to a policy's GPR. GPR is the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect and including provision for moderately adverse developments. It measures the present value of benefits and expenses less the present value of premiums. The Guaranty Association coverage limits are stated nominally (that is the total to be paid over time, no matter how long that time) and not at present value. The GPR equivalent of stated Guaranty Association Limit depends on factors individual to each policyholder, mostly related to the expected timing and amount of benefit and premium payments. Thus, a \$300,000 Guaranty Association limit may equate to a GPR of \$270,000 or some other amount less than \$300,000 for a given policyholder.

Neither the Rehabilitator nor SHIP would be responsible for coverage decisions of the Guaranty Associations. Each Guaranty Association evaluates its own liability and makes its own coverage determinations in accordance with applicable law. Those laws vary to some degree among the states and benefits available in some states may differ from those available in others. For example, in some states the Guaranty Associations do not provide coverage for any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds a specified rate, typically set by reference to Moody's Corporate Bond Yield Average over a specified time. These interest rate limitations often apply retrospectively (to interest earned pre-liquidation) and prospectively (to interest earned after liquidation), though perhaps in different ways. Other states have adopted legislation making such provisions inapplicable to LTCI.

SHIP REHABILITATION PLAN

As noted above, Guaranty Association benefits are subject to statutory conditions and limits. For example, PLHIGA is not obligated to provide more than \$300,000 in benefits to a covered individual. In some states that limit can be significantly higher. However, the fact that applicable limits may be higher in another state does not entitle Pennsylvania residents to the higher protection afforded by the Guaranty Association of another state. In addition, the Guaranty Association statutes contain certain residency and other requirements that must be met in order to receive benefits. Some of SHIP's policyholders may have aggregate claims in excess of these limits or which do not qualify for Guaranty Association benefits for other reasons (Uncovered Benefits).

The methods by which Guaranty Associations discharge their statutory responsibilities vary from case to case but normally involve assumption by a Guaranty Association or an insurer of the contractual obligations created by the policies issued by the failed insurer, up to statutorily prescribed limits and subject to statutory conditions. Policyholders are required to continue paying their premiums without interruption in order to preserve their insurance coverage, unless those premiums have been suspended by Premium Waiver provisions in their policies. However, once benefits paid by the Guaranty Association reach the applicable statutory limit (and those benefits are therefore discontinued), the policyholder will no longer be required by the Guaranty Association to continue making premium payments.

As noted, SHIP has not been placed in liquidation and Guaranty Association coverage and associated limits are therefore not applicable to SHIP policies. While it is hoped that it will not be necessary to place SHIP in liquidation, and no specific plans exist to do so, past experience provides guidance about some likely aspects of such an eventuality. Specifically, it is probable that if the Guaranty Associations are "triggered" for a SHIP liquidation they would seek to raise rates to If Knew Premium levels. To the extent that the Plan does so now, it should reduce or eliminate the need for the Guaranty Associations to do so if that were to occur.

K. JURISDICTION OF COMMONWEALTH COURT

The Commonwealth Court has exclusive *in rem* jurisdiction over SHIP and all of its assets. That means it is the only court with jurisdiction over SHIP's assets and business. Note by way of distinction that other courts may have *in personam* jurisdiction over SHIP, its policyholders and claimants. The Commonwealth Court has authority to approve a rehabilitation plan for the company. 40 P.S. § 221.16 expressly authorizes the rehabilitator to "prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger, or other transformation of" SHIP. Without going into detail, that statute gives the rehabilitator broad discretion to develop a plan to correct the conditions that led to the need to place SHIP's in rehabilitation, including changing the Company's policies (and rates) as part of the Plan. So long as all affected parties (including other state insurance departments) are provided an opportunity to object, they will be bound by the Court's approval of the Plan, and its modification of policies and premium rates as part of the Plan.

Some concern has been expressed by certain state regulators about the notion that premium

SHIP REHABILITATION PLAN

rate modifications under the Plan will not require approval of the states in which the policies were issued. The concern is understandable given that there have not been many troubled companies for which the issue of rate increases in rehabilitation has arisen. Moreover, insurance rate regulation tends to be an area of intense public and political focus. In some states, Commissioners are constrained by statute in the magnitude of rate increases they can authorize for long-term care insurance policies. The Rehabilitator believes strongly that there is fundamental distinction between rate increases for companies in the market place and the extraordinary case of rate increases as part of a court supervised rehabilitation plan for a troubled company. While the matter is without an abundance of clear specific legal precedent, the Rehabilitator believes that the applicable legal authorities support the conclusion that it is properly within the purview of the Rehabilitator and the Commonwealth Court in an Article V rehabilitation proceeding. More importantly, the Plan would not be feasible, and would fail in a key goal, if rate modifications required approval from each of the states in which SHIP policies have been issued. First, that would prevent the plan from accomplishing its key goal of placing policyholders on “a level playing field” by having them pay substantially the same premium for the same coverage, thereby reducing or eliminating the much-criticized historical subsidies. Second, the need to obtain such approvals would insert a lengthy delay in the time-line that would be costly, if not fatal, to the Plan.

L. REINSURANCE

SHIP has assumed a number of LTC policies through co-insurance or reinsurance.

1. Transamerica

On October 11, 1994 JC Penney Insurance Company and JC Penney Life Insurance Company (collectively “JCP”) entered into a Reinsurance and Purchase Agreement and Administrative Services Agreement with American Travelers Life Insurance Company (“American Travellers”). The Reinsurance and Purchase Agreement was structured on an Indemnity Reinsurance basis and a trust account was later established pursuant to a Trust Agreement executed on December 31, 2002. American Travellers was purchased by Conseco in 1996 and subsequently changed its name to Conseco Senior Health Insurance Company and then to Senior Health Insurance Company of Pennsylvania (“SHIP”). JCP changed its name to Stonebridge Life Insurance Company in 2002 and, as a result of corporate transactions, is now Transamerica Life Insurance Company.

2. Primerica

On December 20, 1995 Primerica Life Insurance Company (“Primerica”) and Transport Life Insurance Company (“Transport Life”) entered into a Reinsurance and Administration Agreement whereby Transport Life, on an indemnity basis, accepted 100% of the policy liabilities of Primerica’s individual and group accident and health insurance policies. Transport Life merged with Conseco Senior Health Insurance Company in November 1997 and, with the separation from

SHIP REHABILITATION PLAN

Conseco, Senior Health Insurance Company of Pennsylvania (“SHIP”) became the successor under the Reinsurance and Administration Agreement. Amendment #2 to the Reinsurance and Administration Agreement, dated November 11, 2008, limits the scope of SHIP’s reinsurance and administration to long term care policies only.

3. **American Health and Life**

Pursuant to a Reinsurance Agreement dated November 1, 1996, Transport Life entered into a Reinsurance Agreement whereby Transport Life agreed to administer and reinsure, on a coinsurance basis, 100% of the liability of American Health and Life Insurance Company’s long term care policies. As a result of certain corporate transactions, and later the separation of SHIP from Conseco, SHIP became the successor to Transport Life’s interests under the Reinsurance Agreement and continues to administer the policies.

4. **Washington National Insurance Company**

On June 30, 1998, American Travellers entered into a Coinsurance Agreement with Conseco Life whereby American Travellers ceded 100% of its net liability for certain Connecticut resident state policies to SHIP, including servicing and administration of these policies. On April 1, 2013, CNO assumed, through novation, all of the policies with the exception of certain Connecticut policies which opted out of the assumption. Washington National Insurance Company reinsured those Connecticut policies that opted out.

5. **Conseco Life Insurance Company**

Under an Assignment Agreement effective October 1, 2008 with Conseco Life Insurance Company (“CLIC”), all the assets and liabilities pertaining to SHIP’s non-long term care business were assigned to, and assumed by, CLIC, which, together with DXC Technology, administers all of the business. SHIP remains contingently liable for the assigned business in the event CLIC fails to perform its obligations under the Assignment Agreement. In recognition of this liability, CLIC is required to and does maintain assets in a trust account of which SHIP is beneficiary. That account appears to be adequately funded. The business they manage consists of

1. 7,106 Traditional Life,
2. 213 Universal Life,
3. 80 Deferred Annuity,
4. 223 Medicare Supplement,
5. 40,273 Specified Disease,
6. 756 Accident Only,
7. 667 Hospital Indemnity,
8. 521 Long term disability, and
9. 43 Other.

SHIP REHABILITATION PLAN**6. Teacher's Protective Mutual Life Insurance Company**

Teacher's Protective Mutual Life Insurance Company ("Teachers") and Senior Health Insurance Company of Pennsylvania ("SHIP") entered into an Indemnity and Assumption Reinsurance and Administrative Services Agreement on December 28, 2015 pursuant to which Teachers ceded to SHIP, on an indemnity reinsurance basis, 100% of liabilities and obligations paid or payable by Teacher's. These policies have been novated by SHIP so that they are treated as if they had been issued by SHIP in the first place.

All of these assumed LTCI policies have historically been treated administratively in material respects as if they had been issued directly by SHIP. That treatment will continue under the Plan unless the Court orders otherwise or a different agreement is reached with the cedents of those policies.

M. COMMISSIONS

The payment of commissions owed to Agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Plan until policyholders have been made whole, that is, all their contractual claims have been paid in full and adequate provision made for reasonably anticipated future claims. Further, the Plan will suspend the accrual of commissions as of the Initial Plan Effective Date. Agents and brokers may assert claims for commissions earned prior to the Initial Plan Effective Date but, under the Plan, those claims will be subordinated to amounts owed to policyholders under SHIP insurance policies.

The Rehabilitator notes that Agents are not currently providing services at the request of and in support of the Rehabilitator. Since entering rehabilitation, SHIP has evaluated the ongoing role of Agents. It is the belief of the Rehabilitator that most policyholders do not have a close relationship with their Agents, often have not spoken with their Agents since their policies were purchased, and do not contact their Agents for questions about their policies or benefits. Most policyholders contact SHIP directly for policy information or questions, or a financial advisor or trusted professional (lawyer, banker, trustee or family member).

N. OPT OUT

The Company's LTC policies do not provide for any cash or surrender value and policyholders are not entitled to any cash payment upon cancellation either in the ordinary course of business or in liquidation. In short, upon liquidation, policyholders would not receive cash payments.

While the Plan does not propose a separately-identified cash opt-out option, certain features of the Plan satisfy an opt-out requirement. First, many policyholders will not be required by the Plan to make any changes in their policies. Second, every policyholder will have an option in every

SHIP REHABILITATION PLAN

scenario to select a Non-forfeiture Option under which no more premium will be due and he or she will receive at least the coverage that can be provided at the current benefit level by the aggregate of all premiums paid by the policyholder to date less claims paid under the policy to date. In fact, elements of the Plan make the NFO option materially more valuable than this baseline. See section II.I, page 22. Finally, every policyholder will have at least one option under which he or she would receive at least as much in benefits as would be provided by his or her Guaranty Association coverage.

O. STATE DEPOSITS

SHIP has been required to place deposits with various states as a condition of its licensing in those states. These state deposits total approximately \$19.3 million. The Rehabilitator believes that once the Plan is approved (whether or not modified), she should pursue recovery of those deposits so that the funds can be used to support the Plan.

P. TAX MATTERS

The Plan is not intended to create net adverse tax consequences for policyholders or SHIP, and the Rehabilitator does not believe that it will do so if it is implemented as proposed. However, the tax effects of the Plan depend in part on events, circumstances and the conduct of other parties that are not within the control of, nor can be predicted by, the Rehabilitator.

While a number of federal income tax issues may arise under the Plan, two areas are of particular concern. First, will any modification of LTC policies under the Plan create adverse tax consequences for policyholders? Second, will the inability to fund fully policy obligations or provisions of the Plan create adverse tax consequences for SHIP?

1. Policy Modifications.

It does not appear that the Plan is likely to create adverse tax consequences for policyholders. However, if further analysis indicates that Policy Modifications or other provisions of the Plan, may raise such issues, it is likely that the Rehabilitator will seek from the Internal Revenue Service of the Department of the Treasury (the “IRS”) a favorable private letter ruling (“PLR”) to the effect that Policy Modifications under the Plan would not produce taxable deemed exchanges or other adverse tax consequences for policyholders.

2. Tax Issues for SHIP

It is possible that reductions in insurance reserves resulting from Policy Modifications or other elements of the Plan would be deemed taxable reserve releases creating taxable income. However, the Plan contemplates the restructuring of SHIP’s policies, bifurcating the liabilities arising under them as between their IFRPV and their UBL, which will minimize this tax exposure.

SHIP REHABILITATION PLAN

The Plan contemplates discharge of SHIP's UBL to the extent that SHIP cannot pay them.

SHIP is part of consolidated group for federal income tax compliance purposes, which also includes its affiliates, the Trust and Fuzion. The group files a consolidated tax return. SHIP and its affiliates currently possess substantial Deferred Tax Assets ("DTAs") such as net operating loss carry-forwards. These DTAs may serve to offset taxable income generated by operation of the Plan. It is possible that implementation of the Plan may give rise to tax liability, however, because of certain limitations on the use of such carry-forwards in the Internal Revenue Code. The ability of SHIP to realize the benefit of these DTAs may also depend in part on decisions made by other members of the consolidated group. While Fuzion is SHIP's wholly owned subsidiary, and under its control, the Trust is governed independently. Current tax law may affect the degree to which other parties may make decisions adverse to SHIP's interest and rehabilitation. Moreover, the discharge of indebtedness under the Plan may also result in reducing or eliminating SHIP's ability to take advantage of these DTAs.

As indicated above, to the extent that the Plan results in the reduction of policy obligations through the modification of policies to make them properly priced or Self-sustaining (thereby removing their UBL), it is possible that such reduction will be subject to federal income tax. It is possible that not all of such income may be excludable under an insolvency exception for discharge of indebtedness income, or be offset against net operating loss carry-forwards and other DTAs. It is also possible, as noted, that implementation of the Plan may give rise to tax liability. The Plan is designed, and the Rehabilitator intends to implement it, in a manner that will minimize or eliminate such potential adverse tax consequences. However, there can be no assurances that these measures will be effective.

Nothing in the Plan Document is intended to provide, nor shall be interpreted as providing tax or legal advice. Policyholders and other persons affected by the Plan should consult their own tax or legal and other advisors regarding the possible tax and other effects of the Plan. The Rehabilitator may seek guidance (such as a private letter ruling) from the U.S. Secretary of the Treasury regarding certain potential tax aspects or consequences of the Plan.

Q. PRINCIPLES AND FAIRNESS OF THE PLAN

The Plan is designed to comply with applicable statutory provisions. In addition, by reference to Pennsylvania statutes and judicial opinions governing other insurance rehabilitation and insolvency proceedings in this and other states, the Rehabilitator has adopted the following core principles that should guide implementation of the Plan:

1. To the extent reasonably possible under the circumstances, the Plan should correct the conditions which constituted the grounds for the order to rehabilitate the Company;

SHIP REHABILITATION PLAN

2. The paramount goal of the Plan should be protection of policyholders;
3. The Plan should be fair and equitable;
4. The Plan should put policyholders and creditors as a group in a position not materially inferior to what liquidation of SHIP as of the Effective Date would produce; and
5. The Plan should include metrics to gauge progress.

The Rehabilitator believes that the Plan reasonably embodies these principles and that it is fair and equitable to policyholders, creditors and affected parties. It addresses historically discriminatory premium rates through asset allocations in determining Self-sustaining Policies and through the premium rate increase structure governing Policy Modifications. Within the means available, as regards policyholders the Plan is designed to reduce the Funding Gap which principally led to the inception of the rehabilitation proceeding. It does so through premium rate increases and benefit reductions to reduce or eliminate on a policy-by-policy basis the shortfall between assets and liabilities. The principal goal of the Plan is to protect the interests of policyholders by maximizing preservation of their insurance coverage. It treats similarly situated policyholders in the same way and devotes SHIP's assets to the fulfillment of its purposes in a non-discriminatory and non-arbitrary manner.

R. RISK FACTORS

There are substantial risks and uncertainties associated with the Plan and its implementation. Those described herein are not the only ones that could materially impact SHIP, the Plan, its implementation, and its impact on policyholders, creditors and the public.

1. The actuarial assumptions and projections used to develop the Plan, including investment income, default rates, lapse rates, expenses and claims may be materially different from actual results. Therefore, the benefits and claims that SHIP will be able to pay may be materially higher or lower than the amounts assumed in the Plan.
2. Although the Plan does not contemplate that SHIP will, as a result of the Plan, implement future premium rate increases not described in the Plan, there can be no assurances that such rate increases will not be sought by Guaranty Associations if SHIP is placed in liquidation.
3. Objections may be lodged against the Plan or its implementation which may not be able to be overcome without material changes in the Plan.
4. The Rehabilitator believes that the provisions of the Plan can be implemented with approval of the Commonwealth Court and without the need that insurance regulators in every state approve the Plan, including premium rate increases implemented under the Plan. However,

SHIP REHABILITATION PLAN

regulators in other states may conclude that their approval is required. The Rehabilitator cannot provide any assurance that approval from other regulators will not ultimately be deemed necessary. Neither can the Rehabilitator provide assurances that if such other state approvals are necessary they can be obtained consistent with the timing and substance of the Plan.

5. Governmental authorities may change the laws and regulations that apply to SHIP, its business and state insurance receiverships in ways that impact policyholders, SHIP, the Plan, or its implementation negatively.
6. Adverse developments in the broader economy may affect adversely the performance of SHIP's invested assets, the costs of its operations or the development of its liabilities. As a result, financial assumptions made in the Plan may differ materially from actual events.
7. Certain changes in the general health of SHIP's insured population (such as developments prolonging the period that such persons remain on claim, the severity of such claims, or the frequency with which policyholders go on claim) may affect materially the development of SHIP's insurance liabilities. As a result, loss assumptions made in the Plan may differ materially from actual events.
8. The emergence of the Coronavirus disease known as "COVID-19" has created unprecedented and wide-ranging disruptions in virtually every facet of American society. Its economic implications, and the changes that will result in American healthcare and insurance are only now beginning to surface and will take a prolonged time to develop completely and be fully understood. The Rehabilitator cannot predict what effect COVID-19 will have on the Plan and its implementation. The Special Deputy Rehabilitator and rehabilitation team are making efforts to incorporate in the Plan expanded timelines and elements of flexibility that will facilitate responding to these recent and continuing developments.
9. The Plan depends on implementation of a complex restructure of SHIP's insurance business for which there is no close precedent and which depends in part on legal provisions that may be difficult to implement. Failure to implement these provisions may have a material adverse effect on the success of the Plan.
10. The success of the Plan will depend in part on policyholder elections which are difficult to predict. The actual results of those elections may have a material adverse effect on the Plan.

S. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented if approved by the Court as proposed by the Rehabilitator. If the Plan is

SHIP REHABILITATION PLAN

modified by the Court or pursuant to subsequent amendments proposed by the Rehabilitator, its implementation may differ materially from the description herein.

The Plan includes information concerning SHIP's history and current and projected financial condition. This information was prepared based on information available to SHIP and the Rehabilitator, including information provided by SHIP to the Rehabilitator or available in historical public filings, and on actuarial projections that inherently include a degree of uncertainty. The Rehabilitator has yet to conclude an investigation of all the reasons that led to the Company's distressed financial condition. Pursuant to her statutory ability to do so, the Rehabilitator has delegated broad responsibility to the SDR and in the Plan references to Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make any warranty, express or implied, as to the accuracy or completeness of the information contained in the Plan. In particular, events and forces beyond the control of the Rehabilitator and SHIP may alter the assumptions upon which the disclosures in the Plan are based. The Plan Document includes certain projections, but they cannot forecast and reflect fully any events that may occur subsequent to the date hereof. Such events may have a material impact on the information contained in the Plan Document and any recovery or benefits that may be received by policyholders and other creditors of the Company. The Rehabilitator may or may not update the Plan (including the financial information and underlying assumptions) or may only update it in part or only after the passing of substantial amounts of time. Therefore, the financial information and projections set forth in this Plan document may become outdated with the passage of time.

THE REHABILITATOR AND SHIP ARE NOT OFFERING LEGAL, BUSINESS, FINANCIAL, TAX OR OTHER ADVICE TO ANY PERSON AND THE PLAN SHOULD NOT BE CONSIDERED TO CONTAIN ANY ADVICE OR INSTRUCTION CONCERNING SUCH MATTERS. THE READER SHOULD CONSULT WITH HIS OR HER LEGAL, BUSINESS, FINANCIAL, TAX AND OTHER ADVISORS AS TO ANY MATTERS CONCERNING THE PLAN.

The Plan document is not required to be prepared in accordance with federal or state securities laws. None of the Securities and Exchange Commission ("SEC"), any state securities commission, or any similar governmental body has approved the Plan Document or has opined on the accuracy or adequacy of the statements contained therein. None of the financial information in the Plan Document was prepared to comply with published guidelines of the SEC, the American Institute of Certified Public Accountants, U.S. Generally Accepted Accounting Principles or prescribed statutory accounting principles, except as specifically described therein.

The Plan Document may not be relied upon for any purpose (including to trade, buy or sell claims or securities) other than to obtain information about the details of the Plan and the related proceeding. Nothing contained herein is intended as or constitutes an admission of any fact or any party's liability with regard to any claim or litigation, including, but not limited to, any proceeding involving the Rehabilitator, SHIP, or any other party, or any proceeding with respect to the legal

SHIP REHABILITATION PLAN

effect of the transactions contemplated by the Plan. Nothing contained in the Plan Document constitutes an admission, or can be deemed evidence, of the tax or other legal effects of the Plan on SHIP or on holders of claims against, or equity interests in, SHIP or its affiliates. Statements as to the rationale underlying the treatment of claims and other matters under the Plan are not intended to, and will not, waive, compromise or limit any of the Rehabilitator's or SHIP's rights or causes of action.

The Plan document contains statements that are, or may be deemed to be, "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Any such forward-looking statements are based upon a variety of estimates and assumptions that, though considered reasonable by the Rehabilitator, may not be realized, and are inherently subject to significant business, economic and other uncertainties and contingencies. Some assumptions inevitably will not materialize and events and circumstances occurring subsequent to the date on which the statements were prepared may be significantly different from those assumed, or may be unanticipated, and thus may affect financial or other results in a material and possibly adverse manner. The statements, therefore, should not be relied upon as a guaranty or other assurance of the actual results that will occur.

To ensure compliance with Internal Revenue Service Circular 230, holders of claims and other interests are hereby notified that: (a) any discussion of United States federal tax issues contained or referred to in the Plan Document is not intended or written to be used, and cannot be used, by holders of claims and other interests for the purpose of avoiding penalties that may be imposed on them under the Internal Revenue Code; (b) such discussion is provided solely in connection with the transactions or matters addressed herein; and (c) holders of claims and other interests should seek advice based on their particular circumstances from an independent tax advisor.

All summaries of the Plan contained herein or in other materials prepared by the Rehabilitator or others, including other filings with the Court, are qualified in their entirety by reference to the Plan as set forth in its entirety herein. Summaries of the Plan herein are not complete and are subject to, and qualified in their entirety by, reference to the full text of the Plan.

VII. GLOSSARY

The following are terms used in, or helpful in understanding, the Plan.

- 1) **"Accumulated Premium"** means, for a policy or group of policies, the total Gross Premiums paid, and premium waived under Waiver of Premium provisions, from inception until the valuation date.
- 2) **"Accumulated Premium Method"** means allocation of assets in proportion to the Accumulated Premium of the relevant policies as is more fully explained in Section II.E.4.e, page 17.

SHIP REHABILITATION PLAN

- 3) **“Active Allocable Assets”** is a notional determination applicable to policies not on claim and consisting of the Company’s Allocable Assets less the amount required to fund fully the Disabled Life Reserve.
- 4) **“Active Asset Premium Ratio”** means the ratio of Active Allocable Assets to the aggregate of Accumulated Premiums for all Active Lives.
- 5) **“Active Block”** means the LTC insurance policies issued or assumed by the Company that remain in force and are not on claim.
- 6) **“Active Life Reserve”** or **“Statutory Active Life Reserve”** means the excess of the present value of future benefits over the present value of future Net Premiums. Net Premiums do not include provisions for any expenses and are typically set at policy issue. The assumptions used in statutory active life reserve calculations are locked-in and several of the assumptions are prescribed by law.
- 7) **“Active Policies”** or **“Active Policyholders”** referred to also as Policies Not On claim and Policyholders Not On claim, means respectively policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company’s records as having been approved for benefit payments and are not in the process of being approved for benefit payments as of the Determination Date.
- 8) **“Activities of Daily Living”** or **“ADL”** means eating, bathing, dressing, ambulating, transferring, toileting and continence.
- 9) **“Adult Day Care”** means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home. It is generally administered as part of home health care benefits.
- 10) **“Adult Day Care Center”** means a facility which provides Adult Day Care programs and services and which is operated pursuant to the provisions of applicable state law relating to licensing and quality of care requirements.
- 11) **“Agent”** means any insurance agent, broker or producer that solicited, sold or placed insurance business issued or assumed by the Company or any of its predecessors.
- 12) **“Allocable Assets”** is a notional determination consisting of the total value of the Company’s liquid invested assets, after making provision for costs and expenses of administration, contingencies, and accrued but unpaid claim payments.

SHIP REHABILITATION PLAN

- 13) **“Allocated Assets”** means, for a LTC policy or group of policies, the portion of the Allocable Assets notionally allocated to that policy or group of policies in accordance with the terms of, and solely for the purposes described in, the Plan. All asset allocations are notional and do not give any policyholder a right to any Allocated Assets or any particular sum of money.
- 14) **“Approval Order”** means an Order from the Commonwealth Court approving the Plan.
- 15) **“Article V”** means Article V of the Pennsylvania Insurance Department Act of 1921, P.L. 780, as amended, 40 P.S. § 221.1, et. seq.
- 16) **“Basic Policy Endorsements”** means certain endorsements that together constitute the policyholder Option Two under the Plan. They consist of specific Policy Modifications described fully in Section III.A.2.d, page 36, intended to provide reasonable benefits and premiums that will be immune from changes in Phase Two of the Plan. Policyholders making this election will not face additional modifications under the Plan except from paying full premium rather than Differential Premium if a Premium Waiver becomes inactive.
- 17) **“Benefit Triggers”** means the conditions that must be satisfied in order to be eligible for benefits under an LTC insurance policy.
- 18) **“Claim Reserve”** means the Disabled Life Reserve plus the reserve for pending and incurred but not reported claim payments as further defined herein.
- 19) **“Claim Waiver of Premium”** means a provision in a LTC insurance policy under which a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care.
- 20) **“Commonwealth Court”** or **“Court”** means the Commonwealth Court of Pennsylvania , which is the rehabilitation court for SHIP and has exclusive jurisdiction over SHIP’s rehabilitation.
- 21) **“Company”** means SHIP.
- 22) **“Cost of Insurance”** means the amount of premium expected to fund future policyholder benefits. It does not include amounts for future operating expenses and profits.
- 23) **“Court”** means for purposes of the Plan, and unless otherwise specified, the Commonwealth Court of Pennsylvania.

SHIP REHABILITATION PLAN

- 24) **“Covered Benefits”** means the amount of policy benefits provided by SHIP’s insurance policies that, if SHIP were placed in liquidation, would be within the limits, conditions and scope of coverage of the responsible Guaranty Association taking into account the residence and other attributes of the policyholders as determined by the responsible Guaranty Association in accordance with applicable law.
- 25) **“Current Premium”** means the premium paid by or waived for a LTCI policy before the applicable Effective Date under the Plan. This is also the target premium for the Downgrade Process. See Section III.A.1.c, page 30.
- 26) **“Daily Benefit Amount”** or **“DBA”**, also called Maximum Daily Benefit (MDB), means a maximum daily dollar amount available on a covered day of care as specified in the policy.
- 27) **“Default Option”** means the Plan Option selected automatically for a policyholder who fails to make a valid election by the required date.
- 28) **“Determination Date”** means a date, which may vary among policyholders, after the Policyholder Election Date and before the Initial Plan Effective Date or Supplemental Plan Effective Date (whichever is applicable) to be selected by the Rehabilitator pursuant to the Plan as of which all the determinations and calculations required to construct the options available to each policyholder will be made by the Rehabilitator.
- 29) **“Differential Premium”** means the applicable premium (If Knew, Phase One, or Self-sustaining) less the Current Premium and is payable under the Plan in lieu of the applicable premium by policyholders on waiver. Under the terms of the Plan, differential premiums cannot be less than zero.
- 30) **“Disabled Allocable Assets”** is a notional allocation consisting of the portion of the Company’s assets allocable to policyholders on claim for purposes of determining whether they are Self-sustaining, and if not, their Shortfall Amounts. The method of determining the amount of such assets is described in Section II.E.4.d, page 16.
- 31) **“Disabled Life”** means a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided, or have been approved, by the Company and is also referred to as a policyholder on claim.
- 32) **“Disabled Life Reserve”** or **“DLR”** means the present value of expected future benefits calculated for each policyholder listed in the Company’s records as a policyholder on claim.
- 33) **“Downgrade Process”** means the process for reducing the benefits of a policy pursuant to Option One so that the policyholder may retain the Current Premium but reduce the benefits

SHIP REHABILITATION PLAN

provided by that policy to those that premium can fund on an If Knew basis in Phase One and a Self-sustaining Basis in Phase Two. It is described in detail at Section III.A.1.c, page 30.

- 34) **“Dual Waiver of Premium”** or **“Dual Waiver”** (DWOP), sometimes called Spousal Waiver of Premium, means a provision in a LTC insurance policy under which the premium of a spouse is also waived when the policyholder’s premium is waived upon going on claim.
- 35) **“Effective Date”** means the date as of which the provisions of the Plan, including modification of LTC policies and Policyholder Elections, will become effective following the approval of the Plan. For most policyholders the Effective Date will be the Initial Plan Effective Date. For policyholders who undergo specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26 the Effective Date will be the Supplemental Plan Effective Date.
- 36) **“Elimination Period”** or **“EP”** means the time period during which a policyholder’s circumstances qualify for Long-term Care insurance benefits but for which no such benefits are yet payable by the Company. The Elimination Period is similar to a deductible or waiting period. The length of the elimination period varies by policy. The majority of the Company’s policies include elimination periods of zero days, 30 days, 60 days, 90 days, and 110 days, although the Company has some policies with elimination periods up to 365 days.
- 37) **“Expected Losses”** means the average future benefit payments and increases in reserves calculated for a given policy using original issue assumptions as adjusted from time to time by the Company, including its demographic characteristics, policy characteristics, assumed claim incidence rates, assumed claim termination rates, and assumed claim intensity.
- 38) **“Final Approval Date”** means the date upon which the Approval Order becomes final and non-appealable or upon which an appellate Order affirming the Approval Order has itself become final and no longer appealable.
- 39) **“Fully Covered”** means that the maximum liability projected for a particular policy (its MPV) is no greater than the limits of Guaranty Association coverage that would apply to that policy if SHIP were placed in liquidation. A Fully Covered policy has no Uncovered Benefits.
- 40) **“Funding Gap”** means the gap between: (a) the sum of: (1) the amount of SHIP’s assets, (2) projected future premiums, and (3) projected earnings on investments, and (b) the sum of: (1) SHIP’s future policy benefits, (2) related expense payment obligations, and (3) other expenses.
- 41) **“Fuzion”** means Fuzion Analytics, Inc., a subsidiary of SHIP that, among other things,

SHIP REHABILITATION PLAN

provides management and administrative services to SHIP.

- 42) **“Gross Premium”** means the periodic payments that are required to keep the policy in force. The rates used to establish the Gross Premium are typically filed with, and subject to approval of, insurance regulators. Gross Premium includes provisions for expenses and profit margins.
- 43) **“Gross Premium Reserve” or “GPR”** means the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect and including provision for moderately adverse developments. Expected expenses include commissions and premium taxes (if applicable). GPR is the reserve amount that results from performing a GPV. For a Self-sustaining Policy GPR is no more than the assets allocated to that policy under the Plan for calculation purposes only.
- 44) **“Gross Premium Valuation” or “GPV”** is the determination of the present value of expected future benefits and related expenses less the present value of expected future premiums at current and anticipated rates where “expected” consists of best estimate assumptions including a provision for moderately adverse deviation. The gross premium valuation process is used in determining the GPR.
- 45) **“Guaranty Association”** means the life, health and accident insurance Guaranty Association or equivalent entity in a particular state responsible for providing benefits to the policyholders of an insolvent long-term care insurer.
- 46) **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, which among other things establishes data privacy and security safeguards for patient health information and which also provides that premiums paid for “Tax Qualified policies” as defined in the Act, may be deductible from federal income tax.
- 47) **“IBNR” or “Incurred But Not Reported”** reserve means a reserve for claims or rights to benefits that have occurred but which are not yet known to the Company.
- 48) **“If Knew Differential Premium”** means the If Knew Premium less the Current Premium. It is the Differential Premium when the applicable premium is the If Knew Premium. Under the terms of the Plan differential premiums cannot be less than zero.
- 49) **“If Knew Premium”** means the premium that if charged from inception would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, this will be assumed to be 60%. It is sometimes described as the premium the insurer would have charged from inception had it known then what it knows now.

SHIP REHABILITATION PLAN

- 50) **“Impaired Policy”** means an LTCI policy: (1) for which the Current Premium is less than the If Knew Premium, and/or (2) that is Non-self-sustaining.
- 51) **“Inflation Protection”** means riders purchased by policyholders or policy features that provide for defined increases in benefits at regular intervals in order to protect against the effects of inflation on the cost of care.
- 52) **“Initial Funded Restructured Policy Value”** or **“IFRPV”** means a policy value equal to the portion of the liabilities arising under the policy that SHIP can reasonably be expected to meet based on future premiums and Allocated Assets. For a policy that is not an Impaired Policy, the IFRPV will be equal to the full amount of those liabilities.
- 53) **“Initial Plan Effective Date”** is the Effective Date for all policyholders other than those to whom the Supplemental Plan Effective Date applies. It will not be the same specific day for all policyholders. For each policyholder, the Initial Plan Effective Date will be the policy’s *Monthiversary Date* occurring during the *Initial Plan Effective Month*. See definitions, pages 95 and 97. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26.
- 54) **“Initial Plan Effective Month”** means the calendar month immediately following the Plan Preparation Period. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26.
- 55) **“Instrumental Activities of Daily Living”** or **“IADL”** means such activities as meal preparation, shopping and travel, light housekeeping, laundry, telephoning, money handling, taking medications, and bill paying.
- 56) **“Insurance Regulatory Authority”** means with respect to any state or the District of Columbia, the jurisdiction’s applicable insurance department or equivalent regulatory agency or authority.
- 57) **“Lifetime Waiver of Premium”** or **“LWP”** means a provision in a LTC insurance policy under which the premium payments are permanently suspended upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years).
- 58) **“Limited Benefit Period”** means any Maximum Benefit Period that is subject to a stated limit by the terms of the policy. It refers to a policy that is not a lifetime or unlimited benefit

SHIP REHABILITATION PLAN

policy.

- 59) **“Liquidation Benefits”** means the benefits a policyholder would reasonably be expected to receive if SHIP were liquidated under the provisions of Article V, taking into account the Company’s history, the orders of the Court, the risks and uncertainties of the liquidation process, and the effect of Guaranty Association coverage.
- 60) **“Long-term Care”** or **“LTC”** insurance means defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care.
- 61) **“LTCI”** means long-term care insurance.
- 62) **“Maximum Benefit Amount”** means the dollar maximum in benefits available under a LTC policy.
- 63) **“Maximum Benefit Period”** or **“MBP”** means the maximum time (typically stated as number of days, either lapsed time or days of provided service) during which benefits will be available under a LTC policy. Benefits are usually defined in the contract to be a maximum amount payable per day or per month, for a maximum number of years. However, in some policies if the claimant uses less than the maximum amount permissible in a given period, the unused excess typically serves to lengthen the Maximum Benefit Period under what is known as the “pool of money” clause. Benefits commence after satisfaction of an Elimination Period (EP) and continue until the recovery or death of the claimant or until the pool of money has been exhausted. In these cases the Maximum Benefit Period is sometimes expressed as a dollar amount, the Maximum Benefit Amount. Under other policies (sometimes called “days of care” policies) reducing the daily benefit amount utilized does not extend the benefit period. For these policies the Maximum Benefit Period is expressed as the number of days, months or years during which coverage remains available under the policies. In either case, modifications by the policyholder under the Plan may have the effect of reducing the Maximum Benefit Period.
- 64) **“Maximum Daily Benefit”** or **“MDB”** also called Daily Benefit Amount (DBA), means a maximum daily dollar amount available on a covered day of care as specified in the policy.
- 65) **“Maximum Guaranty Association Benefits”** means the maximum amount of benefits to which a particular policyholder would be entitled from the applicable Guaranty Association (typically determined by state of residence at the time of liquidation) if the Company were to be liquidated.
- 66) **“Maximum Policy Value”** or **“MPV”** means the product of a policy’s Maximum Benefit Period times its Maximum Daily Benefit.

SHIP REHABILITATION PLAN

- 67) **“Monthiversary Date”** means the day of the month upon which premium is due under a particular policy or would be due except for a Premium Waiver provision.
- 68) **“NAIC”** means the National Association of Insurance Commissioners.
- 69) **“Net Accumulated Premium”** means the total gross premiums paid under a policy from inception until the valuation date, less the Expected Losses for that policy.
- 70) **“Net Premium”** means the part of the Gross Premium that is intended to cover the cost of future claims, as opposed to future operating expenses and profit margin. The Net Premium is typically set at issue.
- 71) **“Non-core Policy Benefits”** means certain benefits provided by some SHIP LTC policies other than nursing home, facility, home health (which often includes hospice) or adult day care. They are enumerated in section II.G, page 21.
- 72) **“Non-forfeiture Option”** or **“NFO”** traditionally means an option to exchange an existing LTC policy for a reduced paid up contract on which no future premiums need be paid by the policyholder but under which benefits are limited to premiums previously paid less benefits previously received. NFO benefits are enhanced substantially under the Plan.
- 73) **“Non-Self-Sustaining Policy”** means a LTC policy the Projected Benefit Amount (PBA) of which exceeds its Projected Credit Amount (PCA). It is a policy for which Current Premium rates are inadequate given assets available to be allocated to it and its projected liability for benefits and expenses.
- 74) **“Non-Tax-Qualified”** or **“NTQ”** benefit triggers means LTC insurance policy provisions under which the conditions that must be satisfied to be eligible for benefits do not conform to the legal standards for Tax Qualified policies. Such provisions were formerly called “traditional” Long-term Care Insurance. They often include a benefit “trigger” called a “medical necessity” trigger under which the insurer is obligated to pay if the policyholder’s own doctor, or that doctor in conjunction with someone from the insurance company, determines that the policyholder needs covered care for any medical reason. The United States Department of the Treasury has not fully clarified the tax status of premiums paid for and benefits received under a NTQ Long-term Care Insurance policy as precisely as the status of benefits received under a tax qualified policy. Therefore, the federal taxation of benefits under a NTQ policy is not certain. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**
- 75) **“Partnership-Qualified”** (PQ), means LTC policies that are intended to satisfy the requirements under the Deficit Reduction Act of 2006 entitling the policyholder to a dollar

SHIP REHABILITATION PLAN

of asset disregard or spend-down credit with respect to Medicaid eligibility for every dollar of benefit received under the LTC policy.

- 76) **“On claim”** refers to a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided by the Company.
- 77) **“Paid-Up Policy”** means an in-force policy that is paid in full and no longer requires premium payments under its terms.
- 78) **“Phase One Differential Premium”** means the Phase One Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Phase One Premium. Under the terms of the Plan, the Phase One Differential Premium cannot be less than zero.
- 79) **“Phase One Premium”** means the premium calculated for a specified policy (or group of policies) on the If Knew basis, but not less than the Current Premium.
- 80) **“Phase Two Policyholder Election Package”** means the Policyholder Election Package sent to certain policyholders to inform them of options available in Phase Two of the Plan and to enable them to elect from among those options.
- 81) **“PID”** means the Pennsylvania Insurance Department.
- 82) **“Plan”** means this Rehabilitation Plan.
- 83) **“Plan Document”** means this document describing the Plan.
- 84) **“Plan Limits”** means the minimum and maximum modifications permitted by the Plan for Option One in Phase One a policy’s Maximum Benefit Period (MBP) and Maximum Daily Benefit (MDB). A policy’s MBP cannot be reduced by the Plan below the lower of (a) the current MBP or (b) four years, and cannot be increased by the Plan above the greater of (a) the current MBP or (b) six years. A policy’s MDB cannot be reduced by the Plan below the lower of (a) the current MDB or (b) \$300, and cannot be increased by the Plan above the greater of (a) the current MDB or (b) \$600. As a practical matter, the minimum MPV under the Plan is \$438,000 except for policies the current MPV of which is below that or the applicable GA limits for which are above that. The maximum MPV is \$1,314,000 except for policies the current MPV of which, or the applicable GA limits for which, are above that.
- 85) **“Plan Operation Fund”** means an allocation of the Company’s assets reserved for funding policyholder liabilities as part of the rehabilitation in an amount determined by the Rehabilitator in consultation with her advisors.

SHIP REHABILITATION PLAN

- 86) **“Plan Option”** means any of the options available to policyholders under the Plan, which are described on page 12.
- 87) **“Plan Premium”** means the premium that a policyholder must pay under the terms of the Plan. Depending on the policyholder’s circumstances, it could be the Phase One Premium, If Knew Premium, Self-Sustaining Premium, Phase One Differential Premium, If Knew Differential Premium, or Self-sustaining Differential Premium.
- 88) **“Plan Preparation Period”** means the time between the Final Approval Date and the Effective Date of the Plan, during which preparatory steps necessary to implement the Plan will be completed. It includes the period during which policyholders will make elections under the Plan.
- 89) **“Policies Not On claim”** or **“Policyholders Not On claim”**, also called Active Policies or Policyholders, means policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company’s records as having been approved for benefit payments or in the process of being approved for benefit payments as of the Determination Date.
- 90) **“Policy Modifications”** means Premium Rate Increases or Benefit reductions selected by a policyholder, or made applicable, in accordance with the terms of the Plan.
- 91) **“Policyholder Election”** means the election by a policyholder to modify the premiums or benefits of a policy under the Plan.
- 92) **“Policyholder Election Date”** means the date by which the Rehabilitator must receive properly completed Policyholder Election Forms in order to give them effect.
- 93) **“Policyholder Election Form”** means the form on which a policyholder specifies whether, and if so how, he or she elects to modify his or her LTC policy in accordance with the terms of of the Plan.
- 94) **“Policyholder Election Package”** means the materials, including the Policyholder Election Form, to be sent to policyholders by the Rehabilitator so that they may make the elections available under the Plan.
- 95) **“Policyholders”** means holders of insurance policies and certificate holders under group insurance policies.
- 96) **“Policyholder Transition Period”** means the period between the Policyholder Election Date and the Initial Plan Effective Date during which policyholders may experience changes

SHIP REHABILITATION PLAN

in circumstances (such as going on claim) as the result of which they may have to make new elections under the Plan.

- 97) **“Possible Active Benefit Reductions”** means the list of possible benefit reductions applicable to premium paying active policyholders who select a Downgrade option as described fully beginning on page 32.
- 98) **“Possible On Claim Benefit Reductions”** means the list of possible benefit reductions applicable to policyholders on claim who select a Downgrade option as described fully beginning on page 41.
- 99) **“Premium Waiver”** means a policy provision that allows a policyholder to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.
- 100) **“Projected Benefit Amount” or “PBA”** means the present value as of the valuation date of unpaid expected benefits and unpaid expected policy expenses. For purposes of this determination “expected” consists of best estimate assumptions including a provision for moderately adverse deviation.
- 101) **“Projected Credit Amount” or “PCA”** means, for a LTC insurance policy, the sum of (a) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (b) the assets allocated to that policy using the Accumulated Premium Method. For purposes of this determination “expected” consists of best estimate assumptions including a provision for moderately adverse deviation.
- 102) **“Reduced Paid-up Policy” or “RPU”** means a policy offering reduced long-term care benefits but for which no more premium has to be paid and which will not lapse before the death of the policyholder. The Non-forfeiture Option offered under the Plan is a RPU.
- 103) **“Rehabilitation Plan”** means this Plan for the rehabilitation of SHIP’s Long-term Care insurance business.
- 104) **“Rehabilitator”** means Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, and her successors in office, in the capacity of Statutory Rehabilitator of the Company. Pursuant to her statutory authority to do so, the Rehabilitator has delegated broad responsibility to the Special Deputy Rehabilitator and in the Plan documents references to the Rehabilitator should be interpreted as including the SDR unless specified otherwise.
- 105) **“Restoration of Benefits”** means a LTC insurance policy feature under which the benefit period for a policyholder who has received benefits will be restored to the original Maximum

SHIP REHABILITATION PLAN

Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).

- 106) **“Restructured Policy”** means a policy that has been restructured as described in Section VI.H, page 77, to reduce the liabilities arising under the policy to its IFRPV.
- 107) **“Return of Premium”** means a LTC insurance policy feature which provides for the return of a percentage of premium paid by the policyholder (such as 80%) if the policyholder does not make a claim (or has a limited expected amount of benefits paid) during a given period of time in which the policy was in force (such as ten years).
- 108) **“Self-sustaining”** means a policy for which its Projected Credit Amount (PCA) equals or exceeds its Projected Benefit Amount (PBA). It is a policy for which Current Premium rates are adequate given assets available to be allocated to it and its projected liability for benefits and claims expenses.
- 109) **“Self-sustaining Differential Premium”** means the Self-sustaining Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Self-sustaining Premium. Under the terms of the Plan, differential premiums cannot be less than zero.
- 110) **“Self-sustaining Premium”** means the premium calculated by determining the amount of premium required to eliminate a policy’s Shortfall Amount.
- 111) **“Senior Health Care Oversight Trust”** means the Pennsylvania business trust governed by an independent Board of Trustees comprised of former insurance regulators and an independent actuary, who also served as members of the board of directors of SHIP, created in 2008 to be the sole owner of SHIP.
- 112) **“SHIP”** means the Senior Health Insurance Company of Pennsylvania, the subject of this Rehabilitation Plan.
- 113) **“Shortfall Amount”** for a LTC policy means the difference between its Projected Benefit Amount and its Projected Credit Amount where the difference is more than zero. The Shortfall Amount can also be expressed as a policy’s GPR less its Allocated Assets. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.
- 114) **“Shortfall Percentage”** means for an LTC policy a fraction (expressed as a percentage) the numerator of which is the policy’s Shortfall Amount and the denominator of which is the policy’s Projected Benefit Amount. For a Self-sustaining Policy the Shortfall Percentage will be zero or less.

SHIP REHABILITATION PLAN

- 115) **“Special Deputy Rehabilitator”** or **“SDR”** means Patrick H. Cantilo or his successors, appointed by the Rehabilitator to serve as the Special Deputy Rehabilitator for SHIP.
- 116) **“Standard Rate Increases”** means those premium rate increases sought or obtained by the Company for groups of policies in the ordinary course of its business and unrelated to the Plan.
- 117) **“Statutory Reserve”** means the insurance reserve required by Pennsylvania insurance laws to be included in an insurer’s financial statement on account of its insurance business in force.
- 118) **“Supplemental Plan Effective Date”** is the Effective Date for policyholders who undergo certain changes in status during the Policyholder Transition Period as described in Section II.K.3.c, page 26. It will occur on the policy’s Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.
- 119) **“Tax Qualified”** or **“TQ”** benefit triggers means the conditions that must be satisfied to be eligible for benefits under a LTC insurance policy that is designed to conform to certain standards in federal law and may offer certain federal tax advantages. TQ policies were created as a result of HIPAA, which included provisions for favorable tax treatment of qualified Long Term Care Insurance contracts. To comply with those standards, TQ policies are required to cover services for a chronically ill individual, and do not have a “medical necessity” benefit trigger. A TQ benefit trigger requires that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. Premiums paid for a TQ policy may be deductible from taxable income, and benefits from a TQ policy may not be subject to federal income tax. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**
- 120) **“Total Allocable Assets”** means the Company’s invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority.
- 121) **“TQ Triggers”** means the requirements that must be met under a Tax Qualified LTC policy in order to receive benefits.
- 122) **“Trust”** means the Senior Health Care Oversight Trust, as defined above.
- 123) **“Uncovered Benefits”** means the portion of the LTC policy benefits to which policyholders are contractually entitled on the Effective Date that exceed Guaranty Association statutory

SHIP REHABILITATION PLAN

limits or otherwise are not covered by Guaranty Associations as determined by the responsible Guaranty Association in accordance with applicable law.

- 124) **“Waiver of Premium”** see Claim Waiver of Premium, Dual Waiver of Premium, and Lifetime Waiver of Premium.

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Senior Health Insurance : No. 1 SHP 2020
Company of Pennsylvania in :
Rehabilitation :

CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that a Notice of Filing of the foregoing Application is being served on all parties listed on the Master Service List, if any, by electronic mail or facsimile, or by First Class Mail where no electronic mail address or facsimile number was available, and that an electronic copy of the foregoing Application has been posted on SHIP's website at <https://www.shipltc.com/court-documents>.

/s/ Michael J. Broadbent
Michael J. Broadbent

Dated: April 22, 2020

Middle District of Louisiana

Signature of Clerk or Deputy Clerk

Civil Action No. 20-00604

PROOF OF SERVICE*(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))*

This summons for *(name of individual and title, if any)* _____
 was received by me on *(date)* _____ .

☐ I personally served the summons on the individual at *(place)* _____
 _____ on *(date)* _____ ; or

☐ I left the summons at the individual's residence or usual place of abode with *(name)* _____
 _____ , a person of suitable age and discretion who resides there,
 on *(date)* _____ , and mailed a copy to the individual's last known address; or

☐ I served the summons on *(name of individual)* _____ , who is
 designated by law to accept service of process on behalf of *(name of organization)* _____
 _____ on *(date)* _____ ; or

☐ I returned the summons unexecuted because _____ ; or

☐ Other *(specify)*: _____

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

Server's signature

Printed name and title

Server's address

Additional information regarding attempted service, etc:

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS

James J. Donelon in His Official Capacity as Commissioner of Insurance
for the State of Louisiana

(b) County of Residence of First Listed Plaintiff East Baton Rouge Parish
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)
See attachment

DEFENDANTS

Jessika K. Altman, Insurance Commissioner for the Commonwealth of
Pennsylvania, in Her Capacity as Statutory Rehabilitator of Senior
Health Insurance Company of Pennsylvania

County of Residence of First Listed Defendant Dauphin County, PA
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF
THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff
☒ 3 Federal Question (U.S. Government Not a Party)
☐ 2 U.S. Government Defendant
☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

- | | PTF | DEF | | PTF | DEF |
|---|---------------------------------------|---------------------------------------|---|----------------------------|----------------------------|
| Citizen of This State | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 1 | Incorporated or Principal Place of Business In This State | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| Citizen of Another State | <input type="checkbox"/> 2 | <input checked="" type="checkbox"/> 2 | Incorporated and Principal Place of Business In Another State | <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
| Citizen or Subject of a Foreign Country | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 | Foreign Nation | <input type="checkbox"/> 6 | <input type="checkbox"/> 6 |

IV. NATURE OF SUIT (Place an "X" in One Box Only)

Click here for: [Nature of Suit Code Descriptions.](#)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
<input type="checkbox"/> 110 Insurance <input type="checkbox"/> 120 Marine <input type="checkbox"/> 130 Miller Act <input type="checkbox"/> 140 Negotiable Instrument <input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment <input type="checkbox"/> 151 Medicare Act <input type="checkbox"/> 152 Recovery of Defaulted Student Loans (Excludes Veterans) <input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits <input type="checkbox"/> 160 Stockholders' Suits <input type="checkbox"/> 190 Other Contract <input type="checkbox"/> 195 Contract Product Liability <input type="checkbox"/> 196 Franchise	PERSONAL INJURY <input type="checkbox"/> 310 Airplane <input type="checkbox"/> 315 Airplane Product Liability <input type="checkbox"/> 320 Assault, Libel & Slander <input type="checkbox"/> 330 Federal Employers' Liability <input type="checkbox"/> 340 Marine <input type="checkbox"/> 345 Marine Product Liability <input type="checkbox"/> 350 Motor Vehicle <input type="checkbox"/> 355 Motor Vehicle Product Liability <input type="checkbox"/> 360 Other Personal Injury <input type="checkbox"/> 362 Personal Injury - Medical Malpractice PERSONAL INJURY <input type="checkbox"/> 365 Personal Injury - Product Liability <input type="checkbox"/> 367 Health Care/Pharmaceutical Personal Injury Product Liability <input type="checkbox"/> 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY <input type="checkbox"/> 370 Other Fraud <input type="checkbox"/> 371 Truth in Lending <input type="checkbox"/> 380 Other Personal Property Damage <input type="checkbox"/> 385 Property Damage Product Liability	<input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881 <input type="checkbox"/> 690 Other LABOR <input type="checkbox"/> 710 Fair Labor Standards Act <input type="checkbox"/> 720 Labor/Management Relations <input type="checkbox"/> 740 Railway Labor Act <input type="checkbox"/> 751 Family and Medical Leave Act <input type="checkbox"/> 790 Other Labor Litigation <input type="checkbox"/> 791 Employee Retirement Income Security Act IMMIGRATION <input type="checkbox"/> 462 Naturalization Application <input type="checkbox"/> 465 Other Immigration Actions	<input type="checkbox"/> 422 Appeal 28 USC 158 <input type="checkbox"/> 423 Withdrawal 28 USC 157 PROPERTY RIGHTS <input type="checkbox"/> 820 Copyrights <input type="checkbox"/> 830 Patent <input type="checkbox"/> 835 Patent - Abbreviated New Drug Application <input type="checkbox"/> 840 Trademark SOCIAL SECURITY <input type="checkbox"/> 861 HIA (1395ff) <input type="checkbox"/> 862 Black Lung (923) <input type="checkbox"/> 863 DIWC/DIWW (405(g)) <input type="checkbox"/> 864 SSID Title XVI <input type="checkbox"/> 865 RSI (405(g)) FEDERAL TAX SUITS <input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant) <input type="checkbox"/> 871 IRS—Third Party 26 USC 7609	<input type="checkbox"/> 375 False Claims Act <input type="checkbox"/> 376 Qui Tam (31 USC 3729(a)) <input type="checkbox"/> 400 State Reapportionment <input type="checkbox"/> 410 Antitrust <input type="checkbox"/> 430 Banks and Banking <input type="checkbox"/> 450 Commerce <input type="checkbox"/> 460 Deportation <input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations <input type="checkbox"/> 480 Consumer Credit (15 USC 1681 or 1692) <input type="checkbox"/> 485 Telephone Consumer Protection Act <input type="checkbox"/> 490 Cable/Sat TV <input type="checkbox"/> 850 Securities/Commodities/Exchange <input checked="" type="checkbox"/> 890 Other Statutory Actions <input type="checkbox"/> 891 Agricultural Acts <input type="checkbox"/> 893 Environmental Matters <input type="checkbox"/> 895 Freedom of Information Act <input type="checkbox"/> 896 Arbitration <input type="checkbox"/> 899 Administrative Procedure Act/Review or Appeal of Agency Decision <input type="checkbox"/> 950 Constitutionality of State Statutes
REAL PROPERTY <input type="checkbox"/> 210 Land Condemnation <input type="checkbox"/> 220 Foreclosure <input type="checkbox"/> 230 Rent Lease & Ejectment <input type="checkbox"/> 240 Torts to Land <input type="checkbox"/> 245 Tort Product Liability <input type="checkbox"/> 290 All Other Real Property	CIVIL RIGHTS <input type="checkbox"/> 440 Other Civil Rights <input type="checkbox"/> 441 Voting <input type="checkbox"/> 442 Employment <input type="checkbox"/> 443 Housing/Accommodations <input type="checkbox"/> 445 Amer. w/Disabilities - Employment <input type="checkbox"/> 446 Amer. w/Disabilities - Other <input type="checkbox"/> 448 Education PRISONER PETITIONS Habeas Corpus: <input type="checkbox"/> 463 Alien Detainee <input type="checkbox"/> 510 Motions to Vacate Sentence <input type="checkbox"/> 530 General <input type="checkbox"/> 535 Death Penalty Other: <input type="checkbox"/> 540 Mandamus & Other <input type="checkbox"/> 550 Civil Rights <input type="checkbox"/> 555 Prison Condition <input type="checkbox"/> 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN (Place an "X" in One Box Only)

- ☒ 1 Original Proceeding
☐ 2 Removed from State Court
☐ 3 Remanded from Appellate Court
☐ 4 Reinstated or Reopened
☐ 5 Transferred from Another District (specify)
☐ 6 Multidistrict Litigation - Transfer
☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
US Constitution Article IV, 15 USC 1101; 15 USC 6701.

Brief description of cause:
Declaratory judgment and permanent injunction

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION DEMAND \$
UNDER RULE 23, F.R.Cv.P.

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions):

JUDGE

DOCKET NUMBER

DATE

SIGNATURE OF ATTORNEY OF RECORD

David S. Rubin

FOR OFFICE USE ONLY

RECEIPT #

AMOUNT

APPLYING IFP

JUDGE

MAG. JUDGE

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA**

JAMES J. DONELON **CIVIL ACTION:**
IN HIS OFFICIAL CAPACITY AS COMMISSIONER
OF INSURANCE FOR THE STATE OF LOUISIANA

VERSUS

JESSICA K. ALTMAN, INSURANCE COMMISSIONER OF THE
COMMONWEALTH OF PENNSYLVANIA, IN HER CAPACITY AS
STATUTORY REHABILITATOR OF SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

**ATTACHMENT TO CIVIL COVER SHEET
ATTORNEYS FOR PARTIES**

ATTORNEYS FOR PLAINTIFF

James J. Donelon, in his official capacity as Commissioner of Insurance for the State of Louisiana

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Louisiana Department of Justice
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