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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

REHABILITATOR'S PRE-HEARING MEMORANDUM

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Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as the Statutory Rehabilitator ("Rehabilitator") of Senior Health Insurance Company of Pennsylvania ("SHIP"), hereby submits this Pre-Hearing Memorandum in anticipation of the hearing scheduled to begin on May 17, 2021 ("Plan Hearing"), for the Court's consideration and approval of a Plan of Rehabilitation ("Rehabilitation Plan") for SHIP.

I. INTRODUCTION

SHIP faces a substantial—but not insurmountable—funding deficit. The proposed plan is designed to eliminate or significantly reduce that deficit in the hopes of rehabilitating SHIP for the benefit of its policyholders and other interested parties. The primary aim of the plan is to increase revenues and reduce liabilities through a combination of policy modifications for most of the approximately 45,000 policies in force at the time the plan was filed. Importantly, by proceeding in three phases, the plan is designed to flexibly meet the needs of SHIP as such modifications are made effective and the future of SHIP's financial condition becomes clearer.

Faced with SHIP's insolvency, policyholders have two competing considerations: their anticipated need for long-term care benefits and their ability to pay the cost of maintaining coverage for those benefits. The proposed plan offers various options to address those two concerns while simultaneously seeking to correct SHIP's financial condition. It is policyholders, however, and not the

Rehabilitator or other state regulators, who are in the best position to balance those competing considerations in each policyholder's individual case. Thus, the Rehabilitator has proposed that the policy modification mechanism maximize policyholder choice by relying on each individual's circumstances and chosen preferences—an invaluable benefit to policyholders which would not be available if SHIP were liquidated immediately and the state guaranty associations assumed responsibility for coverage. The plan includes, as it must, certain default provisions in the event a policyholder fails to make an election or an issuing state decides that it will limit the choices available to its governed policyholders, but the plan offers policyholders the opportunity to determine *for themselves* how to apportion their share of the unavoidable losses that SHIP faces and will face in the event its financial condition is not corrected. Importantly, by setting rates and benefits at the policyholder level, the proposed plan eliminates many of the inequities created by the widely-varying premium rates across the country, which cause certain policyholders to pay more in premiums and thus subsidize the premiums paid by others for the same or substantially similar coverage.

The options and phases in the plan are set forth in the previously-filed plan documents and will be addressed in detail at the Plan Hearing. This Memorandum supplements those prior filings by summarizing the Rehabilitator's position on

important legal and factual questions and describing the witnesses and exhibits the Rehabilitator expects to present at the Plan Hearing.

II. BACKGROUND

SHIP is a domestic life and health insurance company organized pursuant to the laws of the Commonwealth of Pennsylvania and wholly owned by the Oversight Trust.[1] It was established to run off a closed block of long-term care insurance previously indirectly owned and administered by Conseco, Inc. SHIP has not written any new business since at least July 2003. At present, SHIP has approximately 41,000 policyholders, $1.4 billion in assets, and $2.6 billion in liabilities.

SHIP has been in a declining financial condition for many years, beginning no later than the period of 2009 to 2011, when the value of its capital and surplus declined by nearly $80 million. By the time SHIP filed its 2018 Annual Statement, SHIP reported a deficit exceeding $466 million on assets of approximately $2.2 billion and liabilities of approximately $2.6 billion. (Application for Rehabilitation at ¶ 11.) In addition SHIP filed its mandatory Risk-Based Capital Report for 2018, disclosing that SHIP's capital deficit was far below the capital required (approximately $36 million) to avoid falling into a "mandatory control level." (*Id.*

[1] SHIP's principal place of business is in Carmel, Indiana. For a description of the Oversight Trust, see page 84 of the Amended Plan.

at ¶ 13.) Based on these circumstances, the Board of Trustees of the Oversight Trust voted to give consent to the rehabilitation of SHIP. (*Id.* at ¶ 15.)

On January 22, 2020, Commissioner Jessica Altman filed an Application asking this Court to place SHIP in rehabilitation on the grounds of (a) insolvency pursuant to 40 P.S. § 221.14(1) and § 221.3, because SHIP's liabilities exceeded its capital and surplus; (b) the occurrence of a mandatory control level event pursuant to 40 P.S. § 221.1A, because SHIP's total adjusted capital was less than its mandatory control level of risk-based capital; and (c) consent by the Board of Trustees of the Oversight Trust. As the Rehabilitator explained at the time, "SHIP's financial condition is dire." (Application for Order of Rehabilitation at ¶ 33.)

On January 29, 2020, this Court entered an Order ("Rehabilitation Order") placing SHIP in rehabilitation and appointing the Rehabilitator, 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. §§ 221.21-221.63 (Rehabilitation Order at ¶¶ 1-2.) In the Rehabilitation Order, the Court directed the Rehabilitator 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 the Court. (*Id.* at ¶ 3.) The Court also directed the Rehabilitator to "prepare a plan of rehabilitation," with a preliminary plan to be filed on or before April 22, 2020, together with "a timeline for the preparation of a final plan of rehabilitation." (*Id.* at ¶¶ 4, 16.)

The Rehabilitator has since filed two proposed rehabilitation plans. On April 22, 2020, the Rehabilitator filed a complete proposed Plan of Rehabilitation (the "April 22 Plan"), together with applications for approval of the Plan and a Form and Distribution of Notice. On October 21, 2020, after receiving and considering various comments on the April 22 Plan, the Rehabilitator filed an Amended Rehabilitation Plan ("Amended Plan").

Among other matters, the Amended Plan included:

- projections of the Amended Plan's likely effectiveness under different scenarios, beginning at page 17;
- a detailed description of the methodology employed in the Plan's design, at pages 18 through 36;
- a detailed description of a change in the treatment of reinsurance assumed which is responsive to a concern expressed by certain regulators in other states, beginning at page 91;
- a description of alternatives considered in arriving at the Plan, beginning at page 98;
- a new mechanism to address concerns expressed by certain regulators about premium rates being set under the Plan and not by them, beginning at page 102;
- new material to address concerns about premiums suspended for policyholders on waiver, beginning at page 102; and
- robust financial information about SHIP, appearing in Appendix B of the Amended Plan.

Moreover, since the filing of the Amended Plan, the Rehabilitator has made available to the parties additional facts, analyses, and proposals by way of a data site ("SHIP

Data Site"). Much of that information is expected to be presented at the Plan Hearing through testimony or exhibits.

III. THE PROPOSED PLAN

The Rehabilitator has filed two complete plans of rehabilitation: the April 22 Plan, and the Amended Plan. Pursuant to the schedule set forth in the Court's February 25, 2021 Scheduling Order, the Rehabilitator will file an updated proposed plan on or before May 3, 2021. This plan will include, *inter alia*, a revised issue-state rate proposal allowing state regulators who object to the plan to opt-out and set rates for policyholders within their governance. (A copy of the current issue-state rate approval option is attached hereto as proposed Exhibit 15.)

IV. FACTUAL AND LEGAL ISSUES TO BE ADDRESSED AT THE PLAN HEARING

In support of her request for approval, the Rehabilitator intends to present facts consistent with the April 22 Plan, the Amended Plan, and the information made available on the SHIP Data Site. In addition, based on the legal standards applicable in rehabilitation and on the comments and objections of certain intervening parties, the Rehabilitator anticipates addressing the following issues at the Hearing, either in her affirmative case or to rebut the allegations and arguments of intervening parties.

A. The Proposed Plan Satisfies All Constitutional Requirements

In *Neblett v. Carpenter*, the Supreme Court of the United States held that from a constitutional perspective, in rehabilitation, an insurer's policyholders are entitled

to no less favorable treatment "as that which would result from the sale of the assets and pro-rata distribution in solution of all resulting claims for the breach of outstanding policies." *Neblett v. Carpenter*, 305 U.S. 297, 305 (1938). This standard has been widely interpreted in the ensuing decades as requiring that a rehabilitation plan offer policyholders no less than what they would have received in liquidation. This is so because if the insurer's policyholders are receiving the same or better treatment than what they would have received in liquidation, they are unable establish any injury or resulting harm from a rehabilitation plan as a matter of law. *Id.*; *see also Consedine v. Penn Treaty Network Am. Ins. Co.*, 63 A.3d 368, 452-53 (Pa. Commw. Ct. 2012), as amended (2013) ("*Penn Treaty*"). Accordingly, the Amended Plan will avoid constitutional scrutiny entirely so long as SHIP's policyholders <u>*as a group*</u> fare at least as well under the Plan as they would have in liquidation. *Penn Treaty*, 63 A.3d 368, 452-53 (Pa. Commw. Ct. 2012), *as amended* (2013); *Carpenter v. Pacific Mut. Life Ins. Co.*, 74 P.2d 761, 777-79 (Cal. 1937), *aff'd sub nom. Neblett*, 305 U.S. 297 (1938); *see also Commercial Nat'l Bank v. Superior Court*, 17 Cal. Rptr. 2d 884, 890 (Cal. Ct. App. 1993), *as modified on denial of reh'g* (Apr. 16, 1993); *In re Ambac Assurance Corp.*, 841 N.W.2d 482, 503-04 (Wis. Ct. App. 2013); *Catania v. Commonwealth, State Emps.' Ret. Bd.*, 455 A.2d 1250, 1256 (Pa. Commw. Ct. 1983) (quoting *Catania v. Commonwealth, State Emps.' Ret. Bd.*, 450 A.2d 1342, 1353 (Pa. 1982) (Nix, J., concurring)) (recognizing

that the action complained of must be to the detriment of the petitioner in order to violate the constitution); *Blumenthal v. Di Giorgio Fruit Corp.*, 85 P.2d 580, 584 (Cal. Ct. App. 1938) (same); *United States v. Norris*, 486 F.3d 1045, 1048 (8th Cir. 2007) (same); *Tineybey v. Peters*, No. 99 C 2861, 2000 WL 705983, at *3 (N.D. Ill. May 18, 2000) (same).

The courts have not, however, adopted a formulaic or mathematical test for the satisfaction of this standard. The Rehabilitator believes that in the case of a company like SHIP with its unique insurance coverages, a simple arithmetic computation cannot suffice to determine whether policyholders fare better or worse under particular circumstances. By way of illustration, little value is provided to a policyholder by giving her a six-year benefit period at substantial cost when, due to her heath condition, she reasonably does not expect to live more than one or two more years. Ultimately, the determination of whether SHIP's Rehabilitation Plan treats policyholders at least as well as would liquidation within the meaning of *Neblett v. Carpenter* is one to be made by the Court evaluating whether the Rehabilitator has abused her discretion as informed by the totality of the Plan provisions and applicable circumstances.

The hallmark of the Amended Plan is that it affords policyholders meaningful choices not available in liquidation. This feature alone has material value for policyholders, albeit a value that cannot be quantified readily. Among these choices,

for example, is the ability to retain up to 30 months of coverage for no additional premium. This can be a very valuable option for the exemplar policyholder described herein, and no such alternative would be available in liquidation, making the rehabilitation plan a much better outcome than liquidation even if the plan offered in liquidation might have more valuable benefits.

Even disregarding these important aspects of the Plan and focusing only on an arithmetic comparison of projected benefits, the majority of SHIP's policyholders are unable to establish any injury or resulting harm from the Amended Plan. Indeed, approximately 85% of SHIP's policyholders are offered at least one option under the Amended Plan no less favorable than what they would have in liquidation, and perhaps materially better. Importantly, a substantial number of policyholders' policies and policy rates will be unaffected by the Amended Plan. In any event, these policyholders will have at least one option under the Amended Plan where they will receive at least as much in benefits as would be provided by their respective guaranty associations.

The rationale of *Neblett v. Carpenter* extends to all of an insurer's creditors, not just its policyholders. The Amended Plan subordinates the claims of certain general creditors of SHIP to those of the company's policyholders; those general creditors fare at least as well under the Plan as they would in liquidation because SHIP has insufficient assets to pay the claims of the company's policyholders in full. In

liquidation, the claims of SHIP's general creditors would not be entitled to any payment until the claims of the company's policyholders were paid in full. *See* 40 P.S. § 221.44 (liquidation priority scheme providing that after administrative expenses, policyholder claims must be paid in full before the claims of other creditors are considered). By subordinating general creditor claims to policyholder claims in rehabilitation, SHIP's general creditors will receive the same treatment that they would have received in liquidation under the Amended Plan. Of course, to the extent that the Plan reduces or eliminates the deficit and increases the probability that these creditors will receive some payment, the Plan is materially better for them than liquidation. Therefore, like policyholders, SHIP's general creditors are unable to establish any injury or resulting harm from the Amended Plan which could prevent this Court from approving it. *See id.*; *Koken v. Fid. Mut. Life Ins. Co.*, 803 A.2d 807, 811, 827 (Pa. Commw. Ct. 2002) (approving a rehabilitation plan that tracked 40 P.S. § 221.44 in its implementation of distribution priorities); *see also* Wis. Stat. § 645.68 (1967) intro. cmt. (explaining liquidation priorities are "structured to . . . apportion loss equitably.").[2]

[2] The Wisconsin insolvency statutes and their related comments are persuasive authority on these issues. *See Koken v. Reliance Ins. Co.*, 893 A.2d 70, 84–85 (Pa. 2006) (providing that Wisconsin's comments to its insurance insolvency statutes, "in essence, the blueprint for the Pennsylvania statute[s]", are persuasive and citing such a comment in support of its holding).

1. There is No Constitutional Requirement that All Policyholders Must Fare as Well in Rehabilitation as They Would in Liquidation

The Rehabilitator expects certain intervenors to argue that a rehabilitation plan is *per se* impermissible under *Neblett v. Carpenter* if all policyholders do not fare at least as well under the plan as they would have in liquidation. This is not the law. As set forth herein, the jurisprudence contouring the constitutional boundaries of Pennsylvania's exercise of its police power is much less stringent, and, in effect, all that is required is a rational basis that explains why certain policyholders do not fare as well in rehabilitation as in liquidation. There is simply no reason to deviate from this jurisprudence in reviewing the Plan, nor is there a reason to apply a more exacting rule to Pennsylvania's exercise of its police power through a rehabilitation plan. This Court has declined the invitation to do so in the past, and should decline the invitation to do so here. *Penn Treaty*, 63 A.3d at 452–53. The Rehabilitator will respond in her rebuttal and supplemental filings—and at the Plan Hearing—to any contrary arguments by the parties

2. The Constitutional Constraints on the Plan are Met Here

Because a simple arithmetic comparison might be used to argue that certain of SHIP's policyholders do not fare at least as well under the Amended Plan as they would have in liquidation (albeit only 15% of them), the Rehabilitator anticipates

the further argument that the Plan cannot avoid constitutional scrutiny entirely and is circumscribed by three constitutional constraints:

- The Plan must not unconstitutionally impair the company's contractual obligations to these policyholders. U.S. CONST. ART. I, §10, cl. 1; PA. CONST. ART. I, § 17.

- The Plan must not unconstitutionally deprive these policyholders of their contract rights. U.S. CONST. AMENDS. V, XIV, § 1; PA. CONST. ART. I, § 1; *see also Harris v. Mississippi Valley State Univ.*, 873 So. 2d 970, 985 (Miss. 2004) (holding that "[a] contract right constitutes an enforceable property interest."); *Carpenter*, 74 P.2d at 776 ("The . . . due process clause[] prohibited the company from making any changes [to its policies]. But th[is] prohibition[] do[es] not apply to the state acting under its police powers [in a rehabilitation plan].") (internal citation omitted).

- The Plan must not unconstitutionally discriminate between the company's policyholders to the detriment of these policyholders. U.S. CONST. AMEND. XIV, § 1; PA. CONST. ART. I, §§ 1, 26.

The Plan satisfies each one of these considerations, as explained herein and as will be addressed at the Plan Hearing as necessary.

a. Any Contractual Impairment is a Necessary, Reasonable and Permissible Use of Pennsylvania's Police Power

Pennsylvania law clearly allows the Rehabilitator and this Court to restructure SHIP's policies through an approved plan of rehabilitation. In *Foster v. Mut. Fire, Marine & Inland Ins. Co.*, the Supreme Court of Pennsylvania adopted a three-part test for determining whether the legislature may exercise its police power through a rehabilitation plan to impair an insurer's contractual obligations in order to effect a successful rehabilitation. 614 A.2d 1086 (Pa. 1992), *cert denied.* Specifically,

> [t]he threshold inquiry is to determine whether the state statute in reality has operated to substantially impair a contractual relationship. Should it be determined that a substantial impairment has occurred, the state must set forth a legitimate and significant public purpose. Once that purpose is identified, the final inquiry concerns whether the adjustment of contractual rights is reasonable and of a nature appropriate to the public purpose justifying the legislation's adoption; however, if the state is not a contracting party, deference is given to the state's enunciated purpose.

Id. at 1094 n.4 (addressing both the federal constitution and Pennsylvania's constitution and citing to *Energy Reserves Grp., Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 410 (1983) on constitutional accommodation of a state's police power).

Assuming *arguendo* that the rehabilitation plan effects a substantial impairment of the contractual rights of policyholders who do not fare as well arithmetically in rehabilitation as in liquidation, the Rehabilitator's decision is supported by two "legitimate and significant public purpose[s]."

First, the Supreme Court of Pennsylvania in *Foster* recognized that the state's interest in effecting a successful rehabilitation—specifically, "regulat[ing] the fiscal affairs of its insurers for the welfare of the public"—was a legitimate and significant public purpose. *Id.* at 1094 n.4; *Koken v. Legion Ins. Co.*, 831 A.2d 1196, 1241 (Pa. Commw. Ct. 2003) ("*Legion*") (recognizing that "Article V authorizes reformation and novation [through a rehabilitation plan] where appropriate to avoid prejudice to policyholders."); *Grode v. Mut. Fire, Marine & Inland Ins. Co.*, 572 A.2d 798, 804-

05 (Pa. Commw. Ct. 1990), *aff'd in part, remanded in part sub nom. Foster*, 614 A.2d 1086; *see also Carpenter*, 74 P.2d at 774, 776 ("The state has an important and vital interest in the liquidation or reorganization of [insurers] . . . . The contract . . . clause[] prohibited the company from making any changes [to its policies]. But th[is] prohibition[] do[es] not apply to the state acting under its police powers [in a rehabilitation plan].") (internal citation omitted); *In re Ambac Assurance Corp.*, 841 N.W.2d at 509; *Mendel v. Garner*, 678 S.W.2d 759, 761 (Ark. 1984) ("The rehabilitation of insurance companies pursuant to state insolvency statutes does not impair the obligation of contracts."); *Caminetti v. Pac. Mut. Life Ins. Co.*, 139 P.2d 908, 917 (Cal. 1943) ("I[t] is settled that contract . . . rights must yield to legislation in the interest of the general welfare . . . . That the power of the commissioner with respect to statutory proceedings against insolvent or delinquent insurers is of general public concern is not open to question.").

Second, this Court and others have held that ensuring equitable apportionment of unavoidable loss in rehabilitation is a legitimate and significant public purpose. *See Penn Treaty*, 63 A.3d at 460–61 (reviewing the policyholder population in order to determine whether the impaired insurer's assets were equitably administered therein; determining that they were not, reasoning that underpriced policies were unfairly subsidized by properly priced policies; reviewing whether a rehabilitation plan could remedy the identified deficiency; and finding that it could,

thus ordering the rehabilitator to file a rehabilitation plan that reformed and repriced policies in a manner designed to eliminate policyholder subsidies); *Foster*, 614 A.2d at 1098–1100, 1105 (affirming the approval of a rehabilitation plan that did not track priorities of payment that would have otherwise been required in liquidation (40 P.S. § 221.44), holding that despite the fact that it adversely affected some individual interests, the plan legitimately sought to equitably apportion unavoidable loss); *In re Ambac Assurance Corp.*, 841 N.W.2d at 502–04, 508 (recognizing that individual policyholders interests may need to be compromised in rehabilitation, and that "the purpose of rehabilitation proceedings is . . . to apportion unavoidable losses in a manner that is fair and equitable to policyholders, creditors, and the public in general").

In restructuring SHIP's policies, the Amended Plan constitutionally employs the police power to impair the company's contractual obligations in service of these twin purposes. Simply put, restructuring SHIP's policies as described in the plan is necessary to effecting a successful rehabilitation and to equitably apportioning unavoidable loss. Deference must be given to this determination by the Rehabilitator. *See Foster*, 614 A.2d at 1091-92 ("[I]t is not the function of the [C]ourt[] to reassess the determinations of fact and public policy made by the Rehabilitator. Rather, the involvement of the judicial process is limited to the safeguarding of the [P]lan from any potential abuse of the Rehabilitator's

discretion"). Accordingly, restructuring SHIP's policies is reasonable and of an appropriate nature, and the Plan survives scrutiny on this issue. Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

b. The Plan Respects and Does Not Violate Any Substantive Due Process Rights of Policyholders

Similarly, the Amended Plan may deprive some of SHIP's policyholders of their contract rights without violating due process principles. In *Balent v. City of Wilkes-Barre*, the Supreme Court of Pennsylvania recognized that the Pennsylvania legislature may exercise its police power to deprive individuals of their property without compensation. *Balent*, 669 A.2d 309, 314–15 (Pa. 1995) (addressing the federal constitution); *see also Commonwealth v. Handley*, 213 A.3d 1030, 1038 (Pa. Super. Ct. 2019) (addressing Pennsylvania's constitution on same issue). In *Balent*, the Supreme Court explained it reviews such an exercise for a "recognized police purpose," effectively mirroring the rehabilitation impairment analysis. *Balent*, 669 A.2d at 315. To satisfy due process concerns, if a recognized police purpose is implicated by the state action, the exercise "must not be unreasonable, unduly oppressive or patently beyond the necessities of the case, and the means which it employs must have a real and substantial relation to the objects sought to be attained." *Handley*, 213 A.3d at 1038; *see also Balent*, 669 A.2d at 315 (applying a less strict version of this test).

As noted, the Pennsylvania legislature may exercise its police power through a rehabilitation plan to deprive an insurer's policyholders of their contract rights in order to effect a successful rehabilitation. *See Foster*, 614 A.2d at 1094 n.4 (effecting a successful rehabilitation is a recognized police purpose). As this Court explained in *Penn Treaty*, effecting a successful rehabilitation of an LTC insurer and equitably apportioning unavoidable loss may require depriving the insurer's policyholders of their contract rights and, implicitly, then, at the very least, that doing so may not be unreasonable, unduly oppressive, or patently beyond the necessities of the case, and there may be a real and substantial relation between the two. *Penn Treaty*, *63* A.3d at 451–52, 459–61; *see also Carpenter*, 74 P.2d at 776 ("The . . . due process clause[] prohibited the company from making any changes [to its policies]. But th[is] prohibition[] do[es] not apply to the state acting under its police powers [in a rehabilitation plan]") (internal citation omitted); *In re Ambac Assurance Corp.*, 841 N.W.2d at 528–29; *Caminetti*, 139 P.2d at 917 ("I[t] is settled that . . . property rights must yield to legislation in the interest of the general welfare.").

In restructuring SHIP's policies, the Amended Plan constitutionally employs the police power to deprive the company's policyholders of their contract rights. Deference must be given to the Rehabilitator's conclusion—consistent with this Court's findings in *Penn Treaty*—that restructuring SHIP's policies is necessary to effect a successful rehabilitation and to equitably apportion unavoidable loss. *Foster*,

614 A.2d at 1091–93. Accordingly, restructuring SHIP's policies is not unreasonable, unduly oppressive, or patently beyond the necessities of the case, and there is a real and substantial relation between the two. Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

c. The Plan Satisfies Equal Protection Concerns and Does Not Impermissibly Discriminate Amongst Policyholders

Under Pennsylvania law, the Amended Plan may discriminate between SHIP's policyholders. Indeed, Pennsylvania courts have recognized that the Pennsylvania legislature may exercise its police power to discriminate between groups of individuals. *Moyer v. Phillips*, 341 A.2d 441, 443 (Pa. 1975); *see also Commonwealth v. Bonadio*, 415 A.2d 47, 51 (Pa. 1980) (affirming that *Moyer v. Phillips* analyzed the scope of Pennsylvania's police power). As with other constitutional concerns, courts review such an exercise for a recognized police purpose. *See Bonadio*, 415 A.2d at 49. If a recognized police purpose is implicated, the exercise "must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation so that all persons similarly circumstanced shall be treated alike." *See Moyer*, 341 A.2d at 443 (recognizing this test under bother the federal constitution and Pennsylvania's constitution).

As explained herein, effecting a successful rehabilitation is a recognized police purpose *Foster*, 614 A.2d at 1094 n.4. Accordingly, the Pennsylvania legislature may exercise its police power through a rehabilitation plan that discriminates among the insurer's policyholders in order to effect a successful rehabilitation. Indeed, this Court recognized in *Penn Treaty* that effecting a successful rehabilitation of an LTC insurer and equitably apportioning unavoidable loss may require impairing certain of the insurer's contractual obligations, but not others, and depriving certain of the insurer's policyholders, but not others, of their contract rights and, implicitly, then, at the very least, that doing so may be reasonable, not arbitrary, and may rest upon some ground of difference having a fair and substantial relation to effecting a successful rehabilitation so that all persons similarly circumstanced shall be treated alike. *Penn Treaty*, *63* A.3d at 451–52, 459–61; *see also Carpenter*, 74 P.2d at 774–75, 778–81 (holding that discrimination between groups of policyholders is proper where justified); *In re Ambac Assurance Corp.*, 841 N.W.2d at 518 n.16; *Ballesteros v. New Jersey Prop. Liab. Ins. Guar. Ass'n*, 530 F. Supp. 1367, 1372 (D.N.J. 1982), *aff'd sub nom. Appeal of Ballesteros*, 696 F.2d 980 (3d Cir. 1982) ("Here, the New York court, acting in the interests of the policyholders and the public, determined that in order to successfully rehabilitate the company, it was necessary to cancel the policies held by non-resident insureds. The court's action had a rational basis. The court was attempting to restrict the business of the company and ease the costs of

administration by requiring that the company do its business locally. Because the New York court's order was a rational attempt to reduce the potential liabilities of the company and to reduce administrative expenses, this court finds that the equal protection rights of the insured were not violated.").

Notably, in restructuring SHIP's policies, the Amended Plan does not discriminate among the company's policyholders paying insufficient premiums. Quite the opposite; the Amended Plan utilizes consistent pricing metrics to develop various options for restructuring SHIP's policies. (*See* Amended Plan at page 22.) The Amended Plan indiscriminately presents those options to SHIP's policyholders for their election depending on their individual circumstances. (*See* Amended Plan at page 19.) In opt-out states—*i.e.*, states whose chief insurance regulators elect to make rate increase decisions for polices issued in those states rather than leave them to the Rehabilitator and this Court—policyholders will be presented with somewhat different choices. In that case, however, it is decisions by the insurance regulators in the opt-out states, not the Amended Plan itself, that will determine the choices available to these policyholders. In any event, the different treatment of these policyholders is reasonable, not arbitrary, and rests upon factors that have a fair and substantial relation to the object of the legislation so that all persons similarly circumstanced shall be treated alike. (*See* Amended Plan at page 102 and Exhibit A.)

Certain intervenors may argue that the Amended Plan discriminates between policyholders that are currently on claim and policyholders that may go on claim at some later date, preferring the former, but the Plan does not do so. The underlying complaint appears to stem from the belief that SHIP's ultimate liquidation is a foregone conclusion. It is not. Even if it were, however, disparate treatment of policyholders that may go on claim at some later date would not result from the Amended Plan; it would result from the *termination* of the Plan and its replacement by and application of statutes governing liquidation and guaranty associations.

Ultimately, public policy dictates rehabilitating an insurer if at all possible. *See Penn Treaty*, 63 A.3d at 440 (recognizing liquidation as a remedy of last resort); *Legion*, 831 A.2d at 1230 (same); *Grode*, 572 A.2d at 803 (recognizing rehabilitation is preferable to liquidation); *Foster*, 614 A.2d at 1094 (affirming *Grode* court's observation); *Carpenter*, 74 P.2d at 775 ("The public has a grave and important interest in preserving the business [of the insolvent insurer] if that is possible. Liquidation is the last resort."); *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d 453, 459 (Cal Ct. App. 1995) ("[W]hile the Commissioner . . . has the power either to rehabilitate the insolvent insurer or to liquidate it, liquidation is a last resort.") (citations omitted); *Kueckelhan v. Fed. Old Line Ins. Co.*, 418 P.2d 443, 453 (Wash. 1996) ("[I]t should be remembered that the process of insurer rehabilitation is preferred to that of liquidation . . . ."); *State ex rel. Pope v. Xantus Healthplan of*

Tenn., Inc., No. M2000–00120–COA–R1O–CV, 2000 WL 630858, at *11 (Tenn. Ct. App. May 17, 2000) ("Rehabilitation is preferred over liquidation because of the public interest in insurance."). Nor is the Rehabilitator required to establish that there is a 100% chance that rehabilitation will be successful or that policyholders that are currently on claim and policyholders that may go on claim at some later date will be treated equally. As is the case with the Rehabilitator's other findings, deference must be given to this determination by the Rehabilitator on this issue and related questions of discrimination. *Foster*, 614 A.2d at 1091–93. Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

B. The Plan is Feasible and Should Be Approved

Although not required by Pennsylvania law, the Rehabilitator believes and will establish at the Plan Hearing that, upon consideration of all available information, the Amended Plan will be feasible. Pennsylvania law does not in fact reference, let alone require, a showing of feasibility as a prerequisite to obtaining a court's approval of a rehabilitation plan. To the contrary, meaningful references to feasibility concern modification of a previously-approved rehabilitation plan after the rehabilitator, in consultation with the rehabilitation court, determined that modification was necessary. *See id.*; *Grode*, 572 A.2d at 801–03; *Grode v. Mut. Fire, Marine & Inland Ins. Co.*, 688 A.2d 233, 234 (Pa. Commw. Ct. 1996) ("*Grode*

II"). Moreover, feasibility is not a one-time decision made upon the filing of a rehabilitation plan—or even at the time of a plan hearing—as certain intervenors have suggested. Instead, Pennsylvania law clearly shows that feasibility is an ongoing question to be addressed by the rehabilitator, in consultation with this Court, as rehabilitation progresses. *See Foster*, 614 A.2d at 1090 (describing multiple feasibility reports). Accordingly, the Rehabilitator has addressed and will continue to address feasibility questions before, during, and after the Plan Hearing, including during the eventual implementation of the plan if approved.

1. Feasibility Means Properly Conserving and Equitably Administering the Assets of the Involved Insurer

As a rule, "[s]o long as [a] rehabilitation [plan] properly conserves and equitably administers 'the assets of the involved [insurer] in the interest of investors, the public and others, (with) the main purpose being the public good' the plan . . . is appropriate. *See Foster*, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d § 22.10). Accordingly, although feasibility is not defined in any Pennsylvania statute, it can be fairly interpreted to mean properly conserving and equitably administering the assets of the involved insurer, as the Rehabilitator has proposed to do.

Importantly, in the context of rehabilitation, the feasibility of a rehabilitation plan does not hinge on returning the involved insurer to financial viability, as argued by some of the interested parties. Indeed, a feasible rehabilitation plan is not even required to contemplate the resuscitation of the involved insurer's operations. *See*

Foster, 614 A.2d at 1093 (declining to take issue with a rehabilitation plan that did not contemplate a resuscitation of the involved insurer's operations). This is particularly true in the context of an insurer which, like SHIP, is in runoff mode and is not selling any new business. Because the Amended Plan will properly conserve and equitably administer SHIP's assets as set forth herein, it is feasible such that it should be approved.

2. Though not Required, the Plan May Also Successfully Return SHIP to Financial Viability

Although the feasibility of the rehabilitation plan does not hinge on returning SHIP to financial viability, the Rehabilitator has prepared some hypothetical results that could be expected from operation of the Amended Plan. (*See* Amended Plan at page 17.) For purposes of these projections, it is assumed that SHIP's Funding Gap will be $1.2 billion on the date the approved plan goes into effect. It should be emphasized that these hypothetical projections depend on future events that may evolve in a manner different from the assumptions in the projections.[3] Subject to these caveats, it is the belief of the Rehabilitator that if the Amended Plan is implemented as proposed, there are scenarios (dependent on policyholder elections) under which Phase One of the Plan could result in eliminating most or all of the

[3] The numerous hypotheticals and the need to make projections is not a weakness of the plan; rather, it demonstrates that there are too many unpredictable variables that could affect the implementation of any plan, offering another reason why a feasibility analysis cannot hinge on the likelihood of success.

Funding Gap. *Id.* Moreover, Phase Two of the Amended Plan is self-calibrating to eliminate the most or all of any remaining deficit. (*See* Amended Plan at page 11.) As the Plan's projections suggest, the probability of the Amended Plan's success increases materially the more policyholders elect more affordable policies and thus give up their benefit-rich policies which may be more than they want or need.

In short, despite the contrary assertions of certain intervenors, the Plan meets clearly the minimal feasibility required suggested by applicable law and has a material chance of going much further and reducing substantially or fully eliminating the deficit. As noted, public policy dictates attempting to rehabilitate an insurer if at all possible. *See Penn Treaty*, 63 A.3d at 440, *aff'd but criticized sub nom. In re Penn Treaty Network Am. Ins. Co.*, 119 A.3d 313 (Pa. 2015) (recognizing liquidation as a remedy of last resort); *Legion*, 831 A.2d at 1230 (same); *Grode*, 572 A.2d at 803 (recognizing rehabilitation is preferable to liquidation); *Foster*, 614 A.2d at 1094 (affirming *Grode* court's observation); *Carpenter*, 74 P.2d at 775 ("The public has a grave and important interest in preserving the business [of the insolvent insurer] if that is possible. Liquidation is the last resort."); *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d at 459 ("[W]hile the Commissioner . . . has the power either to rehabilitate the insolvent insurer or to liquidate it, liquidation is a last resort.") (citations omitted); *Kueckelhan*, 418 P.2d at 453 ("[I]t should be remembered that the process of insurer rehabilitation is preferred to that of liquidation . . . ."); *State*

ex rel. Pope, 2000 WL 630858, at *11 ("Rehabilitation is preferred over liquidation because of the public interest in insurance.").

C. The Effect of the Collateral Regulatory Litigation

To the extent it is relevant, if the Amended Plan is approved by this Court, collateral challenges to the Plan from other states will be unsuccessful. In regard to whether the Amended Plan would be binding on other states, in *Baker by Thomas v. Gen. Motors Corp.*, the late Justice Ginsburg observed:

> Our precedent differentiates the credit owed to laws (legislative measures and common law) and to judgments. "In numerous cases this Court has held that credit must be given to the judgment of another state although the forum would not be required to entertain the suit on which the judgment was founded." *Milwaukee County [v. M.E. White]*, 296 U.S. [268,] 277, 56 S.Ct. [229], 234 [(1935)]. The Full Faith and Credit Clause does not 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." *Pacific Employers Ins. Co. v. Industrial Accident Comm'n*, 306 U.S. 493, 501, 59 S.Ct. 629, 632, 83 L.Ed. 940 (1939); *see Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 818–819, 105 S.Ct. 2965, 2977–2978, 86 L.Ed.2d 628 (1985). Regarding judgments, however, the full faith and credit obligation is exacting. A final judgment in one State, if rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, qualifies for recognition throughout the land. For claim and issue preclusion (*res judicata*) purposes, in other words, the judgment of the rendering State gains nationwide force. *See, e.g., Matsushita Elec. Industrial Co. v. Epstein*, 516 U.S. 367, 373, 116 S.Ct. 873, 878, 134 L.Ed.2d 6 (1996); *Kremer v. Chemical Constr. Corp.*, 456 U.S. 461, 485, 102 S.Ct. 1883, 1899, 72 L.Ed.2d 262 (1982); *see also* Reese & Johnson, The Scope of Full Faith and Credit to Judgments, 49 COLUM. L. REV. 153 (1949).

> A court may be guided by the forum State's "public policy" in determining the law applicable to a controversy. *See Nevada v. Hall*, 440 U.S. 410, 421–424, 99 S.Ct. 1182, 1188–1190, 59 L.Ed.2d 416 (1979). But our decisions support no roving "public policy exception" to the full faith and credit due judgments. *See Estin [v. Estin]*, 334 U.S. [541,] 546, 68 S.Ct. [1213,] 1217 (Full Faith and Credit Clause "ordered submission . . . even to hostile policies reflected in the judgment of another State, because the practical operation of the federal system, which the Constitution designed, demanded it."); *Fauntleroy v. Lum*, 210 U.S. 230, 237, 28 S.Ct. 641, 643, 52 L.Ed. 1039 (1908) (judgment of Missouri court entitled to full faith and credit in Mississippi even if Missouri judgment rested on a misapprehension of Mississippi law). In assuming the existence of a ubiquitous "public policy exception" permitting one State to resist recognition of another State's judgment, the District Court in the Bakers' wrongful-death action, *see supra*, at 662, misread our precedent. "The full faith and credit clause is one of the provisions incorporated into the Constitution by its framers for the purpose of transforming an aggregation of independent, sovereign States into a nation." *Sherrer v. Sherrer*, 334 U.S. 343, 355, 68 S.Ct. 1087, 1092–1093, 92 L.Ed. 1429 (1948). We are "aware of [no] considerations of local policy or law which could rightly be deemed to impair the force and effect which the full faith and credit clause and the Act of Congress require to be given to [a money] judgment outside the state of its rendition." *Magnolia Petroleum Co. v. Hunt*, 320 U.S. 430, 438, 64 S.Ct. 208, 213, 88 L.Ed. 149 (1943).

Baker, 522 U.S. 222, 232–34 (1998) (footnote citations omitted).

Simply put, should this Court approve the Amended Plan, other states may not disregard the Plan; courts in those states will be constitutionally compelled to uphold and enforce it. *See United States v. Obaid*, 971 F.3d 1095, 1098–105 (9th Cir. 2020) (recognizing "minimum contacts" is not a required component of in rem jurisdiction); *United States v. Real Prop. Located in Los Angeles*, 4:20-CV-2524, 2020 WL 7212181, at *4 (S.D. Tex. Dec. 4, 2020) (same); *F.D.I.C. v. De Cresenzo*, 616 N.Y.S.2d 638, 639

(N.Y. App. Div. 1994) (recognizing a judgment stemming from application of in rem jurisdiction is entitled to full faith and credit); *Denny v. Searles*, 143 S.E. 484, 493 (Va. 1928) (same).

Regardless, no other court may interfere with this Court's exclusive control over matters concerning the distribution of SHIP's assets. *See Ballesteros*, 530 F. Supp. at 1371 (recognizing that in insurer delinquency proceedings, "other courts, except when called upon by the court of primary jurisdiction for assistance, are excluded from participation"). Should this fact be ignored and other states be able to obtain injunctions purporting to enjoin this Court's enforcement of the Amended Plan, as some states are currently attempting to do (*see Donelon v. Altman*, Case No. 3:20-cv-00604 (M.D. La.); *Farmer v. Altman*, Case No. 3:21-cv-00097 (D.S.C.). and No. 2020-CP-4005802 (S.C. C.C.P.)), those injunctions will be wholly ineffective, and this Court's ability to enforce the Plan will in no way be impacted. *See Barnes v. Buck*, 346 A.2d 778, 782 (Pa. 1975) ("[T]he full faith and credit clause does not require that we give recognition to a judgment rendered without jurisdiction . . . .").

Thus, although the threat of collateral litigation from other states has been raised as a challenge to the Amended Plan's feasibility (without citation to supportive legal precedent), the collateral litigation should be expected to have little to no impact. Once this Court approves the Amended Plan, the Plan will be binding in all forums. Injunctions from other courts purporting to enjoin this Court's enforcement of the

Amended Plan will be wholly ineffective. In any event, should this Court determine that the Amended Plan is lawful, feasibility of the Plan should not be held hostage by dissatisfied parties' threats to intentionally thwart its application and challenge this Court's authority. Public policy dictates serving the interests of policyholders. *See Grode*, 572 A.2d at 802 n.5, 804–05 (reviewing a rehabilitation plan for constitutionality and recognizing "the equitable purpose of rehabilitation and liquidation is to protect first of all consumers of insurance") (emphasis in original); *Legion*, 831 A.2d at 1242 (reviewing a rehabilitation plan for constitutionality and recognizing "[c]ase law teaches that it is the Court's task to ensure that the Rehabilitator's actions are consistent with equitable principles and serve the interests of policyholders."). The Rehabilitator cannot capitulate to the desires of disgruntled states to the detriment of policyholders and the efforts to rehabilitate the insurer. Instead, this Court should adhere to the Rehabilitator's articulation of public policy and decline the invitation to reach a different result. *See Foster*, 614 A.2d at 1091–92 ("[I]t is not the function of the [C]ourt[] to reassess the determinations of fact and public policy made by the Rehabilitator. Rather, the involvement of the judicial process is limited to the safeguarding of the [P]lan from any potential abuse of the Rehabilitator's discretion"). Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

D. This Court Can Approve the Rehabilitator's Proposed Policy Restructuring Mechanism

1. The Court Has Jurisdiction to Approve the Proposed Plan

In SHIP's rehabilitation proceeding, the Court has original and exclusive jurisdiction over matters concerning the distribution of the company's assets. Jurisdiction is addressed in 42 P.S. § 761(a)(3), which, in pertinent part, provides:

> The Commonwealth Court shall have original jurisdiction of all civil actions or proceedings: . . . Arising under Article V of the act of May 17, 1921 (P.L. 789, No. 285), known as "The Insurance Department Act of 1921."

Read in conjunction with 40 P.S. § 221.15(a) and (c), which recognize that an impaired insurer's assets shall be administered pursuant to further orders from the Court, it becomes clear that the Court has exclusive jurisdiction over matters concerning the distribution of an impaired insurer's assets. *See also* 42 P.S. § 761(b) (recognizing the Court's jurisdiction is generally exclusive except that the Commissioner as Rehabilitator may also initiate actions and proceedings in the several courts of common pleas); 40 P.S. § 221.15(d) (recognizing the Court determines whether to approve, disapprove, or modify a proposed rehabilitation plan); 40 P.S. § 221.1(c)(iv) ("The purpose of this article is the protection of the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through . . . equitable apportionment of any unavoidable loss"); *Foster*, 614 A.2d at 1094 (holding court approval of a rehabilitation plan is mandated "[s]o long as the

rehabilitation properly conserves and equitably administers the assets of the involved corporation in the interest of investors, the public and others, with the main purpose being the public good . . . .") (internal punctuation and citation omitted); *Penn Treaty*, 63 A.3d at 451 ("The Supreme Court held that the goal of rehabilitation is the equitable administration of 'the assets of the insurer in the interests of investors, the public, the main purpose being the public good.") (internal punctuation omitted).

The Court's exclusive control over matters concerning the distribution of SHIP's assets was acknowledged in *Ballesteros*, where the court observed "[a] rehabilitation proceeding is an *in rem* action in which the state court generally has exclusive control over the assets of the impaired insurance company." *See Ballestros*, 530 F. Supp. at 1370–71 (citing *Mathias v. Lennon*, 474 F.Supp. 949, 957 (S.D.N.Y.1979)); *see also Matter of Rehab. of Nat'l Heritage Life Ins. Co.*, 656 A.2d 252, 259 (Del. Ch. 1994) ("I concur that a rehabilitation is an in rem proceeding . . . ."); *In re Rehab. of Manhattan Re-Ins. Co.*, No. CIV.A. 2844-VCP, 2011 WL 4553582, at *4 (Del. Ch. Oct. 4, 2011) ("I find that . . . this Court does possess original and exclusive jurisdiction over the in rem proceedings of the rehabilitation."); *Garamendi v. Exec. Life Ins. Co.*, 21 Cal. Rptr. 2d 578, 583-90 (Cal Ct. App. 1993) (holding "A State Court Overseeing an Insurance Insolvency Proceeding Has In Rem Jurisdiction Over the Assets of Third Parties Which Have an 'Identity of Interest' With the Insolvent Insurer."); *All Star Advert. Agency, Inc.*

v. Reliance Ins. Co., 898 So. 2d 369, 382–83 (La. 2005) (holding because Pennsylvania is a reciprocal state under Louisiana's receivership statutes, Louisiana courts are deprived of subject matter jurisdiction over matters over which a Pennsylvania receivership court has asserted exclusive control); *Tennessee Student Assistance Corp. v. Hood*, 541 U.S. 440, 447, 453 (2004) (recognizing "[t]he discharge of a debt by a bankruptcy court is . . . an in rem proceeding", "[b]ankruptcy courts have exclusive jurisdiction over a debtor's property", and "bankruptcy [courts'] in rem jurisdiction allows it to adjudicate the debtor's discharge claim without in personam jurisdiction over [creditors]."). Put differently, "those who have claims against the [impaired insurer] can have those claimed corporate obligations affected in [a] domestic rehabilitation . . . whether or not they are subject to *in personam* jurisdiction in the state where the dissolution or rehabilitation is taking place." *Matter of Rehab. of Nat'l Heritage Life Ins. Co.*, 656 A.2d at 260.

The Court's exclusive control over matters concerning the distribution of SHIP's assets is built into the statutory scheme and common law because it is necessary to successfully rehabilitating SHIP. "The need for giving one state exclusive jurisdiction over delinquency proceedings has long been recognized in the courts." *Ballesteros*, 530 F. Supp. at 1371. Indeed:

> Experience has demonstrated that, in order to secure an economical, efficient, and orderly liquidation and distribution of

> the assets of an insolvent corporation for the benefit of all creditors and stockholders, it is essential that the title, custody, and control of the assets be entrusted to a single management under the supervision of one court. Hence other courts, except when called upon by the court of primary jurisdiction for assistance, are excluded from participation. This should be particularly true as to proceedings for the liquidation of insolvent insurance companies, for the reasons adverted to by Mr. Justice Cardozo in *Clark v. Williard*, 292 U.S. 112 (54 S.Ct. 615, 78 L.Ed. 1160). *Motlow v. Southern Holding & Securities Corp.*, 95 F.2d 721, 725-26 (8th Cir.), *cert. denied*, 305 U.S. 609 (59 S.Ct. 68, 83 L.Ed. 388) (1938).

Id.

Just as courts in other states may not interfere with the Court's jurisdiction, it follows that other states' laws may not curtail or otherwise qualify it. *See Ferrelli v. Commonwealth*, 783 A.2d 891, 894 (Pa. Commw. Ct. 2001) ("'[T]he Full Faith and Credit Clause does not require a state to subordinate public policy within its borders to the laws of another state . . . .'" (citation omitted)); *Neyman v. Buckley*, 153 A.3d 1010, 1018 (Pa. Super. Ct. 2016) ("[W]e recognize that the legal principle of comity should only be utilized when the application of another state's law contradicts no public policy of Pennsylvania."); *Succession of King*, 170 So. 2d 129, 131–32 (La. Ct. App. 1964), *writ refused*, 171 So. 2d 666 (La. 1965) ("[I]t is quite clear that the presence of the tangible subject property within the territorial jurisdiction of Louisiana gives the courts of this state jurisdiction In rem, sovereignty prevents the use of the full faith and credit clause of the Federal Constitution to compel any state to substitute the laws of another state for its own

laws in dealing with such a subject matter, and the state having jurisdiction In rem may make a binding distribution to legatees.") (string cite omitted).

The Court's exclusive control over matters concerning the distribution of SHIP's assets extends to the distribution of the company's assets through its policies. Some states statutorily recognize this fact; for example, Hawaii acknowledges that a guaranty association may modify benefits, but may only do so "subject to the approval of the domiciliary commissioner or the receivership court." Haw. Rev. Stat. Ann. § 431:16-208(b)(2)(E)(i); *see also* Colo. Rev. Stat. Ann. § 10-20-108(2)(c)(V)(A); Idaho Code Ann. § 41-4308(2)(B)(v)(1); N.M. Stat. Ann. § 59A-42-7(B)(2)(e); 27 R.I. Gen. Laws Ann. § 27-34.3-8(b)(2)(v)(A); Vt. Stat. Ann. tit. 8, § 4158(2)(B)(v)(I). Hawaii likewise acknowledges that a guaranty association may modify rates, but may only do so "subject to the approval of the domiciliary commissioner or the receivership court." *Id.*

These statutory acknowledgments implicitly recognize that modifying an impaired insurer's policies affects the amount of assets available to all policyholders and, therefore, falls within the purview of the Court's exclusive jurisdiction. *See Penn Treaty*, 63 A.3d at 451, 460 ("The Supreme Court held that the goal of rehabilitation is the equitable administration of the assets of the insurer in the interests of investors, the public, the main purpose being the public good. Further, the goals of rehabilitation necessitate the reality that individual interests may need

to be compromised in order to avoid greater harm to a broader spectrum of policyholders and the public . . . . Restructuring rates can remove the subsidies, unfair to all policyholders, that presently exist.") (internal punctuation and quotation omitted); *Foster*, 614 A.2d at 1094 n. 4, 1105 (affirming the approval of a rehabilitation plan restructuring the contractual rights of the insurer's creditors); *Legion*, 831 A.2d at 1241–42 (recognizing "Article V authorizes reformation and novation [of contracts through a rehabilitation plan]"); Memorandum Opinion and Order, *Koken v. Reliance Ins. Co.*, No. 269 M.D. 2001 (Pa. Commw. Ct. Aug. 17, 2004), available at http://www.reliancedocuments.com/pdfs/1035.pdf (approving decision by liquidator of insolvent insurer to reach settlement with reinsurers despite the fact that it terminated the reinsurers' direct access obligations to the insolvent insurer's policyholders, reasoning that it was empowered to do so because the reinsurers' direct access payments to specific policyholders instead of to the insurer reduced the amount of funds available to all policyholders, thereby implicating its jurisdiction).[4] Put differently, controlling distribution of an impaired

[4] The weight of authority confirms this view. *See, e.g.*, *In re Ambac Assurance Corp.*, 841 N.W.2d at 509 ("[I]t is axiomatic that the commissioner, in the reasonable exercise of the state's police power, may structure a rehabilitation plan that has the potential to adversely affect the interests of individual policyholders when the plan advances the broader interests of the policyholders, the creditors, and the public as a whole."); *Carpenter*, 74 P.2d at 776 ("The old company was powerless to change the existing non-can policies. The contract and due process clauses prohibited the company from making any changes therein. [Cal.] CONST. ART. 1, §§ 13, 16. But these prohibitions do not apply to the state acting under its police powers."); *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d at 479–80 ("[T]he police power of the state exercised by the Commissioner as conservator permits modification of insurance contracts issued by an insolvent insurer.");

insurer's assets by modifying and qualifying the insurer's obligations to policyholders falls within the purview of the Court's exclusive control. Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

2. The Rehabilitator's Broad Discretion and Authority in Devising a Rehabilitation Plan

Recognizing the Court's exclusive control over matters concerning the distribution of an impaired insurer's assets through 40 P.S. § 221.16, the legislature granted the Rehabilitator broad discretion and authority in devising a rehabilitation plan for the Court's consideration. In purposeful and broad strokes, the statute charges the Rehabilitator with "tak[ing] such action as [s]he deems necessary or expedient to correct[ing] the condition or conditions which constituted the ground

Kentucky Cent. Life Ins. Co. v. Stephens, 897 S.W.2d 583, 587 (Ky. 1995) ("The policyholders' contracts as well as others with interest in the company, are subject to a reasonable exercise of state police power [in receivership]."); *Underwriters Nat'l Assurance Co. v. N. Carolina Life & Accident & Health Ins. Guar. Ass'n*, 455 U.S. 691, 696-97, 699 (1982) (recognizing "[i]n order to preserve the financial health of the company and to provide continuing coverage for policyholders, the Rehabilitator proposed that the [Indiana] Rehabilitation Court reform the policies to require increased premiums and reduced benefits[, which the Rehabilitation Court ultimately did]."); *Brooks*, 480 F.3d at 581 (acknowledging that "policyholders . . . were given the option either to receive 55% of their policies' cash surrender value, or to have their policies restructured and transferred . . . at their full value" in a rehabilitation plan for a New Jersey insurer); *Ballesteros*, 530 F. Supp. at 1372 (acknowledging that all out-of-state policies were cancelled in a rehabilitation plan for a New York insurer); 44 C.J.S. § 267 ("The goals of rehabilitation necessitate the reality that individual [policyholder] interests may need to be compromised . . . ."); 44 C.J.S. § 270 ("A rehabilitation plan is permitted to impair the contractual rights of some policyholders in order to minimize the potential harm to all of the affected parties, and court approval of a rehabilitation plan is not precluded because policyholder benefits are modified."); 26-161 APPLEMAN ON INS. LAW & PRACTICE ARCHIVE § 161.4 (2nd 2011) ("The usual powers granted to a rehabilitator include . . . cancelling insurance policies").

or grounds . . . for the order of the [C]ourt to rehabilitate [SHIP]," expressly including "prepar[ation of] a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of [the company]." 40 P.S. § 221.16 (b), (d). The scope of the Rehabilitator's authority, and the ways in which that authority grants the Rehabilitator control over the rates and benefits of each plan, is addressed herein.

a. The Rehabilitator's Authority to Propose a Rehabilitation Plan under 40 P.S. § 221.16

Although the Rehabilitator was empowered to file a rehabilitation plan under 40 P.S. § 221.16, she was not required to do so. Prior to SHIP's placement in rehabilitation, however, the Commissioner identified the root causes of the company's statutory insolvency and concerns with the company's RBC level as including the underpricing of its policies. (*See* Amended Plan at page 82.) The Commissioner recognized a mere change in SHIP's management could not remedy this issue. (*See* Application for Order Placing SHIP in Rehabilitation at 10.) Many State regulators had historically resisted the company's efforts to obtain adequate rate increases. (*See* Proposed Exhibit 2, Premium Rate Increase History.) Accordingly, the Commissioner understood a rehabilitation plan reforming and repricing SHIP's policies would be necessary. (*See* Application for Order Placing SHIP in Rehabilitation at 10.) Therefore, in her Application, the Commissioner indicated her intent to file a rehabilitation plan once she was appointed SHIP's rehabilitator. (*Id.*)

b. The Court's Rehabilitation Order Directed the Rehabilitator to Propose a Rehabilitation Plan

Acknowledging the Commissioner's intent, as expressed in her Application, in its Order of Rehabilitation, the Court directed the Commissioner as Rehabilitator to "prepare a plan of rehabilitation" and, "[o]n or before April 22, 2020 . . . file a preliminary plan of rehabilitation with the Court, [to] include a timeline for the preparation of a final plan of rehabilitation." (*See* Order of Rehabilitation, p. 3, ¶7, p. 5, ¶ 16.) In compliance with the Court's Order of Rehabilitation, the Rehabilitator presented her original Plan, which provided a preliminary sequence of events, to the Court for its consideration and ultimate approval on April 22, 2020. Thereafter, following analysis of comments and objections from policyholders and other interested parties to the Original Plan, the Rehabilitator filed her Amended Plan with the Court on October 21, 2020.

c. The Authority Granted to the Rehabilitator under 40 P.S. § 221.16 and Related Authority

Discretion and authority granted to the Rehabilitator under 40 P.S. § 221.16 is necessarily broad, and "[i]t is well settled that [a legislature] may enact a statute in broad outlines, leaving to the executive officials the duty of arranging the details." *Application of People, by Van Schaick,* 268 N.Y.S. 88, 96 (App. Div. 1933), *aff'd sub nom. People, by Van Schaick, v. Nat'l Sur. Co.*, 191 N.E. 521 (N.Y. 1934) (citing *Field v. Clark*, 143 U. S. 649 (1892); *Buttfield v. Stranahan*, 192 U. S. 470 (1904);

Trustees of Village of Saratoga Springs v. Saratoga Gas, Electric Light & Power Co., 83 N. E. 693 (N.Y. 1908)). Accordingly, it is properly, and exclusively, within the Rehabilitator's (*i.e.*, the Commissioner's) domain to determine how the law should be reasonably interpreted and applied. *See Starr v. Dep't of Envtl. Res.*, 607 A.2d 321, 323 (Pa. Commw. Ct. 1992) ("[T]he construction given a statute by those charged with its execution and application is entitled to great weight and should not be disregarded unless it is clear that the agency's interpretation is incorrect.") (citing *T.R.A.S.H., Ltd. v. Department of Environmental Resources*, 574 A.2d 721 (Pa. Commw. 1990), *appeal denied*, 527 Pa. 659, 593 A.2d 429 (1990); *Slovak–American Citizens Club of Oakview v. Pennsylvania Liquor Control Board*, 549 A.2d 251 (Pa. Commw. Ct. 1988)); *In re Ambac Assur. Corp.*, 841 N.W.2d at 495 (holding a rehabilitator's interpretation of a governing statute will be affirmed if it is "reasonable, even if . . . another interpretation is more reasonable."); 44 C.J.S. § 268 ("The courts will defer to the insurance commissioner's interpretation and application of statutes governing rehabilitation.").

As such, the Rehabilitator as Commissioner is not constrained by other states' laws. *See Ferrelli*, 783 A.2d at 894 ("'[T]he Full Faith and Credit Clause does not require a state to subordinate public policy within its borders to the laws of another state . . . .'" (citation omitted)); *Neyman*, 153 A.3d at 1018 ("[W]e recognize that the legal principle of comity should only be utilized when the application of another

state's law contradicts no public policy of Pennsylvania."); *Foster*, 614 A.2d at 1091-1094 (recognizing "the significant interest on behalf of the state to regulate the fiscal affairs of its insurers for the welfare of the public" and that "it is not the function of the courts to reassess the determinations of . . . public policy made by the Rehabilitator").

i. *The Rehabilitator Wields the Police Power in Rehabilitation*

In the context of rehabilitating SHIP, the state is promoting its "significant interest . . . [in] regulat[ing] the fiscal affairs of its insurers for the welfare of the public." *Foster*, 614 A.2d at 1094 n.4. Thus, the Rehabilitator wields the state's police power in effecting that rehabilitation. *See id.* (implicitly recognizing a rehabilitation plan is an extension of the state's police power); *Grode*, 572 A.2d at 804 (recognizing that insurance insolvency statutes derive from the state's police power and implicitly recognizing a rehabilitation plan is an extension of the state's police power); *see also Carpenter*, 74 P.2d at 776 (recognizing that a rehabilitation plan is an extension of the state's police power); *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d at 479–80 (same); *Minor v. Stephens*, 898 S.W.2d 71, 82 (Ky. 1995) (same); *In re Ambac Assurance Corp.*, 841 N.W.2d at 509 (same). This "power is one of the most essential powers of government that allows it to promote the public health, morals or safety and the general well-being of the community." *Lester v. Dep't of Envtl. Prot.*, 153 A.3d 445, 463 (Pa. Commw. Ct. 2017). "The state's police powers

are . . . one of the state's least limitable powers." *Lester*, 153 A.3d at 463. Indeed, "for if in its exercise there is conflict with parts of the Constitution, the police power exercised to promote its major objects will prevail . . . ." *Appeal of White*, 134 A. 409, 411 (Pa. 1926); *see also Foster*, 614 A.2d at 1094 n.4.

ii. *The Rehabilitator has Broad Discretion and Broad Powers in the Rehabilitation of SHIP*

It is well settled that the "[R]ehabilitator may take such action *as [she] deems necessary or expedient* to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate [SHIP]." 40 P.S. § 221.16(b) (emphasis added). "This mandate explicitly defers all actions to the skill of the Rehabilitator and implicitly recognizes her expertise in these matters." *Foster*, 614 A.2d at 1091; *see also Legion*, 831 A.2d at 1231 ("The legislature conferred broad discretion upon [the] [R]ehabilitator to devise a plan that will correct [SHIP's] problems . . . ."); *Vickodil v. Com., Ins. Dep't*, 559 A.2d 1010, 1013 (Pa. Commw. Ct. 1989) ("Once ordered, the Insurance Commissioner is appointed rehabilitator by the Court and has broad discretion to structure a plan of rehabilitation.") (citation omitted); *Muir v. Transp. Mut. Ins. Co.*, 523 A.2d 1190, 1192 (Pa Commw. Ct. 1987) ("[T]he General Assembly has given broad discretion to the Commissioner, as Rehabilitator, to structure a plan of rehabilitation for an insurer."); 26-161 APPLEMAN ON INS. LAW & PRACTICE

ARCHIVE § 161.4 (2nd 2011) ("The scope of discretionary authority afforded to the rehabilitator is very broad . . . .").

Similarly, the Rehabilitator was granted broad powers when this Court appointed her to the position. "The [R]ehabilitator may take *such action* as [she] deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate [SHIP]." *See* 40 P.S. § 221.16(b) (emphasis added); *see also* Rehabilitation Order. This mandate grants the Rehabilitator "every conceivable right which it might be necessary [or expedient] for [her] to assert tending toward the removal of the causes and conditions which brought about the rehabilitation order . . . . [In other words, the Rehabilitator was] given powers, without any limitation whatever, to do all things necessary [or expedient] to rehabilitate [SHIP]." *Gallin v. Burdick*, 273 N.Y.S. 456, 459 (Sup. Ct. 1934), *aff'd* 271 N.Y.S. 1086 (App. Div. 1934), *aff'd* 193 N.E. 286 (N.Y. 1934); *see also Comm'r of Ins. v. Arcilio*, 561 N.W.2d 412, 418 n.5 (Mich. 1997) (recognizing the "rehabilitator's broad authority to take whatever action is deemed necessary or appropriate to reform and revitalize the insurer" under 40 P.S. § 221.16(b)); 26-161 APPLEMAN ON INS. LAW & PRACTICE ARCHIVE § 161.4 (2nd 2011) ("The rehabilitator's mission is to reform the insurer's business and to cure the specific problems that led to the need for rehabilitation, and the rehabilitator is authorized to take all actions necessary to

accomplish that mission."). These principles of broad discretion and authority are incorporated into all of SHIP's policies, policies that made their way through regulatory approval across the country. *See Clairton City Sch. Dist. v. Mary*, 541 A.2d 849, 851 (Pa. Commw. Ct. 1988) ("Insurance contracts are presumed to have been made with reference to substantive law, including applicable statutes in force, and such laws enter into and form a part of the contractual obligation as if actually incorporated into the contract." (citing *First Nat'l Bank of Pennsylvania v. Flanagan*, 528 A.2d 134 (Pa. 1987) and *Neel v. Williams*, 45 A.2d 375 (Pa. Super. Ct. 1946)); regulatory statutes appearing at, *e.g.*, La. Stat. Ann. § 22:861(A)(1); Md. Code Ann., Ins. § 12-203(a)(1), (b)(1); Wis. Stat. Ann. § 631.20(1)(a).

iii. *Rehabilitation is a Flexible Process that Emphasizes Management, Not Strict and Unwavering Compliance*

In rehabilitating SHIP, the Rehabilitator must remain flexible and focus on the management process, not the legal process. Accordingly, the Rehabilitator has broader discretion than she would as liquidator to effectuate the protection of insurers, creditors, and the public. *See Grode v. Mut. Fire, Marine and Inland Ins. Co.*, No. 91-1179, 1991 WL 245007, at *4-*5 (E.D. Pa. Nov. 15, 1991) (recognizing Commonwealth Court authority on the scope of rehabilitator's powers). Affirming this view, the comments to the Wisconsin receivership statutes that served as the

"blueprint" for Pennsylvania law explain that "[r]ehabilitation should emphasize the management process, not the legal process. Flexibility, informality and expertise should be encouraged, as they are . . . ." *See* Wis. Stat. § 645.01(4)(b) (1967) cmt. on subset. 4; *Koken v. Reliance Ins. Co.*, 893 A.2d 70, 84-85 (Pa. 2006) (Wisconsin statutes as "blueprint" for Pennsylvania law). Indeed, the Wisconsin statutes go further, declaring that

> rehabilitation is designed to be a very flexible procedure. It is essential that it be regarded as a management rather than as a legal task. Though it is called a formal proceeding because it begins with a formal petition to a court and a hearing, thereafter it should be essentially informal in operation. The order is formulated to emphasize flexibility and informality, and the rehabilitator is given broad powers.

Id. at § 645.32 (1967) intro. cmt. As the Supreme Court of Pennsylvania has recognized, such comments are useful in elucidating the intended application of Pennsylvania's own receivership statutes and serve that purpose here. *Reliance Ins. Co.*, 893 A.2d at 84–85.

3. The Amended Plan is within the Discretion and Authority Granted to the Rehabilitator

Against this backdrop, the Amended Plan is clearly within the discretion and authority granted to the Rehabilitator. In sum, through the police power, the Rehabilitator exercised her broad discretion and authority to reduce or remove the conditions leading up to SHIP's rehabilitation in a flexible manner that emphasized the management process, not the legal process.

a. The Amended Plan was Designed to Reduce or Remove the Conditions Leading to Rehabilitation

The Amended Plan was designed to reduce or remove the conditions leading up to SHIP's rehabilitation, the company's statutory insolvency and concerns with the company's RBC level. It addresses the root cause of these issues, the underpricing of SHIP's policies. Under the Amended Plan—and the proposed Issue-State Rate Approval process for opt-out states—policies will be reformed and repriced in a manner intended to reduce SHIP's liabilities through benefit modifications, and increase the company's revenues through rate increases, on a policy-by-policy basis.

b. The Rehabilitator May Use the Amended Plan to Restructure Policies

The Rehabilitator may use the Amended Plan to restructure SHIP's policies. "[T]he police power of the state exercised by the Commissioner as [Rehabilitator] permits modification of insurance contracts issued by an insolvent insurer." *Carpenter*, 74 P.2d at 776. "The policyholders' contracts as well as others with interest in the company, are subject to a[n] . . . exercise of state police power." *Kentucky Cent. Life Ins. Co.*, 897 S.W.2d at 587. To be clear, "Article V authorizes reformation . . . [of contracts through a rehabilitation plan] . . . ." *Legion*, 831 A.2d at 1241–42. "The goals of rehabilitation necessitate the reality that individual [policyholder] interests may need to be compromised . . . ." 44 C.J.S. § 267 "[C]ourt

approval of a rehabilitation plan is not precluded because policyholder benefits are modified." 44 C.J.S. § 270. Requiring strict adherence to contracts in rehabilitation would "run[] contrary to the stated purpose of the rehabilitation statutory scheme[,] . . . transforming a management process into a legal process." *In re Ambac Assur. Corp.*, 841 N.W.2d at 528.

For purposes of illustration, in *Underwriters Nat'l Assurance Co. v. N. Carolina Life & Accident & Health Ins. Guar. Ass'n*, the Supreme Court of the United States acknowledged that to further the goals of rehabilitation, "the [r]ehabilitator proposed that the [r]ehabilitation [c]ourt reform the [Indiana insurer's] policies to require increased premiums and reduced benefits[, which the rehabilitation court ultimately did]." *Underwriters Nat'l Assurance Co.*, 455 U.S. 691, 696–97 (1982). All of this despite the fact that, at the time, the impaired insurer operated in 45 states (*id.* at 694) most states required regulatory approval of policy forms and rates (*id.* Appendix 2 (health and life insurer rate and form laws on the books in 1976)), and the rehabilitator did not obtain regulatory approval to reduce benefits or increase rates. Likewise, in *Brooks v. AIG SunAmerica Life Assur. Co.*, the Court of Appeals for the First Circuit acknowledged that to further the goals of rehabilitation, "policyholders . . . were given the option either to receive 55% of their policies' cash surrender value, or to have their policies restructured and transferred . . . at their full value" in an approved rehabilitation plan for a New Jersey insurer. 480 F.3d 579,

581 (1st Cir. 2007). The court did not include commentary questioning this course of action. Indeed, on the outer end of the spectrum, in *Ballesteros*, the District Court for New Jersey overruled objections to and upheld an approved rehabilitation plan for a New York insurer that cancelled out-of-state policies in order to further the goals of rehabilitation. *Brooks*, 530 F. Supp. at 1372. The Court of Appeals for the Third Circuit affirmed. *Appeal of Ballesteros*, 696 F.2d at 980. If a rehabilitation plan may cancel an insurer's policies without policyholder input, surely it can also restructure an insurer's policies in order to allow policyholders an alternative to cancelling their policies outright. Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

c. The Restructuring Mechanism in the Plan is Consistent with Prior Cases

From a national perspective, the Amended Plan's restructuring of policies is not unique. In the seminal case *Carpenter v. Pacific Mut. Life Ins. Co.*, an insurer became financially impaired and was placed into receivership after charging insufficient premiums for some of its policies. 74 P.2d at 776. The rehabilitation plan provided for modification of the terms of those policies in order to effect a successful rehabilitation. *Id.* The California receivership court approved the plan. *Id.* at 771. The California appellate court affirmed the plan's approval. *Id.* at 780-81. The appellate court recognized all the way back in 1937 that the plan could

modify the terms of the insurer's polices, even though the insurer could not have modified their terms outside of rehabilitation. *Id.* at 776.

Indeed, in Pennsylvania itself the Amended Plan's restructuring of policies is not unique either. In *Penn Treaty*, another LTC insurer that became financially impaired was placed into rehabilitation after charging insufficient premiums for some of its policies. *Penn Treaty*, 63 A.3d at 375, 459. The Court held that those policies had to be dealt with in order to effect a successful rehabilitation. *Id.* at 461. The Court acknowledged that the insurer's policies could be modified in rehabilitation. *Id.* at 451–52, 455. The Court also acknowledged that "a series of rate increase scenarios . . . constitute one type of rehabilitation plan" and ordered the rehabilitator to file such a plan for its consideration. *Id.* at 449 n.55, 453 n.61, 461. The Court explained, in response to the rehabilitator's argument to the contrary, that "there is no support for the . . . position that [a rehabilitation court] cannot modify policyholder benefits as part of an approved rehabilitation plan", concluding that "[i]n a rehabilitation . . . policies can be reformed and repriced." *Id.* at 452–53, 455, 459.

d. Repricing Policies is an Authorized Form of Policy Restructuring

The Amended Plan's repricing of policies is simply another method of authorized policy restructure that has long been recognized as proper in rehabilitation proceedings in Pennsylvania. The Court's conclusion in *Penn Treaty* that "[i]n a rehabilitation . . . policies can be reformed and repriced" was not novel.

Rather, it flowed from recognition of prior Pennsylvania precedent. In both *Foster v. Mut. Fire, Marine & Inland Ins. Co.* and *Koken v. Legion Ins. Co.*, the Pennsylvania courts held that a rehabilitation plan may reform the terms of an insurer's contracts in order to effect a successful rehabilitation. *See Foster*, 614 A.2d at 1094 n. 4, 1105 (affirming the receivership court's approval of a rehabilitation plan restructuring the contractual rights of its creditors); *Legion*, 831 A.2d at 1241–42 (recognizing that "Article V authorizes reformation and novation [through a rehabilitation plan] where appropriate to avoid prejudice to policyholders."). In *Penn Treaty*, the Court merely recognized that these holdings extend to and include an insurer's policies. 63 A.3d at 452–53, 455, 459.

e. The Police Power is Used to Restructure Policies in Matters Other Than Insolvency, Confirming this Court's Authority to Approve the Plan

Outside of rehabilitation, the police power has been consistently recognized as a proper vehicle for restructuring policies across the nation. By way of example, in *American Manufacturers Mutual Insurance. Company v. Commissioner of Insurance*, the highest court in Massachusetts upheld a state statute directing insurance policies to be rewritten at reduced rates. 372 N.E.2d 520, 521, 529 (Ma. 1978). The court held that the statute reflected a permissible exercise of the state's police power. *Id.* at 526. Courts in other jurisdictions have rendered similar holdings in regards to their own statutes restructuring policies. *E.g.*, *Hinckley v. Bechtel Corp.*, 116 Cal. Rptr. 33, 39 (Cal. Ct. App. 1974) (holding that a California

statute could render provisions within previously issued insurance policies unenforceable); *Country-Wide Ins. Co. v. Harnett*, 426 F. Supp. 1030, 1035 (S.D.N.Y. 1977) (holding that a New York Statute could render provisions within previously issued insurance policies unenforceable). The import of these cases is clear: in relation to an exercise of a state's police power, an insurer's policies and policy rates are not inviolate. Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

E. The Rehabilitator Can Suspend Agent Commissions

SHIP policies were sold through independent agents working with their clients at the time of sale. Those agents are not currently providing services at the request of and in support of the Rehabilitator, and the Rehabilitator believes that most policyholders do not have a close relationship with their agents. Indeed, it is likely that policyholders 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. Based on SHIP's experience before and after liquidation, most policyholders contact SHIP directly for policy information or questions, or a financial advisor or trusted professional (lawyer, banker, trustee or family member).

The proposed plan suspends agent commissions under agreements made prior to the inception of the rehabilitation proceedings. Such commissions shall be suspended—and no commissions shall accrue—until policyholders have been made

whole, that is, all their contractual claims have been paid in full with adequate provision made for reasonably anticipated future claims. As set forth herein, and as will be addressed at the Plan Hearing and in further filings, the Rehabilitator has the authority to suspend and potentially terminate such commissions.

1. General Principles

The authority granted to the rehabilitator is broad. She may "take such action as [s]he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer." 40 P.S. § 221.16(b). The statutory scheme grants the rehabilitator the power to "deal with the property and business of the insurer" and to prepare a plan for the reorganization or other transformation of the insurer. *Id.*; *see also* § 221.16(d). Indeed, the Rehabilitator is recognized to have broader discretion than she would as liquidator to effectuate the protection of insurers, creditors, and the public. *See Grode*, 1991 WL 245007, at *4-*5 (recognizing Commonwealth Court authority on the scope of rehabilitator's powers). Moreover, the Court is vested with the authority to approve a plan in which the Rehabilitator seeks to prevent "(i) the transfer of property," "(iv) waste of the insurer's assets," "(vii) the obtaining of preferences" or "(xi) any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors or shareholders." 40 P.S. § 221.5(a). Where, as here, premium payments on which commissions might be

calculated are collected by the insurer, the full premiums are property of the insurance company, making agent commissions debts of the company—not agent property. *Foster v. Health Market, Inc.*, 604 A.2d 1198, 1203 (Pa. Commw. Ct. 1992); *Holmes v. Wakelin*, 48 Pa. Super. 643 (1912).

Thus, the Rehabilitator can suspend or terminate agent commissions as with any other contract, so long as she does not impermissibly impair any rights held by those agents. As explained herein, and for similar reasons to those set forth with respect to policy modifications, the proposed plan permissibly impairs the agents and brokers rights and should be approved on this issue. Should any intervenor argue otherwise, the Rehabilitator will address the issue in her rebuttal or supplemental memoranda, or as necessary at the Plan Hearing.

2. Agent Commissions are General Creditor Claims

The Rehabilitator's plan to suspend commission payments and the accrual of commissions does not diminish any rights which the agents and brokers would have in liquidation and thus does not create any constitutional or other concerns which could prevent approval. As a matter of policy, the governing Insurance Department Act is designed so that rehabilitation, like liquidation, serves to protect policyholders first and foremost. *E.g.*, *Foster*, 614 A.2d 1086 (1992). This consumer-first approach is reflected in the distribution scheme under the Act, which prioritizes costs of administration and claims for losses over all else. 40 P.S. § 221.44 (a), (b). In

general, agent commissions due from an insurer and calculated as a percentage of premiums the insurer collects are ordinary claims by a creditor of the insurer. *See Id.* at § 221.3. General creditor claims are paid only after also paying the additional claims of the federal government and employee debts. *Id.* at 221.44 (c), (e). At present, SHIP's liabilities for policyholder obligations exceed its assets—meaning that if it were placed in liquidation today, there would be insufficient assets to satisfy policyholder-level claims in Class (b), let alone Class (e) general creditor claims like those for agent commissions.

Pennsylvania law governing agent commissions in liquidation proceedings is instructive here, as it defines the potential rights of the agents against which their claims and objections to the plan must be judged. That premiums are the property of SHIP—and commissions merely a contractual claim—is not reasonably subject to dispute. Indeed, 40 P.S. § 221.35 allows the liquidator to call in all earned (*i.e.*, attached to policy periods prior to the liquidation) or unearned (*i.e.*, attached to policy periods after the liquidation) premiums from any party that pays the insurer, including agents collecting premiums from the insured on the insurer's behalf. The liquidator is entitled to receive "any part of an unearned premium that represents commissions of such person." 40 P.S. § 221.35. Commissions may be withheld from earned premiums but only when those commissions are received and held by agents.

The Commonwealth Court addressed this issue in *Foster v. Health Market, Inc.*, 604 A.2d 1198 (Pa. Commw. Ct. 1992) ("*Health Market*"), and the reasoning of *Health Market* affirms the Rehabilitator's position here. In *Health Market*, the Commonwealth Court held that commission payments from the insurer to agents could be voided as creditor preferences upon the request of the liquidator to satisfy the debts of the insurer pursuant to 40 P.S. § 221.30. The agents objected on the grounds that such payments were "earned" and thus could not be called in with the premiums under § 221.35. The Commonwealth Court disagreed, in part because it was "reasonable to infer that agents are creditors within the meaning of Section 503 of the Act" and "there is no distinction made between earned and unearned commissions" in defining the scope of creditor claims. By refusing to sustain the agents' objections, the *Health Market* court confirmed that § 221.35 does not create a broader right to agent commissions and instead applies only in the limited set of circumstances where agents actually *collect* premiums from the insureds *and* are asked to turn them over to the receiver for the estate—something that does not occur for SHIP, depriving the agents of any protected interest in the commissions on SHIP's policies.[5] Indeed, this Court's Rehabilitation Order directed "all insurance

[5] Insolvency cases in which commissions were recognized as "earned" are rare. In *Pa. Ass'n of Life Underwriters v. Foster*, 645 A.2d 907 (Pa. Commw. Ct. 1994), the Commonwealth Court agreed that § 221.35 excluded commissions on earned premiums and, thus, the liquidator could not force the agents to turn over commissions on earned premiums held by the agent. *Id.* at 910-911. The Commonwealth Court offered little in the way of analysis; it primarily relied upon the plain language of the statute and the Commissioner's 1991 holding in *In re Professional 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 . . . within thirty (30) days of this Order and that premium monies owed to SHIP must be remitted to the Rehabilitator." (Rehabilitation Order at ¶ 3(c).) No such premiums were received, confirming that the agents were not collecting premiums on behalf of the insurer.

3. Other Pennsylvania Law Confirms the General Creditor Status of Agent Commissions

This broad application of an agent's creditor status and limited impact of § 221.35 is consistent with other decisions under Pennsylvania law. In *Holmes v. Wakelin*, 48 Pa. Super. 643 (1912), an agent brought an accounting claim for commissions held by an insurance agency for policies written by him, as well as for renewals. In defining the nature of premium payments, the Superior Court recognized the "presumption," in the absence of a contrary contractual provision, that "money paid on account of policies and renewals [is] the property of the

Agents, reaching the same result. *Id.* In *Professional Insurance Agents*, the Insurance Commissioner addressed whether or not the department could demand that agents who had collected premiums from policyholders submit gross premiums to the estate without deducting their earned commissions. In that case, however, the agents' agreements specifically provided that *agents* would collect premiums, deduct commissions, and hold the remaining premium in trust before sending it to the insurer. (Slip. Op. at 10). Thus, *Professional Insurance Agents* turned on language in the agency agreement that no party has shown to be present here in defining the insurer's property interest in the premiums collected by the agent as the post-commission amount. (Slip. Op. at 16-17). Moreover, actual experience demonstrates that premiums are paid *to SHIP*, not to the agents, making premiums property of SHIP itself subject to potential general creditor claims by the agents.

company and not of the agents." *Id.* at 647. Going further, the court commented that an agreement for compensation on a percentage basis "did not invest the plaintiff with title to the money due the company as premiums on the policies." *Id.* Notably, these arguments are also consistent with Pennsylvania law governing similar disputes over commissions or property interests. *See, e.g.*, *Darlington v. Reilly*, 101 A.2d 900, 902 (Pa. 1954) (no lien or property interest on burial grounds for agency employees).

This presumption that premiums paid to an insurer are the insurer's property is not easily overcome. *See Presbytery of Beaver-Butler v. Middlesex Presbyterian Church*, 489 A.2d 1317, 1324 (Pa. 1985) (trust requires clear and unambiguous language of intent). Moreover, the role of general trust principles in resolving a dispute over commissions cannot be overstated: only where state law might recognize the existence of a trust, the insurer would take the premiums subject to a property interest in the agent. *See generally Professional Insurance Agents* (Slip Op. 1991) (relying upon agency agreement providing that only net premiums were insurer's property, held in trust by the agent upon receipt). Pennsylvania law is well settled on this issue, however, and it dictates that the funds received by the insurer are not held in trust *unless* clear and convincing evidence exists otherwise, such as through express language in the agency agreement or unambiguous conduct. In short, unless an agent can meet its high burden and show that the parties intended

for a trust arrangement, such agents and brokers could have nothing more than a contractual claim against the insurer for their commissions.

4. The Authority to Suspend Payments to General Creditor Claims is Well Settled

As noted, the Rehabilitator has broad authority over the business and assets of SHIP in rehabilitation. Accordingly, this court routinely suspend payments to creditors in rehabilitation and insolvency matters. *E.g.*, *Koken v. Legion Ins. Co.*, No. 183 M.D. 2002 (Pa. Commw. Ct. Mar. 28, 2002); *Koken v. Reliance Ins. Co.*, No. 269 M.D. 2001 (Pa. Commw. Ct. May 29, 2001); *Koken v. PHICO Ins. Co.*, 427 M.D. 2001 (Pa. Commw. Ct. Aug. 16, 2001). That result is consistent with insolvency matters in other jurisdictions. *E.g.*, *In re Liquidation of Workmen's & Suffolk Mut. Ins. Co.*, 345 N.Y.S. 2d 64, 66 (N.Y. App. 1973); *Comm. Nat'l Bank in Shreveport v. Super. Ct.*, 17 Cal. Rptr. 2d 884, 887 (Cal App. 1993).

In addition, the Pennsylvania Supreme Court has held that pre-rehabilitation contractual arrangements must be reduced or eliminated to conserve the insurer's resources for paying policyholder claims. Addressing retainer agreements in *Foster*, the Court explained that "presented with a dire need to economize in order to survive, the Rehabilitator must lead the process, *free to eliminate or reduce many of the self-serving interests involved*." 614 A.2d at 1102. The result of such actions "may cause economic suffering to some private contracting parties," but in rehabilitation, "individual interests might have to be sacrificed or compromised in order to preserve

the ultimate goal of this process, the overall good of the general public and the insurer's policyholders." *Id.*

5. Other State Law on Agent Commissions Similarly Favors the Rehabilitator

The agents may argue that they have a vested property interest in the commissions, but that claim is unsupportable. The argument "that agents may have an indefeasible property right in renewal commissions [] has been rejected time and again." *Myers v. Protective Life Ins. Co.*, 342 So. 2d 277, 777 n.* (Ala. 1977). Indeed, it is widely accepted that contractual obligations may be rendered subservient to the broad rehabilitation interest in protecting policyholders. *See, e.g.*, *Liberty Nat'l Ins. Co. v. Reins. Agency Inc.*, 307 F.2d 164 (9th Cir. 1963) ("It is settled that contract and property rights must yield to legislation in the interest of the general welfare. . . . Agents do not have a vested interest in future insurance premiums against insolvency receivers or against rehabilitators."). For example, agent renewal commission were terminated in *Roush v. Nat'l Old Line Ins. Co.*, 453 F. Supp. 247 (W.D. Okla. 1978) and *Layton v. Ill. Life Ins. Co.*, 81 F.2d 600, 602-603 (7th Cir. 1936) ("*Layton I*"). As the *Layton I* court pointed out, agent and insurer must accept both the "continued solvency of the company and its continued ability to collect and receive future premiums" as contingencies to the contract remaining in force. The Seventh Circuit later explained its holding in *Layton I* to mean that there is no "fixed and definite engagement on the part of the company to pay in all

events." *Layton v. Ill. Life Ins. Co.*, 83 F.2d 277, 277-278 (7th Cir. 1936) ("*Layton II*"). By taking jurisdiction over the assets of the insolvent insurer, the court terminates the agency contract as a matter of law and no breach can occur. *See Thacher v. H.C. Baldwin Agency, Inc.*, 283 F.2d 857, 861 (7th Cir. 1960) (affirming district court order).

The same holds in bankruptcy law when courts are asked to determine the status of commissions relative to the bankruptcy estate.[6] *See, e.g., In re Oxford Mgmt., Inc.*, 4 F.3d 1329, 1334-35 (5th Cir. 1993) (agreeing that "commissions paid to [petitioner-broker] by [client] were [petitioner-broker's] property, and that while [petitioner-broker] had an obligation to pay the [appellee-agent] under separate and distinct contracts, the relationship between the parties was that of debtor and creditor"); *In re Brockway Pressed Metals, Inc.*, 363 B.R. 431 (Bankr. W.D. Pa. 2007), *aff'd* 304 Fed. App'x 113 (3d Cir. 2008) (finding no property interest under Pennsylvania law and concluding that full receivables, including commissions, were property of the estate); *Brown v. Capital Title Agency (In re Pauley & McDonald, Inc.)*, 215 B.R. 37, 41-52 (Bankr. D. Ariz. 1996) (concluding that real estate commissions were property of the estate because title companies paid the debtor,

[6] Pennsylvania courts recognize and accept the guidance of federal bankruptcy courts in interpreting the insurance insolvency statutes. *See, e.g., Ario v. Ingram Micro, Inc.*, 965 A.2d 1194, 1203 (Pa. 2009) ("Use of federal bankruptcy law for guidance in interpreting ambiguous state insurance insolvency law is commonly accepted.").

who then paid commissions to agents, and there was no agreement prohibiting commingling of commissions with other funds or prohibiting the use of the money for other purposes even where it was to be "turned over promptly" to the agents); *In re Taylor & Campaigne, Inc.*, 157 B.R. 493, 495 (M.D. Fla. 1993) ("[S]uch commissions were due to the debtor because each of the real estate contracts provided that the entire commission is payable to the debtor. Therefore, the commissions earned from the sales were due to the debtor pre-petition and thus constituted property of the estate, leaving the plaintiff with nothing more than an unsecured claim against the debtor."); *Halloway v. Hyman (In re Bob Hamilton Real Estate, Inc.)*, 138 B.R. 301, 302 (Bankr. M.D. Fla. 1992) ("The Plaintiff fails to cite any law which would justify this conclusion. The Plaintiff's rights arise only out of the independent contractor agreement which does not create a trust relationship between the parties.").

Brockway Metals is particularly helpful in its analysis of commission agreements. *Brockway Metals* addressed the existence of a trust over commission payments sent to the principal under Pennsylvania law. *See* 363 B.R. at 439 (noting that state law determines the existence of a trust and the nature of property rights). The court noted that the contract right to commissions placed no limits on the principal for the use of the receivables. *Id.* at 441. Noting that not every agency is a trust, the court further refused to "elevate every debtor relationship involving an

unpaid obligation to compensate a commission sales agent to express trust status" simply because the parties trusted each other in a moral sense. Finally, the court rejected any argument that a constructive trust arises because the debtor would be "unjustly enriched" by retaining such commissions alongside receivables created by the efforts of those entitled to commissions, because that sort of unjust enrichment occurs (as with every insurance insolvency proceeding) in every bankruptcy. *Id.* at 456.

These principles have also been applied in other state insolvency cases as well. The Hawaiian Supreme Court has addressed whether the insurance commissioner had the right to "retain the 'earned' commissions that were 'vested' in Plaintiffs [independent insurance agents] and held in 'trust' by the Commissioner." *Four Star Ins. Agency, Inc. v. Hawaiian Elec. Indus., Inc.* 974 P.2d 1017, 1025 n.8 (Haw. 1999). The court relied upon the same principle underlying *Health Market*, where the key distinction is which entity receives the premium payments. The court noted that "the record indicates that the premiums paid by the insureds were paid directly to [the insurer] and were the property of [the insurer]." *Id.* The insurer would then pay percentage commission and "[b]ecause the premiums collected by [the insurer][were not *specifically* set aside (*i.e.*, encumbered) for the benefit of the

Plaintiffs [agents], the commissions collected were part of [the insurer's] general assets." *Id.*[7] (emphasis in original).

Similarly, Florida's First District Court of Appeal rejected the "vested rights" approach in *D.R. Mertens, Inc. v. State*, 478 So. 2d 1132 (Fla. Ct. App. 1985). The court entertained and denied an insurance agency's attempt to collect commissions due after the date of rehabilitation. *Id.* at 1133. The agency agreement obligated the insurer to pay certain renewal commissions even five years after termination of the agreement. *Id.* The court recognized a "general rule" that "insurance agency contracts ordinarily imply that the agent's right to commissions on renewal premiums is conditioned upon the insurance company's continued operation in business." *Id.* at 1135. The court could not find a contractual reason why the new company was obligated to pay commissions, and, moreover, explained that upon reaching insolvency the agency contract was "necessarily terminated." *Id.* at 1136. Importantly, the court also rejected any claim that the insurance agents had some vested property interest in future premiums. Because all of the governing provisions were in place at the time the agency contracts were written, "such provisions became

[7] The court also observed that Plaintiffs could point to no statutory provision that would treat earned commissions differently. The *Health Market* court reached the same conclusion when it rejected a § 222.35 challenge to the general creditor status of agent commissions. Only one state, Oklahoma, has found that agent renewal commissions are property held by the insurer in trust for the agent as a matter of Oklahoma law. *See, e.g.*, *Cockrell v. Grimes*, 740 P.2d 746, 748-49 (Okla. App. 1987). Such decisions under Oklahoma law are anomalies based on specific Oklahoma legal principles not present here, and thus must be afforded little weight.

part of the contract" and, accordingly, set the obligations of the parties. *Id.* Accordingly, any purported property interest in commissions does not pose a constitutional concern.

F. COVID-19

In December 2019, a new virus emerged in Wuhan, China, identified in due course as severe acute respiratory syndrome coronavirus 2, resulting in a pandemic of coronavirus disease 2019 ("COVID-19"). The implications of COVID-19 for the Plan fall in two areas impacting policyholders.

1. Mortality and Morbidity

Although sufficient reliable data is not yet available, preliminary data indicates that COVID-19 may be causing a decrease in the number of SHIP insureds filing claims and an increase in the number of deaths among the aging population insured by SHIP. While these unfortunate developments may combine to reduce slightly SHIP's deficit, it is possible that, at least in part, they are temporary. The Rehabilitator cannot yet project what, if any, permanent impact these consequences will have on the Plan, but SHIP's funding gap is too significant to be resolved to any material degree by the limited impact of these consequences.

2. Suspension of Premium Payments

Many of SHIP policyholders have delayed making their required premium payment. While SHIP delayed lapsing or cancelling policies for non-payment of

premiums because of the exceptional circumstances, protracted delays in making these payments may aggravate SHIP's financial difficulties. These delays are waning gradually. Some regulatory agencies have requested or required that insurers (including SHIP) accommodate some premium deferrals, but many of these deferrals are also expiring or will soon expire. Continued non-payment of premiums beyond the expiration of the deferral period is expected to result in an increased number of policy terminations. The Rehabilitator has already observed a slight increase in the number of policy terminations that appear not to be the result of increased insured mortality. However, in the aggregate they are not expected to be material to the Plan.

G. REINSURANCE ISSUES

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 Travellers 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.

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 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 insurance policies only.

On 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 ("AH&L") long-term care insurance 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.

The insurance policies for which SHIP became responsible from Transamerica, Primerica and AH&L or their predecessors (the "ceding companies") are what is generally referred to in the industry as "reinsurance assumed." All of these assumed LTCI policies have historically been treated by SHIP for administrative purposes in a manner very similar to those issued directly by SHIP. However, communications with policyholders and regulators properly identified them as policies of the ceding companies.

It is important to note that while these policies have been reinsured by SHIP, they were never novated as part of the transactions. Thus, the policyholders retained, and continue to retain, their contractual rights against the ceding companies or their successors. In turn, the ceding companies retain contractual rights against SHIP.

The preliminary plan of rehabilitation filed on April 22, 2020, proposed to treat Direct Business and Reinsurance Assumed in the same way under the Plan. The Rehabilitator believed that this would be most advantageous to the affected policyholders. However, this proposal resulted in a number of objections from insurance regulators around the country, asserting that it departs from established custom and practice and is unsupported by applicable law. In response to these objections, the Rehabilitator changed that provision of the preliminary plan of rehabilitation. The Amended Plan proposes to treat the reinsurance assumed differently from the policies issued directly by SHIP and its predecessors. As a result

of this change, if the Plan is approved as proposed: (1) the reinsurance assumed policies will not be modified under the Plan and the policyholders will not be asked (or have the ability) to make elections under the Plan; (2) SHIP will not be financially responsible for claims and commissions owed under these policies and will not have the right to treat premiums paid by these policyholders as assets of SHIP; and (3) if SHIP is placed in liquidation, the terms of these policies will remain unchanged and the policyholders will not receive benefits from any life and health insurance Guaranty Association. Instead, in that case, the ceding companies (or their successors) will remain fully responsible for these policies and any claims and commissions owed under these policies.

Consistent with this change in the Plan, Transamerica and SHIP entered into a Recapture Agreement though which Transamerica assumed complete responsibility for the LTC insurance policies its predecessors had ceded to SHIP's predecessors. This Agreement was approved by the Court on December 29, 2020, and made effective October 1, 2020.

V. EVIDENCE TO BE PRESENTED AT THE PLAN HEARING

A. Witnesses

1. Patrick Cantilo, Special Deputy Rehabilitator

Mr. Cantilo was appointed by the Rehabilitator as the Special Deputy Rehabilitator and vested by the Rehabilitator with her authority over the rehabilitation of SHIP. Mr. Cantilo will be the primary factual witness for the

Rehabilitator. Mr. Cantilo will testify on the following topics consistent with the contents of the April 22 Plan, the Amended Plan, and any other plan filed with this Court on or before May 3, 2021:

Background Matters

a. A history of SHIP, including its relationship to Conseco and the Oversight Trust;

b. The historical financial condition of SHIP;

c. The current financial condition of SHIP;

d. The market for long-term care insurance;

e. The impact of COVID-19 on SHIP's claims and financial prospects;

f. SHIP's historical rate-increase efforts;

g. The Pennsylvania Insurance Department's involvement with SHIP prior to the filing of the rehabilitation plan;

h. The decision to file an application seeking to place SHIP in rehabilitation, including the alternatives considered prior to filing;

i. The Rehabilitator's efforts at recovering assets and steps taken to rehabilitate SHIP outside of policy modifications; and

j. The Pennsylvania Insurance Department's outreach to regulators before and after SHIP was placed in rehabilitation.

The Proposed Plans

a. The Rehabilitator's approach;

b. A summary of the core elements of the plan;

c. The Plan Phases;

d. The options offered to policyholders;

e. Rate approval issues;

f. Tax considerations;

g. The rights of agents and creditors, including the Rehabilitator's request to suspend commissions;

h. Reinsurance;

i. The outreach to other parties, including policyholders, agents, regulators, and other interested parties during the rehabilitation proceedings, including the comment process and the SHIP Data Site; and

j. The comments and objections received in response to the proposed plans, and how the proposed plan changed over time to address those comments and objections.

The Proposed Rate and Benefit Modification Mechanism

a. The goals of the proposed rate and benefit elements of the plan;

b. The rate and benefit mechanisms set forth in the April 22 Plan and the Amended Plan;

c. Comments and objections received to the rate and benefit mechanisms proposed by the Rehabilitator;

d. The status of collateral litigation against the proposed plan; and

e. The issue-state rate approval option.

Plan Approval Considerations

a. The plan options and phases;

b. The potential outcomes of the plan as proposed;

c. A comparison of the plan to liquidation outcomes;

d. Questions of fairness and equity;

e. The plan implementation timeline, including the feasibility and timing of various outcomes of the plan; and

f. The Rehabilitator's request for approval of the plan.

2. Oliver Wyman Actuaries

The Rehabilitator intends to present factual testimony and expert testimony from certain actuaries at the firm of Oliver Wyman, which was retained by the Rehabilitator and the Special Deputy Rehabilitator to assist in the analysis of SHIP's financial condition and prospects, the preparation of the proposed plans of rehabilitation, and the implementation of any plan approved by this Court. The actuarial witnesses will be one or more of Vincent Bodnar, Marc Lambright, Dean Kerr, Dustin Plotkin, and Gabe Albourkek.

The testimony to be provided by the Oliver Wyman witnesses will include:

a. The historical financial condition of SHIP;

b. The current financial condition of SHIP;

c. The market for long-term care insurance;

d. The impact of COVID-19 on SHIP's claims and financial prospects;

e. A summary of the core actuarial elements of the plan;

f. The rate and benefit mechanisms set forth in the April 22 Plan and the Amended Plan;

g. The issue-state rate approval option;

h. The plan options and phases, including the considerations in developing *IfKnew* premium;

i. The potential outcomes of the plan as proposed;

j. A comparison of the plan to potential liquidation outcomes; and

k. The feasibility and timing of various outcomes of the plan.

3. Other Witnesses

The Rehabilitator reserves the right to identify other witnesses in her rebuttal or supplemental pre-hearing filings, as well as to call in her affirmative case any witness identified by any other party or to identify rebuttal witnesses as necessary at the Plan Hearing.

B. Exhibits

The Rehabilitator may use the documents listed below at the Plan Hearing.[8]

1. Actuarial Assumption Summary 2021-01-11 (Appendix A – inventory of actuarial assumptions 2021 01 11.xlsx)

2. Actuarial Assumption Summary 2021-01-22 (Appendix A – inventory of actuarial assumptions 2021 01 22.xlsx)

3. Additional Information about SHIP and the Rehabilitation Plan (20210226_Info about SHIP and the Rehabilitation Plan.pdf)

[8] Exhibit documents currently on the SHIP Data Site are identified by the exhibit name, followed by the file name in parenthesis. Only those exhibits not available on the SHIP Data Site are being filed with this Pre-Hearing Memorandum (with the exception of Proposed Exhibit 15), and such exhibits will be provided to the Court through hard digital media prior to the Plan Hearing.

4. Amended SHIP Rehabilitation Plan filed 2021-10-21

5. Cash Flow Projections (Appendix C – SHIP cash flow projections 2021 01 11.pdf)

6. Comparison of Rehabilitation to Liquidation (2020-11-12 SHIP – Comparison of Rehabilitation to Liquidation (1).xlsb)

7. Comparison of Rehabilitation to Liquidation Summary

8. Curricula Vitae for Oliver Wyman Actuaries

9. Curriculum Vitae for Special Deputy Rehabilitator Patrick Cantilo

10. Exemplar Agency and Assignment Documents

11. Financials - Q3 2020 (Financials for COSC Q3 2020_SHIP.pdf)

12. Financials YTD December 2020 (SHIPFinancials for COSC YTD Dec 2020 FINAL.pdf)

13. General Expenses Analysis

14. Illustrative Policyholder Guidance Page

15. Issue-State Rate Approval (2021-03-04 REVISED ISSUE STATE RATE APPROVAL SECTION.pdf)

16. Oliver Wyman Actuarial Report dated 2021-01-26 (SHIP – Oliver Wyman Actuarial Report 2021 01 26.pdf)

17. Oliver Wyman Assumption Report dated 2021-01-26

18. Phase I Rehabilitation Plan Cumulative Excess Benefits Analysis dated 2021-03-24

19. Phase I Rehabilitation Plan Funding Gap Exhibits (as of 6/30/2020) dated 2021-03-02 (SHIP - Phase I Funding Gap Exhibits 2021-03-02.pdf)

20. Phase I Rehabilitation Plan Funding Gap Exhibits (as of 6/30/2020) dated 2021-04-02

21. Phase I Rehabilitation Plan Results as of 6/30/2020 (SHIP – Rehabilitation Plan Results 20201120.pdf)

22. Policy Information as of December 31, 2020

23. Probability Weighted Scenario Results (SHIP – Rehabilitation Plan Probability Weighted Results 20201106.xlsb)

24. Proforma Adjusted for Removal of Reinsurance Assumed Business

25. Q2 2020 Liability Cash Flow and Gross Premium Reserves Projections (SHIP – Q2 2020 liability cash flow and GPV projections – 2020 06 24.xlsx)

26. Q4 2020 Gross Premium Reserve Results and Analytics (SHIP – Q4 2020 GPV results 2021 01 25.pdf)

27. Rate Filing History

28. Rate Increase History

29. Seriatim File with Covered Liabilities and Premium Information (Seriatim File with Covered Liabilities and Premium Information_20200630 (3).xls)

30. Seriatim Phase I Option Results (2021-01-21 SHIP – Seriatim Option Results)

31. SHIP Annual Report 2021[9]

32. SHIP Date Site Table of Contents (Table of Contents.pdf)

33. SHIP Policy and Product Overview

34. SHIP Rehabilitation Election Response Audit Process

35. SHIP Reinsurance as of October 1, 2020 (SHIP Reinsurance as of October 2020.pdf)

[9] This document was filed in error as SHIP's Quarterly Report; the Rehabilitator is filing annual reports only and will amend the as-filed report and exhibit prior to the Plan Hearing.

36. SHIP Summary of Balance Sheet Changes

37. Standard Claim File (Standard Claim File - 20191231.txt)

38. Standard Files Data Layout (Data File Layout – Standard Files.xlsx)

39. Standard Policy File (Standard Policy File - 20191231.txt)

40. Treasury Bond Historical Rates

41. Documents posted on the SHIP Data Site

42. Exhibits identified by any other party to the proceedings[10]

The Rehabilitator may present the exhibits in any order, and she reserves the right to omit any of the identified exhibits or identify additional exhibits in her rebuttal or supplemental pre-hearing filings, or in rebuttal as necessary at the Plan Hearing. The Rehabilitator further reserves the right to update the information in any exhibit as needed or revise the formatting of an exhibit.

VI. CONCLUSION

The Rehabilitator firmly believes that the proposed plan is permissible, equitable, and likely to succeed in reducing SHIP's funding gap—if not eliminating it entirely. Accordingly, the Rehabilitator seeks this Court's approval to implement this plan under the Court's supervision for the reasons set forth in the plan documents, this Pre-Hearing Memorandum and any subsequent memoranda, and as presented at the Plan Hearing.

[10] The Rehabilitator reserves and does not waive her right to object to any specific exhibit identified by one of the other parties upon receipt of that exhibit before or during the Plan Hearing.

Dated: April 5, 2021

Respectfully submitted,

/s/ Michael J. Broadbent

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REHABILITATOR'S PRE-HEARING MEMORANDUM

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PROPOSED

EXHIBIT 4

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1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

OCTOBER 21, 2020

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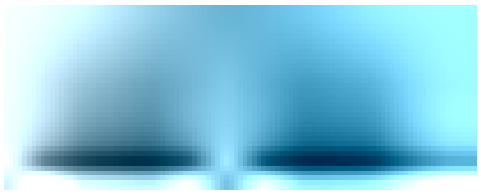
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SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, *IN REHABILITATION*
AMENDED REHABILITATION PLAN

JESSICA K. ALTMAN, REHABILITATOR
PATRICK H. CANTILO, SPECIAL DEPUTY REHABILITATOR

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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 Comments were required to be made by September 15, 2020, in compliance with the June 12, 2020 Case Management Order of the Commonwealth Court of Pennsylvania, which is available at www.shipltc.com. No provision has been made by the Court for additional Formal Comments.

THIS PLAN DOCUMENT PROVIDES DETAILS ABOUT THE PLAN PROPOSED FOR THE REHABILITATION OF SHIP AS AMENDED. 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.

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 THIS 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 SHIP POLICIES OF LONG-TERM CARE INSURANCE THAT ARE ACTUARIALLY PROJECTED TO BE UNDERPRICED IN PHASE ONE AND NON-SELF-SUSTAINING IN PHASE TWO, AS DEFINED IN THE PLAN DOCUMENT. THIS PLAN DOCUMENT ALSO DESCRIBES 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.

THE 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. THIS 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. THEY 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.

THIS PLAN DOCUMENT DESCRIBES THE DETAILED AUTOMATIC 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.

THE PLAN IS DESIGNED TO REDUCE OR ELIMINATE THE SHORTFALL BETWEEN SHIP'S PROJECTED LIABILITIES AND THE ASSETS AND PREMIUMS 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 POSSIBLE 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.

THIS PLAN DOCUMENT STRIVES TO PROVIDE AN EXPLANATION OF THE SIGNIFICANT ELEMENTS 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.

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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 (the "Rehabilitation 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.

The Rehabilitation Order required that the Rehabilitator file a preliminary plan of rehabilitation by April 22, 2020. The Rehabilitator complied with this requirement and has since received many comments, formal and informal, about that preliminary plan of rehabilitation. In addition, the Special Deputy Rehabilitator and the rehabilitation team have continued their analysis of the many issues raised by the plan. As a result, the Rehabilitator and her team have prepared this Amended Rehabilitation Plan among other things addressing many of the issues raised in those comments.

This document ("Plan Document") is intended to provide a sufficient description of the proposed rehabilitation plan (the "Plan" or the "Amended Rehabilitation Plan") to enable policyholders and interested parties to understand the Plan, and 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 changes contemplated by the Plan, if approved as proposed, are expected to be implemented. Many or most existing company practices will continue if the Plan is approved and implemented, and those current practices are largely not discussed in this document.

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 can be expected to 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, beginning at page 63 there are several illustrations of Plan options for several representative policyholders. This Plan Document therefore provides relative and directional guidance about Plan options rather than precise policy-level details for each one.

UNTIL THE PLAN EFFECTIVE DATE, EVEN AFTER THE PLAN IS APPROVED WITH OR WITHOUT MODIFICATION, POLICYHOLDERS WILL HAVE THE SAME RIGHTS, BENEFITS, OPTIONS, AND OBLIGATIONS AS THEY DO NOW UNLESS THE PLAN SPECIFICALLY PROVIDES OTHERWISE.

A. SUMMARY DESCRIPTION OF THE PLAN

The following description of the Plan is intended to provide policyholders the basic general information required for them to understand the options that will be available to them if the Plan is implemented as proposed. 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 81), 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 proposing 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 policies. The If Knew Premium is an accepted methodology for setting premiums for LTCI policies, more fully explained at page 22. Policyholders with Current Premium (see page 107) 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 23. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies the premiums of which 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 109), and which have not selected ***Option Two*** or ***Option Three*** (described below) in Phase One, may be modified in Phase Two.

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 Rehabilitator will make payments to policyholders and other creditors on account of any amounts owed to them.

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 19. 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 modification 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 that the If Knew Premium) have benefits reduced in accordance with Plan provisions 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 provide selected essential benefits (some times greater than benefits provided by Option One) 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. Option Two is designed to provide reasonable coverage at reasonable premium rates.

c. Option Three will be a ***Non-forfeiture Option*** (NFO) 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 substantial 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 Option Three if preferable for their individual circumstances. Options One and Four would not result in any changes for such policyholders.

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 26. 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 24. 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.

3. NO WORSE THAN LIQUIDATION

Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to or exceeding those that would be available from the applicable Guaranty Association in the event of liquidation, but generally no more than the current policy benefits.

a. Policyholders with Current Premium at or above If Knew Premium in fact will not be required to make any changes in their policies. Thus they will be treated at least as well as they would in liquidation, and perhaps better if their policies offer benefits in excess of those that would be offered by Guaranty Associations in liquidation.

b. Option Two will provide at least the benefit value that the Guaranty Association would provide in liquidation for every policyholder whose current policy provides benefits in excess of those limits. In many cases, other options will also provide the benefits that would be available from Guaranty Associations in liquidation. For policyholders with current benefits below Guaranty Association limits, Option Two will provide at least the current level of benefits.

In that respect, the Plan is designed to place policyholders in no worse a position than they would face in a liquidation of SHIP.

4. DEFAULT OPTIONS

For every policyholder there will be a Default Option which will apply automatically if no proper election is made. In Phase One, for every policyholder whose Current Premium is at or above the If Knew Premium, the Default Option will be to leave the policy unchanged. However, if the 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 62). 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 (after taking premium into account) 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 44) will be the Default Option.

In Phase Two, for every policyholder whose Current Premium is at or above the Self-sustaining level, the Default Option will be to leave the policy unchanged. However, if the Current Premium is below the Self-sustaining level, there will be a Default Option similar to Phase One. 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 (after taking premium into account) than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements 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 are elected). For a policyholder whose Current Premium is equal to, or higher than, the If Knew Premium (or Self-sustaining level in Phase Two), the Default Option will be to leave the policy unchanged, 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 between 25% and 40% of policyholders may be in this category.

5. CHANGES IN POLICYHOLDER ELECTIONS

Policyholders will not have the opportunity to change their elections after the Policyholder Election Date. Before the Policyholder Election Date, policyholders may change their elections by submitting new Policyholder Election Forms if they are received before the Policyholder Election Date. A valid new Policyholder Election Form received before the Policyholder Election Date will replace and invalidate a valid or invalid Policyholder Election Date submitted previously. If time permits, the Rehabilitator will attempt to reach policyholders who submit defective election forms (for example because they make no valid election or make more than one election) to attempt to correct the error. However, if there is insufficient time before the Policyholder Election Date, or if the Rehabilitator cannot reach the policyholder, the result of a submitting a defective election form will be that the Default Option will be selected automatically under the Plan.

6. PHASE TWO ELECTIONS

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.

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. This is not a sustainable model and is a key contributor to SHIP's present financial challenge. The Plan is designed 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 consider 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 are very material differences between the costs of a policy that provides 5% Inflation Protection, one that provides 2% Inflation Protection, and one that provides no Inflation Protection at all. Similarly, there are material differences between the costs 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 rather than 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 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 by the policyholders to be insufficient. 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 in order 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 be subject to 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.

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. This is because, in many cases, the premiums for those policies are substantially lower than what they should be relative to the benefits promised. 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. Such policyholders will not be required to make any election. For these policyholders, selecting Option One or Option Four would be meaningless because neither their premiums nor benefits would change in either case. 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 meet precisely 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 choice of options that recognizes 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. COVID-19

In December 2019, a new virus emerged in Wuhan, China, identified in due course as severe acute respiratory syndrome coronavirus 2, resulting in a pandemic of coronavirus disease 2019 ("COVID-19"). As of the filing of this Amended Plan, at least 38 million people have been infected worldwide, resulting in at least 1,000,000 deaths. In the U.S., the first cases were reported in January 2020, with total estimates now exceeding eight million and fatalities exceeding 222,000. COVID-19 is particularly threatening to the elderly and those with impaired respiratory systems or other underlying health conditions. While intense work continues around the globe, no effective cure has yet emerged. There has been progress in efforts to develop one or more effective vaccines, but they are not expected to be widely available for months at best. If the many leading vaccine candidates turn out to be less useful than initial results indicate, the delay could be far longer. The implications of COVID-19 for the Plan fall in three major areas.

1. CASE MANAGEMENT: Restrictions on travel and personal contact imposed as preventive measures have cause SHIP to revise, at least temporarily, the manner in which it confirms eligibility for benefits and other aspects of case management. Although current protocols emphasize other means of communication, the Company remains attentive to the needs of its insureds as well as to the important function of preventing fraud, waste and abuse. At this juncture, these changes are not expected to have a material effect on the Plan or on the options it will offer to eligible policyholders.

2. MORTALITY AND MORBIDITY: Although sufficient reliable data is not yet available, preliminary data indicates that COVID-19 may be causing a decrease in the number of SHIP insureds filing claims and an increase in the number of deaths among the aging population insured by SHIP. While these unfortunate developments may combine to reduce slightly SHIP's deficit, it is possible that, at least in part, they are temporary. The Rehabilitator cannot yet project what, if any permanent impact, these consequences will have on the Plan.

3. SUSPENSION OF PREMIUM PAYMENTS: Many SHIP policyholders have delayed making their required premium payment. While SHIP has delayed lapsing or cancelling policies for non-payment of premiums because of the exceptional circumstances, protracted delays in making these payments aggravate substantially SHIP's financial difficulties. Some regulatory agencies have requested or required that insurers (including SHIP) accommodate some premium deferrals, but many of these deferrals are also expiring or will soon expire. Continued non-payment of premium beyond the expiration of the deferral period is expected to result in an increased number of policy terminations. The Rehabilitator has already observed a slight increase in the number of policy terminations that appear not to be the result of increased insured mortality.

D. TIMELINE

The order placing SHIP in rehabilitation required the Rehabilitator to submit to the Court a preliminary plan for SHIP's rehabilitation by April 22, 2020, and a subsequent case management order has provided for policyholders and other interested parties to comment on the Plan through September 15, 2020. Around 100 people have submitted comments, some formal but most informal, and a few parties have also been admitted as intervenors. This Amended Plan reflects the analysis of those comments and continuing work by the rehabilitation team.

At page 30 is a preliminary sequence of past and expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity and under the current exceptional circumstances, the Rehabilitator expects that a pre-hearing conference with the Court will occur within the next few weeks. Because of the extraordinary circumstances facing our nation, the Rehabilitator asked the Court provide policyholders and others a prolonged period of time to review the Plan before the deadline for comments. Depending on the nature of such comments and formal objections to the Plan filed with the Court, a hearing on the Plan may occur as early as the last quarter of 2020 or early next year. Depending on the outcome of that hearing, implementation of the Plan might commence early in

2021. In that event, policyholders may be asked to make their elections in the first half of 2021. However, this matter is complex and delays in this timetable are very possible.

E. RATIONALE FOR THE PLAN

The Plan hinges on two essential assumptions: (1) in order to maximize policyholder 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, policyholders will have at least one option (Option Two) calibrated to provide outcomes no less favorable than liquidation, including Guaranty Association benefits.

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 have historically been 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.

F. PLAN PROJECTIONS

The magnitude of SHIP's Funding Gap or deficit as of the Effective Date is difficult to predict because it is dependent on several changing circumstances over which the Rehabilitator has little or no control. However, the Rehabilitator believes that, depending on policyholder elections, Phase One of the Plan could greatly reduce, if not eliminate, the Funding Gap. Solely for purposes of directional guidance, the Rehabilitator has prepared some hypothetical results that could be expected from operation of the Plan as proposed. For purposes of these projections, it is assumed that

SHIP's Funding Gap as of the Effective Date will be $1.2 billion. It should be emphasized that these are hypothetical projections dependent on future events that may evolve in a manner different from the assumptions in the projections. Subject to these caveats, it is the belief of the Rehabilitator that if the Plan is implemented as proposed it would produce the following results:

1. If 100 % of disabled SHIP LTC policyholders and 80% of active SHIP LTC policyholders elect Option Four (retaining the current policy benefits and paying the rate increases necessary to reach If Knew Premium), the Funding Gap will be reduced by about $500 million, less than 50%, and a substantial additional reduction will have to be generated by Phase Two of the Plan. This scenario assumes that the remaining 20% of active policyholders would select Options One, Two or Three.

2. If 100 % of disabled policyholders and 65% of active policyholders elected Option Four (the remaining 35% of active policyholders electing one of the other Options), the Funding Gap would be reduced by an additional $150 million, a bit over half of the deficit.

3. If 100 % of disabled policyholders elected Option Four and 100% of active policyholders elected one of Options One, Two or Three, the Funding Gap would be reduced by between 73% (over $850 million) and 86% (over $1 billion).

4. In any of these scenarios, election of an option other than Option Four by a material number of disabled policyholders would materially improve the results of the Plan in reducing the Funding Gap.

5. If 100% of SHIP's active and disabled policyholders elect either Option Two or Option Three, the entire Funding Gap would be eliminated and Phase Two would be unnecessary. If they elected Option One, about 93% of the Funding Gap would be eliminated.

As these projections suggest, the probability of the Plan's success increases materially the more policyholders elect to give up their benefit-rich policies and elect more affordable options. That anticipated probability of success does not vary nearly as substantially by choices among Options One, Two or Three as it does by choices between any the other options vs. Option Four.

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 SHIP's long-term care insurance policies. 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.

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 the holders of those whose premiums are below the If Knew Premium level will be required to elect 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 the holders of which have not elected 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. In the event that funds are available, payment will be made to agents, ceding companies, policyholders, and other creditors on account of sums owed to them.

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 - <u>not</u> premium paying (further segregated between lifetime or dual Premium Waiver);
    (3) Disabled - premium paying; and
    (4) Disabled - <u>not</u> 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 rate for their policies will have four choices, including the ability 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 choices provided by the Plan will be:

a. ***Option One*** - Keep the Current Premium (or Premium Waiver) and downgrade the policy to specified reduced benefits in a manner determined automatically by the Plan. The ***Downgrade Process*** is explained beginning at page 38. 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 44) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. 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. This option may entail both premium increases and benefit reductions for many policyholders, but premium increases will almost always be lower than under Option Four. For some policyholders it may entail a premium reduction. Many policyholders will be offered two variations of this option, a standard version and an enhanced alternative. Details of its provisions are laid out in Section III.A.2.d, page 44, below. As explained below, policyholders who elect this option in Phase One will not be asked to make Policy Modifications in Phase Two;

c. ***Option Three*** - Elect a limited benefit Non-forfeiture Option, a reduced paid up policy on which no additional premium will ever be paid (see Section III.A.3, page 46); and

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. In summary, under the Plan, 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. 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.

3. As noted above, a Default Option will apply if a policyholder required to do so fails to make a valid election by the applicable deadline. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements) will be the Default Option. For policyholders on Premium Waiver, the Default Option will be Option One (the downgrade) unless the NFO would provide these policyholders better benefits.

4. In Phase One, the estimated 25% to 40% of policyholders whose Current Premium on the Determination Date (see page 108) will be 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 choose to 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 (again, for example, because a policyholder on claim recovers). See Section III.A.2.c, page 44.

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 additional 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 44), 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) certain policyholders on premium waiver (or their spouses) may be required to pay full Phase One Premium or If Knew Premium (instead of differential premium) when the waiver ceases to apply. The NFO is expected to remain permanent through policy termination.

10. The approximately 9,500 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 37. For policyholders selecting Option One (retain Current Premium) or Option Two (Basic Policy Endorsements), the target premium will be the If Knew Premium for the policy's benefits. In Phase Two the target premium will be the Self-sustaining Premium.

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 Phase One Premium will be the Current Premium. In short, in Phase One that policyholder can (but is not required to) retain the current policy at Current Premium without change. Correspondingly, for policies with a Current Premium lower than the If Knew Premium (which in this case would be the Phase One 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 37.

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 the policy's ***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 23. Again, for purposes of this determination "expected" consists of best estimate assumptions.

   d. ***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. The ***Asset/Premium Ratio*** is the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies. ***Accumulated Premium*** is the total Gross Premiums paid, and premiums waived, under a policy or group of policies from inception until the valuation date.

   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. The assets allocated to each policy equal the product of the policy's Accumulated Premium times the Asset/Premium Ratio. This approach is designed to allocate assets equitably among policyholders solely for the purpose of calculating Phase Two premiums.

TABLE 1: ILLUSTRATION OF ASSET ALLOCATION		
1	Total Invested Assets	$1,500,000,000
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))**	**$1,240,000,000**
6	Total Accumulated Premium	$3,480,000,000
7	**Asset/Premium Ratio (L5/L6)**	**35.63%**
8	Accumulated Premium - Hypothetical Policy	$50,000
9	**Allocated Assets Hypothetical Active Policy (L7 X L8)**	**$17,816**

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 premium (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. This element of the Plan is intended to avoid having premium-paying policyholders subsidize policyholders on premium waiver unfairly. Because the Phase One Differential Premium calculation is also based on If Knew Premium, policies on waiver that would require their holders to pay premium at or above If Knew Premium but for the waiver would not require Differential Premium. Thus, Differential Premium would only be charged to policies the waived premium of which would be deemed inadequate under Plan provisions. 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 (waived) 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).

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**

7. For a policy's Shortfall Amount to be completely covered, the policyholder would need to pay the entire Self-sustaining Premium. The result of policyholders on premium waiver only paying Self-sustaining Differential Premiums is that the premiums charged for these policies are insufficient to cover their Shortfall Amount. To address the remaining shortfall that is not covered by these policies, a ***Self-sustaining Adjustment Factor*** will be calculated.

a. The Self-sustaining adjustment factor will be a multiplicative adjustment applied to all policies' Self-sustaining premiums. It will be calculated to ensure that the sum of total premiums paid are sufficient to cover the total Shortfall Amount.

b. The Self-sustaining Adjustment Factor will be calculated for all policies in the aggregate. The same adjustment will be applied to all policies' Self-sustaining Premiums.

c. Policies on premium waiver are required 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). The Self-

sustaining Adjustment Factor will be calculated to ensure that the sum of Self-sustaining Premiums paid by premium-paying policyholders and Self-sustaining Differential Premiums paid by policyholders on waiver are sufficient to cover the total Shortfall Amount.

F. PENDING RATE INCREASES

There are a number of LTC policies for which SHIP has sought regulatory approval of premium rate increases that has been granted but the approved premium rate increases have not yet become effective. The following guidelines apply to such pending rate increases.

1. The Plan will assume that the approved premium rate increases will be implemented on the earlier of (a) the date on which they would have been implemented absent the Plan, and (b) the Plan Effective Date for each policy.

2. The Policyholder Election Package will describe premium rates for each option under the Plan reflecting implementation of the approved rate increases. Thus, for some policyholders the Current Premium shown in the Policyholder Election Package will be higher than the policyholder's actual current premium by the amount of the pending approved premium rate increase. This will be true for policyholders for whom the approved premium rate increase would not take effect until after the Plan Effective Date if the Plan were not implemented.

G. 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 resume 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 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 (downgrade), 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 19), the waiver does not apply to the increase and they will be required to pay Differential Premium consisting of the difference between the premium under the elected Plan option and the Current Premium. 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) will be 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 Dual Waiver of Premium (DWOP) provisions will be treated in the same way as policyholders under Claim Waivers 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 the 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 the policyholder has selected Option Two, is paying only the If Knew Differential Premium due to the waiver, and his or her spouse recovers, the 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 the 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.

(4) If the policyholder is on Dual Waiver, has a policy with Claim Waiver of Premium, selects 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 policyholders whose policies contain a Dual Waiver provision select Option Four while neither is on claim, 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 elects 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 Option Four (the If Knew Premium).

(2) If an active 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.

H. CERTAIN "NON-CORE" POLICY BENEFITS UNAFFECTED

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,
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 or how they relate to other benefits, and they will continue once the Plan becomes effective unless the policyholder elects Option Three, the Non-forfeiture Option.

I. 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 from insurance regulators in the states in which the policies were issued.

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, implement a rehabilitation plan, including one that might 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 or benefit 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.

J. NFOs AND PAID-UP POLICIES

The Plan will not affect the approximately 9,500 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.

K. 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.

L. 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 Plan timeline provided an opportunity for policyholders and interested parties to evaluate and object to, or comment upon, the Plan if they chose to do so. The Rehabilitator may suggest modifications of the Plan as a result of those comments and objections, if any. Table 3 provides a high-level sequence for the Plan.

TABLE 3: PLAN SEQUENCE	
1.	April 22, 2020 - Filing of Proposed Rehabilitation Plan and request for approval of notice
2.	June 12, 2020 - Case Management Order
3.	July 31, 2020 - Deadline for intervention applications
4.	August 21, 2020 - Deadline for responses to intervention applications
5.	September 15, 2020 - Deadline for Objections and Comments

6.	Filing of Amended Proposed Rehabilitation Plan
7.	October 30, 2020 - Deadline for authorized interveners to file description of intended testimony and exhibits
8.	[TBD] Order setting pre-hearing conferences
9.	[TBD] Commonwealth Court pre-hearing conference
10.	[TBD] Hearing on Rehabilitation Plan, if necessary
11.	[TBD] Order Approving, Modifying or Disapproving Plan
12.	[TBD] Final Approval Date (assuming approval)
13.	Plan Preparation Period
14.	[TBD] Determination Date
15.	[TBD] Policyholder Election Package
16.	[TBD] Policyholder Election Deadline
17.	Begin Policyholder Transition Period
18.	Evaluation of Policyholder Elections
19.	[TBD] End Policyholder Transition Period
20.	[TBD] Initial Plan Effective Date
21.	[TBD] Supplemental Policyholder Election Package
22.	[TBD] Supplemental Policyholder Election Date
23.	[TBD] Supplemental Plan Effective Date
24.	Evaluation of Phase One
25.	[TBD] Decision on Phase Two
26.	[TBD] Phase Two Policyholder Election Package

27.	[TBD] Phase Two Policyholder Election Deadline
28.	[TBD] Phase Two Effective Date
29.	Evaluation of Plan performance
30.	[TBD] Phase Three, if justified.

a. The Plan will be submitted to the Commonwealth Court for approval, modification, or disapproval. Policyholders and interested parties have been provided an opportunity to offer comments about, or object to, the Plan. The Commonwealth Court may hold a hearing on the Plan. Following the hearing (if one is set by the Court), 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) SHIP's LTC insurance policies will be restructured as described in Section VI.H, page 86. This restructuring will not affect the options available to policyholders under the Plan.

(2) 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.

(3) The ***Policyholder Election Package*** (containing the information required for policyholders to make their elections) and the ***Policyholder Election Forms*** (upon which they will do so) will be prepared and distributed.

(4) Except as noted below in Section II.L.3, page 33, the Policyholder Elections must be made by the ***Policyholder Election Date*** and will be collected and evaluated by the Company as received.

(5) On the ***Initial Plan Effective Date*** all the Policyholder Elections, other than those addressed in Section II.L.3.c, below, will be implemented and the premium and policy changes will take effect.

(6) 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 110 and 112.

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 20), or Option Four (retain current benefits at Phase One Premium - see Section II.C.1.d, page 20), 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 ***Policyholder Transition Period***, when policyholders whose policies contain DWOP are deemed eligible for benefits which are pending and therefore 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 and the DWOP spouses of such policyholders who, during the Policyholder Transition Period, experience any of the following ***Transitional Events***:

(1) discontinue paying premium due to the activation of a Premium Waiver other than those described in subparagraph (a), above),

(2) go on claim (other than those described in subparagraph (b), above),

(3) recover and cease being on claim, or

(4) resume paying premium due to the deactivation of a Premium Waiver,

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***. If such a policyholder experiences a Transitional Event during the Policyholder Transition Period but the Company doesn't learn of it until after the policyholder has submitted an apparently valid Policyholder Election Form or after the Initial Plan Effective Date, the policyholder's election will be invalidated by the Transitional Event and the policyholder will be required to submit a new Policyholder Election Package before the Supplemental Plan Effective Date. If the Company learns of the Transitional Event after the Supplemental Plan Effective Date then the policy will be modified to implement the Default Option that would have applied had the Company learned of the Transitional Event before the Supplemental Plan Effective Date and the policyholder failed to make a valid election.

M. 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.

N. CALCULATION NOTES

1. The assets allocated on an Accumulated Premium basis for determination of Self-sustaining Premium for purposes of Phase Two calculations 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 23.

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. 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 (often 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.

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. The premium for 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. In determining a policy's ***Maximum Policy Value*** (MPV), which is the product of a policy's Maximum Benefit Period (MBP) times its ***Maximum Daily Benefit*** (MDB), changes attributable to claims and benefits (such as inflation protection) will be taken into account. For Plan purposes, MPV will be calculated as if the policyholder went on claim on the Plan Effective Date. A policy with an unlimited benefit period will be deemed to have an unlimited MPV.

8. The Plan contemplates that the minimum premium for Basic Policy Endorsements in Phase Two will be 110% of the Basic Policy 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.2.

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.

O. 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 the Maximum Daily Benefits for ALF care will be limited to 75% of the policy's MDB for Nursing Home benefits.

III. DETAILS OF PHASE ONE OF THE PLAN

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

Policyholders who, as of the Phase One election date, are paying premiums and are not disabled or eligible for benefits will have the following options.

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

   a. Such 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 policyholders that elect Option One and whose Current Premiums are lower than the If Knew Premium for their current policies, the benefit reductions will be calibrated to produce benefits for which the premium on an If Knew Premium basis will be within 2% of the Current Premium, *i.e.*, no lower than 98% nor higher than 102% of the Current Premium. A description of the Downgrade Process follows Table 4.

TABLE 4: IS DOWNGRADE NECESSARY?		
IF:	CASE 1	CASE 2
1. THE CURRENT PREMIUM IS and	$3,000	$3,200
2. THE IF KNEW PREMIUM FOR THE CURRENT BENEFITS IS THEN:	$2,800	$5,000
IN CASE 1, SINCE THE IF KNEW PREMIUM IS LOWER THAN THE CURRENT PREMIUM, THERE WILL BE NO BENEFIT REDUCTIONS.	NO	
IN CASE 2, SINCE THE IF KNEW PREMIUM IS MORE THAN THE CURRENT PREMIUM, BENEFITS WILL BE REDUCED 36% TO THE CURRENT PREMIUM.		YES

c. DOWNGRADE PROCESS: A single combination of one or more of the benefit reductions described in Section III.A.1.f, page 41 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 ability to select 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 required 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.

(3) The Rehabilitator may also adjust 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. Efforts will be made to minimize the number of benefit reductions applied to each policy.

(4) Except as noted in the next paragraph, benefits will not be scaled above or below Plan Limits. Plan Limits for benefit period are a minimum of four years (unless the policy already has a lower MBP) and a maximum of 6 Years. Plan Limits for Daily Benefit are:

(a) For Nursing Home Care, a minimum of the lesser of (a) 80% of current level or (b) $300, and a maximum $600;

(b) For Facility Care, a minimum of the lesser of (a) 80% of current level or (b) $225, and a maximum $450; and

(c) For Home Health Care, a minimum of the lesser of (a) 80% of current level or (b) $150, and a maximum $300.

(5) In order to achieve the Downgrade Target Premium (the Current Premium), for some policyholders for whom other Benefit Reductions have not achieved the desired premium level, the MBP may be reduced below Plan Limits. For those policyholders for whom the Downgrade Option (Option One) is the default, the NFO serves as a safety net against reduction of the Maximum Benefit Period below the lesser of the current Benefit Period and 30 months. For other policyholders who select Option One and it produces a lower Benefit Period than the NFO or other Options, electing one of the other Options may be preferable.

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.

(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% 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 MDB and MBP (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 to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.

(7) 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. ***Benefit Reductions*:**

(1) ***Benefit Reduction One*:** Elimination of Restoration of Benefits (ROB) provisions. This is a binary and non-scalable benefit reduction.

(2) ***Benefit Reduction Two:*** Elimination of Extension of Benefits provisions. This is a binary and non-scalable benefit reduction.

(3) ***Benefit Reduction Three:*** For policies with less restrictive triggers, adoption of the TQ Trigger. See Section III.A.2.d.(7), page 44. This is a binary and non-scalable benefit reduction.

(4) ***Benefit Reduction Four:*** Discontinuation of Return of Premium (ROP) provisions. As of the Plan Effective Date, policies with Return of Premium benefit to which this reduction applies will cease accruing returnable premium. However, for policies which provide that returnable premiums accrue over several years and are then paid, or which make some past premium returnable upon specified events, ROP benefits accrued prior to the Effective Date will not be lost and will be calculated up to the applicable Plan Effective Date. Such returnable premium accrued prior to the Effective Date will be repaid at or around the time when the payment would have been due absent modification under the Plan. This is a binary and non-scalable benefit reduction.

(5) ***Benefit Reduction Five*:** Removal of inflation and "locking" of MDB at their current levels. This is a binary and non-scalable benefit reduction.

(6) ***Benefit Reduction Six*:** Conversion of indemnity to reimbursement. See Section VI.B.9, page 80. This is a binary and non-scalable benefit reduction.

(7) ***Benefit Reduction Seven*:** Reduction of the policy's MDB to the lesser of 80% of current level and $300 for Nursing Home Care; the lesser of (a) 80% of current level or (b) $225 for Facility Care; and the lesser of (a) 80% of current level or (b) $150 for Home Health Care. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits.

(8) ***Benefit Reduction Eight*:** 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.

(9) ***Benefit Reduction Nine*:** Reduction of the policy's 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.

(10) ***Benefit Reduction Ten*****:** 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. The elimination will be prospective only and will not apply to the current waiver. It will apply to any waiver that would otherwise first have become effective after the downgrade.

(11) ***Benefit Reduction Eleven:*** Conversion to pool of money (unless the policy is already pool of money) and reduction of the Maximum Benefit Period to the amount required to achieve the Current Premium.

g. The Downgrade is generally the Default Option for policyholders on Premium Waiver. In those cases, 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 deemed the Default Option.

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 does not have Extension of Benefits, Restoration of Benefits, or Return of Premium, has Inflation Protection, is Tax Qualified, 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, Three, and Four (BR1, BR2, BR3, and BR4) are inapplicable because the policy already has TQ Triggers, and no EOB, ROB or ROP benefits. Benefit Reduction Five (BR5) - 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. BR6 would be inapplicable because this is already a reimbursement policy. Benefit Reduction Seven (BR7) - reduction of MDB to the lesser of 80% of current level or $300 - is evaluated in combination with previously selected BR5 and the result of reducing the MDB 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. BR7 would also be selected and BR8 would be the next to be evaluated.

4. Benefit Reduction Eight (BR8) - Extension of the EP to not less than 90 days - is then evaluated in combination with BR5 and BR7, and the result of extending the EP to 90 days (in combination with BR5 and BR7) 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. BR7 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 BR5, BR7, and BR8.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT CORRESPONDING IF KNEW PREMIUM.

   a. Such 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 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) Removal (discontinuation) of Return of Premium (ROP) benefit. As of the Plan Effective Date, policies with Return of Premium benefit will cease accruing returnable premium. However, for policies which provide that returnable premiums accrue over several years and are then paid, or which make some past premium returnable upon specified events, ROP benefits accrued prior to the Effective Date will not be lost and will be calculated up to the applicable Plan Effective Date. Such returnable premium accrued prior to the Effective Date will be repaid at the time when the payment would have been due absent modification under the Plan.

(4) Removal of Extension of Benefits provisions.

(5) For policies with annual inflation adjustment in MDB above 1.5%, reduction of the adjustment to 1.5%, retaining the original type (simple or compound);

(6) Reduction and adjustment of MDB by site of care. The MDB for Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and $300. The MDB for Facility Care other than Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and $225. The MDB for Home Health Care will be the lesser of 80% of the MDB for such care in the current policy and $150;

(7) Adoption of ***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;

(8) Conversion of reimbursement policies to indemnity;

(9) Conversion of "Days of Care" policies to "Pool of Money;"

(10) Removal of Restoration of Benefits (ROB) provisions; and

(11) 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" at higher If Knew Premium with the terms described above but caps at a five-year benefit period and 2% inflation. 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 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. The inflation type (simple or compound) will be the same as the current policy.

g. Except as noted in the next paragraph, and 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. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

3. OPTION THREE - NFO.

a. Such 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.

(1) Like the Basic Policy Endorsements, this will be an indemnity policy (not reimbursement);

(2) It will not have Extension of Benefits provisions;

(3) It will not have Return of Premium provisions;

(4) It will not have Restoration of Benefits provisions;

(5) It will convert "Days of Care" policies to "Pool of Money;"

(6) it will have a minimum 90-day elimination period;

(7) It will have TQ triggers;

(8) It will not have an inflation protection feature; and

(9) The Maximum Daily Benefit (MDB) will be reduced and adjusted for site of care. The MDB for Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and $300. The MDB for Facility Care other than Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and $225. The MDB for Home Health Care will be the lesser of 80% of the MDB for such care in the current policy and $150.

b. In those rare cases in which the specific policy provides for an NFO that has greater benefits than the Plan NFO, the policy-specific NFO will be offered instead.

c. No additional premiums will be due for this policy and it will never lapse.

d. This policy offers more benefits than traditional NFOs. It cannot be upgraded later.

e. The selection of indemnity, rather that 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. Such policyholders can elect to keep their current benefits and their premiums will increase to the corresponding Phase One Premium. See Section II.E.1, page 22,

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*)

Policyholders who, as of the Phase One election date, are NOT paying premiums due to the applicability of a premium waiver provision, but who are not disabled or eligible for benefits will have the following options.

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 37) 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 38, above).

      (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 41, above.

      (4) The benefit reductions will be calibrated to the Current Premium as explained in Section III.A.1.b, page 37.

      (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 may also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 45.

(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) If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 45. If the current policy provides benefits below the applicable GA limits, the MPV of the endorsed policy will be adjusted so that it is at least equal to the current MPV.

c. OPTION THREE - NFO (see Section III.A.3, page 46).

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 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 38 subject to the following provisions.

(2) The same possible benefit reductions will apply, as described in Section III.A.1.f, page 41. 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 37). 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 44). 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.

(2) Policyholders may also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 45.

(3) If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 45. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

(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 24). 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 37), 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 and benefit reductions described in Sections III.A.1.c, page 38, and III.A.1.f, page 41, above, subject to the following provisions.

b. The following Benefit Reductions would apply to new benefit periods after recovery:

(1) The changes in triggers described in Benefit Reduction Three;
(2) The change to reimbursement described in Benefit Reduction Six;
(3) The extension of elimination period described in Benefit Reduction Eight; and
(4) The elimination of premium waiver provisions in Benefit Reduction Ten.

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 37).

d. Note that the Downgrade Process does not increase the premium being paid prior to the downgrade, although in a few cases it may be reduced slightly.

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 44, at If Knew Premium.

a. For those policies with an MPV that is currently above their applicable Guaranty Association limits, the endorsed policy's MPV will be adjusted to be at least equal to the applicable Guaranty Association limits. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

b. Policyholders may also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 45.

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*)

Policyholders who, as of the Phase One election date, are not paying premiums due to a premium waiver provision and are disabled or eligible for benefits will have the following options.

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 38, and the benefit reductions described in Section III.A.1.f, page 41, above.

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 37). 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 increase the premium being paid prior to the downgrade.

e. The following Benefit Reductions would apply to new benefit periods after recovery:

(1) The changes in triggers described in Benefit Reduction Three;
(2) The change to reimbursement described in Benefit Reduction Six;
(3) The extension of elimination period described in Benefit Reduction Eight; and
(4) The elimination of premium waiver provisions in Benefit Reduction Ten.

f. 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 37).

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.

a. These 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 44, above.

b. Policyholders may also be offered an "Enhanced Basic Policy Endorsement"at higher If Knew Premiums. See Section III.A.2.f, page 45.

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. Although they will be required to pay the full If Knew Premium rather than the Differential Premium upon recovery, policyholders who elect this option in Phase One will not face other 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. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments 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. (See Section II.E.6.b, page 24).

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

Phase Two will be implemented as and when deemed necessary by the Rehabilitator depending on the results of Phase One. As currently contemplated, it will be similar in structure to Phase One though based on Self-sustaining premiums rather than If Knew Premium.

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 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*)

Policyholders who, as of the Phase Two election date, are paying premiums and are not disabled or eligible for benefits will have the following options.

1. OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.

    a. Such 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 38) 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. Such 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 44.

    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 Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

    d. Policyholders may also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 45.

    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. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

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

4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.

   a. These policyholders can elect to maintain the current policy benefits but will be required to pay Self-sustaining Premiums.

   b. As noted previously, 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 23, above.

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

Policyholders who, as of the Phase Two election date, are not paying premiums due to a premium waiver provision, but who are not disabled or eligible for benefits will have the following options.

1. LIFETIME WAIVER - Such 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 55) 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 38, above).

      (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 41, above,

(4) In this case the benefit reductions will be calibrated such that the projected benefits and expenses (the PBA) are equal to the sum of projected premiums and 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. If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 45. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

(1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

(2) Policyholders may also be offered an "Enhanced Basic Policy Endorsement". See Section III.A.2.f, page 45 at higher Self-sustaining Differential Premiums. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

c. OPTION THREE - NFO (see Section III.A.3, page 46).

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. 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 will be downgraded.

(1) The Downgrade Process will be as described in Section III.A.1.c, page 38 subject to the following provisions.

(2) The Benefit Reductions will apply, as described in Section III.A.1.f, page 41. 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 (the Current Premium). 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 44). The policyholder will be required to pay the Self-sustaining Differential Premium.

(2) If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 45. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

(3) Policyholders may also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 45.

(4) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy, reflecting the cost of delay in making this election until 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 benefits and pay the Self-sustaining Differential Premium (see Section IV.C.1.e, page 57).

(1) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-sustaining Premium.

(2) The Self-sustaining Differential Premium cannot be less than zero.

D. 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 IV.B, page 55) subject to the following conditions.

1. 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 38. The Benefit Reductions described in Section III.A.1.f, page 41 will apply, but the benefits will be reduced so that they produce a Self-Sustaining Premium within 2% of the Current Premium.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM. The policy will be endorsed as described in Section III.A.2.d, page 44, at Self-sustaining Premium

a. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

b. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

c. 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. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

d. This will be the default for these policyholders.

e. Policyholders may also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 45.

3. OPTION THREE - NFO. See Section III.A.3.

4. 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.

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.

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

Policyholders who, as of the Phase Two election date, are not paying premiums due to a premium waiver provision, and who are disabled or eligible for benefits will have the following options.

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 38. The Benefit Reductions described in Section III.A.1.f, page 41, above, will apply 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.(7), page 44.

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 44.

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 Basic Policy 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. For those policies with MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that they are at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

e. Policyholders may also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 45.

f. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.

g. If the policyholder recovers, he or she 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 57). If the policyholder recovers he or she will be required to begin paying the full Self-sustaining Premium.

F. SUMMARY OF POLICYHOLDER OPTIONS

The following table summarizes all of the options available to policyholders under the Plan depending on their claim and premium-paying status in both Phase One and Phase Two.

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. Option 2 preserves the GA floor for policyholders with benefits above that.**		

G. POLICY ILLUSTRATIONS

The following twelve examples illustrate how these options work for some representative policies. The policies selected are actual in-force SHIP policies. 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.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$529	ILLUSTR. # 1	YEAR ISSUED	1988	
MAXIMUM DAILY BENEFIT	$160		AGE WHEN ISSUED	57	
MAXIMUM BENEFIT PERIOD (in years)	2.0		CURRENT AGE	89	
MAXIMUM POLICY VALUE	$116,800		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	PA	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	PA	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$529	$529	$172	$172	NO PREMIUM	$618
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$357	-$357	-$529	+$89
				0.0%	-67.5%	-67.5%	-100.0%	+16.8%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$160	$149	$128	$128	$128	$160
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$116,800	$109,036	$116,800	$116,800	$93,440	$116,800
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$618**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$2,835**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$4,116	ILLUSTR. # 2	YEAR ISSUED	1991	
MAXIMUM DAILY BENEFIT	$133		AGE WHEN ISSUED	60	
MAXIMUM BENEFIT PERIOD (in years)	Unlimited		CURRENT AGE	88	
MAXIMUM POLICY VALUE	Unlimited		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	OK	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$4,116	$4,116	$4,758	$4,758	NO PREMIUM	$7,600
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$642	+$642	-$4,116	+$3,484
				0.0%	+15.6%	+15.6%	-100.0%	+84.6%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	2.2	7.7	7.7	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$133	$106	$106	$106	$106	$133
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	$84,906	$300,000	$300,000	$96,845	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	$0	$0	$0	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$7,197**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$6,039**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. # 3	YEAR ISSUED	1995	
MAXIMUM DAILY BENEFIT	$159		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	2.0		CURRENT AGE	89	
MAXIMUM POLICY VALUE	$290,536		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	GA	
PREMIUM AND CLAIM STATUS	Lifetime waiver	Disabled	STATE OF RESIDENCE	GA	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	$0	$0	$0	$0
				NA	NA	NA	NA	NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$159	$159	$127	$127	$127	$159
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$290,536	$290,536	$290,536	$290,536	$116,215	$290,536
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$867**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,614	ILLUSTR. # 4	YEAR ISSUED	2001	
MAXIMUM DAILY BENEFIT	$244		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	4.0		CURRENT AGE	82	
MAXIMUM POLICY VALUE	$354,774		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	PA	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	FL	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,614	$2,614	$3,520	$3,520	NO PREMIUM	$5,344
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$906	+$906	-$2,614	+$2,730
				0.0%	+34.6%	+34.6%	-100.0%	+104.4%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	2.8	4.2	4.2	2.5	4.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$244	$195	$195	$195	$195	$244
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$354,774	$197,227	$300,000	$300,000	$178,365	$354,774
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$54,774	$0	$0	$0	$0	$54,774

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$5,047**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$14,639**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$6,306	ILLUSTR. # 5	YEAR ISSUED	1995	
MAXIMUM DAILY BENEFIT	$339		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	89	
MAXIMUM POLICY VALUE	$395,961		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	OH	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	OH	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$6,306	$6,306	$8,146	$8,169	NO PREMIUM	$10,727
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$1,840	+$1,863	-$6,306	+$4,421
				0.0%	+29.2%	+29.5%	-100.0%	+70.1%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	0.9	3.0	3.0	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$339	$271	$271	$271	$271	$339
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$395,961	$92,110	$302,598	$304,598	$247,207	$395,961
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$95,961	$0	$2,598	$4,598	$0	$95,961

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$10,259**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$18,830**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,906	ILLUSTR. # 6	YEAR ISSUED	1996	
MAXIMUM DAILY BENEFIT	$307		AGE WHEN ISSUED	62	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	85	
MAXIMUM POLICY VALUE	$365,778		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	PA	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	PA	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,906	$2,906	$2,532	$2,549	NO PREMIUM	$4,972
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$375	-$357	-$2,906	+$2,066
				0.0%	-12.9%	-12.3%	-100.0%	+71.1%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.3	3.2	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$307	$246	$246	$246	$246	$307
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$365,778	$269,063	$300,000	$300,000	$224,220	$365,778
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$65,778	$0	$0	$0	$0	$65,778

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$4,360**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$21,738**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,216	ILLUSTR. # 7	YEAR ISSUED	1997	
MAXIMUM DAILY BENEFIT	$246		AGE WHEN ISSUED	63	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	86	
MAXIMUM POLICY VALUE	$286,584		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	IL	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	IL	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,216	$2,216	$2,814	$2,831	NO PREMIUM	$3,597
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$598	+$615	-$2,216	+$1,381
				0.0%	+27.0%	+27.7%	-100.0%	+62.3%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.9	3.9	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$246	$197	$197	$197	$197	$246
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$286,584	$215,251	$286,584	$286,584	$179,376	$286,584
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$3,398**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$13,297**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,995	ILLUSTR. # 8	YEAR ISSUED	1997	
MAXIMUM DAILY BENEFIT	$205		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	5.0		CURRENT AGE	86	
MAXIMUM POLICY VALUE	$432,370		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	OK	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	OK	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,995	$2,995	$1,522	$1,526	NO PREMIUM	$2,995
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$1,473	-$1,468	-$2,995	$0
				0.0%	-49.2%	-49.0%	-100.0%	0.0%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	5.0	5.0	4.8	5.0	2.5	5.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$205	$205	$164	$164	$164	$205
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$432,370	$432,370	$300,000	$317,011	$149,483	$432,370
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$132,370	$132,370	$0	$17,011	$0	$132,370

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$2,995**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$4,393**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. # 9	YEAR ISSUED	1999	
MAXIMUM DAILY BENEFIT	$60		AGE WHEN ISSUED	67	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	88	
MAXIMUM POLICY VALUE	$65,700		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	TX	
PREMIUM AND CLAIM STATUS	Lifetime waiver	Active	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current Your Policy Now	Option 1 Downgrade	Option 2 Basic Policy	Option 2a Enhanced Basic Policy	Option 3 Enhanced RPU	Option 4 Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0 NA	$0 NA	$0 NA	$0 NA	$0 NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.8	3.8	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$60	$60	$48	$48	$48	$60
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$65,700	$65,700	$65,700	$65,700	$43,800	$65,700
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$757**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$6,336	ILLUSTR. #	10	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	$174			AGE WHEN ISSUED	67
MAXIMUM BENEFIT PERIOD (in years)	Unlimited			CURRENT AGE	92
MAXIMUM POLICY VALUE	Unlimited			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	NC
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	NC

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$6,336	$6,336	$2,886	$2,886	NO PREMIUM	$7,695
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$3,450	-$3,450	-$6,336	+$1,359
				0.0%	-54.4%	-54.4%	-100.0%	+21.4%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	5.9	5.9	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$174	$174	$139	$139	$139	$174
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	$300,000	$300,000	$126,801	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	$0	$0	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$6,336**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$9,296**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. # 11	YEAR ISSUED	1991	
MAXIMUM DAILY BENEFIT	$206		AGE WHEN ISSUED	55	
MAXIMUM BENEFIT PERIOD (in years)	Unlimited		CURRENT AGE	84	
MAXIMUM POLICY VALUE	Unlimited		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	TX	
PREMIUM AND CLAIM STATUS	Claim waiver	Disabled	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current Your Policy Now	Option 1 Downgrade	Option 2 Basic Policy	Option 2a Enhanced Basic Policy	Option 3 Enhanced RPU	Option 4 Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	$864
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	$0	$0	$0	+$864
				NA	NA	NA	NA	NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	4.8	5.0	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$206	$185	$165	$165	$165	$206
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	$300,000	$314,012	$150,238	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	$0	$14,012	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$14,325**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$1,198	ILLUSTR. # 12	YEAR ISSUED	1988	
MAXIMUM DAILY BENEFIT	$80		AGE WHEN ISSUED	56	
MAXIMUM BENEFIT PERIOD (in years)	4.0		CURRENT AGE	88	
MAXIMUM POLICY VALUE	$116,800		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	TX	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$1,198	$1,198	$529	$529	NO PREMIUM	$1,198
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$669	-$669	-$1,198	$0
				0.0%	-55.8%	-55.8%	-100.0%	0.0%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	4.0	5.0	5.0	2.5	4.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$80	$80	$64	$64	$64	$80
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$116,800	$116,800	$116,800	$116,800	$58,400	$116,800
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$1,198**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$1,757**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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V. PHASE THREE

Following implementation of Phase One and Phase Two, SHIP will continue managing its LTCI in a run-off mode. While some aspects of Phase Three will be developed in the future, if the Company has improved to the point of having assets available, payments will be made to agents, policyholders, and other creditors on account of amounts owed to them. Certain amounts may be owed to policyholders on account of the ***Unfunded Benefit Liability*** created as part of the policy restructuring. See Section VI.H, page 86. By virtue of the restructuring, this Unfunded Benefit Liability (UBL) will be a non-insurance obligation payable only if SHIP has assets available for payments to general creditors in Phase Three. To the extent such assets are available, they will be applied proportionately to the UBL along with other unpaid general creditors liabilities, such as agent commissions and amounts owed to companies previously reinsured by SHIP.

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 there remain unsatisfied insurance policy obligations, the Guaranty Associations may be triggered to protect the remaining policy obligations, subject to applicable statutory conditions and limits. See Section VI.J, page 87.

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, Conseco, to the newly formed, nonprofit, *Senior Health Care Oversight Trust* (the "Trust" - see page 84) 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, Inc. ("LTCG") for lower-level claims administration functions; Milliman for rate increase analyses and valuations; Conning, Inc., and New England Asset Management, Inc., 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.

TABLE 7 - CORPORATE HISTORY



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 45,000 remain in force. More precisely,

1. As of year-end 2018, SHIP had 51,635 policies in force, of which 6,151 policyholders were on claim. As of that date, it also reinsured 2,620 policies of which 401 were on claim. See Section VI.M , page 91. Thus at that time it administered a total of 54,255 policies of which 6,552 were on claim.

2. By year end 2019, SHIP's direct business was down to 45,518, with 5,776 on claim. Its assumed business was down to 2,267 policies, 376 on claim. At the end of last year, therefore, SHIP was administering 47,785 policies of which 6,152 were on claim.

3. By mid-year (June 30, 2020) these numbers had declined further. The total of direct policies was down to 42,559, of which 5,402 were on claim. Assumed policies numbered 2,114, with 352 on claim. Total of administered LTC policies was therefore 44,673, of which 5,753 were on claim.

A 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'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:

4. 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:

    a. provides insurance coverage only for qualified LTC services;

    b. does not pay or reimburse expenses that are reimbursable under Medicare;

    c. is guaranteed renewable;

    d. 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;

e. 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

f. satisfies certain consumer protection requirements as well as disclosure and nonforfeitability requirements.

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

   a. 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;

   b. 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

   c. requiring substantial supervision to protect such an individual from threats to health and safety due to severe cognitive impairment.

6. 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:

   a. *Your Physician certifies Your care to be Medically Necessary; or*

   b. *You are unable to perform two (2) or more Activities of Daily Living without assistance or supervision; or*

   c. *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.

7. 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.

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

9. 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.

10. 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.

11. 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.

12. 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 resume paying premiums. Approximately 14% of policyholders who otherwise would pay premiums are currently receiving the Waiver of Premium benefit.

13. 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.

14. 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 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	(916,098,229)

More complete financial information as of December 31, 2019, is included at Exhibit B, along with summary updated information through June 30, 2020. It is estimated that SHIP's Funding Gap is more than $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 at least $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 has been conducting and will continue thorough and exhaustive investigations and analyses 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 these insurance 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 when premium rates were 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 was 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.

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 Conseco 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.

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 84) 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 81, 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 consultants 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 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. A Proposed Rehabilitation Plan was filed on that date and this Plan Document is and amended version of the plan required by the Court.

E. SENIOR HEALTH CARE OVERSIGHT TRUST

As mentioned above, SHIP had been a subsidiary of Conseco, Inc. ("Conseco") 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

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.

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, Inc., ("LTCG") and continues providing these services to SHIP.

H. POLICY RESTRUCTURING

Before the Effective Date and before policyholders have made their elections, the Rehabilitator will determine which of SHIP's policies are Impaired Policies in that the assets and premiums projected to be available will not suffice to pay the liabilities projected to arise under such policies. For purposes of implementing the Plan and to facilitate identification and implementation of key economic and tax components of the Rehabilitator's strategy, SHIP's LTC policy liabilities will be restructured to incorporate the terms of the Plan and permit Policyholder Elections. The restructuring must be approved by the Court as part of its approval of the Plan. The Rehabilitator will request that the Court deem SHIP's liabilities for Impaired Policies to have been restructured as of the Effective Date, and before giving effect to Policyholder Elections or modifications under the Plan. However, this restructuring will not affect the elections made by or available to the policyholders.

The restructuring will be for the purpose of separating the liabilities arising under SHIP's LTC policies that it is projected to have sufficient assets to fund (the ***Initial Funded Restructured Policy Value*** - "**IFRPV**"), from those that it is projected to be unable to fund (the Unfunded Benefit Liability - UBL). This restructuring will consist of notionally allocating the liability arising under each such policy (equal to its GPR) to its IFRPV and its UBL, with the UBL for each policy being the difference between its original GPR and its IFRPV. Premiums paid as to each policy and Allocated Assets determined under the Plan as described in Section II.E.4.e, page 23, are projected to suffice to enable the Company to fund its IFRPV. As a result, after the Effective Date, SHIP will have assets and expected premiums at least equal to the aggregate funded liabilities (IFRPV) remaining under the Restructured Policies.

The Company will retain non-insurance indebtedness to the policyholders on account of the amount by which the liabilities have been reduced, *i.e.*, the UBL. However, this liability will not be an insurance obligation arising under SHIP's policies and would not constitute a contractual obligation covered by the Guaranty Associations if SHIP were liquidated. Under the Plan, this liability will be converted to non-insurance general creditor indebtedness. It is possible that realization by SHIP of additional assets will enable it to make at least partial payments of the UBL in Phase Three. In any case, as explained below, the Rehabilitator will request that the portion of SHIP's UBL that it will not be able to fund be discharged by the Commonwealth Court as part of the Plan.

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 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 Insurance 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 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. Note that many SHIP policyholders have more than one SHIP LTC policy but this limit will apply to all of them combined. If one policy has benefits in excess of the applicable cap, all of the benefits of the other policy or policies will potentially be lost. 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 also 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. 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.

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.

As explained on page 12, the Plan is designed to provide policyholders at least the benefits they would receive from Guaranty Associations in liquidation. Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to those that would be available from the applicable Guaranty Association in the event of liquidation, but no more than the current policy benefits. Option Two will do that for all policyholders, 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.

K. LIQUIDATION CLAIMS IN EXCESS OF GUARANTY ASSOCIATION LIMITS

It is estimated that more that 20% of the benefits to which SHIP policyholders are expected to be entitled under current policies would exceed the statutory limits of guaranty association

coverage as described in the preceding Section. While the Rehabilitator believes that applicable law would authorize her to use SHIP assets to pay at least part of those "uncovered benefits," some members of the insurance industry hold the opposite view. These insurers have been engaged in a years-long legal proceeding that has so far prevented the liquidator of Penn Treaty Network America Insurance Company and American Network Insurance Company from making such payments. These two insurers are also Pennsylvania-domiciled long-term care insurers and the Rehabilitator, who is also the Liquidator in those cases, is concerned that she might be prevented from paying uncovered benefits to SHIP's policyholders if it also has to be placed in liquidation. Thus, it is possible that placing SHIP in liquidation might result in "truncating" to the limits of guaranty association coverage the contractual benefits for which policyholders have been paying premiums.

L. 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 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 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.

M. REINSURANCE

SHIP has assumed a number of LTC policies through co-insurance or reinsurance and ceded other policies under other reinsurance agreements. This Section describes those arrangements.

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 Travellers 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 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.

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.

7. TREATMENT OF REINSURANCE ASSUMED

The insurance policies for which SHIP became responsible from Transamerica, Primerica and American Health and Life or their predecessors (the "ceding companies") are what is generally referred to in the industry as "reinsurance assumed." All of these assumed LTCI policies have historically been treated by SHIP for administrative purposes in a manner very similar to those issued directly by SHIP. However, communications with policyholders and regulators properly identified them as policies of the ceding companies.

It is important to note that while these policies have been reinsured by SHIP, they were never "novated" as part of the transaction. Novation occurs when the assuming company substitutes for the ceding company so that all of the policyholders' contractual rights are against the assuming

company and the ceding company is relieved of further obligation for the policies at issue. That did not happen in these cases. That means that the policyholders retained, and continue to retain, their contractual rights against the ceding companies (the companies that transferred the policies to SHIP through reinsurance) or their successors. These assumed policies would not be treated as if they had been issued by SHIP if it were placed in liquidation. In liquidation these policies also would not be subject to the statutory Guaranty Association limits. In the event that SHIP is placed in liquidation, these policies reinsured and administered by SHIP, but not novated, will be administered as the responsibility of the ceding companies.

For purposes of the Plan, it is also important to note that the law governing financially troubled insurers generally requires that liabilities arising under insurance policies issued by the troubled company ("Direct Business") be paid in full before those arising under reinsurance assumed can receive any payment. The companies (or their successors) from which SHIP assumed the Reinsurance Assumed remain responsible to the policyholders if SHIP fails to fulfill the contractual obligations arising under those policies.

The preliminary plan of rehabilitation filed on April 22, 2020 proposed to treat Direct Business and Reinsurance Assumed in the same way under the Plan. The Rehabilitator believed that this would be most advantageous to the affected policyholders. However, this proposal resulted in a number of objections from insurance regulators around the country, asserting that it departs from established custom and practice and is unsupported by applicable law. In response to these objections, the Rehabilitator has decided to change that provision of the preliminary plan of rehabilitation and to treat the reinsurance assumed differently from the policies issued directly by SHIP and its predecessors. As a result of this change:

a. The reinsurance assumed policies will not be modified under the Plan and the policyholders will not be asked (or have the ability) to make elections under the Plan;

b. SHIP will not be financially responsible for claims and commissions owed under these policies and will not have the right to treat premiums paid by these policyholders as assets of SHIP; and

c. If SHIP is placed in liquidation, the terms of these policies will remain unchanged and the policyholders will not receive benefits from any life and health insurance Guaranty Association. Instead, in that case, the ceding company (or its successor) will remain fully responsible for these policies and any claims and commissions owed under these policies.

Whether, and to what extent, premium rate increases will be sought for these policies in the future will be decided by the ceding companies, not the Rehabilitator. It is possible that SHIP will enter into agreements to administer some or all of these policies in exchange for appropriate fees.

N. 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).

O. 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 scenario to select a Non-forfeiture Option under which no more premium will be due. In fact, elements of the Plan make the NFO option materially more valuable than traditional NFOs. See section II.J, page 30. 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.

P. 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.

Q. 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 importance. 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, because Policy Modifications and 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 create significant taxable income. However, the Plan contemplates offsets to taxable income arising from the restructuring of SHIP's policies, bifurcating the liabilities arising under them as between their Initial Funded Restructured Policy Value (IFRPV) and their Unfunded Benefit Liability (UBL), constituting general creditors obligations and not insurance policy liabilities. The Plan also contemplates the eventual discharge by the Commonwealth Court of the portion of the UBL that cannot be paid, which will minimize this tax exposure. The IFRPV is the portion of a policy's liability that SHIP is expected to be able to fund. The UBL is the portion of that liability that SHIP is not expected to be able to fund.

SHIP is part of a consolidated group for federal income tax compliance purposes, which also includes its affiliates, the Trust and Fuzion. The group files a consolidated federal income 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 in the Internal Revenue Code on the use of such carry-forwards. 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, it is possible that such reduction would result in federal income tax. It is possible that not all of such income may be excludable under an insolvency exception 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, 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.

R. 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;

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.

S. 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, 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.

T. ALTERNATIVES TO THE PLAN

Before determining that the Proposed Rehabilitation Plan is the best option for SHIP's policyholders, the Rehabilitator and the rehabilitation team considered a number of alternatives. Each of these is described briefly below, although a complete explanation of what their terms would include would be too lengthy to be included here and would require further development not justified under the circumstances.

1. SALE OR RECAPITALIZATION

Before SHIP was placed in rehabilitation, its management and the Trustees explored many alternatives to avoid delinquency proceedings. These included sale of the company, reinsurance transactions, recapitalization transactions, and restructuring of the investment portfolio. All of these options were deemed impractical or insufficient. SHIP has a closed block of highly unprofitable LTC insurance business making it very unattractive to buyers and investors. Its financial composition is such that legitimate reinsurance transactions would not offer the prospect of material economic improvement. There is no sufficiently profitable block of insurance within the company to absorb the excess risk of the LTC block. The broad capital markets comprise a low-yield environment that also does not offer a reasonable prospect of material economic improvement from restructuring of SHIP's invested assets. Working with Pennsylvania Insurance Department representatives, management did implement a number of cost saving measures, but the net result is too small to avoid the need for rehabilitation.

2. LIQUIDATION

Before embarking on designing the details of the Proposed Rehabilitation Plan the team evaluated whether policyholders would be better served by placing the Company in liquidation. After extensive analysis and discussion it was determined that policyholders would fare better under the Proposed Rehabilitation Plan. The principal reasons that the Plan was deemed preferable to liquidation were:

a. It would offer policyholders additional choices to address their individual needs under these difficult circumstances.

b. It would provide policyholders the ability to preserve their current coverage if they were willing and able to pay the required premium rate increase.

c. It would eliminate the historical premium rate inequities and subsidies prospectively so that all policyholders would pay comparable premiums for comparable coverages. This is viewed as particularly important since widely different responses to requests for approval of premium rate increases among the states over time have resulted in holders of policies issued in certain states paying substantially higher premiums than holders of similar policies issued in other states. This has created a much-criticized subsidy problem in which the higher premiums paid by the former theoretically have been used in part to pay the claims of the latter.

d. It would avoid the truncation of policy benefits to the applicable Guaranty Association limit ($300,000 in most states). This would be particularly important to the policyholders who have more than one SHIP LTC policy since the Guaranty Association limits apply to each insured for all policies combined. See Section VI.K, page 89.

e. Unlike what would occur under the Plan, premium rate increases sought by Guaranty Associations in liquidation would inure to the benefit of insurers assessed to fund the Guaranty Associations, not for policyholder claims.

3. GOOD BANK - BAD BANK

Consideration was also given to a rehabilitation plan along the lines that had been proposed for Penn Treaty Network America Insurance Company and its subsidiary, American Network Insurance Company. Under such a "business division" plan, SHIP's LTC business would be divided between a "Good Bank" and a "Bad Bank." Separate legal entities would hold each group of policies, liquidating one with Guaranty Association benefits, and placing the self-sustaining policies, in the other for continued coverage. Many aspects of this plan would be unprecedented and potentially controversial.

It is doubtful that both companies could retain insurance licenses in all the states in which SHIP has been licensed. Many of those licenses have already been suspended or revoked and may be hard to recover in SHIP's current condition. This is problematic because Good Bank needs the licenses to continue the self-sustaining policies in business and Bad Bank may need them in order to remain a "member insurer" so as to retain Guaranty Association protection.

In order to afford policyholders the option to make non-self-sustaining policies self-sustaining and eligible to be in "Good Bank," a complicated elective modification process would have to be implemented. That process would be vulnerable to the same criticism as the Proposed Rehabilitation Plan in that the required modifications would have to be approved by the Rehabilitator and the Rehabilitation Court, not the issuing state.

The Plan would be even more complex than the Proposed Rehabilitation Plan and would likely draw even more objections.

4. PROPOSED REHABILITATION PLAN

The Proposed Rehabilitation Plan is the Rehabilitator's recommended approach for SHIP's rehabilitation. However, there are a number of states that have objected with varying degrees of formality to the aspect of the Proposed Rehabilitation Plan under which the premium rates and benefits of SHIP's policies issued in their states would be modified with the approval of the Commonwealth Court but not of the insurance regulator of the issuing state ("Objecting States"). The following alternatives have also been considered in response to this issue. The Rehabilitator has considered several alternatives to address these concerns.

5. ANCILLARY APPROVAL OF MODIFICATIONS

One such alternative would have been to submit benefit and premium rate modifications for approval by each issuing state. The Rehabilitator has concluded that this would even be inferior to liquidation. First, past experience indicates that the process of obtaining approval for rate and benefit modifications would take a prolonged period of time. Second, the same experience indicates that the outcome can be expected to be widely divergent rates for similar policies, perpetuating the premium subsidies, inadequate premium rates, and hodgepodge of reduced-benefit options. In addition, implementation of such an approach would be immensely more complicated than the normal multi-state insurance rehabilitation in which the domiciliary regulator and court manage the entire proceeding.

6. EXCLUDE OBJECTING POLICIES

Another possible approach would have been to avoid rate increases for policies issued in Objecting States ("Objecting Policies"). That would have required that those policyholders not be able to select Option One (Downgrade), Option Two (Basic Policy Endorsements), or Option Four (If Knew Premium rate increases for current benefits). Those three options entail modification of rates or benefits in the existing policies. That would have left only the Non-forfeiture Option

("NFO") for these policyholders. Although the NFO eliminates premiums permanently, it reduces benefits substantially, though not as much as the NFO or reduced paid-up policy ("RPU") currently offered to lapsing policyholders. This very limiting outcome would have been highly undesirable.

As a variation of this alternative, the Objecting States could have been asked to permit SHIP to offer Objecting Policies Option 1 under the Plan as well, allowing them to retain reduced benefits without premium changes. For some policyholders that could have been preferable to the NFO, although for others the NFO might be the better deal. Objecting States might also have allowed SHIP to offer Option Two, which entails more moderate rate increases, and even no rate increases in some cases.

This approach might have allowed the Plan to proceed without making the objectionable modifications to the Objecting Policies while retaining all the Plan benefits for other policyholders. The net effect could have been beneficial for the outcome of the Plan if more policyholders elected to give up their current rich policies which collectively account for the bulk of SHIP's problem.

However, for the affected policyholders this would have been materially inferior to the *status quo* and the Proposed Rehabilitation Plan because policyholders would have had much more limited options and would not have had the possibility of retaining their current benefits even by paying the required premiums. Accordingly, the Rehabilitator did not favor this approach that effectively would have put the Objecting Policies at a disadvantage when compared to the treatment of other policyholders under the Plan.

7. ISSUE-STATE RATE APPROVALS

The Rehabilitator has concluded that a better alternative is to let the Commissioner (or equivalent officer) in a particular state withdraw all of the policies issued in that state from the rate increase determination provisions of the Plan and instead have that Commissioner make the rate increase determination for those policies independent of the Plan. Under this approach, if a commissioner advises the Rehabilitator to that effect, the rate increases resulting from Options under the Plan will not apply to the policies issued in that state (the "opt-out state"). Instead, the insurance department of the opt-out state will make the rate increase determinations for those policies and the benefits under Plan provisions will be adjusted to correspond to the premium rates approved by the opt-out state. The Rehabilitator believes that elements of this approach should be adopted as part of the Proposed Rehabilitation Plan. Section VI.U, below at page 102 describes the basic elements of a mechanism for enabling states to make their own rate increases decisions within the context of the Plan. Note that, apart from the rate increase determinations, under this approach the policies issued in the opt-out state will still be administered by the Rehabilitator under the Plan so that the opt-out state will not have to provide that administration.

8. CONCLUSION

On balance, the Rehabilitator believes that the best approach is the Proposed Rehabilitation Plan with a component as suggested in alternative seven, above. Accordingly, the Amended Plan now includes the additional following section.

U. ISSUE-STATE RATE APPROVAL

This summary describes the issue-state rate approval alternative for states that object formally to the Rehabilitator and the Commonwealth Court modifying rates for SHIP LTC policies issued in those states ("opt-out states").

1. If the chief insurance regulator ("Commissioner") of an issue-state formally advises the Rehabilitator that his or her state elects to "opt-out" of the rate increase component of the Proposed Rehabilitation Plan, the Plan would not apply in the same way to the policies issued in that state (the "opt-out policies" and "opt-out state" respectively). In that case, the holders of the opt-out policies would not be able to elect from among the Plan options and would instead have the choices described below.

2. The Rehabilitator would promptly file with the opt-out state a request for approval of the full amount of actuarially justified rate increases (on an If Knew Premium basis) for the SHIP LTC policies issued in that state. No rate increases would be sought for opt-out policies the premiums of which are already equal to or above the If Knew Premium. If an opt-out state did not respond to the application for rate increases within 60 days, the request would be deemed denied in its entirety. The opt-out state's decision as to the requested rate increases would govern the choices available to the holders of opt-out policies.

3. If the opt-out state timely approves the requested rate increases in full, it will be treated as if it had not opted out of the Plan and its policyholders will be included in the Plan just as those issued in non-opt-out states. If the opt-out state does not timely approve the full rate increase sought by the Rehabilitator, the policies issued in that state will be deemed opt-out policies subject to the following provisions.

4. Holders of opt-out policies would be able to choose from among several choices, which are designed to preserve as much choice as reasonably possible while giving effect to the opt-out state's rate decision and avoiding or minimizing subsidies by other policyholders. In Phase One of the Plan, the choices for holders of opt-out policies would be:

   OPTION A: Pay the required premium (including approved premium rate increases) and keep the current policy. However every opt-out policy with premiums below the If Knew level (after implementing the rate increase approved by the opt-out state) would be downgraded, using the Plan downgrade mechanism (see Section III.A.1.c, page 38), to the benefit level supported (on an If Knew Premium basis) by the premium charged. The downgrade would be "floored" at the lesser of the policy's

current Maximum Policy Value (MPV) or the applicable guaranty association limits, extending the policy's Maximum Benefit Period (MBP) as necessary to accomplish that. This will be the default option for opt-out policies.

OPTION B: In lieu of the approved rate increase, take a benefit downgrade calibrated to the current premium on an If Knew basis using the Plan downgrade mechanism. If no rate increase is approved for the policy, Options A and B produce the same result.

OPTION C: Accept the opt-out state-required reduced paid-up policy ("RPU") or Non-forfeiture Option ("NFO"). If the state does not require a particular reduced paid-up policy or NFO, policyholders would be offered the NFO or RPU currently specified in their policy or, if none is specified in the policy, an NFO used by SHIP before the Plan.

OPTION D: Keep the current policy benefits and accept a premium increase to the If Knew Premium for the benefits offered by the policy.

5. Every opt-out policyholder on premium waiver would retain the waiver as long as required by the policy, but if the waived premium is below the If Knew level and its current MPV is greater than the GA limit, the MBP would be reduced to the longer of (1) what can be supported by the current premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above If Knew level, the MBP would be left unchanged. This would provide no less benefits than what would happen in liquidation.

6. Once the waiver expires, such policyholders with waived premium below If Knew level would have their policies downgraded on an If Knew basis to the approved rates or the current rates, depending on whether they had selected the rate increase or benefit downgrade option in response to the approved rate increase.

7. If and when Phase Two is implemented for policyholders participating in the Plan, the process above would be repeated for opt-out policies using Self-sustaining premiums instead of If Knew Premium. However, policies that would be fully covered by the applicable guaranty association if SHIP were placed in liquidation, are Self-sustaining, or have elected the NFO or RPU would not be affected in this second phase.

8. Other provisions of the Plan not affected by these provisions would remain as applicable to the opt-out policies as to other policies. Additional details of this mechanism will be specified depending on further discussions with other regulators and the Orders of the Court.

9. This approach is designed to defer to the issue-state for rate approval by making its decision the default option. It would reduce or eliminate the requirement that other policyholders subsidize the opt-out policies and provides opt-out policyholders benefits at least equal to, and in many cases exceeding, what they would receive in liquidation. It would offer

policyholders benefit downgrade options in lieu of the approved rate increases as well as a reduced paid-up policy option. In addition, to reduce the disadvantage of being excluded from the Plan, these policyholders would also be offered the option of retaining the current coverage if they are able and inclined to pay the required premium.

V. 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 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 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, and 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 23.

3) **"Active Block"** means the LTC insurance policies issued or assumed by the Company that remain in force and are not on claim.

4) **"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.

5) **"Activities of Daily Living"** or **"ADL"** means eating, bathing, dressing, ambulating, transferring, toileting and continence.

6) **"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.

7) **"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.

8) **"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, accrued but unpaid claim payments, and certain debts of higher priority.

9) **"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.

10) **"Approval Order"** means an Order from the Commonwealth Court approving the Plan.

11) **"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.

12) "**Asset/Premium Ratio"** means the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies.

13) **"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 44, 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 that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.

14) **"Benefit Triggers"** means the conditions that must be satisfied in order to be eligible for benefits under an LTC insurance policy.

15) **"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.

16) **"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.

17) **"Company"** means SHIP.

18) **"Court"** means for purposes of the Plan, and unless otherwise specified, the Commonwealth Court of Pennsylvania.

19) **"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.

20) **"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 38.

21) **"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.

22) **"Default Option"** means the Plan option selected automatically for a policyholder who fails to make a valid election by the required date.

23) **"Determination Date"** means a date, which may vary among policyholders, after the Final Approval Date and before the applicable Policyholder Election Date 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.

24) **"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.

25) **"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.

26) **"Disabled Life Reserve"** or **"DLR"** means the present value of expected future benefits and expenses calculated for each policyholder listed in the Company's records as a policyholder on claim.

27) **"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 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 38.

28) **"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.

29) **"Effective Date"** means the date as of which the provisions of the Plan, including Policyholder Elections and modification of LTC policies, 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.L.3.c, page 33 the Effective Date will be the Supplemental Plan Effective Date.

30) **"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.

31) **"Extension of Benefits"** provision means a provision in the policy permitting claim payments to continue for a policy on claim that lapses due to non-payment of premium.

32) **"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.

33) **"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.

34) **"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.

35) **"Fuzion"** means Fuzion Analytics, Inc., a subsidiary of SHIP that, among other things, provides management and administrative services to SHIP.

36) **"Gross Premium"** means the periodic payments that are required to keep the policy in force. In the absence of rehabilitation, 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.

37) **"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. 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.

38) **"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.

39) **"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 in liquidation.

40) **"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.

41) **"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.

42) **"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.

43) **"Impaired Policy"** means an LTCI policy: (1) for which on Phase One the Current Premium is less than the If Knew Premium, and/or (2) that in Phase Two is Non-self-sustaining.

44) **"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.

45) **"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 the liabilities currently expected to arise under the policy.

46) **"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 110 and 112. 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.L.3.c, page 33.

47) **"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.L.3.c, page 33.

48) **"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).

49) **"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 policy.

50) **"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.

51) **"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.

52) **"LTCI"** means long-term care insurance.

53) **"Maximum Benefit Amount"** means the dollar maximum in benefits available under a LTC policy.

54) **"Maximum Benefit Period"** or **"MBP"** means the maximum time (typically stated as number of years or days, either lapsed time or 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.

55) **"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.

56) **"Maximum Policy Value"** or **"MPV"** means the product of a policy's Maximum Benefit Period times its Maximum Daily Benefit determined as of a specified date, adjusted for inflation protection. For Plan purposes, MPV will be calculated as if the policyholder went on claim on the Plan Effective Date.

57) **"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.

58) **"NAIC"** means the National Association of Insurance Commissioners.

59) **"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.

60) **"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.H, page 28.

61) **"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.

62) **"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.

63) **"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.**

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

65) **"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.

66) **"Paid-Up Policy"** means an in-force policy that is paid in full and no longer requires premium payments under its terms.

67) **"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.

68) **"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.

69) **"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.

70) **"PID"** means the Pennsylvania Insurance Department.

71) **"Plan"** means this Rehabilitation Plan.

72) **"Plan Document"** means this document describing the Plan.

73) **"Plan Limits"** means the minimum and maximum modifications permitted by the Plan for a policy's Maximum Benefit Period (MBP) and Maximum Daily Benefit (MDB). Except as noted in Section III.A.1.c.(4), page 39, 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 lesser of 80% of current level and $300 for Nursing Home Care; the lesser of (a) 80% of current level or (b) $225 for Facility Care; and the lesser of (a) 80% of current level or (b) $150 for Home Health Care. The MDB cannot be increased by the Plan above the greater of (a) the current MDB or (b) $600 for Nursing Home Care, $450 for Facility Care and $300 for Home Health Care.

74) **"Plan Option"** means any of the options available to policyholders under the Plan, which are described on page 19.

75) **"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.

76) **"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.

77) **"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.

78) **"Policy Modifications"** means Premium Rate Increases or Benefit reductions selected by a policyholder, or made applicable, in accordance with the terms of the Plan.

79) **"Policyholder Election"** means the election by a policyholder to modify the premiums or benefits of a policy under the Plan.

80) **"Policyholder Election Date"** means the date by which the Rehabilitator must receive properly completed Policyholder Election Forms in order to give them effect.

81) **"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 the Plan.

82) **"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.

83) **"Policyholders"** means holders of insurance policies and certificate holders under group insurance policies.

84) **"Policyholder Transition Period"** means the period between the Policyholder Election Date and the Initial Plan Effective Date during which policyholders may experience changes in circumstances (such as going on claim) as the result of which they may have to make new elections under the Plan.

85) **"Possible 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 41.

86) **"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.

87) **"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.

88) **" 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.

89) **"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.

90) **"Rehabilitation Plan"** means this Plan for the rehabilitation of SHIP's Long-term Care insurance business.

91) **"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.

92) **"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 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).

93) **"Restructured Policy"** means a policy that has been restructured as described in Section VI.H, page 86, to allocate the liabilities arising under the policy between its IFRPV and its UBL.

94) **"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).

95) **"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.

96) **"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.

97) **"Self-sustaining Premium"** means the premium calculated by determining the amount of premium required to eliminate a policy's Shortfall Amount.

98) **"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.

99) **"SHIP"** means the Senior Health Insurance Company of Pennsylvania, the subject of this Rehabilitation Plan.

100) **"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.

101) **"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.

102) **"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.

103) **"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.L.3.c, page 33. It will occur on the policy's Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.

104) **"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.**

105) **"TQ Triggers"** means the requirements that must be met under a Tax Qualified LTC policy in order to receive benefits.

106) **"Transitional Events"** means the events described on page 33 as a result of which a policyholder must make an election after the Initial Policyholder Election Date and before the Supplemental Plan Effective Date.

107) **"Trust"** means the Senior Health Care Oversight Trust, as defined above.

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

109) **"Unfunded Benefit Liability"** or **"UBL"** means the portion of a policy's Unmodified Policy Value that exceeds its IFRPV.

110) **"Waiver of Premium"** see Claim Waiver of Premium, Dual Waiver of Premium, and Lifetime Waiver of Premium.

VIII. APPENDIX A - CHANGES FROM APRIL 22 PLAN

1. A number of typographical or grammatical errors have been corrected. In addition, clarifying language has been added ro substituted at various places. Material changes are listed below.

2. The plan addresses treatment before the Plan Effective Date. See page 10.

3. The description of why the Plan treats policyholders at least as well as they would be in liquidation has been clarified. See Section I.A.3, page 12.

4. The applicability of Default Options, especially in Phase Two, has been clarified. See Section I.A.4, page 13.

5. The Plan now addresses changes in policyholder elections. See Section I.A.5, page 13.

6. A new Plan Projection section has been added. See Section I.F, page 17.

7. The asset allocation methodology for determination of Phase Two Premium has been simplified and no longer distinguishes between active and disabled policyholders. See Section II.E.4.d, page 23.

8. The explanation of Differential Premium has been expanded. See Section II.E.6, page 24.

9. The Plan now makes provision for approved premium rate increases that have not yet been implemented. See Section II.F, page 26.

10. The Waiver section and a few provisions throughout the Plan have been clarified to reflect that now the Basic Policy Endorsements remove all premium waivers so that only Option Four will allow policyholders to have both dual and claim waiver benefits while paying Differential Premium. See Section II.G, page 26, and Section III.B.1.b.(2), page 48 as an example.

11. The language in the Non-core Benefits section has been edited to clarify that their relationship to other benefits remains unchanged. See Section II.H, page 28.

12. Table 3, the Plan Sequence, has been updated to reflect the Court's June 12, 2020, Case Management Order, October 7, 2020, hearing cancellation Order, and other developments. See page 30.

13. The language governing Transitional Events and Supplemental Policyholder Elections has been expanded and clarified. See page 33 and definition on page 117.

14. The calculation of Maximum Policy Value (MPV) has been clarified to specify that changes, such as due to inflation protection, will be taken into account. See Section II.N.7, page 36.

15. The Plan Limit floor on MDB has been changed from $300 to the lesser of 80% of current level or $300. See Sections III.A.1.c.(4), page 39; III.A.1.f.(7), page 41; III.A.2.d, page 44; and III.A.3, page 46; and the definition on page 113.

16. The Plan Limits definitions have been revised to include Facility and Home Health Care and explicit maxima. See Section III.A.1.c.(4), page 39, and definition at page 113.

17. The Plan has been revised to enable reduction of the MBP below Plan Limits to effect Option One (Downgrade). See Section III.A.1.c.(5), page 39.

18. The Plan Limits floor on reduction of MBP in the downgrade Process has been removed since the NFO now acts as a safety net. See Section III.A.1.d.(6), page 40 and Section III.A.1.f.(9), page 41.

19. In the Downgrade Process, elimination of Restoration of Benefits has been moved up from downgrade step10 to step1. See Section III.A.1.f, page 41.

20. The adjustment of the minimum "recovery period" for Restoration of Benefits provisions has been eliminated as a downgrade step. See Section III.A.1.f.(1), page 41.

21. A Benefit Reduction has been added to both the downgrade process and the Basic Policy Endorsements removing Extension of Benefits provisions (for which a definition has also been added). See Section III.A.1.f.(2), page 41, Section III.A.2.d.(4), page 44, and page 109.

22. The Downgrade provision has been further clarified to make accrued Return of Premium payment payable on the due date that would have applied absent Plan modification so as to avoid adverse selection and payment that would not have been owed. It now characterizes the elimination as a "discontinuation" to distinguish between pre and post Effective Date accrual. See Section III.A.1.f.(4), page 41.

23. The reduction in DB percentage depending on site of care in the Basic Policy Endorsements will apply to all policies, not just to comprehensive policies. Language has been added to Sections III.A.1.f.(7), page 41, III.A.2.d.(6) (page44), and III.A.3.a (page 46), to avoid ambiguity.

24. Clarification has been added that for policies that are already pool of money, Downgrade Step 10 still applies but conversion won't be necessary; just reduction of the Maximum Benefit Amount. See Section III.A.1.f.(11), page 42.

25. The minimum six-month recovery period has been removed from the Basic Policy Endorsements conditions since it has been made inapplicable by the removal of Restoration of Benefits provision. See Section III.A.2.d, page 44.

26. The conversion of Days of Care to Pool of Money has been removed from the description of the Basic Policy Endorsements since these are indemnity policies for which this distinction is inapplicable. See Section III.A.2.d, page 44.

27. The Basic Policy Endorsements removal of Return of Premium benefit has been clarified and the return date under the Plan date has been retained at the original return date. See Section III.A.2.d.(3), page 44.

28. The Basic Policy Endorsements descriptions have been clarified to provide for retention of the existing inflation type. See Sections III.A.2.d.(5) and III.A.2.f, pages 44 and 45.

29. The provisions for adjusting MDB for site of care in the Basic Policy Endorsements and the NFO have been simplified and the distinction between comprehensive and non-comprehensive policies has been eliminated. See Section III.A.2.d.(6), page 44; and Section III.A.3.a, page 46.

30. The provisions governing the Guaranty Association "floor" have been clarified. See Sections III.A.2.h (page 45).

31. Removal of the Alternative Plan of Care option has been eliminated as a downgrade step because it produces too little reduction and is very difficult to value as actually administered by the Company.

32. The order of Downgrade Benefit Reductions has been revised so that Reduction of MBP is now Benefit Reduction Nine and reduction of MDB is now Benefit Reduction Seven.

33. A provision has been added specifying that richer policy specific NFOs will be offered in lieu of the Plan NFO in the rare cases where they are applicable. See Section III.A.3.b, page 46.

34. Clarification has been added that the same Benefit Reductions will apply to active policies and policies on claim. However, certain Benefit Reductions will only apply to disabled policyholders after recovery. See Section III.C.1.a, page 50. Note that for policyholders on claim this may mean a reduction in reimbursement for pending claims.

35. Table 6 has been edited to note that Option 2 applies the with GA Floor. See page 62.

36. The policy restructuring under the Plan has been specified to occur before policyholder elections. This will not affect the elections. See Section VI.H, page 86.

37. The reinsurance section has been updated to reflect that assumed business will not be treated as direct business under the Plan. See Section VI.M.7, page 92.

38. A section has been added to describe other measures considered as alternatives to the Proposed Rehabilitation Plan. See Section VI.T, page 98.

39. A section has also been added to describe an option for issue-states to approve premium rate increases. See Section VI.U, page 102.

40. The definition of *Determination Date* has been corrected so that it now occurs between the Final Approval Date and the applicable Policyholder Election Date. See page 108.

41. The definition of MPV has been expanded to make clear that it is as adjusted for claims and benefits. See page 111.

42. The discussion of minimum and maximum MPV has been removed as unnecessary. See page 113.

APPENDIX B
SELECTED FINANCIAL INFORMATION



SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
IN REHABILITATION

THE ATTACHED PAGES ARE SELECTED EXCERPTS FROM THE COMPANY'S UNFILED 2019 STATUTORY FINANCIAL STATEMENT AND INTERNAL 2020 FINANCIAL INFORMATION. NO REPRESENTATION, EXPRESS OR IMPLIED, IS MADE AS TO THEIR ACCURACY OR COMPLETENESS.

THIS INFORMATION IS PROVIDED SOLELY FOR INFORMATION AND 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 INFORMATION WAS 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 INFORMATION, THEREFORE, SHOULD NOT BE RELIED UPON AS A GUARANTY OR OTHER ASSURANCE OF THE ACTUAL RESULTS THAT WILL OCCUR.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)	1,721,888,236		1,721,888,236	2,006,961,967
2. Stocks (Schedule D):				
2.1 Preferred stocks	86,271,292		86,271,292	109,432,792
2.2 Common stocks	3,578,386		3,578,386	1,813,578
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens	12,681,751		12,681,751	17,540,853
3.2 Other than first liens			0	
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $.....0 encumbrances)			0	
4.2 Properties held for the production of income (less $.....0 encumbrances)			0	
4.3 Properties held for sale (less $.....0 encumbrances)			0	
5. Cash ($.....(6,955,915), Schedule E-Part 1), cash equivalents ($.....53,638,393, Schedule E-Part 2) and short-term investments ($.....0, Schedule DA)	46,682,478		46,682,478	20,755,355
6. Contract loans (including $.....0 premium notes)			0	
7. Derivatives (Schedule DB)			0	
8. Other invested assets (Schedule BA)	25,617,716	9,916,628	15,701,088	11,834,651
9. Receivables for securities	135,570		135,570	10,149
10. Securities lending reinvested collateral assets (Schedule DL)			0	
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	1,896,855,429	9,916,628	1,886,938,801	2,168,349,345
13. Title plants less $.....0 charged off (for Title insurers only)			0	
14. Investment income due and accrued	12,081,945		12,081,945	15,264,664
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	929,722	1,699	928,023	1,071,261
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $.....0 earned but unbilled premiums)			0	
15.3 Accrued retrospective premiums ($.....0) and contracts subject to redetermination ($.....0)			0	
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	22,002		22,002	13,421
16.2 Funds held by or deposited with reinsured companies			0	
16.3 Other amounts receivable under reinsurance contracts	(48)		(48)	
17. Amounts receivable relating to uninsured plans			0	
18.1 Current federal and foreign income tax recoverable and interest thereon	2,364,433		2,364,433	(138,737)
18.2 Net deferred tax asset			0	
19. Guaranty funds receivable or on deposit	1,208,738		1,208,738	1,448,680
20. Electronic data processing equipment and software			0	
21. Furniture and equipment, including health care delivery assets ($.....0)			0	
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	
23. Receivables from parent, subsidiaries and affiliates	49,541		49,541	49,639
24. Health care ($.....0) and other amounts receivable	30,700	30,700	0	
25. Aggregate write-ins for other-than-invested assets	3,587,702	0	3,587,702	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	1,917,130,164	9,949,027	1,907,181,137	2,186,058,273
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	
28. TOTAL (Lines 26 and 27)	1,917,130,164	9,949,027	1,907,181,137	2,186,058,273

DETAILS OF WRITE-INS

1101.			0	
1102.			0	
1103.			0	
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0
2501. Reimbursement from Insurance Carrier	3,587,702		3,587,702	
2502.			0	
2503.			0	
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	3,587,702	0	3,587,702	0

LIABILITIES, SURPLUS AND OTHER FUNDS

		1 Current Year	2 Prior Year
1.	Aggregate reserve for life contracts $.....0 (Exhibit 5, Line 9999999) less $.....0 included in Line 6.3 (including $.....0 Modco Reserve)		
2.	Aggregate reserve for accident and health contracts (including $.....0 Modco Reserve)	2,766,443,751	2,608,580,649
3.	Liability for deposit-type contracts (Exhibit 7, Line 14, Col. 1) (including $.....0 Modco Reserve)		
4.	Contract claims:		
	4.1 Life (Exhibit 8, Part 1, Line 4.4, Col. 1 less sum of Cols. 9, 10 and 11)		
	4.2 Accident and health (Exhibit 8, Part 1, Line 4.4, sum of Cols. 9, 10 and 11)	37,734,617	35,658,375
5.	Policyholders' dividends/refunds to members $.....0 and coupons $.....0 due and unpaid (Exhibit 4, Line 10)		
6.	Provision for policyholders' dividends, refunds to members and coupons payable in following calendar year - estimated amounts:		
	6.1 Policyholders' dividends and refunds to members apportioned for payment (including $.....0 Modco)		
	6.2 Policyholders' dividends and refunds to members not yet apportioned (including $.....0 Modco)		
	6.3 Coupons and similar benefits (including $.....0 Modco)		
7.	Amount provisionally held for deferred dividend policies not included in Line 6		
8.	Premiums and annuity considerations for life and accident and health contracts received in advance less $.....0 discount; including $.....1,462,254 accident and health premiums (Exhibit 1, Part 1, Col. 1, sum of Lines 4 and 14)	1,462,254	1,655,643
9.	Contract liabilities not included elsewhere:		
	9.1 Surrender values on canceled contracts		
	9.2 Provision for experience rating refunds, including the liability of $.....0 accident and health experience rating refunds of which $.....0 is for medical loss ratio rebate per the Public Health Service Act		
	9.3 Other amounts payable on reinsurance, including $.....16,032 assumed and $.....1,910 ceded	17,942	35,585
	9.4 Interest Maintenance Reserve (IMR, Line 6)	4,746,341	1,564,865
10.	Commissions to agents due or accrued - life and annuity contracts $.....0, accident and health $.....0 and deposit-type contract funds $.....0	580,812	699,855
11.	Commissions and expense allowances payable on reinsurance assumed		
12.	General expenses due or accrued (Exhibit 2, Line 12, Col. 7)	6,629,583	3,792,089
13.	Transfers to Separate Accounts due or accrued (net) (including $.....0 accrued for expense allowances recognized in reserves, net of reinsured allowances)		
14.	Taxes, licenses and fees due or accrued, excluding federal income taxes (Exhibit 3, Line 9, Col. 6)	414,345	603,523
15.1	Current federal and foreign income taxes, including $.....0 on realized capital gains (losses)		(2,573,298)
15.2	Net deferred tax liability		
16.	Unearned investment income		
17.	Amounts withheld or retained by reporting entity as agent or trustee		
18.	Amounts held for agents' account, including $.....0 agents' credit balances		
19.	Remittances and items not allocated	329,763	336,270
20.	Net adjustment in assets and liabilities due to foreign exchange rates		
21.	Liability for benefits for employees and agents if not included above		
22.	Borrowed money $.....0 and interest thereon $.....0		
23.	Dividends to stockholders declared and unpaid		
24.	Miscellaneous liabilities:		
	24.01 Asset valuation reserve (AVR Line 16, Col. 7)	206,126	58,003
	24.02 Reinsurance in unauthorized and certified ($.....0) companies		
	24.03 Funds held under reinsurance treaties with unauthorized and certified ($.....0) reinsurers		
	24.04 Payable to parent, subsidiaries and affiliates		
	24.05 Drafts outstanding		
	24.06 Liability for amounts held under uninsured plans		
	24.07 Funds held under coinsurance		
	24.08 Derivatives		
	24.09 Payable for securities	1,975,610	
	24.10 Payable for securities lending		
	24.11 Capital notes $.....0 and interest thereon $.....0		
25.	Aggregate write-ins for liabilities	2,738,221	2,519,689
26.	Total liabilities excluding Separate Accounts business (Lines 1 to 25)	2,823,279,366	2,652,931,248
27.	From Separate Accounts Statement		
28.	Total liabilities (Line 26 and 27)	2,823,279,366	2,652,931,248
29.	Common capital stock	2,500,005	2,500,005
30.	Preferred capital stock	5,000,000	5,000,000
31.	Aggregate write-ins for other-than-special surplus funds	0	0
32.	Surplus notes	50,000,000	50,000,000
33.	Gross paid in and contributed surplus (Page 3, Line 33, Col. 2 plus Page 4, Line 51.1, Col. 1)	1,198,824,011	1,196,326,042
34.	Aggregate write-ins for special surplus funds	0	0
35.	Unassigned funds (surplus)	(2,172,422,245)	(1,720,699,022)
36.	Less treasury stock, at cost:		
	36.1 .....0.000 shares common (value included in Line 29 $.....0)		
	36.2 .....0.000 shares preferred (value included in Line 30 $.....0)		
37.	Surplus (Total Lines 31 + 32 + 33 + 34 + 35 - 36) (including $.....0 in Separate Accounts Statement)	(923,598,234)	(474,372,980)
38.	Totals of Lines 29, 30 and 37 (Page 4, Line 55)	(916,098,229)	(466,872,975)
39.	Totals of Lines 28 and 38 (Page 2, Line 28, Col. 3)	1,907,181,137	2,186,058,273

DETAILS OF WRITE-INS

2501.	Unclaimed funds	2,738,221	2,519,689
2502.			
2503.			
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	2,738,221	2,519,689
3101.			
3102.			
3103.			
3198.	Summary of remaining write-ins for Line 31 from overflow page	0	0
3199.	Totals (Lines 3101 through 3103 plus 3198) (Line 31 above)	0	0
3401.			
3402.			
3403.			
3498.	Summary of remaining write-ins for Line 34 from overflow page	0	0
3499.	Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)	0	0

SUMMARY OF OPERATIONS

		1 Current Year	2 Prior Year
1.	Premiums and annuity considerations for life and accident and health contracts (Exhibit 1, Part 1, Line 20.4, Col. 1, less Col. 11)	78,564,611	1,237,392,658
2.	Considerations for supplementary contracts with life contingencies		
3.	Net investment income (Exhibit of Net Investment Income, Line 17)	69,898,620	81,934,412
4.	Amortization of Interest Maintenance Reserve (IMR) (Line 5)	497,421	192,717,772
5.	Separate Accounts net gain from operations excluding unrealized gains or losses		
6.	Commissions and expense allowances on reinsurance ceded (Exhibit 1, Part 2, Line 26.1, Col. 1)	244	945,401
7.	Reserve adjustments on reinsurance ceded		
8.	Miscellaneous Income:		
	8.1 Income from fees associated with investment management, administration and contract guarantees from Separate Accounts		
	8.2 Charges and fees for deposit-type contracts		
	8.3 Aggregate write-ins for miscellaneous income	0	0
9.	Totals (Lines 1 to 8.3)	148,960,896	1,512,990,242
10.	Death benefits		
11.	Matured endowments (excluding guaranteed annual pure endowments)		
12.	Annuity benefits (Exhibit 8, Part 2, Line 6.4, Cols. 4 + 8)		
13.	Disability benefits and benefits under accident and health contracts	371,758,091	390,323,186
14.	Coupons, guaranteed annual pure endowments and similar benefits		
15.	Surrender benefits and withdrawals for life contracts		
16.	Group conversions		
17.	Interest and adjustments on contract or deposit-type contract funds		
18.	Payments on supplementary contracts with life contingencies		
19.	Increase in aggregate reserves for life and accident and health contracts	157,863,106	1,391,115,603
20.	Totals (Lines 10 to 19)	529,621,197	1,781,438,788
21.	Commissions on premiums, annuity considerations and deposit-type contract funds (direct business only) (Exhibit 1, Part 2, Line 31, Col. 1)	5,172,110	6,133,056
22.	Commissions and expense allowances on reinsurance assumed (Exhibit 1, Part 2, Line 26.2, Col. 1)	482,173	569,135
23.	General insurance expenses and fraternal expenses (Exhibit 2, Line 10, Columns 1, 2, 3, 4 and 6)	29,395,680	34,197,614
24.	Insurance taxes, licenses and fees, excluding federal income taxes (Exhibit 3, Line 7, Cols. 1 + 2 + 3 + 5)	3,889,989	2,640,964
25.	Increase in loading on deferred and uncollected premiums		
26.	Net transfers to or (from) Separate Accounts net of reinsurance		
27.	Aggregate write-ins for deductions	0	12,570,929
28.	Totals (Lines 20 to 27)	568,561,149	1,837,550,486
29.	Net gain from operations before dividends to policyholders, refunds to members and federal income taxes (Line 9 minus Line 28)	(419,600,253)	(324,560,244)
30.	Dividends to policyholders and refunds to members		
31.	Net gain from operations after dividends to policyholders, refunds to members and before federal income taxes (Line 29 minus Line 30)	(419,600,253)	(324,560,244)
32.	Federal and foreign income taxes incurred (excluding tax on capital gains)	(1,632,614)	(463,908)
33.	Net gain from operations after dividends to policyholders, refunds to members and federal income taxes and before realized capital gains or (losses) (Line 31 minus Line 32)	(417,967,639)	(324,096,336)
34.	Net realized capital gains (losses) (excluding gains (losses) transferred to the IMR) less capital gains tax of $.....2,815,978 (excluding taxes of $.....(977,935) transferred to the IMR)	(44,066,405)	(175,822,458)
35.	Net income (Line 33 plus Line 34)	(462,034,044)	(499,918,794)
	CAPITAL AND SURPLUS ACCOUNT		
36.	Capital and surplus, December 31, prior year (Page 3, Line 38, Col. 2)	(466,872,971)	12,649,170
37.	Net income (Line 35)	(462,034,044)	(499,918,794)
38.	Change in net unrealized capital gains (losses) less capital gains tax of $.....0	842,233	131,852
39.	Change in net unrealized foreign exchange capital gain (loss)		
40.	Change in net deferred income tax		
41.	Change in nonadmitted assets	9,616,707	(19,510,668)
42.	Change in liability for reinsurance in unauthorized and certified companies		11,626,473
43.	Change in reserve on account of change in valuation basis (increase) or decrease		
44.	Change in asset valuation reserve	(148,123)	28,148,996
45.	Change in treasury stock, (Page 3, Lines 36.1 and 36.2 Col. 2 minus Col. 1)		
46.	Surplus (contributed to) withdrawn from Separate Accounts during period		
47.	Other changes in surplus in Separate Accounts Statement		
48.	Change in surplus notes		
49.	Cumulative effect of changes in accounting principles		
50.	Capital changes:		
	50.1 Paid in		
	50.2 Transferred from surplus (Stock Dividend)		
	50.3 Transferred to surplus		
51.	Surplus adjustment:		
	51.1 Paid in	2,497,969	0
	51.2 Transferred to capital (Stock Dividend)		
	51.3 Transferred from capital		
	51.4 Change in surplus as a result of reinsurance		
52.	Dividends to stockholders		
53.	Aggregate write-ins for gains and losses in surplus	0	0
54.	Net change in capital and surplus for the year (Lines 37 through 53)	(449,225,258)	(479,522,141)
55.	Capital and surplus, December 31, current year (Lines 36 + 54) (Page 3, Line 38)	(916,098,229)	(466,872,971)

DETAILS OF WRITE-INS

08.301.			
08.302.			
08.303.			
08.398.	Summary of remaining write-ins for Line 8.3 from overflow page	0	0
08.399.	Totals (Lines 08.301 through 08.303 plus 08.398) (Line 8.3 above)	0	0
2701.	Termination of Roebling Reinsurance Agreement		12,570,929
2702.			
2703.			
2798.	Summary of remaining write-ins for Line 27 from overflow page	0	0
2799.	Totals (Lines 2701 through 2703 plus 2798) (Line 27 above)	0	12,570,929
5301.			
5302.			
5303.			
5398.	Summary of remaining write-ins for Line 53 from overflow page	0	0
5399.	Totals (Lines 5301 through 5303 plus 5398) (Line 53 above)	0	0

CASH FLOW

		1 Current Year	2 Prior Year
	CASH FROM OPERATIONS		
1.	Premiums collected net of reinsurance	62,752,519	73,765,461
2.	Net investment income	75,782,728	91,432,001
3.	Miscellaneous income	244	1,057
4.	Total (Lines 1 through 3)	138,535,491	165,198,519
5.	Benefit and loss related payments	353,928,567	351,102,177
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7.	Commissions, expenses paid and aggregate write-ins for deductions	36,182,999	42,838,983
8.	Dividends paid to policyholders		
9.	Federal and foreign income taxes paid (recovered) net of $.....0 tax on capital gains (losses)	135,301	(671,176)
10.	Total (Lines 5 through 9)	390,246,866	393,269,984
11.	Net cash from operations (Line 4 minus Line 10)	(251,711,376)	(228,071,464)
	CASH FROM INVESTMENTS		
12.	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds	432,428,356	452,604,302
	12.2 Stocks	1,474,442	15,714,528
	12.3 Mortgage loans	4,859,102	14,266,387
	12.4 Real estate		
	12.5 Other invested assets	5,040,743	283,790
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments		(1,834)
	12.7 Miscellaneous proceeds	1,975,610	728,906
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	445,778,253	483,596,079
13.	Cost of investments acquired (long-term only):		
	13.1 Bonds	158,454,700	651,406,627
	13.2 Stocks	67,901	77,189,849
	13.3 Mortgage loans		
	13.4 Real estate		
	13.5 Other invested assets	5,900,000	
	13.6 Miscellaneous applications	125,421	0
	13.7 Total investments acquired (Lines 13.1 to 13.6)	164,548,022	728,596,476
14.	Net increase (decrease) in contract loans and premium notes		
15.	Net cash from investments (Line 12.8 minus Lines 13.7 minus Line 14)	281,230,231	(245,000,397)
	CASH FROM FINANCING AND MISCELLANEOUS SOURCES		
16.	Cash provided (applied):		
	16.1 Surplus notes, capital notes		
	16.2 Capital and paid in surplus, less treasury stock		0
	16.3 Borrowed funds		
	16.4 Net deposits on deposit-type contracts and other insurance liabilities		
	16.5 Dividends to stockholders		
	16.6 Other cash provided (applied)	(3,591,732)	(2,264,237)
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(3,591,732)	(2,264,237)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	25,927,123	(475,336,098)
19.	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	20,755,358	496,091,456
	19.2 End of year (Line 18 plus Line 19.1)	46,682,481	20,755,358

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001		

EXHIBIT 6 - AGGREGATE RESERVES FOR ACCIDENT AND HEALTH CONTRACTS - ACCIDENT AND HEALTH (a)

	1	Comprehensive		4	5	6	7	8	9	10	11	12	13
		2	3										
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Credit A&H	Disability Income	Long-Term Care	Other Health
ACTIVE LIFE RESERVE													
1. Unearned premium reserves	12,003,829											12,003,829	
2. Additional contract reserves (b)	1,223,633,993											1,223,633,993	
3. Additional actuarial reserves - Asset/Liability analysis	636,536,764											636,536,764	
4. Reserve for future contingent benefits	0												
5. Reserve for rate credits	0												
6. Aggregate write-ins for reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Totals (Gross)	1,872,174,585	0	0	0	0	0	0	0	0	0	0	1,872,174,585	0
8. Reinsurance ceded	806,876											806,876	
9. Totals (Net)	1,871,367,710	0	0	0	0	0	0	0	0	0	0	1,871,367,710	0
CLAIM RESERVE													
10. Present value of amounts not yet due on claims	895,879,794											895,879,794	
11. Additional actuarial reserves - Asset/Liability analysis	0												
12. Reserve for future contingent benefits	0												
13. Aggregate write-ins for reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Totals (Gross)	895,879,794	0	0	0	0	0	0	0	0	0	0	895,879,794	0
15. Reinsurance ceded	803,753											803,753	
16. Totals (Net)	895,076,042	0	0	0	0	0	0	0	0	0	0	895,076,042	0
17. TOTALS (Net)	2,766,443,751	0	0	0	0	0	0	0	0	0	0	2,766,443,751	0
18. TABULAR FUND INTEREST	94,796,751											94,796,751	
DETAILS OF WRITE-INS													
0601.	0												
0602.	0												
0603.	0												
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0	0	0	0	0	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0	0	0	0	0	0	0	0
1301.	0												
1302.	0												
1303.	0												
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	0	0	0	0
1399. Totals (Lines 1301 through 1303 + 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	0	0	0	0

(a) Indicate if blocks of business in run-off that comprise less than 5% of premiums and less than 5% of reserve and loans liability are aggregated with material blocks of business and which columns are affected.

(b) Attach statement as to valuation standard used in calculating this reserve, specifying reserve bases, interest rates and methods.

EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 1 - Liability End of Current Year

	1	2	Ordinary			6	Group		Accident and Health		
			3	4	5		7	8	9	10	11
	Total	Industrial Life	Life Insurance	Individual Annuities	Supplementary Contracts	Credit Life (Group and Individual)	Life Insurance	Annuities	Group	Credit (Group and Individual)	Other
1. Due and unpaid:											
1.1 Direct	0										
1.2 Reinsurance assumed	0										
1.3 Reinsurance ceded	0										
1.4 Net	0	0	0	0	0	0	0	0	0	0	0
2. In course of settlement:											
2.1 Resisted:											
2.11 Direct	0										
2.12 Reinsurance assumed	0										
2.13 Reinsurance ceded	0										
2.14 Net	0	0	(b) 0	(b) 0	0	(b) 0	(b) 0	0	0	0	0
2.2 Other:											
2.21 Direct	31,934,537								470,450		31,464,087
2.22 Reinsurance assumed	2,601,162								373,231		2,227,931
2.23 Reinsurance ceded	28,754										28,754
2.24 Net	34,506,945	0	(b) 0	(b) 0	0	(b) 0	(b) 0	0	(b) 843,682	(b) 0	(b) 33,663,264
3. Incurred but unreported:											
3.1 Direct	2,875,720								72,350		2,803,370
3.2 Reinsurance assumed	352,675								49,835		302,840
3.3 Reinsurance ceded	723										723
3.4 Net	3,227,672	0	(b) 0	(b) 0	0	(b) 0	(b) 0	0	(b) 122,185	(b) 0	(b) 3,105,486
4. Totals:											
4.1 Direct	34,810,257	0	0	0	0	0	0	0	542,801	0	34,267,457
4.2 Reinsurance assumed	2,953,837	0	0	0	0	0	0	0	423,066	0	2,530,771
4.3 Reinsurance ceded	29,477	0	0	0	0	0	0	0	0	0	29,477
4.4 Net	37,734,617	(a) 0	(a) 0	0	0	0	(a) 0	0	965,867	0	36,768,750

(a) Including matured endowments (but not guaranteed annual pure endowments) unpaid amounting to $.....0 in Column 2, $.....0 in Column 3 and $.....0 in Column 7.

(b) Include only portion of disability and accident and health claim liabilities applicable to assumed "accrued" benefits. Reserves (including reinsurance assumed and net of reinsurance ceded) for unaccrued benefits for Ordinary Life Insurance $.....0, Individual Annuities $.....0, Credit Life (Group and Individual) $.....0, and Group Life $.....0, are included in Page 3, Line 1, (See Exhibit 5, Section on Disability Disabled Lives); and for Group Accident and Health $.....19,896,545, Credit (Group and Individual) Accident and Health $.....0 and Other Accident and Health $.....875,179,497 are included in Page 3, Line 2, (See Exhibit 6, Claim Reserve).

EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 2 - Incurred During the Year

	1	2	Ordinary			6	Group		Accident and Health		
			3	4	5		7	8	9	10	11
	Total	Industrial Life (a)	Life Insurance (b)	Individual Annuities	Supplementary Contracts	Credit Life (Group and Individual)	Life Insurance (c)	Annuities	Group	Credit (Group and Individual)	Other
1. Settlements during the year:											
1.1 Direct	343,343,970								4,931,883		338,412,086
1.2 Reinsurance assumed	26,475,718								4,222,270		22,253,448
1.3 Reinsurance ceded	129,258								-		129,258
1.4 Net	(d) 369,690,430	0	0	0	0	0	0	0	9,154,153	0	360,536,277
2. Liability December 31, current year from Part 1:											
2.1 Direct	34,810,257	0	0	0	0	0	0	0	542,801	0	34,267,457
2.2 Reinsurance assumed	2,953,837	0	0	0	0	0	0	0	423,066	0	2,530,771
2.3 Reinsurance ceded	29,477	0	0	0	0	0	0	0	0	0	29,477
2.4 Net	37,734,617	0	0	0	0	0	0	0	965,867	0	36,768,750
3. Amounts recoverable from reinsurers Dec. 31, current year	22,002										22,002
4. Liability December 31, prior year:											
4.1 Direct	32,821,419								486,861		32,334,558
4.2 Reinsurance assumed	2,881,635								488,252		2,393,383
4.3 Reinsurance ceded	44,679										44,679
4.4 Net	35,658,375	0	0	0	0	0	0	0	975,112	0	34,683,262
5. Amounts recoverable from reinsurers Dec. 31, prior year	13,421										13,421
6. Incurred benefits:											
6.1 Direct	345,332,808	0	0	0	0	0	0	0	4,987,823	0	340,344,985
6.2 Reinsurance assumed	26,547,920	0	0	0	0	0	0	0	4,157,084	0	22,390,836
6.3 Reinsurance ceded	122,637	0	0	0	0	0	0	0	0	0	122,637
6.4 Net	371,758,091	0	0	0	0	0	0	0	9,144,908	0	362,613,183

(a) Including matured endowments (but not guaranteed annual pure endowments) amounting to $.....0 in Line 1.1, $.....0 in Line 1.4, $.....0 in Line 6.1 and $.....0 in Line 6.4.

(b) Including matured endowments (but not guaranteed annual pure endowments) amounting to $.....0 in Line 1.1, $.....0 in Line 1.4, $.....0 in Line 6.1 and $.....0 in Line 6.4.

(c) Including matured endowments (but not guaranteed annual pure endowments) amounting to $.....0 in Line 1.1, $.....0 in Line 1.4, $.....0 in Line 6.1 and $.....0 in Line 6.4.

(d) Includes $.....(15,834,951) premiums waived under total and permanent disability benefits.

EXHIBIT OF NONADMITTED ASSETS

	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)			0
2. Stocks (Schedule D):			
2.1 Preferred stocks			0
2.2 Common stocks			0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens			0
3.2 Other than first liens			0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company			0
4.2 Properties held for the production of income			0
4.3 Properties held for sale			0
5. Cash (Schedule E-Part 1), cash equivalents (Schedule E-Part 2) and short-term investments (Schedule DA)			0
6. Contract loans			0
7. Derivatives (Schedule DB)			0
8. Other invested assets (Schedule BA)	9,916,628	19,513,439	9,596,811
9. Receivables for securities			0
10. Securities lending reinvested collateral assets (Schedule DL)			0
11. Aggregate write-ins for invested assets	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	9,916,628	19,513,439	9,596,811
13. Title plants (for Title insurers only)			0
14. Investment income due and accrued			0
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection	1,699	19,216	17,517
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due			0
15.3 Accrued retrospective premiums and contracts subject to redetermination			0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers			0
16.2 Funds held by or deposited with reinsured companies			0
16.3 Other amounts receivable under reinsurance contracts			0
17. Amounts receivable relating to uninsured plans			0
18.1 Current federal and foreign income tax recoverable and interest thereon			0
18.2 Net deferred tax asset			0
19. Guaranty funds receivable or on deposit			0
20. Electronic data processing equipment and software			0
21. Furniture and equipment, including health care delivery assets			0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0
23. Receivables from parent, subsidiaries and affiliates			0
24. Health care and other amounts receivable	30,700	33,079	2,379
25. Aggregate write-ins for other-than-invested assets	0	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 through 25)	9,949,027	19,565,734	9,616,707
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0
28. TOTALS (Lines 26 and 27)	9,949,027	19,565,734	9,616,707

DETAILS OF WRITE-INS

1101.			0
1102.			0
1103.			0
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0
2501.			0
2502.			0
2503.			0
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	0	0	0

NOTES TO FINANCIAL STATEMENTS

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NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

A. Accounting Practices

The financial statements of Senior Health Insurance Company of Pennsylvania ("Company") are presented on the basis of accounting practices prescribed or permitted by the Pennsylvania Commissioner of Insurance ("Commissioner").

The Commissioner recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Pennsylvania for reporting the financial condition and results of operations of an insurance company and determining its solvency under Pennsylvania Insurance Law. The *Accounting Practices and Procedures* manual ("NAIC SAP") has been adopted as a component of prescribed or permitted practices by the Commonwealth of Pennsylvania. However, Pennsylvania may adopt certain prescribed accounting practices that differ from NAIC SAP. In addition, the Commissioner has the right to permit other specific practices that deviate from prescribed practices. The Company received a permitted practice for a one-time release of the Interest Maintenance Reserve ("IMR") prescribed by NAIC Statement of Statutory Accounting Principles (SSAP) No. 7 – Asset Valuation and Interest Maintenance Reserve effective January 1, 2018. The effect of this permitted practice was a release of the amortized IMR of $192,502,234 which increased the Company's 2018 reported Net Income and negative Surplus balances by $72,502,234. As a result of the IMR release, the Company established a premium deficiency reserve of $120,000,000. The effect of the permitted practice in 2019 was an increase in net income and negative surplus balances of $116,228,684. A reconciliation of the Company's net income and capital & surplus is shown below.

	SSAP #	F/S Page	F/S Line #	2019	2018
NET INCOME					
(1) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	$ (465,369,419)	$ (499,918,794)
(2) State Prescribed Practices that are an increase/decrease from NAIC SAP					
(3) State Permitted Practices that are an increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	4	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	19	(45,730,229)	(68,622,724)
(4) NAIC SAP (1 – 2 – 3 = 4)	XXX	XXX	XXX	$ (581,598,103)	$ (607,934,247)
SURPLUS					
(5) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	$ (919,285,952)	$ (466,872,975)
(6) State Prescribed Practices that increase/decrease from NAIC SAP					
(7) State Permitted Practices that increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	37	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	37	(45,730,229)	(68,622,724)
(8) NAIC SAP (5 – 6 – 7 = 8)	XXX	XXX	XXX	$ (1,035,514,636)	$ (574,888,428)

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of financial statements in conformity with Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates.

C. Accounting Policy

Health premiums are earned ratably over the terms of the related insurance and reinsurance contracts or policies.

In addition, the Company uses the following accounting policies:

(1) Short-term investments are stated at amortized cost.

(2) Bonds are stated at amortized cost using the scientific interest method, except those rated NAIC class 6, which are stated at the lower of amortized cost or fair value.

(3) Common stocks are stated at market value.

(4) Preferred stocks are stated at amortized cost, except those rated NAIC class 4 or lower quality, which are carried at the lower of cost or fair value.

(5) Mortgage loans on real estate are stated at the aggregate unpaid balance, excluding accrued interest.

(6) Loan-Backed securities are stated at amortized cost using the interest method including anticipated prepayments at the date of purchase; significant changes in estimated cash flows from the original purchase assumptions are accounted for using the retrospective method. These assumptions are generally consistent with the current interest rate and economic environment.

(7) The Company reports Fuzion Analytics, Inc., a non-insurance company, at audited GAAP equity.

(8) Ownership interests in joint ventures are classified as other invested assets on the balance sheet. The Company carries these interests based on its proportionate share of the underlying audited GAAP equity of the investee, adjusted for any distributions received.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies, continued

(9) The Company has no investments in derivatives.

(10) The Company anticipates investment income as a factor in the premium deficiency calculation, in accordance with SSAP No. 54R—Individual and Group Accident and Health Contracts.

(11) Unpaid losses and loss adjustment expenses include amounts determined from individual case estimates and loss reports and amounts, based on experience, for losses incurred but not reported. Such liabilities are necessarily based on assumptions and estimates. The ultimate liability may be greater or less than the amount reported. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed. Any adjustments to these liabilities are reflected in the period determined.

(12) The Company has not modified its capitalization policy from the prior period.

(13) The Company receives no pharmaceutical rebates.

D. The Company has suffered recurring losses from operations and has a net capital and surplus deficit. The Company is actively working with the Pennsylvania Insurance Department to develop a corrective action plan.

2. Accounting Changes and Corrections of Errors

A. There are no material changes in accounting principles or corrections of errors.

3. Business Combinations and Goodwill

A. During 2019, the Company did not purchase any interest in another company.

B. During 2019, the Company did not merge with any other insurance company.

C. During 2019, the Company did not participate in an assumption reinsurance agreement.

D. During 2019, the Company did not recognize an impairment loss on the transactions described above.

4. Discontinued Operations

During 2019, the Company did not discontinue any operations.

NOTES TO FINANCIAL STATEMENTS

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

(1) The Company originated no new loans in 2019.

(2) The maximum percentage of any one loan to the value of the security at the time of the loan, exclusive of insured, guaranteed or purchase money mortgages, was 65.00%.

		Current Year	Prior Year
(3)	Taxes, assessments and any amounts advanced and not included in the mortgage loan total:	$ -	$ -

(4) Age Analysis of Mortgage Loans:

			Commercial	
a.	Current Year	Insured	All Other	Total
	1. Recorded Investment			
	a) Current	$ -	$ 12,681,751	$ 12,681,751
	b) 30-59 Days Past Due	-	-	-
	c) 60-89 Days Past Due	-	-	-
	d) 90-179 Days Past Due	-	-	-
	e) 180+ Days Past Due	-	-	-
	2. Accruing Interest 90-179 Days Past Due			
	a) Recorded Investment	-	-	-
	b) Interest Accrued	-	-	-
	3. Accruing Interest 180+ Days Past Due			
	a) Recorded Investment	-	-	-
	b) Interest Accrued	-	-	-
	4. Interest Reduced			
	a) Recorded Investment	-	-	-
	b) Number of Loans	-	-	-
	c) Percent Reduced	-	-	-
b.	Prior Year			
	1. Recorded Investment			
	(a) Current	$ -	$ 17,540,853	$ 17,540,853
	(b) 30-59 Days Past Due	-	-	-
	(c) 60-89 Days Past Due	-	-	-
	(d) 90-179 Days Past Due	-	-	-
	(e) 180+ Days Past Due	-	-	-
	2. Accruing Interest 90-179 Days Past Due			
	a) Recorded Investment	-	-	-
	b) Interest Accrued	-	-	-
	3. Accruing Interest 180+ Days Past Due			
	a) Recorded Investment	-	-	-
	b) Interest Accrued	-	-	-
	4. Interest Reduced			
	a) Recorded Investment	-	-	-
	b) Number of Loans	-	-	-
	c) Percent Reduced	-	-	-

(5) Investment in Impaired Loans With or Without Allowance for Credit Losses:

			Commercial	
a.	Current Year	Insured	All Other	Total
	1. With Allowance for Credit Losses	$ -	$ -	$ -
	2. No Allowance for Credit Losses	-	-	-
b.	Prior Year			
	1. With Allowance for Credit Losses	-	-	-
	2. No Allowance for Credit Losses	-	-	-

(6) Investment in Impaired Loans – Average Recorded Investment, Interest Income Recognized, Recorded Investment on Nonaccrual Status and Amt of Interest Income Recognized Using a Cash-Basis Method

			Commercial	
a.	Current Year	Insured	All Other	Total
	1. Average Recorded Investment	$ -	$ -	$ -
	2. Interest Income Recognized	-	-	-
	3. Recorded Investments on Nonaccrual Status	-	-	-
	4. Amt of Int Inc recognized Using Cash Basis	-	-	-
b.	Prior Year			
	1. Average Recorded Investment	-	-	-
	2. Interest Income Recognized	-	-	-
	3. Recorded Investments on Nonaccrual Status	-	-	-
	4. Amt of Int Inc recognized Using Cash Basis	-	-	-

		Current Year	Prior Year
(7)	Allowance for Credit Losses:		
	a. Balance at beginning of period	$ -	$ -
	b. Additions charged to operations	-	-
	c. Direct write-downs charged against the allowances	-	-
	d. Recoveries of amounts previously charged off	-	-
	e. Balance at end of period	-	-

(8) The Company has no mortgage loans derecognized because of foreclosure.
(9) Interest income on impaired loans is reported as collected when cash is received

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

B. Debt Restructuring

The Company has no investments involving troubled debt restructurings.

C. Reverse Mortgages

The Company has no investment in reverse mortgages.

D. Loan-Backed Securities

(1) The Company uses a proprietary model for loss assumptions and widely accepted models for prepayment assumptions in valuing mortgage-backed and asset-backed securities with inputs from major third-party data providers. It combines the effects of interest rates, volatility, and pre-payment speeds based on various scenario simulations (Monte Carlo) with credit loss analysis and resulting effective analytics (spreads, duration, convexity) and cash-flows on a monthly basis. Credit sensitive cash flows are calculated using a proprietary model which estimates future loan defaults in terms of timing and severity. Model assumptions are specific to asset class and collateral types and are regularly evaluated and adjusted where appropriate.

(2) The Company has no loan-backed securities with a recognized other-than-temporary impairment due to the intent to sell or the inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis.

(3) The Company has no loan-backed securities with a recognized other-than-temporary impairments for which the present value of cash flows expected to be collected is less than amortized cost as of December 31, 2019.

(4) Impaired loan-backed securities for which an other-than-temporary impairment has not been recognized in earnings as a realized loss are as follows:

	Amortized Cost	Fair Value	Unrealized Loss Position
In a continuous loss position less than 12 months	$ 44,288,723	$ 44,126,191	$ (162,532)
In a continuous loss position 12 months or longer	15,051,325	14,926,301	(125,024)
Total	$ 59,340,048	$ 59,052,492	$ (287,556)

(5) There are several factors that are considered in determining whether an “other-than-temporary” impairment exists, including but not limited to debt burden, credit ratings, sector, liquidity, financial flexibility, company management, expected earnings and cash flow stream, and economic prospects associated with the investment.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

The Company has no dollar repurchase agreements and/or securities lending transactions at December 31, 2019.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company has no repurchase agreements transactions accounted for as a secured borrowing at December 31, 2019.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company has no reverse repurchase agreements transactions accounted for as a secured borrowing at December 31, 2019.

H. Repurchase Agreements Transactions Accounted for as a Sale

The Company has no repurchase agreements transactions accounted for as a sale at December 31, 2019.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale

The Company has no reverse repurchase agreements transactions accounted for as a sale at December 31, 2019.

J. Real Estate

The Company has no investment in real estate at December 31, 2019.

K. Low Income Housing Tax Credits (“LIHTC”)

The Company holds no LIHTC property investments at December 31, 2019.

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

L. Restricted Assets

1) Restricted Assets (including Pledged)

	Gross (Admitted & Nonadmitted) Restricted							Current Year			
	Current Year									Percentage	
	1	2	3	4	5	6	7	8	9	10	11
Restricted Asset Category	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Nonadmitted Restricted	Total Admitted Restricted (5 minus 8)	Gross (Admitted & Nonadmitted) Restricted to Total Assets (c)	Admitted Restricted to Total Admitted Assets (d)
a. Subject to contractual obligation for which liability is not shown											
b. Collateral held under security lending arrangements											
c. Subject to repurchase agreements											
d. Subject to reverse repurchase agreements											
e. Subject to dollar repurchase agreements											
f. Subject to dollar reverse repurchase agreements											
g. Placed under option contracts											
h. Letter stock or securities restricted as to sale – excluding FHLB capital stock											
i. FHLB capital stock					513,300		67,900		513,300	0.027	27
j. On deposit with states	18,726,442				18,726,442	19,834,582	(1,108,140)		18,726,442	0.979	0.979
k. On deposit with other regulatory bodies											
l. Pledged as collateral to FHLB (including assets backing funding agreements)											
m. Pledged as collateral not captured in other categories											
n. Other restricted assets											
o. Total Restricted Assets	$ 19,239,742	$	$	$	$ 19,239,742	$ 20,279,982	$(1,040,240)		$ 19,239,742	1.006	.006

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

2. Detail of Assets Pledged as Collateral Not Captured in Other Categories (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

	Gross (Admitted & Nonadmitted) Restricted							8	Percentage	
	Current Year					6	7		9	10
	1	2	3	4	5					
Description of Assets	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Current Year Admitted Restricted	Gross (Admitted & Nonadmitted) Restricted to Total Assets	Admitted Restricted to Total Admitted Assets
	$	$	$	$	$	$	$	$		
Total (c)	$	$	$	$	$	$	$	$		

3. Detail of Other restricted Assets (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

	Gross (Admitted & Nonadmitted) Restricted							8	Percentage	
	Current Year					6	7		9	10
	1	2	3	4	5					
Description of Assets	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Current Year Admitted Restricted	Gross (Admitted & Nonadmitted) Restricted to Total Assets	Admitted Restricted to Total Admitted Assets
	$	$	$	$	$	$	$	$		
Total (c)	$	$	$	$	$	$	$	$		

4. The Company has no collateral received and reflected as assets within the financial statements.

M. Working Capital Finance Investments

The Company has no working capital finance investments.

N. Offsetting and Netting of Assets and Liabilities

The Company has no derivatives, repurchase and reverse repurchases, securities borrowing and securities lending assets and liabilities that are offset per SSAP No. 64—Offsetting and Netting of Assets and Liabilities.

O. 5GI Securities

The Company had no 5GI securities at December 31, 2019 or 2018.

	Number of 5GI Securities		Aggregate BACV		Aggregate Fair Value	
Investment	Current Year	Prior Year	Current Year	Prior Year	Current Year	Prior Year
Bonds – Actual Cost			$	$	$	$
Bonds – Fair Value						
Preferred Stock–Actual Cost						
Preferred Stock – Fair Value						
Total			$	$	$	$

P. Short Sales

The Company had no short sales during 2019.

Q. Prepayment Penalty and Acceleration Fees

The Company had 30 CUSIPs that were called prior to their maturity date in 2019. The securities received proceeds of $21,082,846 and a book/ adjusted carrying value of $20,383,245 resulting in a net realized gain of $699,601.

	General Account
Number of CUSIPs	30
Aggregate Amount of Insurance Income	$692,010

NOTES TO FINANCIAL STATEMENTS

6. Joint Ventures, Partnerships and Limited Liability Companies

M. The Company has no investment in joint ventures, partnerships or limited liability companies that exceeds 10% of its admitted assets.

N. In 2018, the Company recognized other-than-temporary impairments of $43,264,419 on bond securities, common stock, joint venture, partnerships and limited liability companies within its portfolio. These assets are illiquid private placement investments that are in bankruptcy or work out status for which the fair value was determined based on a liquidation analysis. All the assets in the table below have been nonadmitted as of December 31, 2019.

CUSIP	Description	Actual Cost	Fair Value	Book/Adjusted Carrying Value	Current Year's OTTI Recognized
99Y800BE6	Agera Holdings LLC Equity Interest	$ 2,978,104	$ 0	$ 0	$ 2,978,104
00119@AA 4	Agera	7,500,000	0	0	7,500,000
00119@114	Agera	17,500,000	0	0	17,500,000
99Y801WR 2	Agera Parent LLC	2,500,000	0	0	2,500,000
99Y802HM8	Agera Parent LLC	470,000	0	0	470,000
99Y802ZP1	Agera Parent LLC	5,661,500	0	0	5,661,500
76016VAB9	RentPath LLC	2,213,829	0	0	2,213,829
99Y795QL6	Platinum Partners Value Arbitrage	500,000	0	0	500,000
99Y800JH1	Platinum Partners Master Fund	399,548	0	0	399,548
99Y801VN2	Platinum Partners Master Fund	51,000	0	0	51,000
99Y797TA3	Montsant Partners LLC	1,621,035	0	0	1,621,035
99Y798K13	Montsant Partners LLC	378,965	0	0	378,965
99Y802IJ4	Kingdom Energy Resources LLC	930,000	930,000	930,000	489,748
99Y802FD0	Equipment Finance SPE V LLC	7,010,089	7,010,089	7,010,089	1,000,000
608753109	Molycorp Inc	690	0	0	690
TOTAL		$ 49,714,760	$ 7,940,089	$ 7,940,089	$ 43,264,419

7. Investment Income

The Company did not exclude any due and accrued income from investment income in 2019.

8. Derivative Instruments

The Company did not utilize derivatives in 2018 or 2019.

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

A. The Company adopted SSAP 101, a replacement of SSAP No. 10R, effective 1/1/2013. Balances and related disclosures are presented pursuant to SSAP 101.

1. Components of Net Deferred Tax Asset

	2019			2018			Change		
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
a. Gross deferred tax assets	283,857,446	44,894,098	328,751,544	200,637,758	46,166,594	246,804,351	83,219,688	(1,272,496)	81,947,192
b. Statutory valuation allowance adjustment	278,854,808	44,894,098	323,748,907	192,106,517	46,166,594	238,273,110	86,748,291	(1,272,496)	85,475,795
c. Adjusted gross deferred tax assets	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
d. Deferred tax assets non-admitted	0	0	0	0	0	0	0	0	0
e. Net deferred tax asset	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
f. Deferred tax liabilities	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
g. Net admitted deferred tax asset/(liability)	0	0	0	0	0	0	0	0	0

2. Admission Calculation Components

	2019			2018			Change		
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
a. Federal income taxes paid in prior years recoverable through loss carrybacks	0	0	0	0	0	0	0	0	0
b. Adjusted gross deferred tax assets expected to be realized	0	0	0	0	0	0	0	0	0
c. Adjusted gross deferred tax assets offset by gross deferred tax liabilities	0	0	0	0	0	0	0	0	0
g. Deferred tax assets admitted as the result of SSAP No 101	0	0	0	0	0	0	0	0	0

3.

	2019	2018
(a) Ratio Percentage Used to Determine Recovery Period and Threshold Limitation Amount	(1,533%)	(909%)
(b) Amount of Adjusted Capital and Surplus Used to Determine Recovery Period and Threshold Limitation	$ (915,731,212)	$ (466,814,972)

4. Tax planning strategies did not have an effect on the Company's net admitted deferred tax assets for 2019 or 2018.

B. There are no temporary differences for which deferred tax liabilities are not recognized

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

C. Current income taxes incurred consist of the following major components:

	2019	2018	Change
1. Current Income Tax			
(a) Federal	$ (1,632,614)	$ (463,908)	$ (1,168,706)
(b) Foreign			
(c) Subtotal	$ (1,632,614)	$ (463,908)	$ (1,168,706)
(d) Federal income tax on net capital gains	-	-	
(e) Utilization of capital loss carryforwards	-	-	
(f) Other	-	-	
(99) Subtotal	$ (1,632,614)	$ (463,908)	$ (1,168,706)
2. Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	$ -	$ -	$ -
(2) Unearned premium reserve	-	-	-
(3) Policyholder reserves	165,654,143	112,796,962	52,857,181
(4) Investments	-	-	-
(5) Deferred acquisition costs	9,654,853	11,110,674	(1,455,821)
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Nonadmitted Assets	2,089,296	4,108,804	(2,019,508)
(11) Net operating loss carry-forward	106,397,361	72,533,393	33,863,967
(12) Tax credit carry-forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	61,793	87,925	(26,132)
(99) Subtotal	$ 283,857,446	$ 200,637,758	$ 83,219,688
(b) Statutory valuation allowance adjustment	(278,854,808)	(192,106,517)	(86,748,282)
(c) Non-admitted	-	-	-
(d) Admitted ordinary deferred tax assets	$ 5,002,637	$ 8,531,241	$ (3,528,604)
(e) Capital:			
(1) Investments	44,759,823	36,718,851	8,040,972
(2) Net capital loss carry-forward	0	6,723,864	(6,723,864)
(3) Partnerships	134,276	2,723,879	(2,589,603)
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	$ 44,894,098	$ 46,166,594	$ (1,272,495)
(f) Statutory valuation allowance adjustment	(44,894,098)	(46,166,594)	1,272,495
(g) Non-admitted	-	-	-
(h) Admitted capital deferred tax assets	$ -	$ -	$ -
(i) Admitted deferred tax assets	$ 5,002,637	$ 8,531,241	$ (3,528,604)
3. Deferred Tax Liabilities:			
(a) Ordinary:			
(1) Reserves – Transition Adjustment TCJA	$ 4,783,378	$ 7,305,785	$ (2,522,408)
(2) Accrued dividends	24,375	1,000,491	(976,116)
(3) Deferred and uncollected premium	194,885	224,965	(30,080)
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	-	-	-
(99) Subtotal	$ 5,002,637	$ 8,531,241	$ (3,528,604)
(b) Capital:			
(1) Investments	$ -	$ -	$ -
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	$ -	$ -	$ -
(c) Deferred tax liabilities	$ 5,002,637	$ 8,531,241	$ (3,528,604)
4. Net Deferred tax assets/liabilities:	$ -	$ -	$ -

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

The valuation allowance adjustments to gross deferred tax assets as of December 31, 2019 and 2018 were $323,748,907 and $238,273,110 respectively. The net change in the total valuation allowance adjustments for the year(s) ended December 31, 2019 was $85,475,796. The AMT Credits will be fully refunded in future periods, due to the Tax Cuts and Jobs Act ("TJCA") that eliminated the corporate AMT for 2018 and future years. As the Company is going to receive a refund for its AMT credits by 2021, the amount is presented in income tax receivable.

D. Among the more significant book to tax adjustments were the following:

The Company's income tax incurred and change in deferred income tax differs from the amount obtained by applying the federal statutory rate of 35% to income before taxes as follows:

		Current Year	Prior Year
(1)	Current Income Taxes Incurred	$ (1,632,614)	$ (463,908)
(2)	Change In Deferred Income Tax (Without Tax on Unrealized Gains and Losses)	-	-
	Tax on Capital Gain	1,838,060	
(3)	Total Income Tax Reported	$ 205,446	$ (463,908)
(4)	Income Before Taxes	$(465,163,973)	$(496,806,89)
		21%	21%
(5)	Expected Income Tax Expense (Benefit) at Statutory Rate	(97,684,434)	(104,329,448)
(6)	Increase (Decrease) In Actual Tax Reported Resulting From:		
	b. Amortization of IMR	668,110	(40,844,617)
	c. Section 382 Adjustment	-	-
	d. Deferred Tax Benefit on Nonadmitted Assets	2,019,508	696
	e. Return to provision	205,446	(9,760,491)
	f. Impact of tax reform rate change	-	53,355,419
	g. AMT Credit Sequestration	85,475,796	149,480
	h. Change in Valuation Allowance	9,521,020	(80,732,174
	i. Other		(652,144)
(7)	Total Income Tax Reported	$ 205,446	$ (463,908)

E. Operating Loss Carryforwards and Income Taxes Available for Recoupment

(1) As of December 31,2019, the Company has a $256,523,608 operating loss carryforward which will begin to expire in 2031, an $250,130,490 operating loss carryforward with an indefinite carryforward period and a $2,060,618 AMT tax credit carryforward, which will be fully refunded by 2021. The Company also has a $32,018,399 capital loss carryforward, which will begin to expire in 2023.

(2) The amount of Federal income taxes incurred that are available for recoupment in the event of future net losses are $0 as the TCJA eliminated loss carrybacks for life insurance companies.

(3) The aggregate amount of deposits admitted under Section 6603 of the Internal Revenue Code are $0.

F. Consolidated Federal Income Tax Return

(1) The Company files a consolidated return with the following entities:

Senior Health Oversight Trust
Fuzion Analytics, Inc.

(2) The Company is included in a consolidated federal income tax return with its parent company, Senior Health Care Oversight Trust and subsidiary, Fuzion Analytics, Inc. The Company has a written tax sharing agreement, approved by the Pennsylvania Insurance Department, which sets forth the manner in which the total combined federal tax income is allocated to each entity which is a party to the consolidation.

G. The Company does not believe that it is reasonably possible that the liability related to any federal or foreign tax loss contingency will significantly increase within the next 12 months.

NOTES TO FINANCIAL STATEMENTS

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Effective August 20, 2019, Senior Health Oversight Trust ("Oversight Trust") contributed all of its issued and outstanding stock in its wholly-owned subsidiary, Fuzion Analytics, Inc. ("Fuzion"), to the capital of the Company, resulting in Fuzion becoming a wholly-owned subsidiary of the Company. The Company's affiliated investment, Fuzion, has a current equity position of $2,975,269 for December 31, 2019, but is in draft form and could potentially increase by approximately $1.1 million after the filing of the Company's Annual Statement.

B. See Notes 10 F. and 10 I. below.

C. As of December 31, 2019, the Company recognizes an equity valuation for Fuzion of $2,975,269.

D. At December 31, 2019, the Company reported a net receivable from Fuzion of $49,541.

At December 31, 2019, the Company reported no receivable or payable from/to Oversight Trust.

Intercompany payables and receivables are settled on a monthly basis.

E. There are no guarantees or undertakings concerning parent, subsidiaries, affiliates or other related parties.

F. On March 1, 2014, the employees and operating assets of the Company were transferred to Fuzion in connection with the execution of a management services agreement under which Fuzion is responsible for the management of the Company's closed block of long-term care insurance business. First year fees under this agreement were fixed based on expenses the Company would have been expected to incur in the absence of the agreement. In the second and subsequent years of the agreement, fees decline based on the attrition of the Company's runoff block of long-term care business, subject to minimum and maximum annual decreases. The Company paid Fuzion $12,778,644 and $15,477,760 for services under this agreement in 2019 and 2018, respectively.

G. See note 10A and 10F. above.

H. See note 10A and 10F. above.

I. The Company has no investments in SCA entities that exceeds 10 percent of admitted assets.

J. The Company did not recognize any impairment write down for its investments in SCA entities during the statement period

K. The Company has no investments in foreign insurance subsidiaries.

L. The Company has an investment in downstream noninsurance holding companies, Fuzion Analytics, Inc.

M.

Balance Sheet Value of All SCA Entities

	SCA Entity	Percentage of SCA Ownership	Gross Amount	Admitted Amount	Nonadmitted Amount
a.	SSAP No. 97 8a Entities				
b.	SSAP No. 97 8b(ii) Entities				
	Fuzion Analytics, Inc	100%	$ 2,975,269	$ 2,975,269	$ -
	Total SSAP No 97 8b(ii) Entities		$ 2,975,269	$ 2,975,269	$ -
c.	SSAP No. 97 8b(iii) Entities				
d.	SSAP No. 97 8b(iv) Entities				
e.	Total SSAP No. 97 8b Entities		$ 2,975,269	$ 2,975,269	$ -
f.	Aggregate Total (a + e)		$ 2,975,269	$ 2,975,269	$ -

N. The Company has no investments in Insurance SCA entities.

O. The Company has no share of losses in SCA entities that exceeds its investment.

11. Debt

A. The Company has no debt.

B. In 2015, the Company became a member of the Federal Home Loan Bank (FHLB) of Pittsburgh. To date, the Company has no borrowings with the FHLB.

NOTES TO FINANCIAL STATEMENTS

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

The Company has no defined benefit plan.

B. Not applicable

C. Not applicable

D. Not applicable

E. Not applicable

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company does not participate in consolidated/holding company plans.

H. Postemployment Benefits and Compensated Absences

The Company does not offer post-employment benefits but, pursuant to a contract entered into by Conseco Life, provided health insurance coverage in 2019 for three retirees. This cost of this coverage has not been accrued because these benefits are life-contingent, non-accumulating and cannot be reasonably estimated.

I. Impact of Medicare Modernization Act on Postretirement Benefits

The FASB issued FASB Staff Position ("FSP") FAS 106-2, "Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003" ("FSP FAS 106-2") in May 2004. FSP FAS 106-2 provides guidance on accounting for the effects of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "Modernization Act"). The Modernization Act provides, among other things, a federal subsidy to plan sponsors who maintain postretirement health care plans that provide prescription drug benefits and meet certain equivalency criteria. FSP FAS 106-2 superseded FSP SAS 106-1, "Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003". The adoption of FSP FAS 106-2 did not have any impact on the Company's financial statements.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

(1) The Company's capital consists of 200,000 common shares authorized and 166,667 issued and outstanding with a par value of $15 per share.

(2) The Company has 20,000 preferred shares authorized and 5,000 issued and outstanding, with a stated value of $1,000 per share.

(3) The Company may not pay any dividends without the prior written approval of the Pennsylvania Insurance Department.

(4) The Company paid no dividends to shareholders during 2019.

(5) See Note No.13 (3) above.

(6) The Company's parent, the Oversight Trust, is governed by an independent Board of Trustees comprised of former insurance regulators and financial experts. The Oversight Trust's purpose is to support the solvency of the Company and the interests of its policyholders. The Company and the Oversight Trust are subject to the oversight of the Pennsylvania Insurance Department in accordance with an order issued by the Pennsylvania Insurance Department on November 12, 2008.

(7) During 2019, the Company had no advances to surplus.

(8) During 2019, the Company held no stock for special purposes.

(9) During 2019, the Company had no special surplus funds.

(10) As of December 31, 2019, the portion of unassigned funds (surplus) represented or increased by cumulative net unrealized gains was $828,998.

(11) The Company issued a surplus note ("Note") on February 19, 2015 to Beechwood Re Investments, LLC for cash. Payment of principal and interest on the Note is not guaranteed and such payment is subordinated to claims of all policyholders, creditors, and other liabilities of the Company. Interest and principal payments on the Note require prior approval of the Commissioner.

Date Issued	Interest Rate	Par Value	Carrying Value	Interest And Principal Paid Current Year	Total Interest and/or Principal Paid	Unapproved Interest and/or Principal	Date of Maturity
2/19/2015	6.0%	$50,000,000	$50,000,000	-	-	$11,550,000	04/01/2020

(12,13) The Company has not restated surplus due to a quasi-reorganization.

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

(1) The Company has not made any guarantees or undertakings for the benefit of an affiliate that would result in a material contingent exposure of the Company's or any affiliated insurer's assets to liability.

(2) The Company does not have any credit facility commitments at December 31, 2019.

(3) The Company has two credit facilities with Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company currently has investments of $22,500,000 and remaining commitments of $2,250,000 as of December 31, 2019. The Company no longer participates in new investments after December 31, 2018, however, the existing credit facilities may continue to have capital commitments according to the terms of the applicable loan documents. Alliance Bernstein anticipates full repayment of the debt obligations under the existing facilities over the next two years.

B. Assessments

(1) The Company has recorded a liability of $52,739 for guaranty fund assessments on several insolvencies as of December 31, 2019. This amount represents estimated obligations to state guaranty funds to provide for covered claims and other insurance obligations of insolvent insurers, net of the estimated offset to future premium taxes. The period over which the assessments are anticipated to be funded varies by insolvency and is difficult to predict.

The Company's estimate of probable recoveries of prior payments through premium tax credits is $967,227 and is recorded as an asset. The period over which the credits are realized varies by state but typically ranges from five to ten years.

(2) Assessments:

Assets recognized from paid and accrued premium tax offsets and policy surcharges, prior year end	$	1,448,680
Increases:		
Premium tax offsets recognized from current year assessments paid	$	79,112
Decreases:		
Premium tax offsets applied	$	201,761
Change in accrued assessment liability	$	117,292
Assets recognized from paid and accrued premium tax offsets and policy surcharges, current year end	$	1,208,738

(3) Guaranty Fund Liabilities and Assets Related to Assessments from Insolvencies of Entities that Write Long-Term Care
a. Discount Rate Applied: Not Applicable

b. The Undiscounted and Discounted Amount of the Guaranty Fund Assessment and Related Assets by Insolvency are presented in the following table:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty Network American Insurance Co	$ 1,156,420	$ -	$ 890,073	$ -
American Network Insurance Co	65,885	-	53,631	-
Senior American Insurance Co	6,830	-	6,584	-
Total	$ 1,229,136	$ -	$ 950,288	$ -

c. Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency: Not Applicable

C. Gain Contingencies

The Company has not reported all benefits from an Investment Management Services agreement that had a guaranteed return of 5.85% on all assets due to the counterparties inability to fulfill their obligation to pay the interest. However, management continues to proceed in collecting the interest owed to the Company.

D. Claims Related Extra Contractual Obligation ("ECO") and Bad Faith Losses Stemming From Lawsuits

The Company has no ECO and Bad Faith Losses Stemming from Lawsuits.

E. Joint and Several Liabilities

The Company has no joint and several liability arrangements.

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments, continued

F. All Other Contingencies

(1) Various lawsuits against the Company arise in the course of the Company's business. On December 19, 2018, the Receiver for Platinum Partners Credit Opportunities Funds filed an action against the Company, its affiliate Fuzion Analytics, Inc., Beechwood entities and others in the United States District Court for the Southern District of New York captioned *Melanie L. Cyganowski, as Equity Receiver for Platinum Partners Credit Opportunities Master Fund LP, et al. v. Beechwood RE Ltd., et al* ("PPCO Receiver Action"). The Company believes that this claim is not estimable at this time and has been tendered to the Company's insurance carrier. The Company is vigorously defending this matter. SHIP's motion for Summary Judgement was filed on February 14, 2020, which remains pending. In a related action, Company filed third party claims and crossclaims against a number of Beechwood and Platinum individuals and entities on April 19, 2019. Company has reached a settlement in principle for those third party claims and crossclaims. Notwithstanding the foregoing, an unfavorable resolution in the larger PPCO Receiver Action could have an adverse impact on the Company's financial position. The Company has a recorded value of $3.3 million for the PPCO asset, which could change as a result of the pending litigation.

(2) On June 24, 2019 the Company was served with a complaint filed on June 7, 2019 by the Joint Official Liquidators of Platinum Partners Value Arbitrage Fund against the Company in Delaware State Court captioned Principal Growth Strategies, LLC, a Delaware limited liability company; Platinum Partners Value Arbitrage Fund L.P. (in Official Liquidation), a Cayman Islands exempted limited partnership; and Martin Trott & Christopher Smith, Joint Official Liquidators of Platinum Partners Value Arbitrage Fund, L.P. (in official liquidation) v. AGH Parent LLC; Senior Health Insurance Company of Pennsylvania, et al. (the "PPVA Action"). Plaintiffs allege that several transactions involving Agera Energy resulted plaintiff Principal Growth Strategies losing its interests in Agera Energy in exchange for worthless Platinum Funds. Plaintiffs allege the Agera-related transactions were conceived by Beechwood and Platinum Partners insiders to benefit alleged Beechwood preferred investor clients, including the Company. The lawsuit has been removed to Delaware federal court, but a motion to remand is pending. The Company believes that this claim is not estimable at this time and it has been tendered to the Company's insurance carrier. The Company plans to vigorously defend this matter. Nevertheless, an unfavorable resolution could have an adverse impact on the Company's financial position.

(2) On April 10, 2019, David Levy filed a complaint against the Company in the United States District Court for the Southern District of New York captioned David Levy v. Senior Health Insurance Company of Pennsylvania ("Levy advancement action") seeking indemnification and advancement for his legal fees incurred in connection with various third-party actions filed against him, including the above-referenced PPCO Action and PPVA Action, pursuant to provisions in the Investment Management Agreements entered into between the Company and Beechwood entities. Contemporaneously with filing the complaint, Levy also filed a Motion for a Preliminary Injunction seeking the immediate advancement of legal fees incurred by him in connection with the third-party actions. On May 13, 2019, in the preliminary injunction, the court found that Levy is entitled to advancement of third-party claims, but limited fees to only those incurred in defending allegations of conduct by Levy in his role as investment adviser to the Company while an officer of Beechwood. On July 9, 2019, Levy was convicted of fraud and conspiracy to commit fraud in connection with the same scheme for which the court ordered the Company to advance litigation expenses. Following the jury's verdict, the Company moved for and was granted summary judgment in the Levy advancement action on the basis that Levy's criminal conduct eliminated any entitlement to indemnification or advancement. In light of the criminal conviction, on August 7, 2019, the Company filed its notice of appeal of the Preliminary Injunction ruling regarding advancement and posted a bond with the registry of the court in the amount of $765,630. In late September 2019, the judge in Levy's criminal trial granted Levy a post-trial acquittal, which the government has appealed. In light of the appeal of the criminal action, on January 22, 2020, the parties filed a Joint Motion to Stay the Appeal of the Preliminary Injunction Pending Outcome of Pending Criminal Appeal. On February 20, 2020, the court granted the Company's voluntary dismissal and request to withdraw the $765,360 from the registry of the Court, plus interest, less any administrative fees. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.

(3) On May 16, 2019, several Beechwood entities and individuals filed an action for advancement and indemnification for third-party expenses, along with a motion for summary judgment on the advancement claim in the United States District Court of the Southern District of New York captioned BAM et al. v. Senior Health Insurance Company. Similar to the Levy action, the court granted the Beechwood Parties' motion for summary judgment for third-party expenses, which the Company appealed. The parties have reached a settlement in principle which makes the appeal moot. By Order dated February 22, the court ordered that the Company's deposit of $519,252.81, plus interest, less any administrative fees, be returned. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.

(4) Under an assignment agreement effective October 1, 2008 with Conseco Life Insurance Company ("Conseco Life"), all the assets and liabilities pertaining to the Company's non-long-term care business were assigned and assumed by Conseco Life. The Company remains contingently liable for the assigned business in the event Conseco Life fails to perform its obligations under the assignment agreement. In recognition of this liability, Conseco Life is required to maintain assets in a trust account of which the Company is beneficiary, with an aggregate fair market value equal to the estimated reserves of the assigned business. Assets are deposited or withdrawn from the trust on a quarterly basis as needed to maintain the aggregate market value of the trust assets. As of December 31, 2019, the required trust amount was $152,701,732. The market value of trust assets was $154,131,222.

15. Leases

A. Lessee Leasing Arrangements

(1) The Company has no lessee leasing arrangements.

(2) The Company has no initial or remaining noncancelable lessee terms in excess of one year.

(3) The Company has no sale-leaseback transactions.

B. Lessor Leasing Arrangements

(1) The Company has no operating leases as a significant part of its business activity.

NOTES TO FINANCIAL STATEMENTS

(2) The Company has no leveraged leases.

16. Information About Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company does not have any financial instruments with off-balance sheet risk.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. During 2019, the Company had no transfers of receivables reported as sales.

B. Transfer and Servicing of Financial Assets

(1) During 2019, the Company had no transfers or servicing of financial assets.

(2) During 2019, the Company had no transfers or servicing of financial assets and liabilities.

(3) During 2019, the Company had no transfers or servicing of financial assets and liabilities.

(4) During 2019, the Company had no asset-backed financing arrangements and similar transfers accounted for as sales.

(5) During 2019, the Company had no transfers of financial assets accounted for as secured borrowing.

(6) During 2019, the Company had no transfers of receivables with recourse.

(7) During 2019, the Company had no securities subject to repurchase and reverse repurchase agreements.

C. Wash Sales

During 2019, the Company had no securities with NAIC designation 3 or below which were sold and reacquired within 30 days of the sale date.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Portion of Partially Insured Plans

A. The Company does not serve as administrator of any ASO plans.

B. The Company does not serve as administrator of any ASC plans.

C. The Company has no Medicare or similarly structured cost-based reimbursement contracts.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

The Company does not have any direct premiums written by managing general agents or third-party administrators.

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement

A. The Company's valuation techniques and the inputs used to develop the fair value measurements are as follows:

Pricing Level 1 – Valuations are based on unadjusted quoted prices in active markets for identical assets that our pricing sources have the ability to access. Since the valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these securities does not entail a significant amount or degree of judgment.

Pricing Level 2 – Valuations based upon quoted prices for similar assets in active markets, quoted prices for identical or similar assets in inactive markets, or valuations based on models where the significant inputs are observable (e.g. interest rates, yield curves, prepayment speeds, default rates, loss severities), or can be corroborated by observable market data.

Pricing Level 3 – Valuations that are derived from techniques in which one or more of the significant inputs are unobservable, including broker quotes which are non-binding.

(1) Fair Value Measurement as of December 31, 2019.

Description for each class of asset or liability	Level 1	Level 2	Level 3	Net Asset Value (NAV)	Total
a. Assets carried at fair value					
Bonds					
Industrial & Misc.	$ -	$ -	$ -	$ -	$ -
Total Bonds	$ -	$ -	$ -	$ -	$ -
Common Stock					
Industrial & Misc. Other	$ -	$ 513,300	$ -	$ -	$ 513,300
Industrial & Misc. Publicly Traded	$ -	$ -	$ 89,817	$ -	$ 89,817
Parent, Subs, & Affiliates	$ -	$ -	$ 2,975,269	$ -	$ 2,975,269
Total Common Stock	$	$ 513,300	$ 3,065,086	$ -	$ 3,578,386
Money Market Funds					
Exempt Money Market Funds	$ 41,843,393	$ -	$ -	$ -	$ 41,843,393
Other Money Market Funds	11,795,000	-	-	-	11,795,000
Total Money Market Funds	$ 53,638,393	$ -	$ -	$ -	$ 53,638,393
Total Assets carried at fair value	$ 53,638,393	$ 513,300	$ 3,065,086	$ -	$ 57,216,779

(2) Following is a reconciliation of the opening balances to the closing balances for fair value measurements categorized within Level 3 of the fair value hierarchy.

Description	Beginning Balance at 01/01/2019	Transfers into Level 3	Transfers out of Level 3	Total gains and (losses) included in Net Income	Total gains and (losses) included in Surplus	Purchases	Issuances	Sales	Settlements	Ending Balance at 12/31/2019
Assets										
Bonds	$ -	-	-	-	-	-	-	-	-	-
Common Stock	106,627	-	-	(690)	461,179	2,497,970	-	-	-	3,065,086
Total	$106,627	-	-	$(690)	$461,179	$2,497,970	-	-	-	$3,065,086

(3) Pricing level changes are infrequent and occur when the Company's widely accepted pricing service provider is not able to determine a price on observable inputs, in which case the Company uses broker quotes which may use unobservable inputs.

(4) See Note 20 A.

(5) The Company had no derivative activity in 2019 or 2018.

B. The Company reports only on a statutory basis, hence there are no other fair value disclosures.

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement, continued

C. Aggregate fair value for all financial instruments.

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)
Bonds	1,803,159,678	1,721,888,231	2,299,806	1,756,233,799	44,626,073	
Common Stock	3,578,386	3,578,386	-	513,300	3,065,086	-
Perpetual Preferred Stock	86,859,728	86,271,292	-	14,716,228	72,143,500	-
Mortgage Loans	13,530,338	12,681,751	-	-	13,530,338	-
Cash Equivalents	53,638,393	53,638,393	53,638,393	-	-	-
Surplus Notes	1,712,669	1,645,981	-	1,712,669	-	-
Other Invested Assets	20,188,946	10,719,726	-	-	20,188,946	-

D. Not applicable

E. At December 31, 2019, the Company did not hold any investments using the NAV practical expedient pursuant to SSAP No. 100R – Fair Value.

21. Other Items

A. Unusual or Infrequent Items

During 2019 and 2018, there were no unusual or infrequent items.

B. Troubled Debt Restructuring

The Company had no troubled debt restructuring.

C. Other Disclosures

(1) Assets with statement values totaling $18,726,442 and $19,834,582 at December 31, 2019 and 2018, respectively, were on deposit with government authorities or trustees as required by law.

(2) The Pennsylvania Department of Insurance has approved a permitted practice to a one-time release of the Interest Maintenance Reserve ('IMR") of $192.502,234 million effective January 1, 2018. This permitted practice also created a premium deficiency reserve of $120,000,000 million which ultimately increased surplus a net $72,576,741 million between the two transactions.

(3) On September 28, 2018, the Bruckner Investment Trust Class A and Class B Notes were terminated in exchange for the transfer to the Company of Sutton Capital Trust securities and a cash payment. The termination of the Bruckner Class A and B Notes resulted in a net loss to the Company of $9,916,628.

(4) In order to meet the Equity Limited Partnership threshold according to the Pennsylvania Investment statute, the Company nonadmitted $9,916,628 of its holdings in Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company holds this investment at $19,435,088 based upon the October 31, 2019 statements at fair market value (FMV). The December 31, 2019 financial statements received late February reflect a FMV of $17,706,269 and the change in value of $1.7 million will be recorded in 2020.

(5) On July 24, 2018, Senior Health Insurance Company of Pennsylvania ("SHIP") filed a Complaint in the United States District Court for the Southern District of New York entitled Senior Health Insurance Company of Pennsylvania v. Beechwood Re Ltd., B Asset Manager, L.P., Beechwood Bermuda International, Ltd., Beechwood Re Investments, LLC a/k/a Beechwood Re Investors, LLC, Illumin Capital Management, LP, Moshe M. Feuer a/k/a Mark Feuer, Scott A. Taylor, David I. Levy, Dhruv Narain, and John Does 1-20, Case No. 1:18-cv-6658 (JSR) seeking damages for breach of three Investment Management Agreements, fraud, gross negligence, unjust enrichment, and conspiracy (the "SHIP Action"). SHIP filed amended complaints in the SHIP Action on December 14, 2018 and December 28, 2018. The action is currently stayed as to defendant David Levy due to a pending criminal matter. Fact and expert discovery in the SHIP Action as to the remaining parties is now complete. The final pretrial conference is set for April 2, 2020.

NOTES TO FINANCIAL STATEMENTS

21. Other Items, continued

(6) On July 31, 2019 the Company filed litigation in the United States District Court for the Southern District of New York captioned Senior Health Insurance Company of Pennsylvania v. Lincoln International LLC, Lincoln Advisors LLC. The Company filed a Second Amended Complaint on October 31, 2019 seeking damages for aiding and abetting fraud, aiding and abetting breach of fiduciary duty, conspiracy and contribution and indemnity and unjust enrichment/constructive trust. On February 14, 2020, Defendants moved for Summary Judgement. Company's opposition to Defendants Motion for Summary Judgement is due March 6, 2020.

D. The Company had no business interruption insurance recoveries.

E. The Company had no state transferable or non-transferable tax credits at December 31, 2019.

F. Subprime Mortgage Related Risk Exposure

(1) The company has exposure to subprime lending in the fixed maturity (bond) investment portfolio, which contains securities collateralized by mortgages that have characteristics of subprime lending such as low FICO score, adjustable rate mortgages and alternative documentation mortgages. These investments are in the form of asset-backed securities and collateralized mortgage obligations which are collateralized by subprime mortgages. The Company reviews its mortgage-backed investments for other than temporary impairments and records losses to the extent it believes it is probable that not all payments due under these investments will be collected subject to the Company's ability and intent to hold these investments to a point of recovery. The risk to subprime mortgage investments is mitigated through portfolio diversification.

(2) The Company had no direct investments in subprime mortgage loans at December 31, 2019.

(3) At December 31, 2019, the Company had subprime mortgage related risk exposure through mortgage-backed securities as presented below:

Direct Exposure Through Other Investments:

	Actual Cost	Book/Adjusted Carrying Value (excluding interest)	Fair Value	OTTI Losses Recognized
Residential mortgage-backed securities	$ 868,704	$ 854,534	$ 886,263	$ -

(4) The Company does not write Mortgage Guaranty or Financial Guaranty insurance.

G. The Company has no retained assets for 2019 and 2018.

H. Insurance-Linked Securities (ILS) Contracts

The Company has no insurance-linked securities (ILS) contracts.

22. Events Subsequent

(A) On February 27, 2019, as required under 40 P.S. §443 (a), SHIP filed its Risk-Based Capital ("RBC") report reflecting total adjusted capital of -$466,814,972, placing the Company below the "mandatory control level." As a result, on July 30, 2019, a majority of the Oversight Trust Trustees voted to give consent to rehabilitation of the Company and to waive the hearing contemplated by 40 P.S. §221.15. On that same date, a majority of the directors of the Company voted to give consent to rehabilitation of the Company and to waive the hearing contemplated by 40 P.S. §221.15. On January 23, 2020, the Insurance Commissioner of the Commonwealth of Pennsylvania filed an Application in the Commonwealth Court of Pennsylvania seeking to place the Company in rehabilitation pursuant to 40 P.S. §221.1 to §221.63 on the ground that rehabilitation was consented to by the Trustees of the Oversight Trust Trustees and directors of the Company. By Order dated January 29, 2020, the Commonwealth Court of Pennsylvania granted the Application and the Company was placed into rehabilitation.

NOTES TO FINANCIAL STATEMENTS

23. Reinsurance

A. Ceded Reinsurance Report
Section 1 - General Interrogatories

1. Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?
Yes ( ) No (X) If yes, give full details.

2. Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?
Yes ( ) No (X) If yes, give full details.

Section 2 - Ceded Reinsurance Report - Part A

1. Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?
Yes ( ) No (X)

   a. If yes, what is the estimated amount of the aggregate reduction in surplus of a unilateral cancellation by the reinsurer as of the date of this statement, for those agreements in which cancellation results in a net obligation of the Company to the reinsurer, and for which such obligation is not presently accrued? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

   b. What is the total amount of reinsurance credits taken, whether as an asset or as a reduction of liability, for these agreements in this statement?

2. Does the Company have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?
Yes ( ) No (X)
If yes, give full details.

Section 3 - Ceded Reinsurance Report - Part B

1. What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of the statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making the estimate. $0

2. Have any new agreements been executed, or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?
Yes (_) No (X)

   If yes, what is the amount of reinsurance credits, whether an asset or a reduction of liability, taken for such new agreements or amendments? $ 0

B. Uncollectible Reinsurance

Effective January 1, 2018, the Roebling reinsurance treaty was terminated, resulting in a write-off of $11,626,473, all of which was unauthorized in 2017.

C. Commutation of Ceded Reinsurance

During 2019, the Company did not report any income or expenses as a result of commutation of reinsurance.

D. Reporting Entity Ceding to Certified Reinsurer Whose Rating was Downgraded or Status Subject to Revocation

The Company has had no certified reinsurers ratings downgraded or status subject to revocation.

E. The Company has no reinsurance of variable annuity contracts with an affiliated captive reinsurer.

F. The Company has no reinsurance agreements with an affiliated captive reinsurer.

G. The Company does not utilize captives to assume reserves.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

The Company has no retrospectively rated contracts or contracts subject to redetermination.

NOTES TO FINANCIAL STATEMENTS

25. Change in Incurred Losses and Loss Adjustment Expenses

Gross of Reinsurance
Reserves as of December 31, 2018 were $959,644,499. As of December 31, 2019, gross payments of $317,253,364, discounted to December 31, 2018, have been made for incurred losses and estimated waiver of premium to insured events of prior years. Reserves remaining for prior years are now $634,244,696, discounted to December 31, 2018, as a result of re-estimation of unpaid claims and claim adjustment expenses on the long- term care line of insurance. Thus, there has been an $8,146,439 favorable prior year development on an annual basis from December 31, 2018 to December 31, 2019. As additional information becomes known on individual claims experience, the original estimates are adjusted accordingly. None of the Company's accident and health contracts are subject to retrospective rating or experience refunds.

26. Intercompany Pooling Arrangements

The Company is not part of an affiliated intercompany pooling arrangement.

27. Structured Settlements

The Company has not reduced reserves through the purchase of an annuity as part of a structured settlement.

28. Health Care Receivables

The Company has no pharmaceutical rebate receivables or risk sharing receivables.

29. Participating Policies

The Company has no participating policies.

30. Premium Deficiency Reserves

Premium deficiency reserves were necessary.

1)	Liability carried for premium deficiency reserves	$ 636,536,749
2)	Date of most recent evaluation of this liability	12/31/2019
3)	Was anticipated investment income utilized in the calculation?	Yes [x] No []

31. Reserves for Life Contracts and Deposit-type Contracts

The Company had no life contracts or annuity contracts in force as of December 31, 2019.

32. Analysis of Annuity Actuarial Reserves and Deposit Liabilities by Withdrawal Characteristics

The Company had no annuity contracts in force and had no deposit-type liabilities as of December 31, 2019.

33. Premium and Annuity Considerations Deferred and Uncollected

The Company had no life contracts or annuity contracts in force as of December 31, 2019.

34. Separate Accounts

The Company had no separate accounts at December 31, 2019.

35. Loss/Claim Adjustment Expenses

The balance in the liability for unpaid accident and health claim adjustment expenses as of December 31, 2019 and 2018 was $20,947,086 and $21,543,776, respectively. The Company incurred $10,305,677 on a net basis and paid $11,090,455 of net claim adjustment expenses in the current year, of which $1,260,431 of the paid amount was attributable to insured or covered events of prior years. The Company did not increase or decrease the provision for insured events of prior years. The Company does not take into account any anticipated salvage and subrogation in its determination of the liability for unpaid claims/losses.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? If yes, complete Schedule Y, Parts 1, 1A and 2. Yes [X] No [ ]

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes [X] No [ ] N/A [ ]

1.3 State regulating? PENNSYLVANIA

1.4 Is the reporting entity publicly traded or a member of publicly traded group? Yes [ ] No [X]

1.5 If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group.

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [ ] No [X]

2.2 If yes, date of change:

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2018

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. 12/31/2018

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). 12/31/2018

3.4 By what department or departments?
PENNSYLVANIA

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments? Yes [ ] No [ ] N/A [X]

3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [X] No [ ] N/A [ ]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.11 sales of new business? Yes [ ] No [X]

4.12 renewals? Yes [ ] No [X]

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.21 sales of new business? Yes [ ] No [X]

4.22 renewals? Yes [ ] No [X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [ ] No [X]

If the answer is YES, complete and file the merger history data file with the NAIC.

5.2 If yes, provide the name of entity, NAIC company code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [X] No [ ]

6.2 If yes, give full information:
Subsequent to the 2018 Annual Statement filing, certificates of authority in the following states have been suspended: Alaska, Arizona, Idaho, Iowa, Kentuck, Oregon, Virginia, Washington, West Virginia, and Wyoming

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes [ ] No [X]

7.2 If yes,

7.21 State the percentage of foreign control %

7.22 State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1 Nationality	2 Type of Entity

8.1 Is the company a subsidiary of a bank holding company regulated with the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If the response to 8.3 is yes, please provide below the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Eide Bailly, LLP, 800 Nicollet Mall, Ste. 1300, Minneapolis, MN 55402-7033

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [ ] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [ ] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [ ] N/A [ ]

10.6 If the response to 10.5 is no or n/a, please explain:

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Allen J Schmitz, F.S.A, M.A.A.A. Actuary/Consultant with Milliman, Inc., 15800 West Bluemound Road Suite 100, Brookfield, WI 53005

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [ ] No [X]

12.11	Name of real estate holding company	
12.12	Number of parcels involved	0
12.13	Total book/adjusted carrying value	$ 0

12.2 If yes, provide explanation

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [ ] No [ ]

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [ ] No [ ]

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [ ] No [ ] N/A [ ]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]

(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;

(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;

(c) Compliance with applicable governmental laws, rules and regulations;

(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and

(e) Accountability for adherence to the code.

14.11 If the response to 14.1 is no, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [ ] No [X]

14.21 If the response to 14.2 is yes, provide information related to amendment(s).

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [ ] No [X]

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount
			$

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the Board of Directors or a subordinator committee thereof? Yes [X] No [ ]

17. Does the reporting entity keep a complete permanent record of the proceedings of its Board of Directors and all subordinate committees thereof? Yes [X] No [ ]

18. Has the reporting entity an established procedure for disclosure to its Board of Directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person? Yes [X] No [ ]

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [ ] No [X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):

20.11	To directors or other officers	$ 0
20.12	To stockholders not officers	$ 0
20.13	Trustees, supreme or grand (Fraternal only)	$ 0

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):

20.21	To directors or other officers	$ 0
20.22	To stockholders not officers	0
20.23	Trustees, supreme or grand (Fraternal only)	0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reporting in the statement? Yes [ ] No [X]

21.2 If yes, state the amount thereof at December 31 of the current year:

21.21	Rented from others	$ 0
21.22	Borrowed from others	$ 0
21.23	Leased from others	$ 0
21.24	Other	$ 0

22.1 Does this statement include payments for assessments as described in the *Annual Statement Instructions* other than guaranty fund or guaranty association assessments? Yes [ ] No [X]

22.2 If answer is yes:

22.21	Amount paid as losses or risk adjustment	$ 0
22.22	Amount paid as expenses	$ 0
22.23	Other amounts paid	$ 0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No [ ]

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 0

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date (other than securities lending programs addressed in 24.03)? Yes [X] No [ ]

24.02 If no, give full and complete information, relating thereto:

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet (an alternative is to reference Note 17 where this information is also provided).

24.04 Does the company's security lending program meet the requirements for a conforming program as outlined in the *Risk-Based Capital Instructions*? Yes [ ] No [ ] N/A [X]

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. $ 0

24.06 If answer to 24.04 is no, report amount of collateral for other programs $ 0

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [ ] No [ ] N/A [X]

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [ ] No [ ] N/A [X]

24.09. Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending? Yes [ ] No [ ] N/A [X]

24.10 For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2: $ 0

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2: $ 0

24.103 Total payable for securities lending reported on the liability page: $ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is current in force? (Exclude securities subject to Interrogatory 21.1 and 24.03.) Yes [X] No [ ]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	$ 0
25.22	Subject to reverse repurchase agreements	$ 0
25.23	Subject to dollar repurchase agreements	$ 0
25.24	Subject to reverse dollar repurchase agreements	$ 0
25.25	Placed under option agreements	$ 0
25.26	Letter stock or securities restricted as sale – excluding FHLB Capital Stock	$ 0
25.27	FHLB Capital Stock	$ 513,300
25.28	On deposit with states	$ 18,762,440
25.29	On deposit with other regulatory bodies	$ 0
25.30	Pledged as collateral – excluding collateral pledged to an FHLB	$ 0
25.31	Pledged as collateral to FHLB – including assets backing funding agreements	$ 0
25.32	Other	$ 0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount
		$

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [ ] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ] N/A [X]
If no, attach a description with this statement.

Lines 26.3 through 26.5: FOR LIFE/FRATERNAL REPORTING ENTITIES ONLY:

26.3 Does the reporting entity utilize derivatives to hedge variable annuity guarantees subject to fluctuations as a results of interest rate sensitivity? Yes [ ] No [X]

26.4 If the response to 26.3 is yes, does the reporting entity utilize:

26.41 Special accounting provision of SSAP No. 108 Yes [ ] No [ ]

26.42 Permitted accounting practice Yes [ ] No [ ]

26.43 Other accounting guidance Yes [ ] No [ ]

26.5 By responding yes to 26.41 regarding utilizing the special accounting provisions of SSAP No. 108, the reporting entity attests to the following: Yes [ ] No [ ]

- The reporting entity has obtained explicit approval from the domiciliary state.
- Hedging strategy subject to the special accounting provisions is consistent with the requirements of VM-21.
- Actuarial certification has been obtained which indicates that the hedging strategy is incorporated within the establishment of VM-21 reserves and provides the impact of the hedging strategy within the Actuarial Guidance Conditional Tail Expectation Amount.
- Financial Officer Certification has been obtained which indicates that the hedging strategy meets the definition of a Clearly Defined Hedging Strategy within VM-21 and the Clearly Defined Hedging Strategy is the hedging strategy being used by the company in its actual day-to-day risk mitigation efforts.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [ ] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year: $ 0

28. Excluding items in Schedule E-Part 3-Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC *Financial Condition Examiners Handbook*? Yes [X] No [ ]

28.01 For agreements that comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
The Bank of New York Mellon	1 Wall Street, 14th Floor, New York, NY 10286

28.02 For all agreements that do not comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, provide the name, location and a complete explanation

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [ ] No [X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts", "… handle securities"].

1 Name of Firm or Individual	2 Affiliation
New England Asset Management	U
Conning Asset Management Company	U
John Robison, Chief Investment Officer	I

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's invested assets? Yes [X] No [ ]

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's invested assets? Yes [X] No [ ]

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
105900	New England Asset Management	JR85E5PS4GQFZTFC1	SEC	No
107423	Conning Asset Management Company	49300Z0GMKK37BDV4	SEC	No

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D-Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])? Yes [ ] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
		$
29.2999 TOTAL		$

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation
		$	

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

		1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1	Bonds	$ 1,721,888,236	$ 1,803,159,706	$ 81,271,470
30.2	Preferred Stocks	$ 86,271,292	$ 86,859,728	$ 588,436
30.3	Totals	$ 1,808,159,528	$ 1,890,019,434	$ 81,859,906

30.4 Describe the sources or methods utilized in determining the fair values:

See Fair Value Disclosure in Note 20.A of Notes to Financial Statement

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [X] No [ ]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [ ] No [X]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

Prices are obtained from the dealer/market makers for these securities. These prices are non-binding but represent the best estimate of fair value per market conditions

32.1 Have all the filing requirements of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* been followed? Yes [X] No [ ]

32.2 If no, list exceptions:

33. By self-designating 5GI securities, the reporting entity is certifying the following elements for each self-designation 5GI security:

a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.

b. Issuer or obligor is current on all contracted interest and principal payments.

c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

Has the reporting entity self-designated 5GI securities? Yes [ ] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:

a. The security was purchased prior to January 1, 2018.

b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.

c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as an NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

Has the reporting entity self-designated PLGI securities? Yes [ ] No [X]

35. By assigning FE to a Schedule BA non-registered private fund, the reporting entity is certifying the following elements of each self-designated FE fund:

a. The shares were purchased prior to January 1, 2019.

b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.

c. The security had a public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO prior to January 1, 2019.

d. The fund only or predominantly holds bonds in its portfolio.

e. The current reported NAIC Designation was derived from the public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO.

f. The public credit rating(s) with annual surveillance assigned by an NAIC CRP has not lapsed.

Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria? Yes [ ] No [X]

OTHER

36.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any? $ 0

36.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid
	$

37.1 Amount of payments for legal expenses, if any? $ 1,182,189

37.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Stradley Ronon Stevens & Young LLP	$ 486,310

38.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? $ 0

38.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
	$

GENERAL INTERROGATORIES

PART 2 – LIFE, ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

Life, Accident and Health Companies/Fraternal Benefit Societies:

1.1	Does the reporting entity have any direct Medicare Supplement Insurance in force?		Yes [ ] No [X]
1.2	If yes, indicate premium earned on U.S. business only.	$	0
1.3	What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?	$	0
	1.3 Reason for excluding:		
1.4	Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above.	$	0
1.5	Indicate total incurred claims on all Medicare Supplement insurance.	$	0
1.6	Individual policies:		
	Most current three years:		
	1.61 Total premium earned	$	0
	1.62 Total incurred claims	$	0
	1.63 Number of covered lives	$	0
	All years prior to most current three years:		
	1.64 Total premium earned	$	0
	1.65 Total incurred claims	$	0
	1.66 Number of covered lives	$	0
1.7	Group policies:		
	Most current three years:		
	1.71 Total premium earned	$	0
	1.72 Total incurred claims	$	0
	1.73 Number of covered lives	$	0
	All years prior to most current three years:		
	1.74 Total premium earned	$	0
	1.75 Total incurred claims	$	0
	1.76 Number of covered lives	$	0

2. Health Test:

		1 Current Year	2 Prior Year
2.1	Premium Numerator	$ 0	$ 0
2.2	Premium Denominator	$ 78,564,611	$ 1,237,392,658
2.3	Premium Ratio (2.1/2.2)	0.0%	0.0%
2.4	Reserve Numerator	$ 49,738,445	$ 49,770,059
2.5	Reserve Denominator	$ 2,167,641,605	$ 2,270,616,300
2.6	Reserve Ratio (2.4/2.5)	2.3%	2.2%

3.1	Does the reporting entity have Separate Accounts?		Yes [ ] No [X]
3.2	If yes, has a Separate Accounts statement been filed with this Department		Yes [ ] No [ ] N/A[ ]
3.3	What portion of capital and surplus funds of the reporting entity covered by assets in the Separate Accounts statement, is not currently distributable from the Separate Accounts to the general account for use by the general account?	$	0
3.4	State the authority under which Separate Accounts are maintained:		
3.5	Was any of the reporting entity's Separate Accounts business reinsured as of December 31?		Yes [ ] No [ ]
3.6	Has the reporting entity assumed by reinsurance any Separate Accounts business as of December 31?		Yes [ ] No [ ]
3.7	If the reporting entity has assumed Separate Accounts business, how much, if any, reinsurance assumed receivable for reinsurance of Separate Accounts reserve expense allowances is included as a negative amount in the liability for "Transfers to Separate Accounts due or accrued (net)?"	$	0
4.	For reporting entities having sold annuities to another insurer where the insurer purchasing the annuities has obtained a release of liability from the claimant (payee) as the result of the purchase of an annuity from the reporting entity only:		
4.1	Amount of loss reserves established by these annuities during the current year:	$	0
4.2	List the name and location of the insurance company purchasing the annuities and the statement value on the purchase date of the annuities.		

1 P&C Insurance Company and Location	2 Statement Value on Purchase Date of Annuities (i.e., Present Value)

5.1	Do you act as a custodian for health savings accounts?		Yes [ ] No [X]
5.2	If yes, please provide the amount of custodial funds held as of the reporting date.	$	0
5.3	Do you act as an administrator for health savings accounts?		Yes [ ] No [X]
5.4	If yes, please provide the balance of the funds administered as of the reporting date.	$	0
6.1	Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers?		Yes [ ] No [ ] N/A [X]

GENERAL INTERROGATORIES

PART 2 – LIFE, ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

6.2 If the answer to 6.1 is yes, please provide the following:

1	2	3	4	Assets Supporting Reserve Credit		
				5	6	7
Company Name	NAIC Company Code	Domiciliary Jurisdiction	Reserve Credit	Letters of Credit	Trust Agreements	Other
			$	$	$	$

7. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded).

7.1	Direct premiums written	$ 0
7.2	Total incurred claims	$ 0
7.3	Number of covered lives	0

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

8. Is the reporting entity licensed or charted, registered, qualified, eligible or writing business in at least two states? Yes [X] No [ ]

8.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? Yes [ ] No [ ]

Life, Accident and Health Companies Only:

9.1 Are personnel or facilities of this reporting entity used by another entity or entities or are personnel or facilities of another entity or entities used by this reporting entity (except for activities such as administration of jointly underwritten group contracts and joint mortality or morbidity studies)"? Yes [X] No [ ]

9.2 Net reimbursement of such expenses between reporting entities:

9.21	Paid	$ 12,778,644
9.22	Received	$ 0

10.1 Does the reporting entity write any guaranteed interest contracts? Yes [ ] No [X]

10.2 If yes, what amount pertaining to these items is included in:

10.21	Page 3, Line 1	$ 0
10.22	Page 4, Line 1	$ 0

11. For stock reporting entities only:

11.1	Total amount paid in by stockholders as surplus funds since organization of the reporting entity:	$ 1,198,824,011

12. Total dividends paid stockholders since organization of the reporting entity:

12.11	Cash	$ 217,094,930
12.12	Stock	$ 140,004

13.1 Does the reporting entity reinsure any Workers' Compensation Carve-Out business defined as: Yes [ ] No [X]

Reinsurance (including retrocessional reinsurance) assumed by life and health insurers of medical, wage loss and death benefits of the occupational illness and accident exposures, but not the employers liability exposures, of business originally written as workers' compensation insurance.

13.2 If yes, has the reporting entity completed the *Workers' Compensation Carve-Out Supplement* to the Annual Statement? Yes [ ] No [ ]

13.3 If 13.1 is yes, the amounts of earned premiums and claims incurred in this statement are:

		1 Reinsurance Assumed	2 Reinsurance Ceded	3 Net Retained
13.31	Earned premium	$ 0	$ 0	$ 0
13.32	Paid claims	$ 0	$ 0	$ 0
13.33	Claim liability and reserve (beginning of year)	$ 0	$ 0	$ 0
13.34	Claim liability and reserve (end of year)	$ 0	$ 0	$ 0
13.35	Incurred claims	$ 0	$ 0	$ 0

13.4 If reinsurance assumed included amounts with attachment points below $1,000,000, the distribution of the amounts reported in Lines 13.31 and 13.34 for Column (1) are:

	Attachment Point	1 Earned Premium	2 Claim Liability and Reserve
13.41	<$25,000	$ 0	$ 0
13.42	$25,000 — 99,999	$ 0	$ 0
13.43	$100,000 — 249,999	$ 0	$ 0
13.44	$250,000 — 999,999	$ 0	$ 0
13.45	$1,000,000 or more	$ 0	$ 0

13.5 What portion of earned premium reported in 13.31, Column 1 was assumed from pools? $ 0

Fraternal Benefit Societies Only:

14. Is the reporting entity organized and conducted on the lodge system, with ritualistic form of work and representative form of government? Yes [ ] No [ ]

15. How often are meetings of the subordinate branches required to be held?

16. How are the subordinate branches represented in the supreme or governing body?

17. What is the basis of representation in the governing body?

FIVE-YEAR HISTORICAL DATA

Show amounts in whole dollars only, no cents; show percentages to one decimal place, i.e., 17.6.

$000 omitted for amounts of life insurance

		1 2019	2 2018	3 2017	4 2016	5 2015
	Life Insurance in Force (Exhibit of Life Insurance)					
1.	Ordinary - whole life and endowment (Line 34, Col. 4)					
2.	Ordinary - term (Line 21, Col. 4, less Line 34, Col. 4)					
3.	Credit life (Line 21, Col. 6)					
4.	Group, excluding FEGLI/SGLI (Line 21, Col. 9 less Lines 43 & 44, Col. 4)					
5.	Industrial (Line 21, Col. 2)					
6.	FEGLI/SGLI (Lines 43 & 44, Col. 4)					
7.	Total (Line 21, Col. 10)	0	0	0	0	0
7.1	Total in force for which VM-20 deterministic/stochastic reserves are calculated				XXX	XXX
	New Business Issued (Exhibit of Life Insurance)					
8.	Ordinary - whole life and endowment (Line 34, Col. 2)					
9.	Ordinary - term (Line 2, Col. 4, less Line 34, Col. 2)					
10.	Credit life (Line 2, Col. 6)					
11.	Group (Line 2, Col. 9)					
12.	Industrial (Line 2, Col. 2)					
13.	Total (Line 2, Col. 10)	0	0	0	0	0
	Premium Income - Lines of Business (Exhibit 1-Part 1)					
14.	Industrial life (Line 20.4, Col. 2)					
15.1	Ordinary life insurance (Line 20.4, Col.. 3)					
15.2	Ordinary individual annuities (Line 20.4, Col. 4)					
16.	Credit life (group and individual) (Line 20.4, Col. 5)					
17.1	Group life insurance (Line 20.4, Col. 6)					
17.2	Group annuities (Line 20.4, Col. 7)					
18.1	A&H - group (Line 20.4, Col. 8)	1,422,165	25,442,802	1,042,753	(25,926,020)	2,790,823
18.2	A&H - credit (group and individual) (Line 20.4, Col. 9)					
18.3	A&H - other (Line 20.4, Col. 10)	77,142,447	1,211,949,856	44,419,490	(1,127,056,295)	133,931,987
19.	Aggregate of all other lines of business (Line 20.4, Col. 11)					
20.	Total	78,564,611	1,237,392,658	45,462,243	(1,152,982,315)	136,722,811
	Balance Sheet (Pages 2 and 3)					
21.	Total admitted assets excluding Separate Accounts business (Page 2, Line 26, Col. 3)	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
22.	Total liabilities excluding Separate Accounts business (Page 3, Line 26)	2,823,279,366	2,652,931,248	2,675,819,343	2,716,512,099	2,824,037,145
23.	Aggregate life reserves (Page 3, Line 1)					
23.1	Excess VM-20 deterministic/stochastic reserve over NPR related to Line 7.1				XXX	XXX
24.	Aggregate A&H reserves (Page 3, Line 2)	2,766,443,751	2,608,580,649	1,217,465,047	1,296,352,123	2,635,480,160
25.	Deposit-type contract funds (Page 3, Line 3)					
26.	Asset valuation reserve (Page 3, Line 24.01)	206,126	58,003	28,206,999	32,191,000	37,970,000
27.	Capital (Page 3, Lines 29 & 30)	7,500,005	7,500,005	7,500,005	7,500,005	7,500,005
28.	Surplus (Page 3, Line 37)	(923,598,234)	(474,372,980)	5,149,161	20,523,182	48,257,565
	Cash Flow (Page 5)					
29.	Net cash from operations (Line 11)	(251,697,543)	(228,071,464)	(180,642,597)	(1,386,055,168)	(172,813,814)
	Risk-Based Capital Analysis					
30.	Total adjusted capital	(915,731,212)	(466,814,972)	40,856,166	60,214,187	93,727,570
31.	Authorized control level risk-based capital	59,722,365	51,352,310	28,828,614	36,717,738	58,321,985
	Percentage Distribution of Cash, Cash Equivalents and Invested Assets (Page 2, Col. 3) (Line No. /Page 2, Line 12, Col. 3) x 100.0					
32.	Bonds (Line 1)	91.3	92.6	72.5	80.5	81.2
33.	Stocks (Lines 2.1 and 2.2)	4.8	5.1	2.9	5.2	3.3
34.	Mortgage loans on real estate (Lines 3.1 and 3.2)	0.7	0.8	1.2	1.8	2.1
35.	Real estate (Line 4.1, 4.2 and 4.3)					
36.	Cash, cash equivalents and short-term investments (Line 5)	2.5	1.0	19.1	6.6	3.1
37.	Contract loans (Line 6)					
38.	Derivatives (Line 7)					
39.	Other invested assets (Line 8)	0.8	0.5	4.2	5.7	10.4
40.	Receivables for securities (Line 9)	0.0		0.0	0.2	
41.	Securities lending reinvested collateral assets (Line 10)					
42.	Aggregate write-ins for invested assets (Line 11)					
43.	Cash, cash equivalents and invested assets (Line 12)	100.0	100.0	100.0	100.0	100.0

FIVE-YEAR HISTORICAL DATA

(continued)

		1 2019	2 2018	3 2017	4 2016	5 2015
	Investments in Parent, Subsidiaries and Affiliates					
44.	Affiliated bonds (Sch. D Summary, Line 12, Col. 1)					
45.	Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)					
46.	Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	2,975,269				
47.	Affiliated short-term investments (subtotal included in Sch. DA, Verif., Col. 5, Line 10)					
48.	Affiliated mortgage loans on real estate					
49.	All other affiliated					
50.	Total of above Lines 44 to 49	2,975,269	0	0	0	0
51.	Total investment in parent included in Lines 44 to 49 above					
	Total Nonadmitted and Admitted Assets					
52.	Total nonadmitted assets (Page 2, Line 28, Col. 2)	9,949,027	19,565,734	55,065	53,950	57,595
53.	Total admitted assets (Page 2, Line 28, Col. 3)	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
	Investment Data					
54.	Net investment income (Exhibit of Net Investment Income)	69,898,628	81,934,413	100,395,540	148,680,691	159,278,380
55.	Realized capital gains (losses) (Page 4, Line 34, Column 1)	(44,066,405)	(175,822,458)	6,491,743	(23,658,295)	10,206,450
56.	Unrealized capital gains (losses) (Page 4, Line 38, Column 1)	842,233	131,852	3,163,766	6,180,235	(15,016,725)
57.	Total of above Lines 54, 55 and 56	26,674,456	(93,756,193)	110,051,048	131,202,632	154,468,106
	Benefits and Reserve Increase (Page 6)					
58.	Total contract/certificate benefits - life (Lines 10, 11, 12, 13, 14 and 15, Col. 1 minus Lines 10, 11, 12, 13, 14 and 15, Cols. 6, 7 & 8)					
59.	Total contract/certificate benefits - A&H (Lines 13 & 14, Col. 6)	371,758,091	390,323,186	199,171,910	308,511,558	413,521,598
60.	Increase in life reserves - other than group and annuities (Line 19, Col. 2)					
61.	Increase in A&H reserves (Line 19, Col. 6)	157,863,106	1,391,115,603	(78,887,076)	(1,339,128,038)	(100,507,596)
62.	Dividends to policyholders and refunds to members (Line 30, Col 1)					
	Operating Percentages					
63.	Insurance expense percent (Page 6, Col. 1, Lines 21, 22, & 23 less Line (6) / (Page 6, Col. 1, Line 1 plus Exhibit 7, Col. 2, Line 2) x 100.00	44.6	3.2	47.7	(2.7)	29.4
64.	Lapse percent (ordinary only) [(Exhibit of Life Insurance, Col. 4, Lines 14 & 15) / 1/2 (Exhibit of Life Insurance, Col. 4, Lines 1 & 21)] x 100.00					
65.	A&H loss percent (Schedule H, Part 1, Lines 5 & 6, Col. 2)	659.3	51.5	259.1	89.2	263.6
66.	A&H cost containment percent (Schedule H, Part 1, Line 4, Col. 2)	0.2	0.0	1.2	(0.1)	0.3
67.	A&H expense percent excluding cost containment expenses (Schedule H, Part 1, Line 10, Col. 2)	48.1	3.4	49.7	(2.9)	30.7
	A&H Claim Reserve Adequacy					
68.	Incurred losses on prior years' claims - group health (Sch. H, Part 3, Line 3.1, Col. 2)	21,441,957	23,710,984	12,030,545	16,093,686	26,958,966
69.	Prior years' claim liability and reserve - group health (Sch. H, Part 3, Line 3.2, Col. 2)	23,338,313	22,699,092	11,990,691	26,759,010	24,321,970
70.	Incurred losses on prior years' claims - health other than group (Sch. H, Part 3, Line 3.1, Col. 1 less Col. 2)	961,510,874	981,095,409	511,372,752	611,712,185	1,004,808,131
71.	Prior years' claim liability and reserve - health other than group (Sch. H, Part 3, Line 3.2, Col. 1 less Col. 2)	935,631,618	909,860,269	484,840,984	958,623,938	958,289,818
	Net Gains From Operations After Dividends to Policyholders/Members' Refunds and Federal Income Taxes by Lines of Business (Page 6.x, Line 33)					
72.	Industrial life (Page 6.1, Col. 2)					
73.	Ordinary - life (Page 6.1, Col. 1 less Cols. 2, 10 and 12)					
74.	Ordinary - individual annuities (Page 6, Col. 4)					
75.	Ordinary - supplementary contracts	XXX				
76.	Credit life (Page 6.1, Col. 10 plus Page 6.2, Col. 7)					
77.	Group life (Page 6.2, Col. 1 less Col. 7 less Col. 9)					
78.	Group annuities (Page 6, Col. 5)					
79.	A&H - group (Page 6.5, Col. 3)		(5,330,981)	(737,443)	1,168,637	(4,122,548)
80.	A&H - credit (Page 6.5, Col. 10)					
81.	A&H - other (Page 6.5, Col. 1 less Cols. 3 and 10)	(417,967,639)	(318,765,355)	(19,704,154)	(23,507,603)	(15,105,585)
82.	Aggregate of all other lines of business (Page 6, Col. 8)					
83.	Fraternal (Page 6, Col. 7)					
84.	Total (Page 6, Col. 1)	(417,967,639)	(324,096,336)	(20,441,597)	(22,338,965)	(19,228,134)

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [ ] No [ ]

If no, please explain:



DIRECT BUSINESS IN GRAND TOTAL DURING THE YEAR

NAIC Group Code.....0 NAIC Company Code.....76325

LIFE INSURANCE

	1 Ordinary	2 Credit Life (Group and Individual)	3 Group	4 Industrial	5 Total
DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS					
1. Life insurance					0
2. Annuity considerations					0
3. Deposit-type contract funds		XXX		XXX	0
4. Other considerations					0
5. Totals (Sum of Lines 1 to 4)	0	0	0	0	0
DIRECT DIVIDENDS TO POLICYHOLDERS/REFUNDS TO MEMBERS					
Life insurance:					
6.1 Paid in cash or left on deposit					0
6.2 Applied to pay renewal premiums					0
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period					0
6.4 Other					0
6.5 Totals (Sum of Lines 6.1 to 6.4)	0	0	0	0	0
Annuities:					
7.1 Paid in cash or left on deposit					0
7.2 Applied to provide paid-up annuities					0
7.3 Other					0
7.4 Totals (Sum of Lines 7.1 to 7.3)	0	0	0	0	0
8. Grand Totals (Lines 6.5 + 7.4)	0	0	0	0	0
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits					0
10. Matured endowments					0
11. Annuity benefits					0
12. Surrender values and withdrawals for life contracts					0
13. Aggregate write-ins for miscellaneous direct claims and benefits paid	0	0	0	0	0
14. All other benefits, except accident and health					0
15. Totals	0	0	0	0	0
DETAILS OF WRITE-INS					
1301.					0
1302.					0
1303.					0
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0
1399. Total (Lines 1301 through 1303 plus 1398)(Line 13 above)	0	0	0	0	0

NONE

	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1 No. of Pols. & Certifs.	2 Amount	3 No. of Ind. Pols. & Gr. Certifs.	4 Amount	5 No. of Certifs.	6 Amount	7 No. of Pols. & Certifs.	8 Amount	9 No. of Pols. & Certifs.	10 Amount
DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED										
16. Unpaid December 31, prior year									0	0
17. Incurred during current year									0	0
Settled during current year:										
18.1 By payment in full									0	0
18.2 By payment on compromised claims									0	0
18.3 Totals paid	0	0	0	0	0	0	0	0	0	0
18.4 Reduction by compromise									0	0
18.5 Amount rejected									0	0
18.6 Total settlements	0	0	0	0	0	0	0	0	0	0
19. Unpaid Dec. 31, current year (Lines 16 + 17 - 18.6)	0	0	0	0	0	0	0	0	0	0
POLICY EXHIBIT					No. of Pol.					
20. In force December 31, prior year				(a)					0	0
21. Issued during year									0	0
22. Other changes to in force (Net)									0	0
23. In force December 31 of current year	0	0	0	(a) 0	0	0	0	0	0	0

NONE

(a) Includes Individual Credit Life Insurance, prior year $.....0 current year $.....0.
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year $.....0 current year $.....0.
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year $.....0 current year $.....0.

ACCIDENT AND HEALTH INSURANCE

	1 Direct Premiums	2 Direct Premiums Earned	3 Policyholder Dividends Paid, Refunds to Members or Credited on Direct Business	4 Direct Losses Paid	5 Direct Losses Incurred
24. Group policies (b)	553,440	696,731		4,931,308	4,480,908
24.1 Federal Employee Health Benefits Plan premium (b)					
24.2 Credit (group and individual)					
24.3 Collectively renewable policies/certificates (b)					
24.4 Medicare Title XVIII exempt from state taxes or fees					
Other Individual Policies:					
25.1 Non-cancelable (b)					
25.2 Guaranteed renewable (b)	58,544,203	75,086,483		338,322,153	314,349,936
25.3 Non-renewable for stated reasons only (b)	22,491	23,526		40,565	(8,412)
25.4 Other accident only					
25.5 All other (b)					
25.6 Totals (Sum of Lines 25.1 to 25.5)	58,566,694	75,110,009	0	338,362,718	314,341,524
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6)	59,120,134	75,806,740	0	343,294,026	318,822,432

(b) For health business on indicated lines report: Number of persons insured under PPO managed products.....0 and number of persons insured under indemnity only products.....0.

EXHIBIT OF NUMBER OF POLICIES, CONTRACTS, CERTIFICATES, INCOME PAYABLE AND ACCOUNT VALUES IN FORCE FOR SUPPLEMENTARY CONTRACTS, ANNUITIES, ACCIDENT & HEALTH AND OTHER POLICIES

SUPPLEMENTARY CONTRACTS

	Ordinary		Group	
	1 Involving Life Contingencies	2 Not Involving Life Contingencies	3 Involving Life Contingencies	4 Not Involving Life Contingencies
1. In force end of prior year				
2. Issued during year				
3. Reinsurance assumed				
4. Increased during year (net)				
5. Total (Lines 1 to 4)	0	0	0	0
Deductions during year:				
6. Decreased (net)				
7. Reinsurance ceded				
8. Totals (Lines 6 and 7)	0	0	0	0
9. In force end of year	0	0	0	0
10. Amount on deposit		(a)		(a)
11. Income now payable				
12. Amount of income payable	(a)	(a)	(a)	(a)

ANNUITIES

	Ordinary		Group	
	1 Immediate	2 Deferred	3 Contracts	4 Certificates
1. In force end of prior year				
2. Issued during year				
3. Reinsurance assumed				
4. Increased during year (net)				
5. Total (Lines 1 to 4)	0	0	0	0
Deductions during year:				
6. Decreased (net)				
7. Reinsurance ceded				
8. Totals (Lines 6 and 7)	0	0	0	0
9. In force end of year	0	0	0	0
Income now payable:				
10. Amount of income payable	(a)	XXX	XXX	(a)
Deferred fully paid:				
11. Account balance	XXX	(a)	XXX	(a)
Deferred not fully paid:				
12. Account balance	XXX	(a)	XXX	(a)

ACCIDENT AND HEALTH INSURANCE

	Group		Credit		Other	
	1 Certificates	2 Premiums in force	3 Policies	4 Premiums in force	5 Policies	6 Premiums in force
1. In force end of prior year	1,294	1,616,781			48,649	86,663,119
2. Issued during year						
3. Reinsurance assumed						
4. Increased during year (net)		XXX		XXX		XXX
5. Total (Lines 1 to 4)	1,294	XXX	0	XXX	48,649	XXX
Deductions during year:						
6. Conversions	235	XXX	XXX	XXX	XXX	XXX
7. Decreased (net)		XXX		XXX	5,520	XXX
8. Reinsurance ceded		XXX		XXX		XXX
9. Totals (Lines 6 to 8)	235	XXX	0	XXX	5,520	XXX
10. In force end of year	1,059	(a) 1,308,714	0	(a)	43,129	(a) 74,333,137

DEPOSIT FUNDS AND DIVIDEND ACCUMULATIONS

	1 Deposit Funds Contracts	2 Dividend Accumulations Contracts
1. In force end of prior year		
2. Issued during year		
3. Reinsurance assumed		
4. Increased during year (net)		
5. Total (Lines 1 to 4)	0	0
Deductions during year:		
6. Decreased (net)		
7. Reinsurance ceded		
8. Totals (Lines 6 and 7)	0	0
9. In force end of year	0	0
10. Amount of account balance	(a)	(a)

(a) See the Annual Audited Financial Reports section of the Annual Statement Instructions.

FORM FOR CALCULATING THE INTEREST MAINTENANCE RESERVE

Interest Maintenance Reserve

	1 Amount
1. Reserve as of December 31, prior year	1,564,865
2. Current year's realized pre-tax capital gains/(losses) of $.....4,656,834 transferred into the reserve net of taxes of $.....(977,935)	3,678,897
3. Adjustment for current year's liability gains/(losses) released from the reserve	0
4. Balance before reduction for amount transferred to Summary of Operations (Line 1 + Line 2 + Line 3)	5,243,762
5. Current year's amortization released to Summary of Operations (Amortization, Line 1, Column 4)	497,421
6. Reserve as of December 31, current year (Line 4 minus Line 5)	4,746,341

Amortization

Year of Amortization	1 Reserve as of December 31, Prior Year	2 Current Year's Realized Capital Gains/(Losses) Transferred into the Reserve Net of Taxes	3 Adjustment for Current Year's Liability Gains/(Losses) Released from the Reserve	4 Balance Before Reduction for the Current Year's Amortization (Cols. 1 + 2 + 3)
1. 2019	152,863	344,558		497,421
2. 2020	102,734	644,106		746,840
3. 2021	87,317	598,744		686,061
4. 2022	70,864	504,117		574,981
5. 2023	53,661	408,186		461,847
6. 2024	48,782	309,763		358,545
7. 2025	58,169	233,921		292,090
8. 2026	66,394	190,939		257,333
9. 2027	76,165	144,297		220,462
10. 2028	85,726	95,701		181,427
11. 2029	90,433	43,915		134,348
12. 2030	85,715	17,795		103,510
13. 2031	82,562	15,424		97,986
14. 2032	77,862	13,102		90,964
15. 2033	75,301	10,458		85,759
16. 2034	67,396	7,987		75,383
17. 2035	56,934	6,745		63,679
18. 2036	45,989	6,745		52,734
19. 2037	34,153	6,893		41,046
20. 2038	22,854	7,029		29,883
21. 2039	16,482	7,017		23,499
22. 2040	16,523	7,240		23,763
23. 2041	16,097	7,561		23,658
24. 2042	16,326	7,722		24,048
25. 2043	15,956	8,205		24,161
26. 2044	14,667	8,366		23,033
27. 2045	11,674	7,883		19,557
28. 2046	8,381	6,274		14,655
29. 2047	5,089	4,505		9,594
30. 2048	1,796	2,734		4,530
31. 2049 and Later		965		965
32. Total (Lines 1 to 31)	1,564,865	3,678,897	0	5,243,762

ASSET VALUATION RESERVE

	Default Component			Equity Component			7
	1 Other Than Mortgage Loans	2 Mortgage Loans	3 Total (Cols. 1 + 2)	4 Common Stock	5 Real Estate and Other Invested Assets	6 Total (Cols. 4 + 5)	Total Amount (Cols. 3 + 6)
1. Reserve as of December 31, prior year	0	58,003	58,003	0	0	0	58,004
2. Realized capital gains/(losses) net of taxes - General Account	(26,746,425)		(26,746,425)	167,638	(7,552,704)	(7,385,066)	(34,131,491)
3. Realized capital gains/(losses) net of taxes - Separate Accounts			0			0	0
4. Unrealized capital gains/(losses) - net of deferred taxes - General Account	301,032		301,032	84,644		84,644	385,676
5. Unrealized capital gains/(losses) - net of deferred taxes - Separate Accounts			0			0	0
6. Capital gains credited/(losses charged) to contract benefits, payments or reserves			0			0	0
7. Basic contribution	2,698,383	29,414	2,727,797		823	823	2,728,620
8. Accumulated balances (Lines 1 through 5, minus 6 plus 7)	(23,747,010)	87,417	(23,659,593)	252,282	(7,551,881)	(7,299,599)	(30,959,192)
9. Maximum reserve	15,336,443	133,838	15,470,281	601,632	2,079,198	2,680,831	18,151,112
10. Reserve objective	10,013,298	102,680	10,115,978	599,784	2,076,400	2,676,185	12,792,163
11. 20% of (Line 10 minus Line 8)	6,752,062	3,053	6,755,114	69,500	1,925,656	1,995,157	8,750,271
12. Balance before transfers (Lines 8 + 11)	(16,994,948)	90,469	(16,904,479)	321,783	(5,626,225)	(5,304,442)	(22,208,921)
13. Transfers	45,235	(45,235)	(0)	(160,891)	160,891	(0)	(1)
14. Voluntary contribution			0			0	0
15. Adjustment down to maximum/up to zero	16,949,714		16,949,714		5,465,334	5,465,334	22,415,048
16. Reserve as of December 31, current year (Lines 12 + 13 + 14 + 15)	0	45,234	45,235	160,891	0	160,892	206,126

ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

Line Number	NAIC Desig-nation	Description	1 Book/Adjusted Carrying Value	2 Reclassify Related Party Encumbrances	3 Add Third Party Encumbrances	4 Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	Basic Contribution 5 Factor	Basic Contribution 6 Amount (Cols. 4 x 5)	Reserve Objective 7 Factor	Reserve Objective 8 Amount (Cols. 4 x 7)	Maximum Reserve 9 Factor	Maximum Reserve 10 Amount (Cols. 4 x 9)
		LONG-TERM BONDS										
1		Exempt obligations	23,648,054	XXX	XXX	23,648,054	0.0000	0	0.0000	0	0.0000	0
2	1	Highest quality	1,236,645,801	XXX	XXX	1,236,645,801	0.0005	618,323	0.0016	1,978,633	0.0033	4,080,931
3	2	High quality	410,591,075	XXX	XXX	410,591,075	0.0021	862,241	0.0064	2,627,783	0.0106	4,352,265
4	3	Medium quality	14,285,525	XXX	XXX	14,285,525	0.0099	141,427	0.0263	375,709	0.0376	537,136
5	4	Low quality	19,255,293	XXX	XXX	19,255,293	0.0245	471,755	0.0572	1,101,403	0.0817	1,573,157
6	5	Lower quality	6,462,482	XXX	XXX	6,462,482	0.0630	407,136	0.1128	728,968	0.1880	1,214,947
7	6	In or near default	11,000,000	XXX	XXX	11,000,000	0.0000	0	0.2370	2,607,000	0.2370	2,607,000
8		Total unrated multi-class securities acquired by conversion		XXX	XXX	0	XXX		XXX		XXX	
9		Total long-term bonds (sum of Lines 1 through 8)	1,721,888,230	XXX	XXX	1,721,888,230	XXX	2,500,882	XXX	9,419,496	XXX	14,365,436
		PREFERRED STOCKS										
10	1	Highest quality		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
11	2	High quality	84,177,542	XXX	XXX	84,177,542	0.0021	176,773	0.0064	538,736	0.0106	892,282
12	3	Medium quality	2,093,750	XXX	XXX	2,093,750	0.0099	20,728	0.0263	55,066	0.0376	78,725
13	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
14	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
15	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
16		Affiliated life with AVR		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
17		Total preferred stocks (sum of Lines 10 through 16)	86,271,292	XXX	XXX	86,271,292	XXX	197,501	XXX	593,802	XXX	971,007
		SHORT-TERM BONDS										
18		Exempt obligations		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
19	1	Highest quality		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
20	2	High quality		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
21	3	Medium quality		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
22	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
23	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
24	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
25		Total short-term bonds (sum of Lines 18 through 24)	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
		DERIVATIVE INSTRUMENTS										
26		Exchange traded		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
27	1	Highest quality		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
28	2	High quality		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
29	3	Medium quality		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
30	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
31	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
32	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
33		Total derivative instruments	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
34		Total (Lines 9 + 17 + 25 + 33)	1,808,159,522	XXX	XXX	1,808,159,522	XXX	2,698,383	XXX	10,013,298	XXX	15,336,443

ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

Line Number	NAIC Desig-nation	Description	1 Book/Adjusted Carrying Value	2 Reclassify Related Party Encumbrances	3 Add Third Party Encumbrances	4 Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	Basic Contribution 5 Factor	Basic Contribution 6 Amount (Cols. 4 x 5)	Reserve Objective 7 Factor	Reserve Objective 8 Amount (Cols. 4 x 7)	Maximum Reserve 9 Factor	Maximum Reserve 10 Amount (Cols. 4 x 9)
		MORTGAGE LOANS										
		In good standing:										
35		Farm mortgages - CM1 - highest quality			XXX	0	0.0011	0	0.0057	0	0.0074	0
36		Farm mortgages - CM2 - high quality			XXX	0	0.0040	0	0.0114	0	0.0149	0
37		Farm mortgages - CM3 - medium quality			XXX	0	0.0069	0	0.0200	0	0.0257	0
38		Farm mortgages - CM4 - low medium quality			XXX	0	0.0120	0	0.0343	0	0.0428	0
39		Farm mortgages - CM5 - low quality			XXX	0	0.0183	0	0.0486	0	0.0628	0
40		Residential mortgages-insured or guaranteed			XXX	0	0.0003	0	0.0007	0	0.0011	0
41		Residential mortgages-all other			XXX	0	0.0015	0	0.0034	0	0.0046	0
42		Commercial mortgages-insured or guaranteed			XXX	0	0.0003	0	0.0007	0	0.0011	0
43		Commercial mortgages-all other - CM1 - highest quality	7,349,411		XXX	7,349,411	0.0011	8,084	0.0057	41,892	0.0074	54,386
44		Commercial mortgages-all other - CM2 - high quality	5,332,340		XXX	5,332,340	0.0040	21,329	0.0114	60,789	0.0149	79,452
45		Commercial mortgages-all other - CM3 - medium quality			XXX	0	0.0069	0	0.0200	0	0.0257	0
46		Commercial mortgages-all other - CM4 - low medium quality			XXX	0	0.0120	0	0.0343	0	0.0428	0
47		Commercial mortgages-all other - CM5 - low quality			XXX	0	0.0183	0	0.0486	0	0.0628	0
		Overdue, not in process:										
48		Farm mortgages			XXX	0	0.0480	0	0.0868	0	0.1371	0
49		Residential mortgages-insured or guaranteed			XXX	0	0.0006	0	0.0014	0	0.0023	0
50		Residential mortgages-all other			XXX	0	0.0029	0	0.0066	0	0.0103	0
51		Commercial mortgages-insured or guaranteed			XXX	0	0.0006	0	0.0014	0	0.0023	0
52		Commercial mortgages-all other			XXX	0	0.0480	0	0.0868	0	0.1371	0
		In process of foreclosure:										
53		Farm mortgages			XXX	0	0.0000	0	0.1942	0	0.1942	0
54		Residential mortgages-insured or guaranteed			XXX	0	0.0000	0	0.0046	0	0.0046	0
55		Residential mortgages-all other			XXX	0	0.0000	0	0.0149	0	0.0149	0
56		Commercial mortgages-insured or guaranteed			XXX	0	0.0000	0	0.0046	0	0.0046	0
57		Commercial mortgages-all other			XXX	0	0.0000	0	0.1942	0	0.1942	0
58		Total Schedule B mortgages (sum of Lines 35 through 57)	12,681,751	0	XXX	12,681,751	XXX	29,414	XXX	102,680	XXX	133,838
59		Schedule DA mortgages			XXX	0	0.0034	0	0.0114	0	0.0149	0
60		Total mortgage loans on real estate (Lines 58 + 59)	12,681,751	0	XXX	12,681,751	XXX	29,414	XXX	102,680	XXX	133,838

ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

Line Number	NAIC Desig-nation	Description	1 Book/Adjusted Carrying Value	2 Reclassify Related Party Encumbrances	3 Add Third Party Encumbrances	4 Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	Basic Contribution 5 Factor	Basic Contribution 6 Amount (Cols. 4 x 5)	Reserve Objective 7 Factor	Reserve Objective 8 Amount (Cols. 4 x 7)	Maximum Reserve 9 Factor	Maximum Reserve 10 Amount (Cols. 4 x 9)
		COMMON STOCK										
1		Unaffiliated public	89,817	XXX	XXX	89,817	0.0000	0	(a) 0.2000	17,963	(a) 0.2000	17,963
2		Unaffiliated private		XXX	XXX	0	0.0000	0	0.1945	0	0.1945	0
3		Federal Home Loan Bank	513,300	XXX	XXX	513,300	0.0000	0	0.0061	3,131	0.0097	4,979
4		Affiliated life with AVR		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
		Affiliated Investment Subsidiary:										
5		Fixed income exempt obligations				0	XXX		XXX		XXX	
6		Fixed income highest quality				0	XXX		XXX		XXX	
7		Fixed income high quality				0	XXX		XXX		XXX	
8		Fixed income medium quality				0	XXX		XXX		XXX	
9		Fixed income low quality				0	XXX		XXX		XXX	
10		Fixed income lower quality				0	XXX		XXX		XXX	
11		Fixed income in or near default				0	XXX		XXX		XXX	
12		Unaffiliated common stock public				0	0.0000	0	(a)	0	(a)	0
13		Unaffiliated common stock private				0	0.0000	0	0.1945	0	0.1945	0
14		Real estate				0	(b)	0	(b)	0	(b)	0
15		Affiliated - certain other (see SVO Purposes and Procedures Manual)		XXX	XXX	0	0.0000	0	0.1580	0	0.1580	0
16		Affiliated - all other	2,975,269	XXX	XXX	2,975,269	0.0000	0	0.1945	578,690	0.1945	578,690
17		Total common stock (sum of Lines 1 through 16)	3,578,386	0	0	3,578,386	XXX	0	XXX	599,784	XXX	601,632
		REAL ESTATE										
18		Home office property (General Account only)				0	0.0000	0	0.0912	0	0.0912	0
19		Investment properties				0	0.0000	0	0.0912	0	0.0912	0
20		Properties acquired in satisfaction of debt				0	0.0000	0	0.1337	0	0.1337	0
21		Total real estate (sum of Lines 18 through 20)	0	0	0	0	XXX	0	XXX	0	XXX	0
		OTHER INVESTED ASSETS										
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF BONDS										
22		Exempt obligations		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
23	1	Highest quality		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
24	2	High quality		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
25	3	Medium quality		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
26	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
27	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
28	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
29		Total with bond characteristics (sum of Lines 22 through 28)	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0

ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

Line Number	NAIC Desig-nation	Description	1 Book/Adjusted Carrying Value	2 Reclassify Related Party Encumbrances	3 Add Third Party Encumbrances	4 Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	Basic Contribution 5 Factor	Basic Contribution 6 Amount (Cols. 4 x 5)	Reserve Objective 7 Factor	Reserve Objective 8 Amount (Cols. 4 x 7)	Maximum Reserve 9 Factor	Maximum Reserve 10 Amount (Cols. 4 x 9)
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF PREFERRED STOCKS										
30	1	Highest quality	1,645,981	XXX	XXX	1,645,981	0.0005	823	0.0016	2,634	0.0033	5,432
31	2	High quality		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
32	3	Medium quality		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
33	4	Low quality		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
34	5	Lower quality		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
35	6	In or near default		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
36		Affiliated life with AVR		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
37		Total with preferred stock characteristics (sum of Lines 30 through 36)	1,645,981	XXX	XXX	1,645,981	XXX	823	XXX	2,634	XXX	5,432
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF MORTGAGE LOANS										
		In Good Standing Affiliated:										
38		Mortgages - CM1 - highest quality			XXX	0	0.0011	0	0.0057	0	0.0074	0
39		Mortgages - CM2 - high quality			XXX	0	0.0040	0	0.0114	0	0.0149	0
40		Mortgages - CM3 - medium quality			XXX	0	0.0069	0	0.0200	0	0.0257	0
41		Mortgages - CM4 - low medium quality			XXX	0	0.0120	0	0.0343	0	0.0428	0
42		Mortgages - CM5 - low quality			XXX	0	0.0183	0	0.0486	0	0.0628	0
43		Residential mortgages-insured or guaranteed			XXX	0	0.0003	0	0.0007	0	0.0011	0
44		Residential mortgages-all other		XXX	XXX	0	0.0015	0	0.0034	0	0.0046	0
45		Commercial mortgages-insured or guaranteed			XXX	0	0.0003	0	0.0007	0	0.0011	0
		Overdue, Not in Process Affiliated:										
46		Farm mortgages			XXX	0	0.0480	0	0.0868	0	0.1371	0
47		Residential mortgages-insured or guaranteed			XXX	0	0.0006	0	0.0014	0	0.0023	0
48		Residential mortgages-all other			XXX	0	0.0029	0	0.0066	0	0.0103	0
49		Commercial mortgages-insured or guaranteed			XXX	0	0.0006	0	0.0014	0	0.0023	0
50		Commercial mortgages-all other			XXX	0	0.0480	0	0.0868	0	0.1371	0
		In Process of foreclosure Affiliated:										
51		Farm mortgages			XXX	0	0.0000	0	0.1942	0	0.1942	0
52		Residential mortgages-insured or guaranteed			XXX	0	0.0000	0	0.0046	0	0.0046	0
53		Residential mortgages-all other			XXX	0	0.0000	0	0.0149	0	0.0149	0
54		Commercial mortgages-insured or guaranteed			XXX	0	0.0000	0	0.0046	0	0.0046	0
55		Commercial mortgages-all other			XXX	0	0.0000	0	0.1942	0	0.1942	0
56		Total Affiliated (Sum of Lines 38 through 55)	0	0	XXX	0	XXX	0	XXX	0	XXX	0
57		Unaffiliated - In Good Standing with Covenants			XXX	0	(c)	0	(c)	0	(c)	0
58		Unaffiliated - In Good Standing Defeased with Government Securities			XXX	0	0.0011	0	0.0057	0	0.0074	0
59		Unaffiliated - In Good Standing Primarily Senior			XXX	0	0.0040	0	0.0114	0	0.0149	0
60		Unaffiliated - In Good Standing All Other			XXX	0	0.0069	0	0.0200	0	0.0257	0
61		Unaffiliated - Overdue, Not in Process			XXX	0	0.0480	0	0.0868	0	0.1371	0
62		Unaffiliated - In Process of Foreclosure			XXX	0	0.0000	0	0.1942	0	0.1942	0
63		Total Unaffiliated (Sum of Lines 57 through 62)	0	0	XXX	0	XXX	0	XXX	0	XXX	0
64		Total with Mortgage Loan Characteristics (Lines 56 + 63)	0	0	XXX	0	XXX	0	XXX	0	XXX	0

ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

Line Number	NAIC Desig-nation	Description	1 Book/Adjusted Carrying Value	2 Reclassify Related Party Encumbrances	3 Add Third Party Encumbrances	4 Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	Basic Contribution 5 Factor	Basic Contribution 6 Amount (Cols. 4 x 5)	Reserve Objective 7 Factor	Reserve Objective 8 Amount (Cols. 4 x 7)	Maximum Reserve 9 Factor	Maximum Reserve 10 Amount (Cols. 4 x 9)
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF COMMON STOCK										
65		Unaffiliated public		XXX	XXX	0	0.0000	0	(a)	0	(a)	0
66		Unaffiliated private		XXX	XXX	0	0.0000	0	0.1945	0	0.1945	0
67		Affiliated life with AVR		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
68		Affiliated certain other (see SVO Purposes and Procedures Manual)		XXX	XXX	0	0.0000	0	0.1580	0	0.1580	0
69		Affiliated other - all other		XXX	XXX	0	0.0000	0	0.1945	0	0.1945	0
70		Total with Common Stock Characteristics (Sum of Lines 65 through 69)	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF REAL ESTATE										
71		Home office property (general account only)				0	0.0000	0	0.0912	0	0.0912	0
72		Investment properties				0	0.0000	0	0.0912	0	0.0912	0
73		Properties acquired in satisfaction of debt				0	0.0000	0	0.1337	0	0.1337	0
74		Total with Real Estate Characteristics (Sum of Lines 71 through 73)	0	0	0	0	XXX	0	XXX	0	XXX	0
		LOW INCOME HOUSING TAX CREDIT INVESTMENTS										
75		Guaranteed federal low income housing tax credit				0	0.0003	0	0.0006	0	0.0010	0
76		Non-guaranteed federal low income housing tax credit				0	0.0063	0	0.0120	0	0.0190	0
77		Guaranteed state low income housing tax credit				0	0.0003	0	0.0006	0	0.0010	0
78		Non-guaranteed state low income housing tax credit				0	0.0063	0	0.0120	0	0.0190	0
79		All other low income housing tax credit				0	0.0273	0	0.0600	0	0.0975	0
80		Total LIHTC (Sum of Lines 75 through 79)	0	0	0	0	XXX	0	XXX	0	XXX	0
		ALL OTHER INVESTMENTS										
81		NAIC 1 working capital finance investments		XXX		0	0.0000	0	0.0042	0	0.0042	0
82		NAIC 2 working capital finance investments		XXX		0	0.0000	0	0.0137	0	0.0137	0
83		Other invested assets - Schedule BA	13,125,106	XXX		13,125,106	0.0000	0	0.1580	2,073,767	0.1580	2,073,767
84		Other short-term invested assets - Schedule DA		XXX		0	0.0000	0	0.1580	0	0.1580	0
85		Total All Other (sum of Lines 81, 82, 83 and 84)	13,125,106	XXX	0	13,125,106	XXX	0	XXX	2,073,767	XXX	2,073,767
86		Total Other Invested Assets - Schedule BA & DA (Sum of Lines 29, 37, 64, 70, 74, 80 and 85)	14,771,087	0	0	14,771,087	XXX	823	XXX	2,076,400	XXX	2,079,198

(a) Times the company's weighted average portfolio beta (Minimum .1215, Maximum .2431).
(b) Determined using same factors and breakdowns used for directly owned real estate.
(c) This will be the factor associated with the risk category determined in the company generated worksheet.

SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT

		Total		Group Accident and Health		Credit A&H (Group and Individual)		Collectively Renewable		Other Individual Contracts									
										Non-Cancelable		Guaranteed Renewable		Non-Renewable for Stated Reasons Only		Other Accident Only		All Other	
		1 Amount	2 %	3 Amount	4 %	5 Amount	6 %	7 Amount	8 %	9 Amount	10 %	11 Amount	12 %	13 Amount	14 %	15 Amount	16 %	17 Amount	18 %
PART 1 - ANALYSIS OF UNDERWRITING OPERATIONS																			
1.	Premiums written	78,564,612	XXX	1,422,165	XXX	-	XXX	-	XXX	-	XXX	77,119,635	XXX	22,812	XXX	-	XXX	-	XXX
2.	Premiums earned	80,672,475	XXX	1,471,834	XXX	-	XXX	-	XXX	-	XXX	79,177,115	XXX	23,526	XXX	-	XXX	-	XXX
3.	Incurred claims	343,522,577	425.8	6,678,252	453.7	0	0.0	0	0.0	0	0.0	336,852,736	425.4	(8,411)	(35.8)	0	0.0	0	0.0
4.	Cost containment expenses	146,777	0.2	2,542	0.2	-	0.0	-	0.0	-	0.0	144,231	0.2	4	0.0	-	0.0	-	0.0
5.	Incurred claims and cost containment expenses (Lines 3 and 4)	343,669,354	426.0	6,680,794	453.9	0	0.0	0	0.0	0	0.0	336,996,967	425.6	(8,407)	(35.7)	0	0.0	0	0.0
6	Increase in contract reserves	188,206,480	233.3	3,730,616	253.5	0	0.0	0	0.0	0	0.0	184,478,663	233.0	(2,800)	(11.9)	0	0.0	0	0.0
7	Commissions (a)	5,654,040	7.0	165,888	11.3	-	0.0	-	0.0	-	0.0	5,486,929	6.9	1,223	5.2	-	0.0	-	0.0
8	Other general insurance expenses	29,248,903	36.3	506,549	34.4	-	0.0	-	0.0	-	0.0	28,741,522	36.3	832	3.5	-	0.0	-	0.0
9	Taxes, licenses and fees	3,889,990	4.8	67,369	4.6	-	0.0	-	0.0	-	0.0	3,822,510	4.8	111	0.5	-	0.0	-	0.0
10	Total other expenses incurred	38,792,933	48.1	739,806	50.3	0	0.0	0	0.0	0	0.0	38,050,961	48.1	2,166	9.2	0	0.0	0	0.0
11.	Aggregate write-ins for deductions	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
12.	Gain from underwriting before dividends or refunds	(489,996,292)	(607.4)	(9,679,382)	(657.6)	0	0.0	0	0.0	0	0.0	(480,349,476)	(606.7)	32,567	138.4	0	0.0	0	0.0
13.	Dividends or refunds	0	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0
14.	Gain from underwriting after dividends or refunds	(489,996,292)	(607.4)	(9,679,382)	(657.6)	0	0.0	0	0.0	0	0.0	(480,349,476)	(606.7)	32,567	138.4	0	0.0	0	0.0
DETAILS OF WRITE-INS																			
1101.		0	0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0
1102.		0	0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0
1103.		0	0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1199.	Total (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

(a) Includes $.....0 reported as 'Contract, membership and other fees retained by agents.'

SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT (continued)

	1	2	3	4	Other Individual Contracts				
					5	6	7	8	9
	Total	Group Accident and Health	Credit A&H (Group and Individual)	Collectively Renewable	Non-Cancelable	Guaranteed Renewable	Non-Renewable for Stated Reasons Only	Other Accident Only	All Other
PART 2 - RESERVES AND LIABILITIES									
A. Premium Reserves:									
1. Unearned premiums	12,001,851	218,552	-	-	-	11,778,391	4,908	-	
2. Advance premiums	1,462,254	14,467	-	-	-	1,446,484	1,303	-	
3. Reserve for rate credits	0	-	-	-	-	-	-	-	
4. Total premium reserves, current year	13,464,105	233,019	0	0	0	13,224,875	6,211	0	0
5. Total premium reserves, prior year	15,765,356	284,928				15,473,085	7,343		
6. Increase in total premium reserves	(2,301,251)	(51,909)	0	0	0	(2,248,210)	(1,132)	0	0
B. Contract Reserves:									
1. Additional reserves (a)	1,859,365,860	30,472,028	-	-	-	1,828,606,953	286,879		
2. Reserve for future contingent benefits	0	-	-	-	-	-	-		
3. Total contract reserves, current year	1,859,365,860	30,472,028	0	0	0	1,828,606,953	286,879	0	0
4. Total contract reserves, prior year	1,671,159,380	26,741,412				1,644,128,290	289,679		
5. Increase in contract reserves	188,206,480	3,730,616	0	0	0	184,478,663	(2,800)	0	0
C. Claim Reserves and Liabilities:									
1. Total current year	932,810,659	20,862,412	0	0	0	911,905,206	43,041	0	0
2. Total prior year	958,969,931	23,338,313				935,539,601	92,017		
3. Increase	(26,159,272)	(2,475,901)	0	0	0	(23,634,395)	(48,976)	0	0

PART 3 - TEST OF PRIOR YEAR'S CLAIM RESERVES AND LIABILITIES

1. Claims Paid During the Year:									
1.1 On claims incurred prior to current year	327,667,476	8,048,297				319,584,725	34,454		
1.2 On claims incurred during current year	42,014,373	1,105,856				40,902,406	6,111		
2. Claim Reserves and Liabilities, December 31, current year:									
2.1 On claims incurred prior to current year	655,285,355	13,393,660				641,886,828	4,867		
2.2 On claims incurred during current year	277,525,304	7,468,752				270,018,378	38,174		
3. Test:									
3.1 Lines 1.1 and 2.1	982,952,831	21,441,957	0	0	0	961,471,553	39,321	0	0
3.2 Claim reserves and liabilities, December 31, prior year	958,969,931	23,338,313				935,539,601	92,017		
3.3 Line 3.1 minus Line 3.2	23,982,900	(1,896,356)	0	0	0	25,931,952	(52,696)	0	0

PART 4 - REINSURANCE

A. Reinsurance Assumed:									
1. Premiums written	4,762,558	752,793	-	-	-	4,009,765	-		
2. Premiums earned	4,876,022	775,103	-	-	-	4,100,919	-		
3. Incurred claims	24,996,645	2,197,343	-	-	-	22,799,302	-		
4. Commissions	482,173	79,268	-	-	-	402,905	-		
B. Reinsurance Ceded:									
1. Premiums written	10,295	-	-	-	-	10,295			
2. Premiums earned	10,288	-	-	-	-	10,288			
3. Incurred claims	296,501	-	-	-	-	296,501			
4. Commissions	244	-	-	-	-	244			

(a) Includes $.....636,536,764 premium deficiency reserve.

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SCHEDULE H - PART 5 - HEALTH CLAIMS

		1 Medical	2 Dental	3 Other	4 Total
A.	Direct:				
1.	Incurred claims			318,822,432	318,822,432
2.	Beginning claim reserves and liabilities			885,942,063	885,942,063
3.	Ending claim reserves and liabilities			861,420,525	861,420,525
4.	Claims paid	0	0	343,343,970	343,343,970
B.	Assumed Reinsurance:				
5.	Incurred claims			24,996,645	24,996,645
6.	Beginning claim reserves and liabilities			73,702,436	73,702,436
7.	Ending claim reserves and liabilities			72,223,363	72,223,363
8.	Claims paid	0	0	26,475,718	26,475,718
C.	Ceded Reinsurance:				
9.	Incurred claims			296,501	296,501
10.	Beginning claim reserves and liabilities			687,988	687,988
11.	Ending claim reserves and liabilities			855,232	855,232
12.	Claims paid	0	0	129,257	129,257
D.	Net:				
13.	Incurred claims	0	0	343,522,576	343,522,576
14.	Beginning claim reserves and liabilities	0	0	958,956,510	958,956,510
15.	Ending claim reserves and liabilities	0	0	932,788,656	932,788,656
16.	Claims paid	0	0	369,690,430	369,690,430
E.	Net Incurred Claims and Cost Containment Expenses:				
17.	Incurred claims and cost containment expenses			343,669,353	343,669,353
18.	Beginning reserves and liabilities			959,031,665	959,031,665
19.	Ending reserves and liabilities			932,918,182	932,918,182
20.	Paid claims and cost containment expenses	0	0	369,782,836	369,782,836

SCHEDULE T - PREMIUMS AND ANNUITY CONSIDERATIONS (b)

Allocated by States and Territories

States, Etc.	1 Active Status (a)	Direct Business Only					
		Life Contracts		4	5	6	7
		2 Life Insurance Premiums	3 Annuity Considerations	Accident and Health Insurance Premiums, Including Policy, Membership and Other Fees	Other Considerations	Total Columns 2 through 5	Deposit-Type Contracts
1. Alabama AL	L			106,514		106,514	
2. Alaska AK	L			33,188		33,188	
3. Arizona AZ	L			1,421,606		1,421,606	
4. Arkansas AR	L			294,050		294,050	
5. California CA	L			5,183,274		5,183,274	
6. Colorado CO	L			650,164		650,164	
7. Connecticut CT	N			104,227		104,227	
8. Delaware DE	L			158,088		158,088	
9. District of Columbia DC	L			37,270		37,270	
10. Florida FL	L			5,102,403		5,102,403	
11. Georgia GA	L			972,991		972,991	
12. Hawaii HI	L			144,435		144,435	
13. Idaho ID	L			119,857		119,857	
14. Illinois IL	L			3,374,402		3,374,402	
15. Indiana IN	L			1,634,548		1,634,548	
16. Iowa IA	L			1,397,413		1,397,413	
17. Kansas KS	L			1,018,522		1,018,522	
18. Kentucky KY	L			839,943		839,943	
19. Louisiana LA	L			413,911		413,911	
20. Maine ME	L			465,326		465,326	
21. Maryland MD	L			1,807,150		1,807,150	
22. Massachusetts MA	L			510,020		510,020	
23. Michigan MI	L			1,467,232		1,467,232	
24. Minnesota MN	L			853,598		853,598	
25. Mississippi MS	L			338,643		338,643	
26. Missouri MO	L			1,530,613		1,530,613	
27. Montana MT	L			263,422		263,422	
28. Nebraska NE	L			653,491		653,491	
29. Nevada NV	L			148,496		148,496	
30. New Hampshire NH	L			112,549		112,549	
31. New Jersey NJ	L			1,210,622		1,210,622	
32. New Mexico NM	L			262,823		262,823	
33. New York NY	N			340,722		340,722	
34. North Carolina NC	L			2,114,765		2,114,765	
35. North Dakota ND	L			679,940		679,940	
36. Ohio OH	L			2,692,556		2,692,556	
37. Oklahoma OK	L			1,049,596		1,049,596	
38. Oregon OR	L			270,698		270,698	
39. Pennsylvania PA	L			7,288,325		7,288,325	
40. Rhode Island RI	N			32,940		32,940	
41. South Carolina SC	L			744,826		744,826	
42. South Dakota SD	L			471,979		471,979	
43. Tennessee TN	L			936,968		936,968	
44. Texas TX	L			5,707,739		5,707,739	
45. Utah UT	L			372,626		372,626	
46. Vermont VT	N			34,790		34,790	
47. Virginia VA	L			1,326,097		1,326,097	
48. Washington WA	L			1,386,979		1,386,979	
49. West Virginia WV	L			116,884		116,884	
50. Wisconsin WI	L			827,992		827,992	
51. Wyoming WY	L			72,529		72,529	
52. American Samoa AS	N					0	
53. Guam GU	N					0	
54. Puerto Rico PR	N					0	
55. US Virgin Islands VI	L					0	
56. Northern Mariana Islands MP	N					0	
57. Canada CAN	N			6,481		6,481	
58. Aggregate Other Alien OT	XXX	0	0	13,907	0	13,907	0
59. Subtotal	XXX	0	0	59,120,134	0	59,120,134	0
90. Reporting entity contributions for employee benefit plans	XXX					0	
91. Dividends or refunds applied to purchase paid-up additions and annuities	XXX					0	
92. Dividends or refunds applied to shorten endowment or premium paying period	XXX					0	
93. Premium or annuity considerations waived under disability or other contract provisions	XXX			14,626,335		14,626,335	
94. Aggregate other amounts not allocable by State	XXX	0	0	0	0	0	0
95. Totals (Direct Business)	XXX	0	0	73,746,469	0	73,746,469	0
96. Plus reinsurance assumed	XXX			4,795,804		4,795,804	
97. Totals (All Business)	XXX	0	0	78,542,273	0	78,542,273	0
98. Less reinsurance ceded	XXX			10,295		10,295	
99. Totals (All Business) less reinsurance ceded	XXX	0	0	(c) 78,531,977	0	78,531,977	0
DETAILS OF WRITE-INS							
58001. Aggregate Other Alien	XXX			13,907		13,907	
58002.	XXX					0	
58003.	XXX					0	
58998. Summ. of remaining write-ins for line 58 from overflow page	XXX	0	0	0	0	0	0
58999. Total (Lines 58001 thru 58003 plus 58998) (Line 58 above)	XXX	0	0	13,907	0	13,907	0
9401.	XXX					0	
9402.	XXX					0	
9403.	XXX					0	
9498. Summ. of remaining write-ins for line 94 from overflow page	XXX	0	0	0	0	0	0
9499. Total (Lines 9401 thru 9403 plus 9498) (Line 94 above)	XXX	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG 48
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
R - Registered - Non-domiciled RRGs 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 9

(b) Explanation of basis of allocation by states, etc., of premiums and annuity considerations.

(c) Column 4 should balance with Exhibit 1, Lines 6.4, 10.4 and 16.4, Cols. 8, 9, and 10, or with Schedule H, Part 1, Column 1, Line 1. Indicate which:

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

Allocated by States and Territories

States, Etc.	Direct Business Only					
	1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1. Alabama AL						0
2. Alaska AK						0
3. Arizona AZ						0
4. Arkansas AR						0
5. California CA						0
6. Colorado CO						0
7. Connecticut CT						0
8. Delaware DE						0
9. District of Columbia DC						0
10. Florida FL						0
11. Georgia GA						0
12. Hawaii HI						0
13. Idaho ID						0
14. Illinois IL						0
15. Indiana IN						0
16. Iowa IA						0
17. Kansas KS						0
18. Kentucky KY						0
19. Louisiana LA						0
20. Maine ME						0
21. Maryland MD						0
22. Massachusetts MA						0
23. Michigan MI						0
24. Minnesota MN						0
25. Mississippi MS						0
26. Missouri MO						0
27. Montana MT						0
28. Nebraska NE						0
29. Nevada NV						0
30. New Hampshire NH						0
31. New Jersey NJ						0
32. New Mexico NM						0
33. New York NY						0
34. North Carolina NC						0
35. North Dakota ND						0
36. Ohio OH						0
37. Oklahoma OK						0
38. Oregon OR						0
39. Pennsylvania PA						0
40. Rhode Island RI						0
41. South Carolina SC						0
42. South Dakota SD						0
43. Tennessee TN						0
44. Texas TX						0
45. Utah UT						0
46. Vermont VT						0
47. Virginia VA						0
48. Washington WA						0
49. West Virginia WV						0
50. Wisconsin WI						0
51. Wyoming WY						0
52. American Samoa AS						0
53. Guam GU						0
54. Puerto Rico PR						0
55. US Virgin Islands VI						0
56. Northern Mariana Islands MP						0
57. Canada CAN						0
58. Aggregate Other Alien OT						0
59. Totals	0	0	0	0	0	0

NONE

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART



SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
Members															
			75-3269792..				SENIOR HEALTH CARE OVERSIGHT TRUST	PA	UDP					N	
		76325	23-0704970..				SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	PA	RE	SENIOR HEALTH CARE OVERSIGHT TRUST	OWNERSHIP	100.000	SENIOR HEALTH CARE OVERSIGHT TRUST	N	
			45-4844825..				FUZION ANALYTICS, INC	DE	NIA	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	OWNERSHIP	100.000	SENIOR HEALTH CARE OVERSIGHT TRUST	N	

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/ (Liability)
Affiliated Transactions												
	45-4844825	FUZION ANALYTICS, INC.					12,778,644				12,778,644	
76325	23-0704970	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA					(12,778,644)				(12,778,644)	
9999999.	Control Totals		0	0	0	0	0	0	XXX	0	0	0

Senior Health Insurance Company in Rehabilitation
Balance Sheet
($ in thousands)

	YTD 06/30/2020	Year Ended 12/31/2019
Assets		
Bonds	$ 1,604,419	$ 1,721,888
Preferred stock	79,903	86,271
Common stock	4,153	3,578
Mortgage loans	12,212	12,682
Cash and short term investments	30,918	46,682
Other invested assets	12,612	15,701
Receivable for securities	-	136
Total invested assets	1,744,217	1,886,938
Investment income due and accrued	11,720	12,082
Uncollected premiums	997	928
Federal income tax recoverable	2,364	2,364
Guaranty funds receivable	1,218	1,209
Reimbursement from insurance carrier	1,006	3,588
Other	184	72
Total Assets	$ 1,761,706	$ 1,907,181
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	$ 1,177,017	$ 1,234,831
Premium deficiency reserves	761,096	636,537
Claim reserves	896,046	932,811
Premiums paid in advance	1,365	1,462
Interest maintenance reserve	5,525	4,746
Accounts payable and other liabilites	8,386	12,892
Total Liabilities	$ 2,849,435	$ 2,823,279
Capital and Surplus		
Common stock	$ 2,500	$ 2,500
Preferred capital stock	5,000	5,000
Surplus notes	50,000	50,000
Unassigned surplus	(1,145,229)	(973,598)
Total Capital and Surplus	$ (1,087,729)	$ (916,098)
Total Liabilities and Capital and Surplus	$ 1,761,706	$ 1,907,181

Senior Health Insurance Company in Rehabilitation
Income Statement
($ in thousands)

	YTD 06/30/2020	Year Ended 12/31/2019
Premiums	$ 35,628	$ 80,672
Investment Income	36,164	77,412
Investment Expense	(525)	(10,695)
Total Income	71,267	147,389
Benefits Paid	178,970	369,626
Change in Claim Reserves	(36,765)	(26,160)
Change in ALR	(57,366)	(74,651)
Change in PDR Reserves	124,559	262,914
Total Benefits	209,398	531,729
Commissions	2,568	5,654
General Insurance Expenses	16,464	29,396
Insurance Taxes, Licenses and Fees	381	3,888
Total Benefits and Expenses	228,811	570,667
Federal Income Taxes	-	207
Net Loss before Realized Losses	(157,544)	(423,485)
Realized Losses	(13,110)	(38,549)
Net Loss	$ (170,654)	$ (462,034)
Cash from Operations	$ (121,810)	$ (251,711)

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

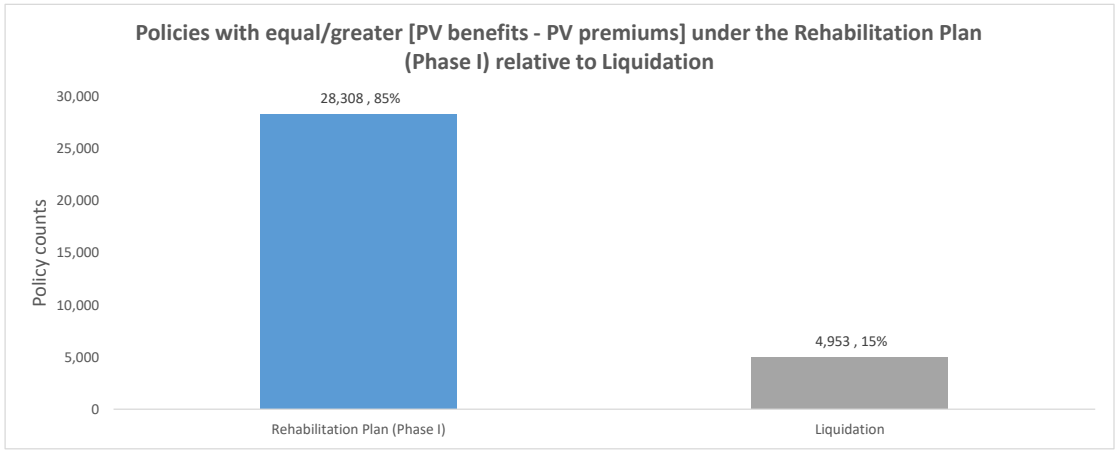
EXHIBIT 7

SHIP - Rehabilitation Plan
Comparison test summary
Figures are as of 6/30/2020 and exclude assumed business and policies currently on non-forfeiture.
Rehabilitation Plan Option results are based on Phase I of the Rehabilitation Plan and are subject to change under Phase II

Purpose:	This spreadsheet enables a user to compare the Rehabilitation Plan against a potential Liquidation by comparing the richness of the two potential outcomes based on the present value ("PV") of benefits less the PV of premiums. The PV of Liquidation benefits assumes that guaranty associations will charge if knew rate increases for benefits within applicable statutory limits, and includes an estimated 48.8% (Cell E33) of uncovered benefits that policyholders could retain in the event of a potential Liquidation. In the exhibit below, the left (blue) bar indicates the number of policyholders for whom there is at least one Rehabilitation Plan Option with a value equal to or greater than projected under a potential Liquidation. The right (grey) bar indicates the number of policyholders for whom Liquidation is projected to be richer than the Plan.
Instructions:	Adjust the three toggles in Cells B13:B15 to filter the policies included in the exhibit. Adjust the toggle in Cell B89 to select the illustrative election rate scenario. Adjust the toggle in Cell B90 to select whether uncovered benefits are funded in a liquidation in this exhibit.

Nationwide summary of all policies

All states	*Select issue state*
All lives	*Select active/disabled status*
Both statuses	*Select premium paying status*



As of 6/30/20:

Est. operational cost / year ($ millions)	$30.0
Assets ($ millions)	
Total assets	$1,762.5
Less trust fund	*-$301.9*
Less est. 5-year operational costs	*-$150.0*
Net assets	**$1,310.6**
Liabilities ($ millions)	
Total liabilities	$2,836.7
Less assumed business	*-$152.0*
Net liabilities	**$2,684.7**
Liquidation dividend[1]	**48.8%**

[1] Liquidation dividend is defined as the percentage of uncovered benefits that would be paid to the policyholder in the event of a liquidation

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 8

GABRIEL ALBOUKREK



Consultant
Gabriel.alboukrek@oliverwyman.com

Oliver Wyman Actuarial Consulting
Two Alliance Center
3560 Lenox Road, Suite 2400
Atlanta, GA 30326

Tel 404 239 6406
Fax 404 239 6404

Professional History

- Oliver Wyman (2016–present)

Education

- University of Florida, BS in Accounting with a Minor in Actuarial Science, (2016) *Cum Laude*

Gabe Alboukrek is a Consultant with the Actuarial Practice of Oliver Wyman and is based in Atlanta. His primary responsibilities are to provide actuarial consulting services to a variety of insurance, reinsurance and self-insured organizations.

Gabriel graduated from the University of Florida in April 2016 with a Bachelor of Science in Accounting with a Minor in Actuarial Science. He joined Oliver Wyman in June 2016.

Professional Experience

- Reviewed the data and methodology used to set a large LTC carrier's key assumptions
- Managed the design, development, and testing of a first principles AXIS model for a large LTC carrier
- Played a key role in the development of a rehabilitation plan for a distressed LTC company
- Completed the review of a Moody's Analytics AXIS™ (AXIS) model for an independent actuary review of a special purpose captive insurance company
- Supported a large AXIS conversion project for an insurer's variable annuity valuation models.
- Played a key role in the development of quarterly model control standards for AXIS models
- Implemented and quantified the impact of model changes and topside adjustments corresponding to validation findings
- Supported a review of the in-force process used for a Variable Annuity valuation model
- Assisted in the completion of IFRS disclosures for a life reinsurer, including liability adequacy testing
- Led an effort to standardize a life insurer's model inventory used for financial reporting
- Assisted in the development of an AXIS forecasting model, including asset reinvestment and statutory reserving
- Assisted in the review of a ULSG model in AXIS by developing a comparative analysis between cash flow testing results and model projections

Software Skills

- MS Excel/VBA
- MS Access
- Moody's Analytics AXIS

OLIVER WYMAN

VINCENT L. BODNAR, ASA, MAAA



Partner and Long-Term Care Practice Leader
vince.bodnar@oliverwyman.com

Oliver Wyman Actuarial Consulting
One University Square Drive, Suite 100
Princeton, NJ 08540

Tel 609 520 2500
Cell 215 617 6592

Professional History

- Oliver Wyman (2019–present)
- Genworth (2017-2019)
- Long Term Care Group (2015-2017)
- Willis Towers Watson (2012-2015)

Professional Memberships

- Associate of the Society of Actuaries (1989)
- Member of the American Academy of Actuaries (1990)

Vince Bodnar is a Partner and leads the Long-Term Care practice of Oliver Wyman. He is recognized as one of the leading long-term care insurance experts in the country, having worked with such products since the 1980s. Vince was recently named one of the "20 Most Creative People in Insurance" by *ThinkAdvisor*. His long-term care experience includes both stand-alone long-term care products and hybrid products in which long-term care benefits are provided through life insurance and annuity chassis.

Prior to joining Oliver Wyman, Vince was Senior Vice President of Product Management at Genworth. Through is career, he has been a highly visible actuarial consultant with a focus on solutions for in-force blocks of long-term care insurance policies and new product innovation.

Vince is a very active contributor to the long-term care industry. He has twice chaired the Society of Actuaries Long-Term Care Insurance Section, its Long-Term Care Think Tank and the ILTCI Conference.

Professional Experience

- Key thought leadership to the guaranty system in the Penn Treaty matter, influencing industry and regulatory support for a broad solution and leading initial implementation.
- Industry leadership on regulator education efforts related to LTC premium rate increases and new product innovation.
- Experience analysis of existing blocks of LTC business.
- Reserve reviews and LTC financial projections that have proven to be accurate over 10+ year periods of time.
- Nationwide LTC premium rate increase filings.
- Actuarial appraisals and merger and acquisition support.
- Development and pricing of new LTC and hybrid products.
- Expert testimony in the fields of LTC and health insurance.
- International market entry.

Publications and Presentations

Vince is a sought-after and frequent speaker at industry and regulatory meetings and his work has been published several times. He is a co-author of the Society of Actuaries 2000-2011 Long-term Care Intercompany Experience Study.



DEAN KERR

FSA, MAAA, ACIA

Partner

dean.kerr@oliverwyman.com

Professional History

- Oliver Wyman (2012–present)
- Munich Reinsurance (2010–2012)
- ING (2008–2010)
- Towers Perrin (2004–2008)
- Transamerica (2001–2002)

Professional Memberships

- Fellow of the Society of Actuaries (2007)
- Member of the American Academy of Actuaries (2014)
- Associate of the Canadian Institute of Actuaries (2011)

Education

- University of Waterloo, B.Math. Honours Co-op, Mathematics/Business Administration

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Dean Kerr is a Partner with the Actuarial Practice of Oliver Wyman and is based in Toronto. Dean has provided actuarial consulting services for over 15 years. Dean's primary responsibilities are to provide actuarial consulting services to insurance entities and self-insured organizations.

Recent Long-Term Care projects include

- Providing senior oversight for the rehabilitation of an LTC carrier
- Supporting an LTC writer with premium rate increase analysis and plaintiff litigation
- Peer reviewing quarterly valuation for a large LTC carrier
- Leading assumptions reviews for multiple LTC writers
- Performing due diligence of LTC blocks for M&A and reinsurance transactions
- Benchmarking a carrier's LTC product design, premiums rates and assumptions
- Overseeing a proprietary database of LTC product features, assumptions and rate increase filings
- Performing in-depth model reviews and validations of both claim cost and first principles LTC models
- Building and testing a multi-state model for LTC
- Leading LTC actuarial system conversions in Singapore and the US

Dean joined Oliver Wyman in July 2012 after having previously worked at Munich Reinsurance, ING, Towers Perrin and Transamerica. He has provided consulting services to LTC businesses in Canada, Singapore and the US.

Dean is a former member of the LTC Principle-Based Work Group and a Friend of the Product Development Section Council. He has been an industry meeting speaker on Life Product Trends, Universal Long-Term Care, and Long-Term Care Combo Products. He is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries and an Associate of the Canadian Institute of Actuaries.

MARC LAMBRIGHT, FSA, MAAA



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Professional History

- Oliver Wyman Actuarial Consulting (2007–present)
- KPMG Actuarial Services, Manager & Firm Qualified Actuary (1998–2007)
- Cigna (1994–1998)

Professional Memberships and Activities

- Chairperson, American Academy of Actuaries' Health Financial Reporting and Solvency Committee (Current)
- Fellow of the Society of Actuaries (2002)
- Member of the American Academy of Actuaries (2000)
- Frequent speaker at Society of Actuaries, Valuation Actuarial Symposium, and Philadelphia Actuaries Club meetings

Education

- Pennsylvania State University, BS Actuarial Science, *with Distinction*

Marc Lambright is a Senior Principal in the Philadelphia office of Oliver Wyman Actuarial Consulting, Inc. He has 27 years of actuarial experience working in various roles as a consulting actuary, company actuary, and auditing actuary for a significant number of insurers, Blue Cross and Blue Shield plans, managed care organizations, regulators, and government agencies.

His work has included pricing, valuation, and financial/capital modeling work for most significant individual and group A&H products, including Medical, Long-Term Care, Long-Term Disability, Dental, and other supplemental health products.

Professional Experience

- **Valuation Work**
  - Marc has served as the Appointed Actuary and signed Actuarial Opinions for multiple medical insurers, A&H insurers and captive insurers
  - Medical, LTC, Disability, Dental, and A&H reserve production, including cash flow testing
  - Financial modeling and budgeting for Life, Accident, and Disability products
  - Systems development and testing, including leading the actuarial effort in the development LTD reserving system for $1 billion block of disabled life reserves
- **Mergers and Acquisitions**
  - DCF analysis and company/block value estimates for A&H targets
  - Valuation of actuarial reserves and balance sheet accruals
  - Pricing and underwriting process reviews
  - Market benchmarking, strategic, and regulatory reviews
- **ERM and Capital Management**
  - Development and evaluation of target surplus ranges for medical insurers, along with regulatory review of target surplus ranges and their quantification
  - Health lead on a large multi-national insurance ERM project: included guiding client to develop risk quantification techniques and practical implementation solutions
  - Own Risk and Solvency Assessment (ORSA) support for multiple insurers including stress testing, current and prospective solvency assessments, Economic Capital modeling, and regulator ORSA report development
- **Pricing**
  - Individual Medical, Medicare Supplement and Long-Term Care product pricing, premium rate and Actuarial Memorandum preparation
  - Group Insurance product pricing for Life, Accident, and Disability products
- **Regulatory and Public Policy**
  - Support to stakeholders responsible for implementing health insurance industry reform and addressing health coverage and funding issues
  - Reviewing actuary during the course of multiple financial examinations, assisting regulators in evaluating for profit conversions, and carrier rehabilitation support
- **Audit Support**
  - External and internal audits of public and private insurers, managed care organizations, and self-insured plans
  - Review of claim and policy reserves, premium sufficiency, and actuarial functions including pricing and reserving
  - Sample clients: Aetna, Kaiser, Anthem, and UnitedHealth Group



DUSTIN PLOTKIN

FSA, MAAA, ACIA

Principal

dustin.plotkin@oliverwyman.com

Professional History

- Oliver Wyman (2015–present)
- Mercer (2012–2015)
- Manulife Financial (2011)

Professional Memberships

- Fellow of the Society of Actuaries (2016)
- Associate of the Canadian Institute of Actuaries (2016)
- Member of the American Academy of Actuaries (2019)

Education

- Concordia University, Bachelor of Sciences, Specialization in Actuarial Mathematics and Finance (2012)

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Dustin Plotkin is a Principal with the Actuarial Practice of Oliver Wyman and is based in Toronto. Dustin specializes in the end-to-end development and review of actuarial models and has been involved in over a dozen actuarial model builds. More recently, Dustin has been involved in the area of long-term care (LTC) insurance and is currently managing the actuarial activities associated with the rehabilitation of one the largest LTC carriers in U.S. history.

Dustin's industry experiences include working with life, disability, long-term care, and other A&H products.

Dustin joined Oliver Wyman in 2015 after having spent three years in the Group Health and Benefits consulting practice at Mercer. Dustin previously worked in the Global Actuarial Audit department at Manulife Financial.

Relevant Experience

- Managing actuarial activities associated with the rehabilitation of a LTC carrier with $3 billion in liabilities
- Overseeing the implementation of US GAAP LDTI for several large blocks of FAS60 life, disability, pension risk transfer, and structured settlements business in AXIS
- Played key roles in developing over a dozen AXIS models across a range of products (traditional life, interest sensitive life, LTC, A&H) and purposes (statutory and GAAP LDTI valuation, CFT, ALM, M&A, reinsurance transactions, Bermuda reporting, and insurer rehabilitation)
- Led the establishment of automated data feeds from internal and external admin systems to AXIS within a data warehouse for annuity, life and health liabilities and assets
- Performed actuarial due diligence on multiple blocks of life, annuity, LTC, and other A&H insurance
- "Key control" model review workstream lead on a multi-year AXIS system transformation for a multinational insurer's Secondary Guarantee Universal Life product line
- Quantified financial impacts for the Secondary Guarantee Universal Life block of a large US insurance company
- Performed actuarial elements of Sarbanes-Oxley (SOX) and Model Audit Rule (MAR) testing on internal business units of an insurance company, across several countries
- Designed and priced traditional and cafeteria-style flexible benefit plans for businesses across a wide range of sizes and industries

Dustin is a member of the SOA LTC insurance Section and is also a frequent speaker at industry conferences, including the 2018 and 2019 SOA Life & Annuity Symposiums and the 2019 SOA Annual Meeting

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 9

Patrick H. Cantilo
Managing Partner
phcantilo@cb-firm.com

Having received a Bachelor of Arts degree with Honors from the University of Texas in 1977, and his Juris Doctorate degree from the University of Texas School of Law in 1980, Patrick Cantilo was admitted to practice law in the State of Texas in November 1980 . He has since been admitted to practice in all Texas State Courts, the courts of the Commonwealth of Pennsylvania, the United States District Courts for the Eastern, Northern, Southern and Western Districts of Texas, the United States Court of Federal Claims, the United States Courts of Appeals for the Fourth and the Fifth Circuits, and the United States Supreme Court.

While most recently Mr. Cantilo's practice has been concentrated in insurance rehabilitation and liquidation, on the reorganization of health services corporations, and in the area of insurance corporate restructuring, merger and acquisition, his experience is far more diverse.

Much of Mr. Cantilo's law practice has been devoted to the area of civil litigation and alternative dispute resolution, including cases in the State and Federal Courts, both at the trial and appellate levels. His litigation experience includes relatively straight-forward matters like the prosecution or defense of insurance claims and very complex matters such as major bankruptcy reorganizations and insurance rehabilitations. Demonstrative of this experience are the roles played by Mr. Cantilo as lead counsel for Texas Insurance regulators in the Maxicare Bankruptcy (reported at In re Family Health Services, Inc., 101 B.R. 618 (Bankr. C.D. Cal. 1989)) and in the bankruptcy proceeding involving an insurance holding company and its affiliates. (See In re First Financial Enterprises, Inc., 99 B.R. 751 (Bankr. W.D. Tex. 1989)).

He has served as lead counsel in cases involving professional negligence, RICO, fraud, reinsurance transactions, transnational conflicts, banking and letters of credit, state licensing, medical privileges, landlord tenant disputes, medical malpractice actions, construction negligence, wrongful lien, insurance fraud, regulatory jurisdiction, commercial lending, deceptive trade practices, defense of a variety of insurance claims, employment issues, liability of officers and directors, bankruptcy, insurance insolvency, and a host of other matters.

Mr. Cantilo has also devoted a significant part of his legal career to complicated business and insurance transactions, including the reorganization or conversion of Blue Cross and Blue Shield plans in several states, negotiation of acquisitions and complex reinsurance transactions, the development and implementation of complex insurance rehabilitation plans, the negotiation of purchase and sale agreements for a variety of businesses, goods and services, participation in corporate reorganizations, participation in complex real estate transactions, mergers, acquisitions, and similar matters.

He has served as Counsel to the Receiver, as Special Deputy Receiver, Deputy Receiver, Deputy Liquidator, or in comparable capacities in literally dozens of insurance and managed care insolvencies throughout the country. He has taken the lead in the rehabilitation and liquidation of

a wide variety of entities ranging from a small trust company to multi-billion dollar life and health insurance companies and including a number of health maintenance organizations, life insurance companies, accident and health insurance companies, property and casualty insurance companies, title insurance companies, insurance agencies, premium finance companies and related entities. He has negotiated the formation and commutation of reinsurance agreements, developed plans for the collection of agents' balances, collected reinsurance recoverables, negotiated agreements with guaranty funds and other regulators, negotiated with federal authorities on such matters as insurance claims disputes, tax claims and related matters, developed and implemented complex plans for the rehabilitation or liquidation of a large variety of insurers and insurance related entities, and has written and lectured numerous times on related topics. This area of practice continues to occupy much of Mr. Cantilo's time, as he continues to play the lead role in the rehabilitation of a multi-billion dollar long-term care insurance company, the receivership of a household name-casualty insurer, the liquidation of a multi-state Workers' Compensation and Professional Liability insurer, and more limited roles in other insurance insolvencies. At the same time, Mr. Cantilo continues to devote much of his attention to complex transactional work and a broad array of regulatory and civil litigation matters.

Mr. Cantilo has also served as consulting and testifying expert witness in several matters involving insurance insolvency.

Current Areas of Practice

Demutualization, conversion, merger, acquisition and other reorganization of insurers and managed care companies; regulation, rehabilitation and insolvency of insurers, including health maintenance organizations; reinsurance contracting, disputes and litigation; insurance litigation; regulation of third-party administrators; formation and development of emerging enterprises, merger, reorganization and acquisition of small and medium sized businesses, and representation of established companies; professional liability litigation; general civil litigation (state and Federal courts); Federal bankruptcy as related to insurance insolvency; professional malpractice defense; mediation; and general business law.

Transactions

Corporate transactions include: demutualization of Trigon Insurance Company; conversion to for profit of Blue Cross Blue Shield of Missouri; litigation arising from the mutualization of Blue Cross and Blue Shield of Kansas, Inc.; sponsored demutualization of Blue Cross and Blue Shield of Kansas, Inc.; Affiliation between Mountain States Blue Cross and Blue Shield and Highmark; proposed conversion of CareFirst of Maryland, Inc. and acquisition by WellPoint Health Networks, Inc.; conversion and sale of Blue Cross and Blue Shield of Colorado, conversion to non-profit mutual of Blue Cross and Blue Shield of North Dakota, proposed conversion of Premera Blue Cross and Blue Shield of Washington, and acquisition of Safeco Insurance Company and its affiliates by Liberty Mutual Insurance Company. Receivership or conservation proceedings include: AF&L Insurance Company, Baldwin-United Companies, Builders Insurance Company, Inc., Commodore County Mutual Insurance Company, Colonial Title Insurance Company, Cotton Belt Insurance Company, East Texas Health Plans, Executive Life Insurance Company, Fidelity Bankers Life Insurance Company, First United Trust Company, Foundation Health Plan of New

Jersey, General Protective Life Insurance Company, Group Health of El Paso, Home Owners Warranty Corporation, Kenilworth Insurance Company, Knickerbocker Life Insurance Company, Maxicare Health Plans, MedCenters of North Dakota, MetroCare, Mission Insurance Company, Mobile County Mutual Insurance Company, Nevada Contractors Insurance Company, Inc., Nevada Health CO-OP, Penn Treaty Network America Insurance Company, Reciprocal of America, Senior American Insurance Company, Senior Health Insurance Company of Pennsylvania, Shenandoah Life Insurance Company, Southern Title Insurance Company, Superior Lloyds Insurance Company, Texas Prepaid Health Plans, Transit Casualty Company, United Bankers Life Insurance Company, United Capital Life Insurance Company, Universal Health Care of Nevada, and Universal Health Services, Inc.

Representative Cases

1. **Great American Insurance Co., v. Alfred Gross, Civil Action No. 3:05CV159,** UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA, RICHMOND DIVISION, Current.

2. **Great American Insurance Co. v. Alfred W. Gross, No. 05-2069,** UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT , 2006.

3. **Alfred W. Gross v. Robert I. Weingarten, Civil Action No. 3:92cv808,** UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA, RICHMOND DIVISION, 1998.

4. **Alfred W. Gross v. Robert Weingarten, No. 98-2000, No. 98-2393, No. 98-2405,** UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT, 2000.

5. **Robert Weingarten v. Alfred W. Gross, No. 012702,** SUPREME COURT OF VIRGINIA, 2002.

6. **In re: Reciprocal of America (ROA) Sales Practices Litigation, MDL No. 1551,** JUDICIAL PANEL ON MULTIDISTRICT LITIGATION, Current.

7. **National Home Insurance Company v. State Corporation Commission of the Commonwealth of Virginia, Civil Action No. 93-1006-A,** UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA, ALEXANDRIA DIVISION , 1993.

8. **Taylor Hawes v. Colorado Division of Insurance, Court of Appeals No. 00CA1144,** COURT OF APPEALS OF COLORADO, DIVISION FOUR, 2001.

9. **In the Matter of The Liquidation of Integrated Resources Life Insurance Company, Steven T. Foster**, Deputy Receiver of Fidelity Bankers Life Insurance Company and Trustee of the Fidelity Bankers Life Insurance Company Trust, Appellant. **No. 381 / 95-1785,** SUPREME COURT OF IOWA, 1997.

10. **Blue Cross And Blue Shield Of Missouri v. Jay Angoff**, in his official Capacity as the Director of the Missouri Department, and of Insurance, and the MISSOURI DEPARTMENT OF INSURANCE, Respondent-Appellant, JEREMIAH W. (JAY) NIXON, in his official capacity as the Attorney General of the State of Missouri, Respondent, **WD 53798, (Consolidated with WD 53799, WD 53800, WD 53851)** COURT OF APPEALS OF MISSOURI, WESTERN DISTRICT, 1998.

11. **Swiss Re Life Company America v. Alfred W. GROSS, Record No. 961078,** SUPREME COURT OF VIRGINIA, 1997.

12. **Bank Of New York v. Fremont General Corp., No. CV03-9238 CAS (PJWx),** UNITED STATES DISTRICT COURT, C.D. CALIFORNIA, 2005. [Expert witness]

13. **In re First Financial Enterprises, Inc., Debtor. Bankruptcy No. 88-30993,** UNITED STATES BANKRUPTCY COURT, W.D. TEXAS, EL PASO DIVISION, 1989.

Publications

1. *"Texas Health Maintenance Organizations: Lessons from Insolvency"*, Texas Health Law Reporter, Vol. 1, Nos. 4 and 5, October and December 1984;

2. *"Insurer Insolvency: A Primer for Malpractice Insureds"*, Texas Health Law Reporter, Vol. 2, No. 5, December 1985;

3. *"What To Do If You Believe Your Malpractice Carrier Is Insolvent"*, Texas Medicine, Vol. 83, No. 3, March 1987;

4. *"New Legislation Affects Fees, Taxes for Texas Third-Party Administrators"*, Houston Insurance News, December 1, 1987;

5. *"Health, HMO and Related Entity Insolvencies"*, American Bar Association, Tort and Insurance Practice Section, Law and Practice of Life Insurance Company Insolvency, June 1993, 1996; and

6. *"Rehabilitation of Managed Care Organizations: A Thumbnail Sketch of Certain Key Considerations"*, The Insurance Receiver, International Association of Insurance Receivers, Winter 1999;

7. *"The Perfect Receiver*," Receivership Plan, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Spring 2010, Volume 19, Number 1;

8. "*The Perfect Receiver*," Reinsurance Reporting, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Summer 2010, Volume 19, Number 2;

9. "*The Perfect Receiver*," Credentials, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Summer 2011, Volume 20, Number 2;

10. "*The Perfect Receiver*," Dodd Frank, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Fall/Winter 2011, Volume 20, Number 3;

11. "*The Perfect Receiver*," Staff Retention, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Winter 2011, Volume 20, Number 1;

12. "*The Perfect Receiver*," Rehabilitation, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Fall/Winter 2012, Volume 21, Number 2;

13. "*The Perfect Receiver*," The Numbers, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Spring 2013, Volume 22, Number 1;

14. "*The Perfect Receiver*," How Not To Play Chess, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Summer 2012, Volume 1, Number 1;

15. "*The Perfect Receiver*," Experts, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Summer 2013, Volume 22, Number 2;

16. "*The Perfect Receiver*," Five Stages of Receivership, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Fall/Winter 2013, Volume 22, Number 3;

17. "*The Perfect Receiver*," Negotiating, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, February 2014, (in publication);

18. "*The Perfect Receiver*," Welcome to the Bazaar, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Spring 2014, Volume 23, Number 1;

19. "*The Perfect Receiver*," Who's Your Daddy?, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Summer 2014, Volume 23, Number 2;

20. "*The Perfect Receiver*," Rules of Life, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Fall 2016, Volume 24, Number 1;

21. *The Perfect Receiver*," Actuaries, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Spring 2017, Volume 24, Number 2;

22. *The Perfect Receiver*," YADADAMEAN, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Summer 2017, Volume 24, Number 3;

23. *The Perfect Receiver*," The Law, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Fall/Winter 2017, Volume 24, Number 4;

24. *The Perfect Receiver*," Document Management, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Spring 2018, Volume 25, Number 1;

25. *The Perfect Receiver*," Brother Can You Spare A Dime? (All About Assets), The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Fall/Winter 2018, Volume 25, Number 2;

26. *The Perfect Receiver*," You and What Army? (Should You Sue?), The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Spring 2019, Volume 26, Number 1;

27. *The Perfect Receiver*," Will You Still Feed Me? (When I'm 64), The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Summer 2019, Volume 26, Number 2; and

28. *The Perfect Receiver*," Doing the Right Thing, The Insurance Receiver, A Publication by the International Association of Insurance Receivers, Fall 2020, Volume 27, Number 1.

Presentations and Lectures

1. "*HMO Issues: A Seminar for State Regulators*," (Bureau of HMOs, U.S. Department of Health and Human Services) 1982, 1983, 1984, and 1986;

2. "*How to Examine HMO Financial Viability*," seminars (NAHMOR and OHMO-DHHS) 1981;

3. "*HMOs: What Do We Know?*" seminar (NCHSR, Texas Departments of Health and Insurance and Texas Senate) 1981;

4. Seminar on Agent's Liability, Texas Association of Life Underwriters Convention, 1985;

5. Group Health Institute (Group Health Association of America, Inc., and NAHMOR) 1986;

6. "*The Regulator's Response to the New Competitive Environment*" (American Medical Care and Review Association and NAHMOR) 1986;

7. "*Current HMO Issues: A Seminar for Regulators*" (NAIC and NAHMOR) 1986;

8. "*HMO Issues 1987: A Seminar for State Regulators*" (NAHMOR and OPHC) 1987;

9. "*HMO Issues 1988: A Seminar for State Regulators*" (NAHMOR and OPHC) 1988;

10. "*HMO Issues 1989: A Seminar for State Regulators*" (NAHMOR and OPHC) 1989;

11. HMO REGULATIONS: THE LATEST TRENDS IN STATE ISSUES - "*Bankruptcy: A Federal or State Problem?*" Group Health Institute 1989, June 15, 1989, Atlanta Georgia;

12. "*A Guide to Insurer Insolvency*," State Bar of Texas Professional Development Program entitled DEALING WITH THE FAILED INSURER, October 1989, Austin and Dallas, Texas;

13. "*HMO Insolvency: State or Federal Jurisdiction?*" National Conference of Insurance Legislators, Austin, Texas, November 1989;

14. "*1988 HMO Law Update*," National Health Lawyers Association Meeting, Chicago, December 1989;

15. "*NAHMOR Education Foundation Advanced Seminar*," San Diego, California, April 27, 1990;

16. "*NAIC/NAHMOR Committee and Industry Advisory Group*," Arlington, Virginia, October 2, 1990;

17. "*HMO Issues 1991: Defining Managed Care*," NAHMOR Annual Meeting, Indianapolis, Indiana, June 6, 1991;

18. LOMA Group Insurance Administration Committee, Guest Speaker, Austin, Texas, March 3, 1992;

19. "*Legal Issues Involved in the Liquidation of Insolvent Insurers*," Texas Department of Insurance, Guest Speaker, Austin, Texas, August 15, 1992;

20. "*Receivership Appeal Procedures*," National Association of Insurance Commissioners/Society of Insurance Receivers, Guest Speaker, Orlando, Florida, February 18-19, 1993;

21. "*Health, HMO and Related Entity Insolvencies*," American Bar Association National Institute on Life Insurer Insolvency, Guest Speaker, Chicago, Illinois, June 19-20, 1993;

22. "*Mock Takeover*," Society of Insurance Receivers, Guest Speaker, New Orleans, Louisiana, December 3, 1994;

23. "*Legal Issues in Managed Care Regulation*," National Association of Managed Care Regulators, Guest Speaker, San Antonio, Texas, May 1, 1995;

24. (EX) Special Committee on Blue Cross Plans, 1995 NAIC Winter National Meeting, San Antonio, Texas, December 4, 1995;

25. "*HMOs, Warranty Insurers, and Other "Special" Receiverships*," National Association of Insurance Commissioners and the Society of Insurance Receivers Insolvency Workshop, Albuquerque, New Mexico, January 25, 1996;

26. "*Risk Retention Groups*," National Association of Insurance Commissioners Federal Preemption of State Insurance Laws, Detroit, Michigan, March 23, 1996;

27. Interim Meeting of the Special Committee on Blue Cross Blue Shield Plans, Dallas, Texas, April 26, 1996;

28. "*Health, HMO, and Related Entity Insolvencies*," American Bar Association National Program, Insurance Regulation of Health Care Arrangements, New York, New York, June 2, 1996;

29. "*Insolvency Issues, Historical Perspective*" (HCFA), Negotiated Rulemaking Committee on PSO Solvency Standards, Arlington, Virginia, October 22, 1997;

30. "*Insurer Restructuring: A Framework for Regulatory Analysis*" (NAAG), National Training Conference for Regulators - Health Care Conversions and Acquisitions, Boston, Massachusetts, July 19, 1998;

31. "*Blue Cross Blue Shield Conversions*" (NAMCR), 1998 Fall Conference, Managed Care's Future, Washington Perspective, Washington, D.C., October 26, 1998;

32. "*Troubled Managed Care Organizations: A Return to Bad Old Times?*" (NAMCR), HMO Insolvency Seminar, San Antonio, Texas, February 18-20, 1999;

33. "*Troubled Managed Care Organizations: Back to the Future!*" (NAMCR), HMO Insolvency Seminar, Charleston, South Carolina, November 3-4, 1999;

34. "*Managed Care: A Different Millennium Bug*," IAIR/NAIC Insolvency Workshop; Tucson, Arizona, January 20-21, 2000;

35. "*HMO Insolvencies and Their Impact: Provider, Patient, Legal, and Financial Issues*," Mealey's Insurance Insolvency & Reinsurance Roundtable, Scottsdale, Arizona, April 13-15, 2000;

36. "*Collaboration: The Future of Healthcare*," National Association of Managed Care Regulators, Albuquerque, New Mexico, May 17, 2000;

37. "*Managed Care Insolvencies: Just When You Thought it Was Safe to Go Back in the Water*," Society of Financial Examiners 2000 Career Development Seminar, Unchartered Waters: Fathoming the Depths of Fraud, San Diego, California, July 23-26, 2000;

38. "*Delegation Agreements - The Legal Issues*," Downstream Contracting and Delegation Summit; National Association of Managed Care Regulators, Philadelphia, Pennsylvania, November 13-15, 2000;

39. "*Solvency vs. Quality - Striking a Balance*," National Association of Managed Care Regulators, Long Beach, California, May 22, 2001;

40. "*Lessons and Implications of Various Blue Cross Blue Shield Conversions*," New York, New York, June 21, 2003;

41. "*The Day after Tomorrow*," 2005 International Association of Insurance Receivers Insolvency Workshop, Lake Buena Vista, Florida, February 3-4, 2005;

42. "*Receiver's Perspective*," NCIGF 2005 Legal Seminar, National Conference of Insurance Guaranty Funds, New York, New York, July 21, 2005;

43. "*Top Ten Ways to Be a Good Lawyer*," Mandalay Bay, Las Vegas, Nevada, June 4, 2005;

44. "*Top Ten Ways to Ensure Your Receivership is Perfect*," Co-Chair, 2006 International Association of Insurance Receivers Insolvency Workshop, Cosmic Tour of Receivership Issues, San Diego, California, February 1-3, 2006;

45. International Association of Insurance Receivers 2007 Insolvency Workshop, Moderator, Tucson, Arizona, January 31 - February 2, 2007;

46. *"Regulatory and Solvency Issues*," Illinois CPA Society 2007 Insurance Conference, Chicago, Illinois, October 16, 2007;

47. *"Bridging the Gap Between the Capital Markets and Troubled Insurers*," Organizer Planning Committee, International Association of Insurance Receivers, Emerging Investment Opportunities, New York, New York, October 24, 2007;

48. *"Insurance and the Globalization of Financial Services: Challenges for Worldwide Regulations and Supervision*," 15th International Association of Insurance Supervisors Annual Conference, Budapest, Hungary, October 14-17, 2008;

49. *"Receivership Feud*," International Association of Insurance Receivers 2009 Post Inaugural Insolvency Conference, Tampa, Florida, January 21-23, 2009;

50. *"Status of the Insurance Industry, What is a Receivership, Insurance Agent's Responsibilities*," RiskProNet International, Construction Practice Group, Chicago, Illinois, February 16-17, 2009;

51. *"Insolvencies Regulations and Safety Net in Insurance International Perspective, Transborder Failures in Insurance: U.S. Experience*," 25th PROGRES International Seminar, Geneva Association, Montreux, Switzerland, April 6-7, 2009;

52. *"Solvency and Receiverships in Insurance*," Illinois CPA Society 2009 Insurance Conference, Chicago, Illinois, October 23, 2009;

53. "*Global Regulatory and Supervisory Repair: Aligning National Interests and International Necessities*," 26th PROGRES International Seminar, Geneva Association, Glion sur Montreux, Switzerland, April 15, 2010;

54. "*DERIVATIVES Financial Innovation and Financial Stability*; Launch Conference of the Financial Stability Review 14;" Paris, France, July 8, 2010;

55. "*Receivership Feud*," International Association of Insurance Receivers 2010 Insolvency Workshop, Miami Beach, Florida, April 21-23, 2010;

56. International Association of Insurance Receivers State Training Program, Chair, Madison, Wisconsin, August 31, 2010;

57. "*Records Retention and Imaging Records*," Chair, International Association of Insurance Receivers State Training Program, Austin, Texas, September 20, 2010;

58. "*The Help Screen*," Chair, Technical Development Series, International Association of Insurance Receivers Asset Management and Recovery, Las Vegas, Nevada, November 5-6, 2010;

59. "*Defining Rehabilitation*," Chair, International Association of Insurance Receivers 2011 Insolvency Workshop Peering Into IAIR's Crystal Ball, New Orleans, Louisiana, January 19-21, 2011;

60. "*News Update - US Developments and Current Issues*," INSOL Singapore - Insurance Insolvency Ancillary Meeting, March 13, 2011;

61. International Association of Insurance Receivers Issues Forum, Presenter, Austin, Texas March 26, 2010;

62. "*Technical Development Series 2*," Chair, International Association of Insurance Receivers 2011 Reinsurance, Las Vegas, Nevada, June 10-11, 2011;

63. "*Statutory and Regulatory Update, Dodd-Frank, The Non-Admitted and Reinsurance Reform Act, and the Federal Insurance Office*," Harris Martin Publishing, Reinsurance Summit: Fresh Perspectives on the Insurance Front, Philadelphia, Pennsylvania, September 22-23, 2011;

64. Technical Development Series 3, The Central Government, Program Chair, International Association of Insurance Receivers, Las Vegas, Nevada, June 22-23, 2012;

65. "*Life Insurer's Assets –"Traps and Pitfalls in the Quest for Yields"*," International Association Insolvency Workshop, Spotlight on Current Issues, Savannah, Georgia, January 29-31, 2013;

66. "*The Importance of Ethics*, " Risk Management Insurance and Financial Planning, Mississippi State University, 26th Anniversary Insurance Day 2013, Starkville, Mississippi, April 2, 2013; and

67. "*Examining the Impact of the Model Insurance Holding Company Act (Amended HCA): Tracking the Effects and Preparing for What's Ahead*," 8th National Forum on

Insurance Regulation, American Conference Institute, New York, New York, February 27-28, 2014.

68. "*The Latest on Credit for Reinsurance and Reinsurance Capital and Collateral Requirements: Reduced Collateral, Revised Credit, New Implementation Issues, Consequences and Market Implications of the NAIC's Recognizing Various Foreign Reinsurers as Qualified Jurisdictions, and More*," American Conference Institute's National Forum on Reinsurance Regulation, New York, New York, July 29 – 30, 2014;

69. "*Receivership Roundup – The Liquidators Speak*," AIRROC Chicago Regional Education Day, Chicago, Illinois, September 24, 2015;

70. "*Examining the Implications of Recent Health Insurance Consolidation, and the Latest Issues Related to the Seeming Demise of Health Insurance CO-Ops*," 11th National Forum on Insurance Regulation, American Conference Institute, New York, New York, February 29 – March 1, 2016;

71."*Insurance Insolvency Course*," University of Connecticut School of Law, Mansfield, Connecticut, April 14, 2016; and

72 "*Antitrust Risks for Managed Care Organizations, Antitrust and other Regulatory and Litigation Issues Raised by the Mega-Mergers*", 7th Annual Advanced Forum on Managed Care Disputes and Litigation, American Conference Institute, Chicago, Illinois, May 2-3, 2016.

73."*An Update on the Status of the Fiduciary Duty Rule: Issues Surrounding the Implementation of the Rule and Impact on the Current Products"*, 10th National Forum on Insurance Regulation, American Conference Institute, New York, New York, July 29 - 30, 2016;

74. *"Insurance Insolvency Course "* , University of Connecticut School of Law, Mansfield, Connecticut, March 2, 2017;

75. *"Dodd-Frank & Insurance Regulatory Modernization: Legal & Economic Concepts"*, NOLHGA 25th Legal Seminar, Chicago, Illinois, July 20-21, 2017;

76. *"SDR Panel: Red Flags & Ethics"*, Financial Regulation Division Annual Training, Texas Department of Insurance, Austin, Texas, July 31-Aug 2, 2017.

77. *"2019 Insurance Resolution Workshop"*, International Association of Insurance Receivers, New Orleans, Louisiana, February 14-15. 2019;

78. *"Les Bons Temps Devant Nous? (Good Times Ahead?)"*, 2019 IAIR INSURANCE RESOLUTION WORKSHOP, Royal Sonesta New Orleans, New Orleans, LA, February 13-15, 2019;

79. *"Current Issues in Insurance Regulation 2020",* New York City Bar Association, April 3, 2020;

80. *"Actuaries and the Law, Part II Other Interactions with Counsel",* Casualty Loss Reserve Seminar and Workshops, Austin, Texas, September 16-17, 2019;

81. *"Current Issues in Insurance Regulation 2020",* New York City Bar Association, October 23, 2020;

82. *"What's in the Carpenter's Toolbag?",* International Association of Insurance Receivers Issues Forum, December 10, 2020; and

83. *"2021 Insurance Resolution Workshop",* International Association of Insurance Receivers, March 9-11, 2021.

Public Service

Counsel for Texas Judicial Insurance Receiver, 1980-1983.

National Association of Insurance Commissioners, Liquidators Task Force 1982-1983.

National Association of Health Maintenance Organization Regulators (now National Association of Managed Care Regulators) Associate Member since 1986.

National Association of Insurance Commissioners/National Association of Health Maintenance Organization Regulators Joint Committee, Advisory Committee 1986.

Chairman, Financial Subcommittee, H.M.O. Advisory Committee established by the State Board of Insurance, 1986.

National Association of Insurance Commissioners, Liquidators Task Force Advisory Committee, 1986.

NAIC/N.A.H.M.O.R. Continuation of Benefits Working Group, Contracts and Services Committee, 1989.

N.A.H.M.O.R. Advisory Committee, 1991.

NAIC Receiver's Handbook Committee, 1991.

International Association for Asset Recovery, Member, 2010.

Community Service

Austin Theater Alliance: Board Member, Finance Committee Member, Development Committee, Search Committee, Advisory Council, Century Club Member.

KUT Austin (Public Radio NPR Affiliate): Past Advisory Board, Leadership Circle.

Austin Lyric Opera: Director's Circle.

The University of Texas at Austin: Keeton Fellow, President's Council, Chancellor's Council, Longhorn Foundation.

Texas Appleseed Foundation, Board Member.

Professional Associations

Travis County Bar Association (Litigation Section); American Bar (Litigation Section and Tort Trial & Insurance Section); State Bar of Texas (Litigation Section); International Association of Insurance Receivers (principal charter member Past President, past Director); International Association for Asset Recovery

Designations

Rated AV Preeminent by Martindale Hubbell, 1992 to present

Selected as one of *Texas' Top Rated Lawyers* by American Lawyer Media;

Selected as one of the *Top Rated Lawyers in Mergers and Acquisitions by* American Lawyer Media;

Selected as on the *Best Lawyers in America* Insurance Law Specialty by Best Lawyers;

Certified Insurance Receiver - Multiple Lines, International Association of Insurance Receivers.

Languages

French and Spanish.

Personal

Born in Santiago, Chile; raised in Buenos Aires, Argentina, and Miami, Florida.

Mr. Cantilo lives in Austin, Texas, with his wife Judy. Together they have seven children ranging from 14 to 37 years of age.

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 10

TRANSPORT LIFE INSURANCE COMPANY
714 MAIN STREET FORT WORTH, TX 76102-5252 (817) 390-8000

December 17, 1993

J[redacted]

Dear MR. [redacted]

Welcome to TRANSPORT LIFE INSURANCE COMPANY, one of the Primerica Companies.

With assets of over $500 Million, Transport has represented quality protection and personal service in Insurance for over 30 years. Transport has long been a leader in the Long Term Care market, and today is recognized as the Premier Long Term Care Insurance provider.

YOUR AGENT NUMBER IS [redacted], AND YOUR SOLICIT DATE IN [redacted] is 11/24/93. Please use your agent number on all applications, new business transmittals and correspondence. Please mail all new business to our corporate office at 714 Main Street, Fort Worth, TX 76102.

Your initial supply order will be sent under separate cover. The 24-hour supply Hot-line Number 1-800-433-0622 is available for your convenience when ordering supplies.

Transport Life Insurance Company prides itself in providing personal service to the field which results in most new business being processed in three days. We are complimented by your choosing to represent Transport and trust this relationship will be mutually beneficial.

Sincerely,

TRANSPORT LIFE INSURANCE COMPANY

Jane Brewer

Agent Contract Administration for Markman Company

Attachments: Advertising Guide
Agency Agreement
Commission Supplement
Explanation of your Transport
Agent Statement
Change of Address-Notification

cc: TA5001-5 MARKMAN COMPANY
MARKMAN COMPANY
Agent Contract File

TRANSPORT LIFE INSURANCE COMPANY

714 Main Street
Fort Worth, Texas 76102

GENERAL AGENT AGREEMENT

This Agreement is made the effective date specified herein between Transport Life Insurance Company, a corporation of the State of Texas ("Company"), and the General Agent ("General Agent") named below.

WITNESSETH:

Company hereby appoints General Agent, and General Agent agrees to the following terms and conditions of such appointment:

1. RELATIONSHIP: The relationship between General Agent and the Company shall be that of an independent contractor. Neither this Agreement nor anything contained herein shall create the relationship of employer and employee between the Company and General Agent. General Agent shall be free to exercise his own judgement as to the persons from whom he will solicit insurance, and the time, manner and place of solicitation, and the Company shall be without right or authority to direct or control the activity or manner of performance of General Agent under this Ageeement, or otherwise to restrict General Agent in the free use of his own energy, initiative and time as an independent contractor. It is agreed that if any training materials, sales aids or similar services are furnished to General Agent by the Company, it is for the purpose of assisting the business of General Agent and not to control General Agent.

   The Company may from time to time prescribe rules and regulations with respect to the conduct of business covered hereby, not interfering with such freedom of action of General Agent. General Agent shall conform to and observe such rules and regulations of which he has knowledge, whether contained herein or otherwise published. General Agent shall endeavor to promote the interest of the Company as contemplated by this Agreement and shall so conduct himself as not to affect adversely the business, good standing or reputation of the Company. General Agent shall not induce or endeavor to induce any policyholder of the Company to discontinue the payment of any premiums on any policy or systematically induce or endeavor to induce any other agent of the Company to leave its service. General Agent agrees that he will not violate any laws, rules or regulations of any federal, state, or city government, department or bureau having jurisdiction nor will he induce or endeavor to induce any other agent to violate such laws, rules or regulations of the Company.

2. AUTHORITY: General Agent shall have the authority to solicit and procure applications for insurance for the Company. Such applications for insurance shall be for such policies as the Company may designate in the Supplements attached hereto and such other Commission Schedules and any amendments as may be published from time to time at the Home Office of the Company. The premium rates for such policies shall be only those rates which are published by the Company. General Agent is not authorized to collect any money due or to become due to the Company except the initial premium on applications solicited and procured by or through him. All premium collected by General Agent is due to the Company except as otherwise provided herein. Any and all premium collected by General Agent that is due the Company shall be held by General Agent in a fiduciary capacity and shall not be used by General Agent for any personal or other purpose whatsoever but shall be promptly paid over to the Company. General Agent has no authority:
   (a) to bind coverage under or to alter, modify, change, waive any forfeiture of or waive performance of any of the terms, rates or conditions of Company's policies or contracts;
   (b) to endorse checks payable to the Company, except as otherwise provided herein;
   (c) to extend the time for payment of premiums or other monies due the Company;
   (d) to make representations not strictly in accordance with the provisions of the policies and contracts issued by the Company;
   e) to make a settlement or agreement in writing or otherwise regarding the settlement of any claim or claims that may be made against the Company, unless specifically authorized by the Company in writing to do so;
   (f) to incur any expense or obligation of any kind or nature in the name of or on behalf of the Company, without first obtaining the express written authority of the Company in each case;
   (g) to fail to return or cause to be returned to the applicant the total sum collected by him from the applicant, when same is returnable to him; or
   (h) to do or perform any act or thing other than is expressly granted herein.

3. FEES AND EXPENSES: General Agent shall be responsible for the payment of all taxes, fees or levies which are imposed on him for the privilege of his doing business, and all expenses incurred by him in the performance of this Agreement. General Agent may be charged with any amount or amounts paid by the Company to any other person for or on behalf of General Agent, including, but not limited to, licensing fees, use taxes and bonding premiums. The Company shall furnish all supplies, blanks and printed matter which the Company finds necessary for conducting business under this Agreement. All printed matter and supplies furnished by the Company are the property of the Company and shall be returned upon request. Any additional materials or supplies ordered from or through the Company shall, according to Company's rules and practices, be charged to General Agent's account unless other arrangements for payment have been made to which the Company has agreed in writing.

4. TERRITORY: The territory within which General Agent shall have the right to operate under the terms of this Agreement shall be as agreed to by the Company. The Company may directly appoint any other agent in any portion of the territory assigned to General Agent, and General Agent shall have no claim for commissions or other remuneration for or on account of insurance effected by such other agent, unless such commissions or other remuneration is assigned to General Agent. The Company may, at any time, at its option and without liability to General Agent, withdraw from doing business in the state or district in which the assigned territory lies and may withdraw, change or alter any policy issued by it without notice to General Agent. General Agent shall not solicit applications in any territory in which either General Agent or the Company is not properly authorized and licensed to act.

5. AGENTS: General Agent is hereby authorized to recruit and recommend to the Company other agents to procure applications for insurance with the Company. All agreements with such proposed or recommended agents shall be between General Agent and such agents. No agreement shall be effective unless the proposed agent is duly licensed in the state. The Company reserves the right to refuse to appoint any propsed or recommended agent and to terminate the appointment of any agent. General Agent shall be responsible for the faithful performance by agents contracted with him according to the terms of their contracts. Payment of all commissions on account of business produced by such agents shall be made by the Company to General Agent who shall be solely responsible for paying such agents. General Agent agrees that all commissions payable to such agents recruited by or assigned to General Agent shall be paid from General Agent's commissions hereunder and

that payment will be made directly to such agents by General Agent. The Company will furnish General Agent with monthly accounts showing commission payments and charges made to General Agent within such accounting period.

General Agent is hereby authorized to recruit and recommend to the Company other general agents, to be contracted with the Company. The Company reserves the right to refuse to contract with any proposed or recommended general agent or to terminate the contract of such general agent. The Company shall also have the right, with the consent of General Agent, to assign a general agent of the Company to General Agent; any general agent so assigned shall be the same as a general agent recruited and recommended by General Agent. General Agent shall be responsible for the faithful performance by general agents recruited by him or assigned to him of their contractual obligations with the Company. Payment of all commissions to such general agents shall be made by the Company. The Company will furnish General Agent with monthly accounts showing commission payments and charges made to General Agent and his general agents within such accounting period.

6. COMMISSIONS: General Agent shall receive as compensation the applicable commission set forth in the Commission Schedules attached hereto and as may be amended or modified from time to time, payable on premiums, paid to and accepted by the Company. The Company reserves the right to discontinue, amend and/or add any plan of insurance and to establish, amend, or modify the commissions of General Agent. No amendment or modification of Commission Schedule shall become effective until the Company has mailed notification of such amendment or modification to the last known address of General Agent. The effective date of the Commission Schedule shall be specified by the Company and it shall govern all policies applied for from its effective date until superseded. Commissions on replacements or conversions shall be allowed in accordance with Company rules in effect at the time application for such replacement or conversion is made. The Company reserves the right, at any time, to modify or withdraw from sale any policy, rider or provision thereof and to adjust commission rates thereon.

General Agent is authorized to remit the initial mode premium collected by General Agent for certain of the Company's policies net of the applicable commission. For this purpose, General Agent is authorized to endorse and deposit checks payable to the Company. This authority extends only to those policies as specified by the Company in the attached Commission Supplements.

7. VESTED COMMISSIONS: From the effective date of this Agreement, General Agent, his successors, administrators, executors, heirs or assigns shall have the vested right to receive all commissions payable under this Agreement. The vesting of commissions under this Agreement shall in no way limit or otherwise affect the right of the Company to service the business on which such vested commissions are payable. Payment of such commissions to General Agent will cease when all such commissions in any preceding calendar year amount to less than Two Hundred Dollars ($200.00), or if the Agreement has been terminated as provided in the first paragraph of Section 23, whereupon no further commissions shall be payable.

8. LAPSES: General Agent shall exert his best efforts to keep all insurance effected hereunder in full force and effect so as to avoid lapses. If any policy written under this Agreement shall lapse and subsequently be reinstated, General Agent shall not be entitled to commissions on premiums collected on the reinstated policy unless such reinstatement was effected directly through the efforts of General Agent or the original writing agent. Upon reinstatement of a lapsed policy within ninety days following the date of lapse, the commission to be paid or allowed by the Company shall be paid in accordance with the Commission Schedule and shall be only on the amount of premium actually collected by the Company.

9. REBATES: General Agent agrees that he will not directly or indirectly or in any manner whatsoever pay or offer to pay or allow any rebate of General Agent's commissions on any policy issued or proposed to be issued by the Company.

10. DELIVERY OF POLICY: General Agent shall make delivery to applicants or policyowners of all policies mailed to him within thirty (30) days from the date said policies are mailed from the Home Office of the Company. Delivery shall not be completed until all delivery receipts, releases and other documents required by the Company shall have been signed by the applicant or policyowner. Commissions shall not be earned on any policies not delivered within such thirty-day period. General Agent shall return any policy not so delivered to the Company on the day following the expiration of said thirty (30) calendar days. In the event any application is secured contrary to the rules and regulations of the Company, or in the event any policy issued as applied for is not delivered, accepted and paid for by the applicant or policyowner, General Agent shall pay, at the discretion of the Company, any costs of medical examinations, inspections, underwriting and accounting incurred by the Company.

11. RECEIPTS: General Agent shall be authorized to collect only the initial premium. Money received by General Agent for the Company shall be held by him in trust, separate and distinct from other funds and shall be immediately due and payable in full to the Company.

2. ACCOUNT STATED: General Agent hereby agrees that the ledger accounts of the Company shall be competent and sufficient prima facie evidence of the state of accounts between parties hereto; and the failure of General Agent to object in writing to any statement of account or accounts furnished by the Company to General Agent within sixty (60) calendar days from the date such statement of account is furnished shall render such statement a correct account as between General Agent and the Company.

General Agent shall keep full and accurate account of his transactions on behalf of the Company. All documents, vouchers, letters and papers connected with the business of General Agent and the Company shall be open to examination by the Company's authorized representative and shall be delivered to the Company or its authorized representative on demand.

3. ADVERTISING: No circular, advertisement, letterhead or other matter or material, including the name of or referring to the Company or its policies, shall be printed, published or used in any way by General Agent unless it shall have been furnished by the Company or prior written approval has been granted by the Company.

14. REJECTIONS: The Company shall have at all times and without liability, the right to reject, at its discretion, any application for insurance without specifying the reason therefor. Should the Company, for any reason, refund any premium on any policies secured hereunder, General Agent shall repay on demand any commission or other benefit received on that premium and such obligation to repay shall be the full personal obligation of General Agent. The Company shall have the right to offset against any commission or compensation due General Agent hereunder any debts now due or which may become due at any time from General Agent, and these debts shall be a first lien against the compensation or commissions due General Agent under this Agreement, anything contained herein to the contrary notwithstanding. The right to offset as defined herein shall apply to any compensation or commissions due to General Agent in General Agent's capacity as an individual agent of the Company. In the event that General Agent is a corporation, the right to offset shall apply to commissions due to the corporate General Agent, as well as commissions and compensation due to the individual stockholders thereof.

ADVANCES TO GENERAL AGENT AND SECURITY FOR INDEBTEDNESS:

(a) The Company may from time to time lend money to General Agent or otherwise create indebtedness from General Agent to the Company, but the Company shall not be under any obligation to make any loans or advances to General Agent. All indebtedness of General Agent to the Company shall be the full personal obligation of General Agent subject to the rightof offset and shall at all times be secured by a first lien against all monies now or hereafter due General Agent under this Agreement or any supplements thereto. For purposes of this Agreement, "indebtedness" shall include, but not be limited to, all monies advanced or loaned by the Company to or for the benefit of General Agent and all expenses incurred against General Agent's account including any amounts specified in section 16 herein.

(b Any indebtedness of General Agent to the Company may be evidenced simply by accounting entries made by the company, and no promissory note shall be necessary. Any indebtedness may bear interest at the highest rate permissible under the laws of the state of Texas in effect at the time, calculated on the indebtedness of General Agent on the last day of each month, while such indebtedness is due.

(c) The principal and interest on indebtedness of General Agent to the Company, except any policy loans, shall be payable on demand. General Agent agrees to execute and deliver to the Company, when requested, a financing statement in compliance with the Uniform Commercial Code of the state in which General Agent resides or has his principal place of business, and General Agent agrees to execute and deliver to the Company such other instruments as may be reasonably required from time to time by the Company in connection with indebtedness of General Agent. It is expressly understood and agreed that the provisions of this Agreement shall be a sufficient Security Agreement to satisfy the Uniform Commercial Code, and no further Security Agreement shall be required unless requested by the Company. General Agent warrants and represents that no other security agreement or financing statement has been made covering any indebtedness referred to in this Agreement.

(d) The Company shall have a first and prior lien against any and all monies now or hereafter due General Agent under this Agreement and any supplement thereto, and the Company shall have the right to deduct such indebtedness from any and all monies now or hereafter due General Agent under this Agreement and any supplement thereto. The Company reserves the right to apply any payments made by General Agent or any credits due or to become due General Agent in satisfaction in whole or in part of the indebtedness of General Agent to the Company, in such order as may be elected by the Company, provided,
however, General Agent may offset indebtedness of the Company to General Agent which has accrued in favor of General Agent. This offset shall not apply, however, to premium remittances due to the Company. If an extension of time for payment of any obligation of General Agent should be granted by the Company, such extension shall not in any way affect any of the terms, conditions, or provisions of this Agreement or in any manner impair the liability of General Agent to the Company.

(e) General Agent shall be jointly and severally liable with each general agent recruited by or assigned to him by the Company and contracted with the Company for the payment of all monies due and liabilities under such general agent's contract. The Company's books and records shall be prima facie evidence of said accounts and liabilities for which purpose General Agent assigns as collateral to the Company all amounts due or to become due General Agent from each general agent and all notes of each such general agent in favor of General Agent.

BONDING AND LEGAL ACTION: Upon demand by the Company, General Agent agrees to furnish a bond satisfactory to the Company to secure the faithful performance of his duties and the payment of any and all indebtedness which may arise under this Agreement. General Agent has no authority to institute legal proceedings on behalf of or in connection with any business of the Company, unless such actions shall have been approved in advance by the Company in writing. General Agent shall defend any and all of his own acts or alleged acts at his own cost and expense and shall pay or reimburse the Company upon demand any costs or expenses incurred by the Company when it is made a party to any regulatory action, lawsuit or threat of either because of any act of General Agent or of agents of General Agent. However, the Company may, if not satisfied with the manner in which any such defense is conducted, employ counsel to conduct the defense and any expense thus incurred shall be paid or reimbursed by General Agent unless, in the judgement of the Company, he is in no way at fault or responsible for such lawsuit or threat therof, and the Company agrees in writing to bear the expense of such litigation.
General Agent shall indemnify and hold the Company harmless from any and all expenses, costs, causes of action and damage resulting from or growing out of unauthorized, negligent, fraudulent or unfaithful acts or omissions by him, his employees or his agents.

CROSS LIABILITY: General Agent agrees to allow Company the right to use and apply any and all monies now or hereafter due under any or all of the contracts General Agent has entered into with the Company to offset any liabilities and indebtedness that may accrue on any and all of said contracts. This cross liability between contracts shall be effective for any contracts in which General Agent has an interest, whether such contracts be between the Company (including its affiliates and subsidiaries) and the General Agent as (a) an individual, (b) a corporation of which General Agent is an officer, director or major shareholder, (c) a partnership in which General Agent is a partner, or (d) any other entity in which General Agent, as a result of such contract, may have any interest, right or title to any compensation payable by the Company, its affiliates or its subsidiaries.

PLACE OF PERFORMANCE: The place of performance for all monies due the Company by General Agent and for the payment of any monies by the Company to General Agent shall be at the Home Office of the Company, provided, however, that the Company may, at its option, discharge any obligation to General Agent by mailing any monies due General Agent to his last known address, regardless of whether this is in the city in which the Home Office is located. Any suit or litigation between these parties resulting from any transaction arising from, based upon, or in any way connected with this Agreement shall be brought in the county in which the Home Office of the Company is located at the time of suit. All of the terms, provisions and conditions of this Agreement shall be construed according to the laws of the State of Texas.

ASSIGNMENT: General Agent is expressly prohibited from making any sale, transfer, assignment, hypothecation or pledge of any interest whatsoever in this Agreement or any supplements thereto or any funds due or to become due hereunder unless expressly approved by the Company in writing. Any assignment shall be subject to any existing or future indebtedness of General Agent to the Company.

DEATH OR DISABILITY: If General Agent should die or become physically or mentally incapacitated (determination of such physical or mental incapacity to be within the sole discretion of the Company and need not be incapacity in the legal sense) while this Agreement is in effect, the Company shall be authorized to offset any indebtedness of General Agent to the Company against commissions then or thereafter due General Agent, and any indebtedness shall be charged against the estate of General Agent. Any credit balance may be paid to General Agent, if alive, or to the personal representative of the estate of General Agent regardless of whether General Agent may have attempted to make some other dispostion of such credit balance.

PARTNERSHIP GUARANTEE: In the event General Agent under this Agreement is a partnership or limited partnership, it is further understood, agreed and guaranteed by the undersigned individuals, who are partners or limited partners, respectively, that all conditions of this Agreement shall be binding upon them severally and jointly in the same manner as upon the entity named as General Agent. Should the undersigned cease to be partners or limited partners as aforesaid, General Agent shall give written notice to the Company within ten (10) days of such event and shall provide replacement signatories.

22. CORPORATION GUARANTEE: In the event General Agent under this Agreement is a corporation, it is further understood, agreed and guaranteed by the individuals or entities, which are principal stockholders of said corporation which are joining in this Agreement, that all conditions of this Agreement shall be binding on them severally and jointly in the same manner as upon the corporation as a General Agent. Should the undersigned cease to be principal stockholders in the corporation, General Agent shall give written notice to the Company within ten (10) days of such event and shall provide replacement signatories.

23. TERMINATION: In the event General Agent violates Section 13 hereof, or General Agent *violates any laws, rules or regulations of any applicable federal, state or city government, department or bureau having jurisdiction*, or acts in such a manner as to affect adversely the business, good standing or reputation of the Company, or knowingly or systematically, directly or indirectly, induces or endeavors to induce any agent of the Company assigned to another agent to violate his agent agreement or terminate his relationship with such other agent or the Company or to violate any laws, rules or regulations of any applicable federal, state or city government, department or bureau or induces or endeavors to induce any policyholder of the Company to discontinue the payment of any premiums on any policy, the Company shall have the right, at its sole discretion, to declare a complete forfeiture to the Company of any and all compensation due or to become due under this Agreement. "Induce" as used herein, includes but shall not be limited to, the receipt by General Agent, directly or indirectly, of any compensation or financial benefit on account of any agent's violation of his agreement or termination of his relationship with the Company or its agents or from any replacement policy of any policyholder of the Company who has been induced to discontinue the payment of any premiums or otherwise lapse or surrender any policies of the Company. The right of the Company to declare a complete forfeiture of any and all compensation as provided herein shall not be construed to preclude the Company's seeking and obtaining injunctive relief or pursuing any other remedies available to the Company for such breach or threatened breach, including, but not limited to recovery of damages.

In the event General Agent fails to comply with any of the obligations contained herein, this Agreement may be immediately terminated by the Company by written notice to General Agent, such notice of termination to be effective on the date specified therein. Forebearance or neglect on the part of the Company to insist upon the performance of any part of this Agreement or to declare a forfeiture or termination shall not be deemed to constitute a waiver of such rights and privileges.

This Agreement shall terminate automatically upon the death of General Agent, and this Agreement may be terminated without cause at any time by either party by giving to the other party thirty (30) days written notice of termination, which notice shall be delivered either personally or mailed to the last known address of the other party.

Upon termination of this Agreement, General Agent or his legal representative shall immediately deliver to the Company all materials and supplies belonging to the Company and shall immediately pay in cash to the Company all sums then due; if such sums are not paid to Company within 180 days of effective date of termination, the Company shall have the right, at its sole discretion, to declare a complete forfieture to the Company of any and all compensation due or to become due under this Agreement. The right of the Company to declare a complete forfeiture of any and all compensation as provided herein shall not be construed to preclude the Company's pursuing any other remedies available to the Company for collection of the indebtedness of General Agent. If any indebtedness due the Company from General Agent by reason of this Agreement is placed in the hands of an attorney or collection agent for collection, or is collected through a probate court, bankruptcy proceeding, or assignment for the benefit of creditors, then the General Agent agrees to pay an additional sum equal to ten percent (10%) of said indebtedness therewith, as attorney's or collection fees.

NOTICE: Any notice pertinent to this Agreement shall be deemed given if delivered personally or mailed to the parties at their respective addresses as follows:

If to theCompany: Transport Life Insurance Company
714 Main Street
Fort Worth, TX 76102

If to General Agent: (Last address shown in General Agent's file)

FULL AND COMPLETE AGREEMENT: The foregoing, together with all Supplements, Commission Schedules and Amend ments hereto, constitutes the full and complete Agreement between the Company and General Agent, and any and all negotiations, discussions, understandings or agreements heretofore entered into between the Company and General Agent are hereby declared to be superseded by this Agreement; however, subject to section 17 herein, this provision shall not affect any commissions due or to become due, liabilities, liens, existing claims or other rights and obligations of the parties hereto arising out of or connected with any prior contract between the Company and General Agent. It is expressly understood that no change in this Agreement and in the Supplements thereto shall be valid and enforceable, and there is no consideration to support any change, unless such change is made pursuant to authorization contained herein or unless such change is reduced to writing and signed by the Company.

IN WITNESS THEREOF, this Agreement is executed in duplicate this 24TH day of NOVEMBER 19 93, and when approved by Transport Life Insurance Company and the Appointing General Agent, shall be effective for all purposes as of that date.

[redacted]
General Agent (please print)

BY: X _____

Street Address

City, State, Zip

License Number(s

Social Security/Federal I.D. Number

TRANSPORT LIFE INSURANCE COMPANY

BY: _____
Vice President

APPROVED: [redacted]

Appointing Ag

80457 (4/92)

TRANSPORT LIFE INSURANCE COMPANY

COMMISSION SCHEDULE

This supplement to the General Agent Agreement, to which it is attached, heretofore entered into by the parties, shall supplement the terms of said Agreement and any Supplement thereto. In the event of any inconsistency or conflict between this Supplement and the Agreement and any supplements thereto, this Supplement shall control. In all other events, the said Agreement and supplements shall be fully binding.

Commission Schedule

PLAN OR POLICY	FORM NUMBER	AGES	PERCENT OF COMMISSIONABLE PREMIUM FIRST YEAR	RENEWAL
LONG TERM CARE &	LTC 11001	50-59	70	12
HOME HEALTH CARE	HHC 10922	60-64	65	12
	& 10927	65-69	60	12
		70-74	55	12
		75-79	50	12
		80-84	45	12

All rider forms have the same commission rate as the policy to which they are attached unless stated otherwise in the Commission Schedule.

Commissions on upgrades of existing policies to the above policy will be paid on the amount of increase, based on schedule above.

Applications submitted on the above listed plan or policy shall be subject to the Commission Schedule on and after the date shown below. Commissions shown above shall be reduced by any commissions paid to agents assigned to General Agent. This supplement is effective the later of the date shown below or the date of the General Agent Agreement.

Transport Life Insurance Company

80459 LV4 IND-RAD - Effective 2/10/92
TLTLP2893

COMMISSION PURCHASE AGREEMENT

between

ACSIA LONG TERM CARE, INC.,
as Buyer,

and

[redacted]
as Seller

Dated as of June 28, 2013

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3.02(o) Insurance Policies and Commission Rates

This COMMISSION PURCHASE AGREEMENT is entered into this 28 day of June, 2013, by and between ACSIA LONG TERM CARE, INC., a Delaware corporation, as buyer (the "Buyer") and [redacted], as seller (the "Seller").

RECITALS

WHEREAS, in the regular course of the Seller's business, the Seller has acted as an insurance agent in the sale of long-term care insurance policies and receives, and has the right to receive, commissions from insurance companies as a result of such sales; and

WHEREAS, the Buyer desires to purchase, and the Seller desires to sell to Buyer, the Assigned Commission Rights (as hereinafter defined) upon the terms and subject to the conditions set forth herein;

NOW, THEREFORE, in consideration of the foregoing, other good and valuable consideration and the mutual terms and covenants contained herein, the parties hereto agree as follows:

Article I
Certain Definitions

As used in this Agreement, the following terms shall, unless the context otherwise requires, have the following meanings (such meanings to be equally applicable to the singular and plural forms of the terms defined):

"Affiliate" means, with respect to any Person, any other Person that directly or indirectly through one or more intermediaries controls, is controlled by or is under common control with such Person. For purposes of this definition, control of a Person means the power, direct or indirect, to direct or cause the direction of the management and policies of such Person whether by contract or otherwise and, in any event and without limitation of the foregoing, any Person owning twenty-five percent (25%) or more of the voting securities of a second Person shall be deemed to control that second Person.

"Agreement" means this Commission Purchase Agreement, as the same may be amended and supplemented from time to time.

"Assigned Commission Rights" means any and all Commission Rights as to compensation payable on or after the Effective Date in respect of policies issued by the Insurance Company(ies) on or prior to the Effective Date under the following agent producer codes: SHIP01XA6684 and SHIP01YA1381. Assigned Commission Rights shall also include all Commission Rights of Seller or any Affiliate of Seller arising from or relating to (i) any replacement or conversion of any of the policies described above whether such new policy is written by the Insurance Company that issued the original policy or another insurance company and whether issued on or after the Effective Date, and (ii) the exercise of a policyholder option to purchase additional coverage without evidence of insurability.

"Assignment" means, with respect to any of the Assigned Commission Rights, an instrument assigning such Assigned Commission Rights and the other Conveyed Assets related

to such Assigned Commission Rights to Buyer, containing an acknowledgment and consent of the applicable Insurance Company and in form and substance acceptable to Buyer in its sole discretion. The term "Assignment(s)" means, collectively, all such instruments necessary to convey all of the Assigned Commission Rights and Conveyed Assets to Buyer.

"Buyer" shall have the meaning set forth in the introductory paragraph to this Agreement.

"Closing" shall have the meaning set forth in Section 2.02.

"Closing Date" shall have the meaning set forth in Section 2.02.

"Commission Rights" means all right, title and interest of Seller or Seller's Affiliates in or to any commission payments or other compensation for the sale of insurance policies, including but not limited to any right to receive first year, new, renewal, contingent or override commission payments, overage, bonuses or other similar payments.

"Conveyed Assets" shall have the meaning set forth in Section 2.01.

"Effective Date" means July 01, 2013.

"Encumbrance" means any lien (including any tax lien), claim, encumbrance, charge, security interest, mortgage, pledge, easement, option, conditional sale or other title retention agreement, defect in title, covenant or any other restriction of any kind or nature.

"Expenses" means any and all costs, fees and expenses incurred in connection with investigating, defending or asserting any claim, action, suit or proceeding incident to any matter indemnified against hereunder (including, without limitation, court filing fees, court costs, arbitration fees or costs, witness fees, and fees and disbursements of legal counsel, paralegals, investigators, expert witnesses, accountants and other professionals) and shall include those incurred in connection with the enforcement of this Agreement, including without limitation the indemnification provisions of Article VI.

"Governmental Body" means any nation or government, any state or other political subdivision thereof, and any agency, department or other entity exercising executive, legislative, judicial, regulatory or administrative functions of or pertaining to government.

"Indemnification Claim Notice" shall have the meaning set forth in 6.03.

"Indemnified Party" shall have the meaning set forth in Section 6.03.

"Indemnifying Party" shall have the meaning set forth in Section 6.03.

"Insurance Company(ies)" means Senior Health Insurance Company of Pennsylvania.

"Insurance Contract(s)" means, with respect to any of the Assigned Commission Rights, all contracts and agreements between Seller (and Seller's Affiliates) and the applicable Insurance Company which provide for or in any way address or affect such Assigned Commission Rights.

"Insurance Policies" means all long-term care insurance policies the sale or renewal of which gave rise to the Assigned Commission Rights. The term "Insurance Policy" means any of the Insurance Policies, as the usage dictates.

"Legal Proceeding" means any action, suit, arbitration, claim or investigation by or before any Governmental Body, any arbitration or alternative dispute resolution panel, or any other legal, administrative or other proceeding.

"Licenses" means all licenses, permits, certificates of authority, variances, authorizations, approvals, registrations, franchises, orders and similar consents issued by any Governmental Body or other Person.

"Losses" means any and all losses, costs, obligations, liabilities, settlement payments, awards, judgments, fines, damages, expenses, deficiencies or other charges (together with interest and penalties thereon, if any).

"Person" means any individual, corporation, partnership, limited liability company, joint venture, association, joint stock company, trust, unincorporated organization or Governmental Body.

"Purchase Price" shall have the meaning set forth in Section 2.01.

"Requirements of Law" means any laws, statutes, regulations, rules, codes, by-laws, guidelines, directives, standards, policies, orders, decrees or ordinances and other requirements enacted, adopted, issued or promulgated by any Governmental Body.

"Seller" shall have the meaning set forth in the introductory paragraph hereto.

"Solvent" means, with respect to any Person on a particular date, that on such date (a) the fair market value of the property of such Person is greater than the total amount of its liabilities, (b) the present fair salable value of the assets of such Person is not less than the amount that will be required to pay the probable liability of such Person on its debts as they become absolute and matured, (c) such Person neither believes nor reasonably should believe that such Person will incur debts or liabilities beyond its ability to pay as such debts and liabilities mature and (d) such Person is not engaged in business or a transaction, and is not about to engage in business or a transaction, for which its property would constitute an unreasonably small amount of capital.

Article II
Conveyance of Assigned Commission Rights

Section 2.01 Conveyance of Assigned Commission Rights. At the Closing, Buyer shall deliver to Seller Two thousand, two hundred fifty Dollars ($ 2,250.00) (the "Purchase Price") and Seller shall sell, transfer, assign, set over and otherwise convey to Buyer all right, title and interest of Seller in and to the following free and clear of all Encumbrances:

(i) the Assigned Commission Rights;

(ii) all monies received with respect to the Assigned Commission Rights on and after the Effective Date or received as an advance payment of amounts which are due on or after the Effective Date;

(iii) any property held by Seller or Seller's Affiliates that secures the Assigned Commission Rights; and

(iv) the proceeds of any and all of the foregoing (collectively, with the assets listed in clauses (i) through (iii) above, the "Conveyed Assets").

It is the intention of Seller and Buyer that the transfer and assignment of the Conveyed Assets at Closing will constitute a complete and absolute sale of the Conveyed Assets from Seller to Buyer and Seller will retain no interest in the Conveyed Assets after the Closing. Accordingly, the beneficial interest in and title to the Conveyed Assets shall not be part of Seller's estate in the event of the appointment of a receiver or conservator for Seller under any receivership, bankruptcy, insolvency or banking law.

Section 2.02 The Closing. The closing of the sale and purchase of the Conveyed Assets contemplated by this Agreement (the "Closing"), shall occur as soon as practicable after the conditions contained in Article V hereto have been satisfied (the "Closing Date").

Article III
Representations and Warranties

Section 3.01 Representations and Warranties of Buyer. Buyer hereby represents and warrants as follows to Seller as of the date hereof and as of the Closing:

(a) Organization and Good Standing. Buyer is duly organized and validly existing as a corporation in good standing under the laws of the State of Delaware, with the power and authority to own its properties and to conduct its business as such properties are currently owned and such business is currently conducted.

(b) Power and Authority. Buyer has the power and authority to execute, deliver and perform this Agreement and, if Buyer is made a party to the Assignment(s), the Assignment(s) and to carry out their respective terms.

(c) Binding Obligation. This Agreement and, if Buyer is made a party to the Assignment(s), the Assignment(s), when duly executed and delivered by the other parties hereto and thereto, will constitute legal, valid and binding obligations of Buyer, enforceable against Buyer in accordance with their respective terms, except as the enforceability thereof may be limited by bankruptcy, insolvency, reorganization or similar laws now or hereafter in effect relating to or affecting creditors' rights generally and to general principles of equity (whether applied in a proceeding at law or in equity).

Section 3.02 Representations and Warranties of Seller. Seller hereby represents and warrants as follows to Buyer as of the date hereof and as of the Closing:

(a) Organization and Good Standing. Seller is duly authorized to transact business and has obtained all necessary Licenses and approvals, which are in good standing in each jurisdiction in which the character of the business transacted by Seller or any properties owned or leased by Seller requires such authorization. Seller is in compliance in all material respects with the requirements of all applicable laws, regulations and orders or decrees of any court or Governmental Body.

(b) Power and Authority. Seller has the power and authority to make, execute, deliver and perform this Agreement and the Assignment(s) and all of the transactions contemplated under this Agreement and the Assignment(s), and has taken all necessary actions to authorize the execution, delivery and performance of this Agreement and the Assignment(s).

(c) Binding Obligation. This Agreement and the Assignment(s), when duly executed and delivered by the other parties hereto and thereto, will constitute legal, valid and binding obligations of Seller, enforceable against Seller, in accordance with their respective terms, except as the enforceability thereof may be limited by bankruptcy, insolvency, reorganization or similar laws now or hereafter in effect relating to or affecting creditors' rights generally and to general principles of equity (whether applied in a proceeding at law or in equity).

(d) No Violation. None of the execution, delivery and performance by Seller of this Agreement and the Assignment(s), nor the consummation of the transactions contemplated hereby and thereby, will (i) violate any provision of any law, rule or regulation or any order or decree of any court or Governmental Body applicable to Seller; (ii) constitute a breach or default (with or without notice or lapse of time or both) under any mortgage, indenture, contract, agreement or other instrument to which Seller is a party or by which Seller may be bound, or (iii) result in the creation or imposition of any lien or other Encumbrance upon any of Seller's properties pursuant to any such mortgage, indenture, contract, agreement or other instrument (other than this Agreement).

(e) No Proceedings. There are no proceedings, investigations or inquiries pending or threatened against Seller before any court or Governmental Body having jurisdiction over Seller or Seller's properties (i) asserting the invalidity of this Agreement or any Assignment, (ii) seeking to prevent the consummation of any of the transactions contemplated by this Agreement or any Assignment, (iii) seeking any determination or ruling that might adversely affect the performance by Seller of Seller's obligations under, or the validity or enforceability of, this Agreement or any Assignment, or (iv) which could in any way impair Buyer's receipt of the Assigned Commission Rights.

(f) Principal Office. The principal office of Seller is located at:

[redacted]

(g) No Consents. Except for the execution of the Assignment(s) by the Insurance Company(ies), Seller is not required to obtain the consent of any other party or any consent, License, approval, registration, authorization, or declaration of or with any Governmental Body

in connection with the execution, delivery, performance, validity, or enforceability of this Agreement or any Assignment.

(h) Bulk Transfer. The transfer, assignment and conveyance of the Conveyed Assets by Seller pursuant to this Agreement and the Assignment(s) is not subject to the Uniform Commercial Code bulk transfer provisions or any similar statutory provisions in effect in any applicable jurisdiction.

(i) Solvency. Seller is and after giving effect to the transactions contemplated by this Agreement and the Assignment(s) will be, Solvent.

(j) Fairness of Consideration. Seller acknowledges that the payment it will receive under this Agreement for the Assignment(s) constitutes reasonably equivalent value, as such term is used in section 548 of the United States Bankruptcy Code, 11 U.S.C. § 101 et seq. and as such term is used in sections 4 and 5 of the Uniform Fraudulent Transfer Act, in exchange for all of the Assigned Commission Rights and the Conveyed Assets.

(k) Creditors. Seller is not selling the Conveyed Assets to Buyer with any intent to hinder, delay or defraud any of Seller's creditors.

(l) No Default, Violation or Litigation. Seller is not in violation of and has operated Seller's business in compliance with all Requirements of Law, and neither Seller nor any Affiliate has received any notice of claimed noncompliance. There are no (i) Legal Proceedings at law or in equity pending or threatened (1) against or involving Seller or Seller's business, or against or involving any of the Assigned Commission Rights or any of the other assets of Seller, (2) to which Seller, any of the Assigned Commission Rights or any of Seller's other assets may be bound, or (3) challenging the validity or enforceability of any Insurance Contract or any of the terms thereof, or (ii) judgments, consents, decrees, injunctions, or any other judicial or administrative mandates outstanding against Seller.

(m) Operation.

(i) Seller is and has been at all times in compliance with all Requirements of Law regulating the practices of selling insurance products sold by Seller, including but not limited to applicable Requirements of Law regulating advertisements or illustrations, requiring mandatory disclosure of policy information, requiring disclosure of information regarding commissions or other compensation payable to the Seller in connection with the sale of insurance policies, prohibiting the use of unfair methods of competition and deceptive acts or practices and regulating replacement transactions.

(ii) Seller is and has been at all times duly appointed by the appropriate insurance carrier to act as an agent, broker or producer for the insurance carrier with respect to the sale of the Insurance Policies and duly licensed as an insurance agent, broker or producer for the sale of the Insurance Policies in the particular jurisdiction in which Seller wrote, sold or produced such business. At the time that each Insurance Policy was marketed and issued, the agent or producer who marketed such Insurance Policy was duly licensed by the appropriate Governmental Bodies in all states in which the owner of the policy resided and all states in which the coverage was marketed.

(iii) Seller was duly appointed by the appropriate insurance carrier to act as a producer, agent or broker for all business written, sold or produced by the Seller.

(iv) Seller is not involved in any material dispute with any other agent, broker or producer involving the Insurance Policies or the Assigned Commission Rights.

(n) Regulatory Filings. Seller has timely filed, or caused to be timely filed, all reports, statements, documents, registrations, filings or submissions required to be filed by Seller with any Governmental Body in connection with Seller's business. All such registrations, filings and submissions were in compliance with all Requirements of Law when filed or as amended or supplemented, and no deficiencies have been asserted by any such Governmental Body with respect to such registrations, filings or submissions.

(o) Commission Rights. Schedule 3.02(o) contains (i) a true, correct and complete list of all Insurance Policies, and (ii) a policy-by-policy listing of commission rates payable to Seller as a result of such policies. The obligations of each Insurance Company in respect of the Assigned Commission Rights are in full force and effect. None of the Assigned Commission Rights is, or will be, subject to any right of set off, rescission, counterclaim, dispute, adverse claim or defense (other than (1) insurance company rights commonly found in agency agreements permitting rescission or suspension of the payment of commissions, none of which have been asserted by any Insurance Company, or (2) a defense that any commission payment is not owed because the underlying Insurance Policy is no longer in force or any premiums due in respect of such policy have not been paid), whether arising in connection with the underlying Insurance Policy, the Insurance Contract(s) or otherwise. All Assigned Commission Rights are fully and freely transferable and assignable with the consent of the Insurance Company(ies), subject to standard restrictions and conditions imposed by the Insurance Company(ies) and Insurance Contract(s). No Insurance Company or Governmental Body has alleged in any proceeding or otherwise alleged in writing, that any Assigned Commission Rights are illegal or unenforceable. Other than the Assignment(s), no further notice to or consent from any Insurance Company is necessary to effect the acquisition of the Assigned Commission Rights by Buyer.

(p) Insurance Contract(s) and Insurance Policies. Seller has delivered to Buyer a true, correct and complete copy of each Insurance Contract. Each Insurance Contract and each of the underlying Insurance Policies is in full force and effect and constitutes a legal, valid and binding agreement of the respective Insurance Company(ies), underwriters, brokers, agencies or insured parties thereto, enforceable in accordance with its terms. Neither Seller nor any other party to an Insurance Contract, is in violation or breach of or default under such Insurance Contract and no condition exists or event has occurred and is continuing that with notice or lapse of time or both, would be a violation or breach of or default under such Insurance Contract or would impair the vesting of the Assigned Commission Rights. To the knowledge of Seller, there is no existing default under the terms of the underlying Insurance Policies and no condition exists or event has occurred and is continuing that with notice, the lapse of time or both would constitute such a default. The Insurance Contract(s) have not been amended or modified and will not be amended or modified without the prior written consent of Buyer. Seller has not and will not waive or otherwise surrender any rights Seller has under the Insurance Contract(s).

(q) Title. Seller has good and marketable title to the Conveyed Assets free and clear of all Encumbrances. None of the Conveyed Assets has been sold, transferred, assigned or pledged by Seller to any Person. At the Closing, Seller will transfer to Buyer good and marketable title to the Conveyed Assets free and clear of any Encumbrances.

(r) No Advances, Loans or Extensions. Seller has disclosed in writing to Buyer all advances, loans, or extensions of credit by any Insurance Company(ies) to Seller.

Article IV
Covenants

Section 4.01 Seller's Covenants. Seller agrees with Buyer as follows:

(a) Books and Records Marked. Seller shall, at Seller's own expense, indicate in Seller's books and records that the Conveyed Assets have been sold to Buyer pursuant to this Agreement.

(b) Protection of Right, Title and Interest.

(i) Filings. Seller agrees that Buyer may file any financing statements and continuation statements and any other documents covering the right, title and interest of Buyer in and to the Conveyed Assets as Buyer deems necessary, all in such manner and in such places as may be required by law fully to preserve and protect the right, title and interest of Buyer in and to the Conveyed Assets. Seller agrees that Buyer may file such financing statements and continuation statements without Seller's signature. Seller further ratifies and confirms the prior filing by Buyer of any financing statements which identify Seller as assignee, Buyer as debtor/assignor and any or all of the Conveyed Assets as the property subject to assignment or sale. Seller shall cooperate fully with Buyer in connection with the rights set forth above and shall execute any and all documents reasonably required to fulfill the intent of this paragraph.

(ii) Name Change. If Seller makes any change in Seller's name that would make any financing statement or continuation statement filed in accordance with paragraph (b)(i) above seriously misleading within the applicable provisions of the Uniform Commercial Code or any title statute, Seller shall give Buyer written notice thereof at least forty-five (45) days prior to such change.

(c) Other Liens or Interests. Except for the conveyances hereunder and pursuant to the Assignment(s), Seller has not and shall not sell, pledge, assign or transfer to any Person, or grant, create, incur, assume, or suffer to exist any Encumbrance on, or any interest in, to or under the Conveyed Assets, and Seller shall defend the right, title and interest of Buyer in, to and under the Conveyed Assets against all claims of third parties claiming through or under Seller.

(d) Maintenance of Insurance Policies and Insurance Contract(s).

(i) In the event that Seller receives any inquiries or requests from policyholders seeking information or assistance regarding their Insurance Policies, Seller shall refer the policyholders to Buyer, which shall provide such information or assistance.

Seller shall provide Buyer with prompt notices of any inquiry, request, notice or other information received by Seller with respect to the replacement, conversion, cancellation, surrender, lapse or forfeit of any Insurance Policy and shall cooperate with Buyer in taking reasonable measure to maintain the Insurance Policies in force. Neither Seller nor any Affiliate of Seller shall, directly or indirectly, (i) engage in any effort to induce any Person to surrender, convert, replace, lapse or forfeit any Insurance Policy, (ii) encourage any agent or other Person to engage in such efforts or activities, (iii) discuss any such efforts or activities with any agent or other Person, (iv) breach or permit the occurrence of a breach with respect to any agreement with any Insurance Company that could result in the impairment of Buyer's receipt of the payments on account of the Assigned Commission Rights, or (v) otherwise engage in any action or activity that could in any way impair Buyer's receipt of the Conveyed Assets

(ii) Seller shall not amend or modify any Insurance Contract without prior written consent of Buyer. Seller shall not waive or otherwise surrender any rights it has under any Insurance Contract.

(e) Further Assurance. After the Closing, Seller shall take all actions and execute and deliver all documents reasonably requested by Buyer to vest in Buyer all right, title and interest in and to the Conveyed Assets, including execution and delivery of any additional documents required to transfer to Buyer all Assigned Commission Rights arising under any replacement or conversion policies. After the Closing, at Buyer's request, Seller shall obtain from the Insurance Company(ies) and deliver to Buyer at such intervals as Buyer may reasonably require, current listings of the in-force Insurance Policies issued by the Insurance Company(ies), the most recent commission statements relating to the Assigned Commission Rights in respect of such Insurance Company(ies) and such other information regarding such Insurance Policies and Assigned Commission Rights as Buyer may reasonably require. In the event that, after the Closing Date, any Insurance Company fails to pay Buyer any of the compensation attributable to the Assigned Commission Rights on the grounds that Buyer does not hold the Licenses required by a particular state as a condition of the receipt of such compensation, Seller, at Buyer's written request, shall use Seller's best efforts to collect such compensation from the Insurance Company and shall promptly remit the amounts collected to Buyer or its designee and shall take any other actions that Buyer may reasonably request in order to give Buyer the full benefit of its bargain hereunder.

(f) Regulatory Compliance. Seller shall at all times comply with Requirements of Law, including laws, regulations, directives and opinions of Governmental Bodies relating to advertising, licensing and sales practice.

Section 4.02 Consummation of Transactions. Buyer and Seller shall use their commercially reasonable efforts to consummate the transactions contemplated hereby and in the Assignment(s).

Article V
Conditions

Section 5.01 Conditions to Obligation of Buyer. The obligation of Buyer to consummate the transactions contemplated hereby is subject to the satisfaction of the following conditions:

(a) Representations and Warranties True. The representations and warranties of Seller hereunder shall be true and correct in all respects on the Closing Date with the same effect as if then made, and Seller shall have performed in all respects all obligations to be performed by Seller hereunder on or prior to the Closing Date.

(b) Assignment(s). Seller shall have delivered to Buyer each of the Assignment(s) duly executed by Seller, and the applicable Insurance Company(ies) shall have executed and delivered each of the Assignment(s).

Section 5.02 Conditions to Obligations of Seller. The obligations of Seller to consummate the transactions contemplated hereby and by the Assignment(s) are subject to the satisfaction of the following conditions:

(a) Representations and Warranties True. The representations and warranties of Buyer hereunder shall be true and correct in all respects on the Closing Date with the same effect as if then made, and Buyer shall have performed all obligations to be performed by it hereunder on or prior to the Closing Date.

(b) Purchase Price. Seller shall receive the Purchase Price.

Article VI
Indemnification

Section 6.01 Indemnification by Seller. Seller shall protect, defend, indemnify and hold Buyer and its assigns and their officers, directors and agents harmless from and against all Losses and Expenses of every kind and character resulting from or relating to or arising out of (i) the inaccuracy, non-fulfillment or breach of any representation, warranty, covenant or agreement made by Seller in this Agreement or (ii) any set off, counterclaim, defense or contractual exclusion asserted by any Insurance Company(ies) with respect to any payment otherwise due Buyer on the Assigned Commission Rights.

Section 6.02 Indemnification by Buyer. Buyer shall protect, defend, indemnify and hold Seller and Seller's assigns and their officers, directors and agents harmless from and against all Losses and Expenses of every kind and character resulting from or relating to or arising out of the inaccuracy, non-fulfillment or breach of any representation, warranty, covenant or agreement made by Buyer in this Agreement.

Section 6.03 Indemnification Procedures.

(a) Any Person making a claim for indemnification pursuant to this Article VI (an "Indemnified Party") must give the Person from whom indemnification is sought (an

"Indemnifying Party") written notice of such claim describing such claim and the nature and amount of such Losses (to the extent that the nature and amount of such Losses is known at such time) (an "Indemnification Claim Notice") promptly after the Indemnified Party receives any written notice of any action, lawsuit, proceeding, investigation or other claim (a "Proceeding") against or involving the Indemnified Party by a Governmental Body or other third party or otherwise discovers the liability, obligation or facts giving rise to such claim for indemnification; provided that the failure to notify or delay in notifying an Indemnifying Party shall not relieve the Indemnifying Party of such party's obligations to indemnify, except to the extent that (and only to the extent that) such failure shall have caused the damages or expenses for which the Indemnifying Party is obligated to be greater than such damages or expenses would have been had the Indemnified Party given the Indemnifying Party prompt notice hereunder.

(b) With respect to the defense of any Proceeding against or involving an Indemnified Party, at such party's option an Indemnifying Party may assume control of such defense and appoint as lead counsel of such defense any legal counsel selected by the Indemnifying Party, and the Indemnified Party shall use commercially reasonable efforts to cooperate and assist the Indemnifying Party at the Indemnifying Party's expense. An Indemnified Party that is seeking indemnification hereunder shall not enter into any settlement of any claim or Proceeding without first obtaining the prior written consent of the Indemnifying Party (which consent shall not be unreasonably withheld).

(c) The Indemnified Party shall be entitled to participate in the defense of such claim and to employ counsel of such party's choice for such purpose at such party's own expense; provided that, the Indemnifying Party shall pay the reasonable fees and expenses of such separate counsel if there exists a conflict of interest which, under applicable principles of legal ethics, would prohibit a single legal counsel from representing both the Indemnified Party and the Indemnifying Party in such Proceeding. The Indemnified Party may take over the defense of any claim at the expense of the Indemnifying Party if the Indemnifying Party has failed or is failing to vigorously defend such claim.

(d) The Indemnifying Party shall not enter into any settlement of any claim or Proceeding that does not include a complete release of the Indemnified Party from all liability with respect thereto or that imposes any liability or obligation on the Indemnified Party without first obtaining the prior written consent of the Indemnified Party (which consent shall not be unreasonably withheld).

Article VII
Termination

Section 7.01 Termination. This Agreement may be terminated prior to the Closing Date only, and then only by any of the following:

(a) by the written agreement of Buyer and Seller.

(b) at the election of Buyer (i) if any of the conditions set forth in Section 5.01 becomes incapable of fulfillment and is not waived by Buyer; (ii) if, in Buyer's sole discretion, Buyer has a concern that any portion of the compensation relating to the Assigned Commission

Rights will not be paid to Buyer after the Closing; or (iii) if the Closing shall have not occurred within fifteen (15) days of the date of this Agreement (other than as a result of a breach of this Agreement by the party seeking termination).

(c) at the election of Seller (i) if any of the conditions set forth in Section 5.02 becomes incapable of fulfillment and is not waived by Seller; or (ii) if the Closing shall have not occurred within fifteen (15) days of the date of this Agreement (other than as a result of a breach of this Agreement by the party seeking termination).

Section 7.02 Liabilities After Termination. Upon termination of this Agreement pursuant to Section 7.01, no party hereto shall thereafter have any further liability or obligation hereunder; provided, however, that such termination shall not relieve any party of (a) any liability arising pursuant to Section 8.01 hereof, (b) for any breach of this Agreement prior to the date of such termination or (c) for fraud.

Article VIII
Miscellaneous Provisions

Section 8.01 Confidentiality. Seller shall not disclose the terms of this Agreement or the Assignment(s); provided, however, that the foregoing shall not preclude communications or disclosures necessary to implement the provisions of this Agreement or to comply with applicable law or the rules or regulations of a national or foreign stock exchange or self-regulatory organization.

Section 8.02 Amendment. This Agreement may be amended at any time and from time to time only by a written amendment duly executed and delivered by Seller and Buyer.

Section 8.03 Waivers. No failure or delay on the part of any party in exercising any power, right or remedy under this Agreement shall operate as a waiver thereof, nor shall any single or partial exercise of any such power, right or remedy preclude any other or further exercise thereof or the exercise of any other power, right or remedy.

Section 8.04 Notices. All demands, notices and communications under this Agreement shall be in writing, personally delivered, faxed and (if faxed) followed by first class mail, or mailed by certified mail, return receipt requested, and shall be deemed to have been duly given upon receipt (a) in the case of Buyer, to 6201 Presidential Court, Fort Myers, Florida 33919; (b) in the case of Seller to the address set forth in Section 3.02(f) of this Agreement; or, as to each of the foregoing, at such other address as shall be designated by written notice to the other parties.

Section 8.05 Survival. The respective representations, warranties, covenants and obligations by each of the parties hereto set forth in or made pursuant to this Agreement shall remain in full force and effect and will survive the Closing indefinitely, subject to the applicable statute of limitations.

Section 8.06 Successors and Assigns. Buyer may sell, assign or otherwise transfer all or any portion of the Assigned Commission Rights, this Agreement, its rights under this Agreement or the Assignment(s) or any interest in any of the foregoing without the prior consent

of any Seller. Seller shall not assign Seller's rights nor delegate Seller's obligations under this Agreement or the Assignment(s) without Buyer's prior written consent. This Agreement, including the representations, warranties, covenants and indemnities contained in this Agreement, shall inure to the benefit of, be binding upon and be enforceable by and against the parties and their respective successors and permitted assigns.

Section 8.07 Headings and Cross-References. The various headings in this Agreement are included for convenience only and shall not affect the meaning or interpretation of any provision of this Agreement. References in this Agreement to section and article names or numbers are to such Sections and Articles of this Agreement.

Section 8.08 Governing Law. This Agreement shall be interpreted and governed by the laws of the State of Florida without regard to principles of choice of law.

Section 8.09 Counterparts. This Agreement may be executed in counterparts, each of which shall be an original, but all of which together shall constitute one and the same instrument.

Section 8.10 No Third Party Beneficiaries. No provision of this Agreement is intended to confer any rights, benefits, remedies, obligations or liabilities hereunder to any Person other than the parties hereto and their respective permitted successors and assigns.

Section 8.11 Entire Agreement. This Agreement and the Assignment(s), supersede all prior agreements and undertakings, both written and oral, of the parties hereto, with respect to the subject matter hereof and constitute the entire understanding of the parties hereto with respect to the subject matter hereof.

[signatures follow]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date and year first above written.

BUYER:

ACSIA LONG TERM CARE, INC.

By:_____
Name: Richard B. Pitbladdo
Title: President

SELLER:

[redacted]

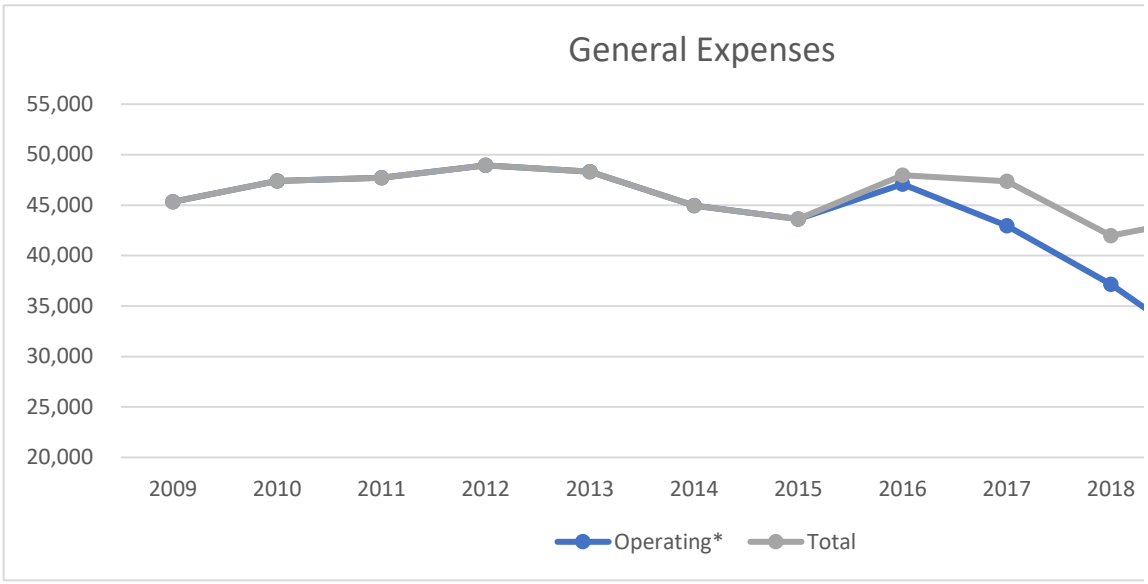
List of Schedules
3.02(o)

Insurance Policies	Rate
EM[redacted]	12%
EM[redacted]	12%
EM[redacted]	12%
EM[redacted]	12%
EM[redacted]	12%
EM[redacted]	12%
EM[redacted]	12%
EM[redacted]	12%
EM[redacted]	2%
EM[redacted]	2%

REHABILITATOR'S PRE-HEARING MEMORANDUM

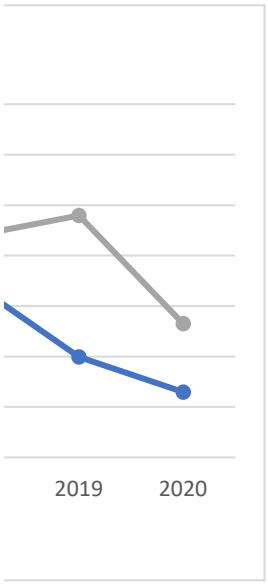
PROPOSED

EXHIBIT 13



	2009	2010	2011	2012	2013	2014	2015
Operating*	45,345	47,401	47,715	48,940	48,311	44,944	43,631
Beechwood Litigation	-	-	-	-	-	-	-
Rehabilitation	-	-	-	-	-	-	-
Total	45,345	47,401	47,715	48,940	48,311	44,944	43,631

* includes taxes, licenses, fees and investment expenses



2016	2017	2018	2019	2020
47,069	42,961	37,141	29,945	26,485
908	4,399	3,926	9,516	(3,354)
-	-	914	4,520	10,128
47,977	47,360	41,981	43,981	33,259

REHABILITATOR'S PRE-HEARING MEMORANDUM
PROPOSED
EXHIBIT 14

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$529	ILLUSTR. # 1	YEAR ISSUED	1988	
MAXIMUM DAILY BENEFIT	$160		AGE WHEN ISSUED	57	
MAXIMUM BENEFIT PERIOD (in years)	2.0		CURRENT AGE	89	
MAXIMUM POLICY VALUE	$116,800		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	PA	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	PA	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$529	$529	$172	$172	NO PREMIUM	$618
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$357	-$357	-$529	+$89
				0.0%	-67.5%	-67.5%	-100.0%	+16.8%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$160	$149	$128	$128	$128	$160
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$116,800	$109,036	$116,800	$116,800	$93,440	$116,800
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$618**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$2,835**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$4,116	ILLUSTR. # 2	YEAR ISSUED	1991	
MAXIMUM DAILY BENEFIT	$133		AGE WHEN ISSUED	60	
MAXIMUM BENEFIT PERIOD (in years)	Unlimited		CURRENT AGE	88	
MAXIMUM POLICY VALUE	Unlimited		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	OK	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$4,116	$4,116	$4,758	$4,758	NO PREMIUM	$7,600
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$642	+$642	-$4,116	+$3,484
				0.0%	+15.6%	+15.6%	-100.0%	+84.6%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	2.2	7.7	7.7	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$133	$106	$106	$106	$106	$133
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	$84,906	$300,000	$300,000	$96,845	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	$0	$0	$0	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$7,197**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$6,039**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. # 3	YEAR ISSUED	1995	
MAXIMUM DAILY BENEFIT	$159		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	2.0		CURRENT AGE	89	
MAXIMUM POLICY VALUE	$290,536		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	GA	
PREMIUM AND CLAIM STATUS	Lifetime waiver	Disabled	STATE OF RESIDENCE	GA	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	$0	$0	$0	$0
				NA	NA	NA	NA	NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$159	$159	$127	$127	$127	$159
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$290,536	$290,536	$290,536	$290,536	$116,215	$290,536
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$867**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,614	ILLUSTR. # 4	YEAR ISSUED	2001	
MAXIMUM DAILY BENEFIT	$244		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	4.0		CURRENT AGE	82	
MAXIMUM POLICY VALUE	$354,774		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	PA	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	FL	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,614	$2,614	$3,520	$3,520	NO PREMIUM	$5,344
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$906	+$906	-$2,614	+$2,730
				0.0%	+34.6%	+34.6%	-100.0%	+104.4%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	2.8	4.2	4.2	2.5	4.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$244	$195	$195	$195	$195	$244
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$354,774	$197,227	$300,000	$300,000	$178,365	$354,774
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$54,774	$0	$0	$0	$0	$54,774

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$5,047**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$14,639**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$6,306	ILLUSTR. # 5	YEAR ISSUED	1995	
MAXIMUM DAILY BENEFIT	$339		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	89	
MAXIMUM POLICY VALUE	$395,961		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	OH	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	OH	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$6,306	$6,306	$8,146	$8,169	NO PREMIUM	$10,727
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$1,840	+$1,863	-$6,306	+$4,421
				0.0%	+29.2%	+29.5%	-100.0%	+70.1%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	0.9	3.0	3.0	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$339	$271	$271	$271	$271	$339
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$395,961	$92,110	$302,598	$304,598	$247,207	$395,961
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$95,961	$0	$2,598	$4,598	$0	$95,961

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$10,259**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$18,830**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,906	ILLUSTR. # 6	YEAR ISSUED	1996	
MAXIMUM DAILY BENEFIT	$307		AGE WHEN ISSUED	62	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	85	
MAXIMUM POLICY VALUE	$365,778		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	PA	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	PA	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,906	$2,906	$2,532	$2,549	NO PREMIUM	$4,972
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$375	-$357	-$2,906	+$2,066
				0.0%	-12.9%	-12.3%	-100.0%	+71.1%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.3	3.2	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$307	$246	$246	$246	$246	$307
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$365,778	$269,063	$300,000	$300,000	$224,220	$365,778
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$65,778	$0	$0	$0	$0	$65,778

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$4,360**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$21,738**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,216	ILLUSTR. # 7	YEAR ISSUED	1997	
MAXIMUM DAILY BENEFIT	$246		AGE WHEN ISSUED	63	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	86	
MAXIMUM POLICY VALUE	$286,584		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	IL	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	IL	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,216	$2,216	$2,814	$2,831	NO PREMIUM	$3,597
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	+$598	+$615	-$2,216	+$1,381
				0.0%	+27.0%	+27.7%	-100.0%	+62.3%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.9	3.9	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$246	$197	$197	$197	$197	$246
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$286,584	$215,251	$286,584	$286,584	$179,376	$286,584
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$3,398**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$13,297**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$2,995	ILLUSTR. # 8	YEAR ISSUED	1997	
MAXIMUM DAILY BENEFIT	$205		AGE WHEN ISSUED	64	
MAXIMUM BENEFIT PERIOD (in years)	5.0		CURRENT AGE	86	
MAXIMUM POLICY VALUE	$432,370		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	OK	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	OK	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$2,995	$2,995	$1,522	$1,526	NO PREMIUM	$2,995
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$1,473	-$1,468	-$2,995	$0
				0.0%	-49.2%	-49.0%	-100.0%	0.0%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	5.0	5.0	4.8	5.0	2.5	5.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$205	$205	$164	$164	$164	$205
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$432,370	$432,370	$300,000	$317,011	$149,483	$432,370
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$132,370	$132,370	$0	$17,011	$0	$132,370

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$2,995**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$4,393**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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CURRENT PREMIUM	NO PREMIUM	ILLUSTR. # 9	YEAR ISSUED	1999	
MAXIMUM DAILY BENEFIT	$60		AGE WHEN ISSUED	67	
MAXIMUM BENEFIT PERIOD (in years)	3.0		CURRENT AGE	88	
MAXIMUM POLICY VALUE	$65,700		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	TX	
PREMIUM AND CLAIM STATUS	Lifetime waiver	Active	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current Your Policy Now	Option 1 Downgrade	Option 2 Basic Policy	Option 2a Enhanced Basic Policy	Option 3 Enhanced RPU	Option 4 Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0 NA	$0 NA	$0 NA	$0 NA	$0 NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.8	3.8	2.5	3.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$60	$60	$48	$48	$48	$60
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$65,700	$65,700	$65,700	$65,700	$43,800	$65,700
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$757**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$6,336	ILLUSTR. #	10	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	$174			AGE WHEN ISSUED	67
MAXIMUM BENEFIT PERIOD (in years)	Unlimited			CURRENT AGE	92
MAXIMUM POLICY VALUE	Unlimited			GUAR ASSN LIMIT[1]	$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	NC
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	NC

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$6,336	$6,336	$2,886	$2,886	NO PREMIUM	$7,695
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$3,450	-$3,450	-$6,336	+$1,359
				0.0%	-54.4%	-54.4%	-100.0%	+21.4%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	5.9	5.9	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$174	$174	$139	$139	$139	$174
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	$300,000	$300,000	$126,801	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	$0	$0	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$6,336**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$9,296**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. # 11	YEAR ISSUED	1991	
MAXIMUM DAILY BENEFIT	$206		AGE WHEN ISSUED	55	
MAXIMUM BENEFIT PERIOD (in years)	Unlimited		CURRENT AGE	84	
MAXIMUM POLICY VALUE	Unlimited		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	5.0%		STATE OF ISSUE	TX	
PREMIUM AND CLAIM STATUS	Claim waiver	Disabled	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current Your Policy Now	Option 1 Downgrade	Option 2 Basic Policy	Option 2a Enhanced Basic Policy	Option 3 Enhanced RPU	Option 4 Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	$864
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	$0	$0	$0	+$864
				NA	NA	NA	NA	NA
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	4.8	5.0	2.5	Unlimited
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$206	$185	$165	$165	$165	$206
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	$300,000	$314,012	$150,238	Unlimited
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	$0	$14,012	$0	Unlimited

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$0**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$14,325**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	$1,198	ILLUSTR. # 12	YEAR ISSUED	1988	
MAXIMUM DAILY BENEFIT	$80		AGE WHEN ISSUED	56	
MAXIMUM BENEFIT PERIOD (in years)	4.0		CURRENT AGE	88	
MAXIMUM POLICY VALUE	$116,800		GUAR ASSN LIMIT[1]	$300,000	
INFLATION PROTECTION	0.0%		STATE OF ISSUE	TX	
PREMIUM AND CLAIM STATUS	Premium paying	Active	STATE OF RESIDENCE	TX	

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators[2,3]

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	**PREMIUM FOR EACH OPTION**	This is the actual premium for your current policy and for each Option available to you.	$1,198	$1,198	$529	$529	NO PREMIUM	$1,198
2	**PREMIUM INCREASE OR DECREASE FOR EACH OPTION**	For each option, this shows the change from your current premium.	N/A	$0	-$669	-$669	-$1,198	$0
				0.0%	-55.8%	-55.8%	-100.0%	0.0%
3	**MAXIMUM BENEFIT PERIOD[4]**	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	4.0	5.0	5.0	2.5	4.0
4	**MAXIMUM DAILY BENEFIT[4]**	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	$80	$80	$64	$64	$64	$80
5	**MAXIMUM POLICY VALUE[5]**	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	$116,800	$116,800	$116,800	$116,800	$58,400	$116,800
6	**INFLATION**	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	**POTENTIAL UNCOVERED BENEFITS**	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	$0	$0	$0	$0	$0	$0

[1] In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **$1,198**

[2] If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **$1,757**

[3] Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

[4] Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

[5] Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 15

THIS IS A REVISED AND MORE DETAILED DESCRIPTION OF THE ISSUE-STATE RATE APPROVAL SECTION OF THE AMENDED REHABILITATION PLAN FOR SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, IN REHABILITATION. IT IS PROVIDED FOR INFORMATION PURPOSES ONLY AND REMAINS SUBJECT TO CHANGE.

ISSUE-STATE RATE APPROVAL

This Section describes the issue-state rate approval alternative for states that object to the Rehabilitator and the Commonwealth Court modifying rates as part of the Plan for SHIP LTC policies issued in those states, and which elect to make their own determinations as to such rate increases themselves (***Opt-out States***).

While this Section was added to the Plan to accommodate that objection, the Rehabilitator makes an important observation. In order to reduce policyholder subsidization and overall burden, and in an effort to achieve the best result possible under the circumstances, the Rehabilitator has undertaken the development of a model that allows her to address each policy individually in a seriatim fashion. Most, if not all, material policyholder calculations under the Plan (including premium rate adjustments) are performed individually for each long-term care policy. As noted more fully below, if a state elects to make its own determination for the rates charged for the policies issued in that state in groups rather than individually, the result may be disadvantageous to many policyholders. In determining whether or not to "opt out" a state should consider carefully its ability to address the circumstances of each policy individually, as does the Rehabilitator. If a state is unable or unwilling to do this, it may want to evaluate whether the results of its premium rate increase decisions may prove to be inferior to those proposed by the Rehabilitator, all things considered.

1. SUMMARY

If the chief insurance regulator ("Commissioner") of an issue-state formally advises the Rehabilitator that his or her state elects to "opt-out" of the rate increase component of the Proposed Rehabilitation Plan, the Plan will not apply in the same way to the policies issued in that state (the ***Opt-out Policies***). In that case, the Rehabilitator will file in the Opt-out State a premium rate increase request for the Opt-out Policies the Current Premiums of which are below If Knew premiums. **Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification.** The holders of the Opt-out Policies with Current Premium below If Knew Premium will not be able to elect from among the Plan options and will instead have the choices described below, determined

by how the Opt-out State responds to the Rehabilitator's premium rate increase request.

THE INTENT OF THIS SECTION IS TO ENABLE STATES THAT OBJECT TO THE REHABILITATOR OR COMMONWEALTH COURT SETTING PREMIUM RATES UNDER THE PLAN WITHOUT THEIR APPROVAL TO REVIEW AND APPROVE (ENTIRELY OR PARTIALLY) OR DISAPPROVE THE PLAN'S PREMIUM RATES THEMSELVES. HOWEVER, THE EFFECTS OF A STATE "OPTING OUT" UNDER THIS SECTION MAY INCLUDE A REDUCED NUMBER OF MEANINGFUL OPTIONS FOR AFFECTED POLICYHOLDERS AND SOME OF THOSE POLICYHOLDERS PAYING HIGHER PREMIUMS THAN THEY WOULD UNDER THE PLAN. IN ADDITION, SOME POLICYHOLDERS WHO DO NOT MAKE AN ELECTION MAY FACE INVOLUNTARY BENEFIT REDUCTIONS.

2. OPT-OUT ELECTIONS

a. Shortly after approval of the Proposed Rehabilitation Plan, the Rehabilitator will provide every state in which SHIP policies in force have been issued the opportunity to opt out of the rate approval provisions of the Plan. Every state that has not by the specified deadline (the ***Opt-out Deadline***) communicated to the Rehabilitator an election to opt out will be deemed to have opted into the Plan and the rest of this Section will not apply to the policies issued in that state. The Rehabilitator will endeavor to provide states at least thirty (30) days to make the Opt-out Election. States may, but are not required to, affirmatively opt into the Plan. States that do not timely communicate an appropriate Opt-out Election to the Rehabilitator will be deemed to have opted into the Plan.

b. The communication necessary to Opt Out (the ***Opt-out Election***) must be signed and sworn by the Commissioner, Director, Superintendent or other senior insurance regulatory official of the state. The communication need not take any particular form but must contain the following statement:

> *On behalf of the State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official I hereby elect to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X]. I have read the Plan and understand the consequences of this election.*

c. The original signed and sworn Opt-out Election must be received by the Rehabilitator at the address specified no later than the Opt-out Deadline, but the Opt-out Election will be effective if an electronic form (including a facsimile) of the Opt-out Election is received by the Rehabilitator on or before the Opt-out Deadline and the original signed and sworn Opt-out Election is received by the Rehabilitator no later than ten

days after the Opt-out Deadline. **It is recommended that states commence the evaluation of whether they want to opt out of the Plan as soon as possible so that they will have ample time to finalize and communicate their decision once the Plan is approved. The Rehabilitator will be pleased to answer any question that may assist a state in evaluating this matter. States are NOT required to take any action under this Section before the Plan is approved.**

d. The Rehabilitator will acknowledge every Opt-out Election in writing. An Opt-out Election sent in advance of the Opt-out Deadline may be canceled by the Opt-out State in a communication sent in the same manner and received by the Rehabilitator no later than the Opt-out Deadline so long as it contains the following language:

> *On behalf of State [or Commonwealth] of [X], and in the exercise of my authority as [X]'s senior insurance regulatory official, having first elected by communication dated [*Opt-out Election date*] to withdraw from the premium rate increase approval provisions of the Rehabilitation Plan for Senior Health Insurance Company of Pennsylvania (SHIP) as to all of the in force long-term care insurance policies currently held by SHIP and first issued by SHIP or its predecessors in [X], I hereby revoke the Opt-out Election and request that all of the SHIP long-term care insurance policies issued in [X] be included in the premium rate increase approval provisions of SHIP's Rehabilitation Plan. I have read the Plan and understand the consequences of this revocation.*

e. Opt-out Elections may only be revoked after the Opt-out Deadline with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.

f. An Opt-out Election will be effective as to all Opt-out Policies the Current Premium of which is below If Knew Premium, even if the Opt-out State determines to approve some (but not all) of the premium rate increases sought by the Rehabilitator from the Opt-out State. A STATE MAY NOT OPT OUT AS TO ONLY SOME OF SHIP'S POLICIES ISSUED IN THAT STATE.

PHASE ONE

3. PREMIUM RATE INCREASE APPLICATION

a. Following approval of the Amended Rehabilitation Plan, and after receipt of a valid Opt-out Election, the Rehabilitator will file in each Opt-out State a request for approval of the full amount of actuarially justified rate increases (on an If Knew Premium basis) for the SHIP LTC policies issued in that state the Current Premium of which is below If Knew Premium. The rate increase application will be submitted

on a seriatim basis (that is, policy-by-policy, not in the aggregate or by policy form), seeking a specific rate increase for each policy. No rate increases will be sought for Opt-out Policies the premiums of which are already equal to or above the If Knew Premium or which are on premium waiver. If an Opt-out State does not respond to the application for rate increases as to any policy within 60 days, the request as to that policy will be deemed denied. If an Opt-out State does not respond to the Rehabilitator's rate increase application within 60 days, the request will be deemed denied in its entirety. An Opt-out State may approve premium rate increases for Opt-out Policies in whatever amount it deems appropriate and the approved percentages may vary among the Opt-out Policies the Current Premium of which is below If Knew Premium. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies the Current Premium of which is below If Knew Premium.

b. If the Opt-out State timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan, it will be deemed to be an ***Opt-in State***, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). If the Opt-out State does not timely approve the full rate increase sought by the Rehabilitator for all Opt-out Policies, all of the policies issued in that state the Current Premium of which is below If Knew Premium will be deemed Opt-out Policies subject to the following provisions.

c. If the Opt-out State responds to the rate increase application in the aggregate or by group (such as policy form) rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. Note that, for some policyholders, the state's approved rate might exceed the requested rate increase.

d. APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM (POLICY-BY-POLICY) COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN.

e. ALSO, APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM COULD RESULT IN SOME POLICYHOLDERS PAYING A LOWER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND RECEIVING BENEFIT DOWNGRADES UNDER THE DEFAULT OPTION (OPTION A).

f. PRELIMINARY MODELING BY THE REHABILITATOR SUGGESTS THAT, IF A STATE WERE TO MAKE A RATE DETERMINATION FOR ALL OF THE LTC POLICIES ISSUED IN THAT STATE (INCLUDING THOSE WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM AS TO WHICH THE

REHABILITATOR DID NOT SEEK A RATE INCREASE) AS A GROUP, AS MANY AS 65% OF POLICYHOLDERS WILL PAY HIGHER PREMIUM RATES THAN THEY WOULD IF THE RATES WERE DETERMINED SERIATIM.

g. IN ADDITION, RATE APPROVAL IN THE AGGREGATE OR BY GROUP, RATHER THAN SERIATIM, MAY RESULT IN A MATERIAL INCREASE IN THE SUBSIDIZATION OF SOME POLICYHOLDERS BY OTHERS.

h. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.

4. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - PREMIUM PAYING POLICIES

a. Holders of Opt-out Policies with Current Premium below the If Knew Premium, will be able to choose from among several options described below. These options are designed to preserve as much choice as reasonably possible while giving effect to the Opt-out State's rate decision and avoiding or minimizing subsidies by other policyholders. Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification.

b. In Phase One of the Plan, the choices for holders of Opt-out Policies with Current Premium below the If Knew Premium, and which are not subject to a premium waiver (*i.e.,* those paying premiums), will be:

OPTION A: Pay the required premium (including approved premium rate increases) and keep the current policy. However, every opt-out policy with premiums below the If Knew level (after implementing the rate increase approved by the Opt-out State) will be downgraded to the benefit level supported (on an If Knew Premium basis) by the premium approved by the Opt-out State. The downgrade will be calculated using a method substantially similar to the Plan downgrade mechanism (see Section III.A.1.c, page 38). The downgrade will be adjusted so that the resulting Maximum Policy Value (MPV) is no lower than the lesser of the policy's current MPV or the applicable guaranty association limits (the "MPV floor"). This will be accomplished by implementing the downgrade and extending the policy's Maximum Benefit Period (MBP) as necessary so that the resulting MPV satisfies that requirement. In the event that the MPV floor applies, Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. Option A will be the default option for Opt-out Policies with Current Premium below If Knew Premium.

NOTE THAT, BECAUSE THIS IS THE DEFAULT OPTION, THE BENEFITS

PROVIDED BY A POLICY FOR WHICH THE RATE APPROVED BY THE OPT-OUT STATE IS BELOW THE IF KNEW PREMIUM RATE WILL AUTOMATICALLY BE DOWNGRADED. POLICYHOLDERS CAN AVOID SUCH DOWNGRADES BY SELECTING OPTION D AND PAYING IF KNEW PREMIUMS.

Opt-out Policies as to which the premiums, taking into account the Opt-out State's decision on the Rehabilitator's rate increase application, are at or above the If Knew Premium will not be downgraded if they select Option A.

OPTION B: In lieu of the approved rate increase, elect a specified benefit downgrade calibrated to the Current Premium (omitting approved premium rate increases) on an If Knew basis. The downgrade will be determined by a calculation substantially similar to the Plan downgrade mechanism and policyholders will not be able to select specific benefit changes. Unlike OPTION A, the downgrade in this case will not be "floored" at the lesser of the current MPV or applicable guaranty association limit. This option allows policyholders to avoid any rate increase.

OPTION C: Select the Opt-out State-required reduced paid-up policy ("RPU") or Non-forfeiture Option ("NFO"). If the state does not require a particular RPU or NFO, policyholders will be offered the RPU or NFO currently specified in their policies. If no RPU or NFO is specified in the policies, policyholders selecting this Option will be provided an NFO used by SHIP before the Plan. In all of these cases, this will be a paid-up policy of moderate benefits for which no premium need ever be paid again. OPT-OUT POLICYHOLDERS WILL NOT BE ABLE TO SELECT THE ENHANCED NFO OFFERED UNDER THE PLAN, WHICH GENERALLY OFFERS A LONGER BENEFIT PERIOD.

OPTION D: Keep the current policy benefits and accept a premium increase to the If Knew Premium for the benefits provided by the policy even though such a rate increase has not been approved by the Opt-out State. This is strictly an elective option that will never apply by default and is intended to provide policyholders the ability to retain the current benefits when they are able and willing to pay the required premium. In other words, this option strives to avoid taking contractual benefits away from policyholders who are willing to pay for them. THIS PROVISION IS INTENDED TO REDUCE POTENTIAL DISADVANTAGES OF OPTING OUT.

5. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - POLICIES ON PREMIUM WAIVER

a. Every Opt-out Policyholder on premium waiver will retain the waiver as long as required by the policy, but if the Current (waived) Premium is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium

(had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged. This is designed to provide substantially no less benefits than what would happen in liquidation while minimizing involuntary subsidies by other policyholders.

b. Once the waiver expires, such policyholders with waived premium below the If Knew level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).

c. In Phase One, Opt-out policyholders on premium waiver will not be subject to rate increases and will not be able to choose any other option.

PHASE TWO

6. IMPLEMENTATION OF PHASE TWO FOR OPT-OUT POLICIES

a. In general, if and when Phase Two of the Plan is implemented for policies issued in Opt-in States, it will also be implemented for Opt-out Policies. The implementation will be similar to that described for Phase One, above but based on Self-sustaining Premiums rather than If Knew Premium. If the Rehabilitator adopts an alternative premium structure for Phase Two it will apply to Opt-out Policies as well. See Section III.E.6, page 25.

b. In Phase Two, the Rehabilitator will file in the Opt-out State a new premium rate increase request for the Opt-out Policies the Current Premiums of which are below Self-sustaining Premiums and which are not on premium waiver. As in Phase One, the Phase Two rate increase application will be filed on a seriatim basis. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies in Phase Two.

c. Because the Opt-out State has already been deemed to have opted out in Phase One, timely approval of the Phase Two requested rate increases in full for all Opt-out Policies will NOT result in the state being treated as if it had not opted out of the Plan. All of the policies issued in that state have been deemed Opt-out Policies in Phase One and remain so in Phase Two.

d. If the Opt-out State responds to the Phase Two rate increase application in the aggregate or by group rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. AS IN PHASE ONE, THIS COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN. That would occur if the state's approval exceeded the requested rate increase for one or more policies.

e. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.

f. Holders of Opt-out Policies with Current Premiums equal to or greater than Self-sustaining Premiums will be unaffected and will retain their current policies without modification. The holders of the Opt-out Policies with Current Premium below Self-sustaining Premiums would not be able to elect from among the Plan options and would instead have the choices described above but based on Self-sustaining Premiums, determined according to how the Opt-out State responds to the Rehabilitator's premium rate increase request.

g. For purposes of calculating the Self-sustaining Premiums of Opt-out Policies in Phase Two, the Rehabilitator will use a separate pool of assets from those used in the calculation of Self-sustaining Premiums for policies in Opt-in States. Assets will be allocated between the two pools in proportion to accumulated premium paid by the then current policyholders of each group of states.

7. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - PREMIUM PAYING POLICIES

a. If and when Phase Two is implemented for policyholders participating in the Plan, the process described above (with the same options) will be repeated for premium-paying Opt-out Policies using Self-sustaining Premiums instead of If Knew Premium. However, policies that would be fully covered by the applicable guaranty association if SHIP were placed in liquidation, are Self-sustaining, or have elected the NFO or RPU would not be affected in this second phase.

b. NOTE THAT THERE CAN BE A MATERIAL DIFFERENCE IN PHASE TWO PREMIUMS BETWEEN POLICIES THAT ARE FULLY COVERED AND THOSE THAT ARE NOT, EVEN IF THEY ARE OTHERWISE SIMILAR AND THEIR MPV DIFFERS BY A SMALL AMOUNT.

8. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - POLICIES ON PREMIUM WAIVER

a. Much as in Phase One, every Opt-out Policyholder on premium waiver will retain the waiver in Phase Two as long as required by the policy. If the waived premium is below the Self-sustaining Premium level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on a Self-sustaining Premium basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at

or above the Self-sustaining Premium level, the MBP will be left unchanged.

b. Once the waiver expires, such policyholders with waived premium below the Self-sustaining Premium level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).

c. As in Phase One, Opt-out Policyholders on premium waiver will not be subject to rate increases in Phase Two and will not be able to choose any other option.

9. Other provisions of the Plan not affected by these provisions would remain as applicable to the Opt-out Policies as to other policies. Additional details of the opt-out provisions will be specified depending on further discussions with other regulators and the Orders of the Court.

10. This approach is designed to defer to the issue-state for rate approval by making its decision the default option. It would reduce or eliminate the requirement that other policyholders subsidize the Opt-out Policies prospectively and provides Opt-out Policyholders benefits at least equal to, and in many cases exceeding, what they would receive in liquidation. It would offer policyholders benefit downgrade options in lieu of the approved rate increases as well as a reduced paid-up policy option. In addition, to reduce the disadvantage of being excluded from the Plan, these policyholders would also be offered the option of retaining the current coverage if they are able and inclined to pay the required premium.

COMPARISON OF OPTIONS FOR OPT-IN AND OPT-OUT POLICYHOLDERS IN PHASE ONE

11. The options available to Opt-out policyholders differ in some respects from those available to Opt-in policyholders.

a. Option One for Opt-in policyholders is the same as Option B for Opt-out policyholders.

b. Opt-in policyholders do not have the equivalent of opt-out Option A - pay the approved rate and be downgraded to what that rate buys on an If Knew basis subject to the GA floor. That is because the "approved rate" for Opt-in policyholders would be the If Knew Premium, which would make Option A the same as Option D. The Opt-in policyholder option most similar to Option A for Opt-in policyholders is Opt-in Option Two, the Basic Policy Endorsement which, like Opt-out Option A, might entail both premium increases and benefit reductions. Note, however, that Option A does not exempt Opt-out policyholders from modifications in Phase Two, while Opt-in policyholders who elect Option Two in Phase One will not face additional rate increases or Benefit Reductions in Phase Two.

c. Opt-out policyholders do not have the equivalent of Opt-in Option Two, the Basic Policy Endorsements (which is the Default Option for premium-paying Opt-in

policyholders) and enhanced Basic Policy Endorsements. The Basic Policy Endorsements consist of specific Policy Modifications intended to provide reasonable benefits and premiums that, if selected in Phase One, will be immune from changes in Phase Two of the Plan. Opt-in policyholders making this election will not face additional modifications in Phase Two of the Plan, except that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.

d. Both Opt-in policyholders and Opt-out policyholders have an NFO option (Option Three for Opt-in policyholders and Option C for Opt-out policyholders); however, it is likely to be "richer" for Opt-in policyholders. For Opt-out policyholders, this is the only option that ensures that they will not face potential premium rate increases or benefit reductions in Phase Two.

e. Both groups have the same If Knew premium option – Option Four for Opt-in policyholders and Option D for Opt out policyholders. Note that Option Four in Phase One for Opt-in policyholders is based on Phase One premium (the greater of the current premium and the If Knew premium) while Option D for Opt-out policyholders is based simply on if knew premium. However, they operate the same way because Opt-out policyholders with premium at or above If Knew premium will have no modifications, rate increases, or options. Thus, both Opt-in and Opt-out policyholders already paying at least If Knew premiums will be exempt from mandatory modifications. Although Opt-in policyholders with current premiums at or above If Knew premiums (and who therefore are not required to elect modifications under the Plan) can voluntarily select other options, Opt-out Policyholders with premiums at or above If Knew Premium will not have that option. They will simply retain their current premium and benefits.

f. For policyholders on premium waiver, the major difference is that Opt-out policyholders will not be required to pay Differential Premium, while Opt-in policyholders will be required to pay a Differential Premium if they elect to keep their current benefits. However, if the waived premium for an Opt-out Policy is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the current premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged.

OLIVER WYMAN

Pennsylvania Insurance Department

SENIOR HEALTH INSURANCE CO. OF PA

Phase I Rehabilitation Plan results as of 6/30/2020

November 24, 2020

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SHIP Rehabilitation

Opt-out state policyholder illustrations **[ILLUSTRATION 1]**

Figures are as of 06/30/2020

OVERVIEW

Policyholders will be subject to different Plan options depending on whether their state of issue formally objects to the Rehabilitator and the Commonwealth Court from modifying premium rates ("opt-out states"). This exhibit compares the Plan options between "opt in" and "opt out" states for an illustrative policyholder.

This illustration assumes that opt-out states approve 50% of the requested If Knew premium rate increase. Two variations of opt-out Option A are presented. The first variation ("aggregate RI by state") assumes that a state approves a single premium rate increase applicable to all policyholders within their state. The second variation ("seriatim RI by state") assumes that a state approves premium rate increases separately for each individual policyholder. This illustration assumes that the state-average If Knew premium rate increase is 54% and that 50% of this premium rate increase is approved by the state, resulting in an average approved premium rate increase of 27% (i.e., 50% of 54%).

FOR THIS ILLUSTRATIVE POLICY

(1) Opt-out Option A yields similar benefits under both the "aggregate RI by state" and "seriatim RI by state" methods. This is driven by the fact that the If Knew premium rate increase for this policyholder (48%) is similar to the state-average If Knew premium rate increase (54%).

Premium-paying Options

Option Name	Current	Downgrade	Basic Policy (Basic)	Basic Policy (Enhanced)	Approved Rate Increase (opt-out states)		Phase I Premium
Option Number		1/B	2	2a	A [aggregate RI by state]	A [seriatim RI by state]	4/D
Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Reimbursement	Reimbursement	Reimbursement
Benefit Period (years)	3.0	3.0	3.8	3.8	3.8	3.8	3.0
Current Maximum Daily Benefit	$265	$244	$212	$212	$226	$221	$265
Elimination Period (days)	0	90	90	90	0	0	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	Yes	Yes	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No	No
Restoration of Benefits Coverage	Yes	No	No	No	No	No	Yes
Return of Premium Coverage	No	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified
Annual Premium	$2,827	$2,827	$2,935	$2,935	$3,591	$3,504	$4,182
Rate increase	N/A	0%	4%	4%	27%	24%	48%
Maximum Policy Value	$290,525	$267,654	$290,525	$290,525	$309,401	$301,915	$290,525

Paid-up Options

Option Name	Current	Enhanced RPU	Standard NFO
Option Number		3	C
Reimbursement Method	Reimbursement	Indemnity	Reimbursement
Benefit Period (years)	3.0	2.5	0.5
Current Maximum Daily Benefit	$265	$212	$265
Elimination Period (days)	0	90	0
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No
Dual Premium Waiver Coverage	No	No	No
Survivorship Premium Waiver Coverage	No	No	No
Restoration of Benefits Coverage	Yes	No	No
Return of Premium Coverage	No	No	No
Benefit Trigger	Non Tax Qualified	Tax Qualified	Tax Qualified
Annual Premium	$2,827	NO PREMIUM	NO PREMIUM
Maximum Policy Value	$290,525	$193,684	$51,016

Legend

	= Current benefits
	= Option offered to policyholders issued in **both opt-in and opt-out states**
	= Option offered to policyholders issued in **opt-in states only**
	= Option offered to policyholders issued in **opt-out states only**

SHIP Rehabilitation
Opt-out state policyholder illustrations **[ILLUSTRATION 2]**
Figures are as of 06/30/2020

OVERVIEW
Policyholders will be subject to different Plan options depending on whether their state of issue formally objects to the Rehabilitator and the Commonwealth Court from modifying premium rates ("opt-out states"). This exhibit compares the Plan options between "opt in" and "opt out" states for an illustrative policyholder.

This illustration assumes that opt-out states approve 50% of the requested If Knew premium rate increase. Two variations of opt-out Option A are presented. The first variation ("aggregate RI by state") assumes that a state approves a single premium rate increase applicable to all policyholders within their state. The second variation ("seriatim RI by state") assumes that a state approves premium rate increases separately for each individual policyholder. This illustration assumes that the state-average If Knew premium rate increase is 54% and that 50% of this premium rate increase is approved by the state, resulting in an average approved premium rate increase of 27% (i.e., 50% of 54%).

FOR THIS ILLUSTRATIVE POLICY
(1) Opt-out Option A yields a lower premium under the "aggregate RI by state" method (relative to the "seriatim RI by state" method). However, the policyholder will experience further benefit downgrades resulting in a lower MDB (by $18) and loss of claim waiver of premium.
(2) The Enhanced RPU may be particularly appealing for this policyholder as the benefits are richer than the Downgrade and this option does not require any premium. Note, this option is only available to opt-in states.

Premium-paying Options

Option Name	Current	Downgrade	Basic Policy (Basic)	Basic Policy (Enhanced)	Approved Rate Increase (opt-out states)		Phase I Premium
Option Number		1/B	2	2a	A [aggregate RI by state]	A [seriatim RI by state]	4/D
Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Reimbursement	Reimbursement	Reimbursement
Benefit Period (years)	4.0	2.4	4.1	4.1	4.1	4.1	4.0
Current Maximum Daily Benefit	$253	$202	$202	$202	$202	$220	$253
Elimination Period (days)	20	90	90	90	90	90	20
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	Yes	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No	No
Restoration of Benefits Coverage	No	No	No	No	No	No	No
Return of Premium Coverage	No	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Annual Premium	$2,040	$2,040	$2,888	$2,888	$2,592	$3,011	$3,981
Rate increase	N/A	0%	42%	42%	27%	48%	95%
Maximum Policy Value	$368,942	$176,284	$300,000	$300,000	$300,005	$326,898	$368,942

Paid-up Options

Option Name	Current	Enhanced RPU	Standard NFO
Option Number		3	C
Reimbursement Method	Reimbursement	Indemnity	Reimbursement
Benefit Period (years)	4.0	2.5	0.6
Current Maximum Daily Benefit	$253	$202	$253
Elimination Period (days)	20	90	20
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No
Dual Premium Waiver Coverage	No	No	No
Survivorship Premium Waiver Coverage	No	No	No
Restoration of Benefits Coverage	No	No	No
Return of Premium Coverage	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified
Annual Premium	$2,040	NO PREMIUM	NO PREMIUM
Maximum Policy Value	$368,942	$184,471	$59,057

Legend

	= Current benefits
	= Option offered to policyholders issued in **both opt-in and opt-out states**
	= Option offered to policyholders issued in **opt-in states only**
	= Option offered to policyholders issued in **opt-out states only**

SHIP Rehabilitation
Opt-out state policyholder illustrations **[ILLUSTRATION 3]**
Figures are as of 06/30/2020

OVERVIEW
Policyholders will be subject to different Plan options depending on whether their state of issue formally objects to the Rehabilitator and the Commonwealth Court from modifying premium rates ("opt-out states"). This exhibit compares the Plan options between "opt in" and "opt out" states for an illustrative policyholder.

This illustration assumes that opt-out states approve 50% of the requested If Knew premium rate increase. Two variations of opt-out Option A are presented. The first variation ("aggregate RI by state") assumes that a state approves a single premium rate increase applicable to all policyholders within their state. The second variation ("seriatim RI by state") assumes that a state approves premium rate increases separately for each individual policyholder. This illustration assumes that the state-average If Knew premium rate increase is 54% and that 50% of this premium rate increase is approved by the state, resulting in an average approved premium rate increase of 27% (i.e., 50% of 54%).

FOR THIS ILLUSTRATIVE POLICY
(1) Opt-out Option A policyholders are worse off under the "aggregate RI by state" method as they are faced with a premium rate increase that is not supported on an If Knew basis at the seriatim-level.
(2) The Basic Policy may be particularly appealing for this policyholder as it provides the same MPV as all other premium-paying Options but at a significantly reduced premium rate. Note, this option is only available to opt-in states.

Premium-paying Options

Option Name	Current	Downgrade	Basic Policy (Basic)	Basic Policy (Enhanced)	Approved Rate Increase (opt-out states)		Phase I Premium
Option Number		1/B	2	2a	A [aggregate RI by state]	A [seriatim RI by state]	4/D
Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Reimbursement	Reimbursement	Reimbursement
Benefit Period (years)	3.0	3.0	3.8	3.8	3.0	3.0	3.0
Current Maximum Daily Benefit	$212	$212	$170	$170	$212	$212	$212
Elimination Period (days)	100	100	100	100	100	100	100
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	Yes	No	No	Yes	Yes	Yes
Dual Premium Waiver Coverage	No	No	No	No	No	No	No
Survivorship Premium Waiver Coverage	No	No	No	No	No	No	No
Restoration of Benefits Coverage	Yes	Yes	No	No	Yes	Yes	Yes
Return of Premium Coverage	No	No	No	No	No	No	No
Benefit Trigger	Non Tax Qualified	Non Tax Qualified	Tax Qualified	Tax Qualified	Non Tax Qualified	Non Tax Qualified	Non Tax Qualified
Annual Premium	$3,059	$3,059	$1,512	$1,512	$3,887	$3,059	$3,059
Rate increase	N/A	0%	-51%	-51%	27%	0%	0%
Maximum Policy Value	$232,458	$232,458	$232,458	$232,458	$232,458	$232,458	$232,458

Paid-up Options

Option Name	Current	Enhanced RPU	Standard NFO
Option Number		3	C
Reimbursement Method	Reimbursement	Indemnity	Reimbursement
Benefit Period (years)	3.0	2.5	0.7
Current Maximum Daily Benefit	$212	$170	$212
Elimination Period (days)	100	100	100
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No
Dual Premium Waiver Coverage	No	No	No
Survivorship Premium Waiver Coverage	No	No	No
Restoration of Benefits Coverage	Yes	No	No
Return of Premium Coverage	No	No	No
Benefit Trigger	Non Tax Qualified	Tax Qualified	Tax Qualified
Annual Premium	$3,059	NO PREMIUM	NO PREMIUM
Maximum Policy Value	$232,458	$154,972	$56,835

Legend

	= Current benefits
	= Option offered to policyholders issued in **both opt-in and opt-out states**
	= Option offered to policyholders issued in **opt-in states only**
	= Option offered to policyholders issued in **opt-out states only**

SHIP Rehabilitation
Opt-out state policyholder illustrations **[ILLUSTRATION 4]**
Figures are as of 06/30/2020

OVERVIEW
Policyholders will be subject to different Plan options depending on whether their state of issue formally objects to the Rehabilitator and the Commonwealth Court from modifying premium rates ("opt-out states"). This exhibit compares the Plan options between "opt in" and "opt out" states for an illustrative policyholder.

This illustration assumes that opt-out states approve 50% of the requested If Knew premium rate increase. Two variations of opt-out Option A are presented. The first variation ("aggregate RI by state") assumes that a state approves a single premium rate increase applicable to all policyholders within their state. The second variation ("seriatim RI by state") assumes that a state approves premium rate increases separately for each individual policyholder. This illustration assumes that the state-average If Knew premium rate increase is 54% and that 50% of this premium rate increase is approved by the state, resulting in an average approved premium rate increase of 27% (i.e., 50% of 54%).

FOR THIS ILLUSTRATIVE POLICY
(1) Opt-out Option A policyholders benefit from the GA MPV floor provision. Although this policyholder is subject to a benefit reduction, the MPV cannot be reduced below the lesser of the GA limit ($300,000 for this policyholder) and the current MPV.
(2) This policyholder benefits from the "aggregate RI by state" method for Option A as the policyholder is subject to a lower approved premium rate without requiring further benefit reductions due to the GA MPV floor.
(3) The Enhanced RPU may be particularly appealing for this policyholder as the benefits are richer than the Downgrade and this option does not require any premium. Note, this option is only available to opt-in states.

Premium-paying Options

Option Name	Current	Downgrade	Basic Policy (Basic)	Basic Policy (Enhanced)	Approved Rate Increase (opt-out states)		Phase I Premium
Option Number		1/B	2	2a	A [aggregate RI by state]	A [seriatim RI by state]	4/D
Reimbursement Method	Reimbursement	Reimbursement	Indemnity	Indemnity	Reimbursement	Reimbursement	Reimbursement
Benefit Period (years)	3.0	1.5	3.8	3.8	3.8	3.8	3.0
Current Maximum Daily Benefit	$241	$193	$193	$193	$193	$193	$241
Elimination Period (days)	100	100	100	100	100	100	100
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No	No	No	No	Yes
Dual Premium Waiver Coverage	Yes	No	No	No	No	No	Yes
Survivorship Premium Waiver Coverage	No	No	No	No	No	No	No
Restoration of Benefits Coverage	No	No	No	No	No	No	No
Return of Premium Coverage	No	No	No	No	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified	Tax Qualified
Annual Premium	$934	$934	$1,740	$1,740	$1,187	$1,469	$2,004
Rate increase	N/A	0%	86%	86%	27%	57%	114%
Maximum Policy Value	$263,523	$103,965	$263,523	$263,523	$263,571	$263,571	$263,523

Paid-up Options

Option Name	Current	Enhanced RPU	Standard NFO
Option Number		3	C
Reimbursement Method	Reimbursement	Indemnity	Reimbursement
Benefit Period (years)	3.0	2.5	0.3
Current Maximum Daily Benefit	$241	$193	$241
Elimination Period (days)	100	100	100
Daily Benefit Annual Inflation	0.0%	0.0%	0.0%
Claim Waiver of Premium Coverage	Yes	No	No
Dual Premium Waiver Coverage	Yes	No	No
Survivorship Premium Waiver Coverage	No	No	No
Restoration of Benefits Coverage	No	No	No
Return of Premium Coverage	No	No	No
Benefit Trigger	Tax Qualified	Tax Qualified	Tax Qualified
Annual Premium	$934	NO PREMIUM	NO PREMIUM
Maximum Policy Value	$263,523	$175,682	$26,309

Legend

	= Current benefits
	= Option offered to policyholders issued in **both opt-in and opt-out states**
	= Option offered to policyholders issued in **opt-in states only**
	= Option offered to policyholders issued in **opt-out states only**

QUALIFICATIONS, ASSUMPTIONS, AND LIMITING CONDITIONS

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REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 17

OLIVER WYMAN

ACTUARIAL ASSUMPTION REPORT SUPPORTING THE REHABILITATION PLAN OF SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

Pennsylvania Insurance Department

January 26, 2021

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Special Deputy Rehabilitator, on behalf of
Pennsylvania Insurance Department

Robert Robinson
Chief Rehabilitation Officer, on behalf of
Pennsylvania Insurance Department

January 26, 2021

Actuarial assumptions supporting the Rehabilitation Plan of Senior Health Insurance Company of Pennsylvania

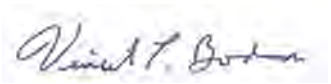
Ms. Slaymaker, Mr. Cantilo and Mr. Robinson:

This report provides the current set of assumptions that we use to perform the actuarial calculations of the Rehabilitation Plan of the Senior Health Insurance Company of Pennsylvania ("SHIP"). We developed them using SHIP's experience data through December 31, 2019 and the approaches and methods described herein.

Section 1 provides background and the scope of our assumption development. Section 2 describes the data we used and our key interpretations of such data. Section 3 provides detail of our approaches and methods and core results. Section 4 specifies the distribution and use of this report. Section 5 defines our reliances and the limitations and restrictions on the usage of this report. Appendix A, which is a Microsoft Excel spreadsheet, contains the complete assumption set.

The report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries. The Oliver Wyman professionals responsible for developing this report are members of the Academy and meet the Qualification Standards of the Academy to render the statements and opinions contained herein.

Sincerely,



Vincent L. Bodnar, ASA, MAAA
Partner and Long-Term Care Practice Leader

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1. BACKGROUND AND SCOPE

The Pennsylvania Insurance Department ("PID") retained Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman", "we", or "us") to provide actuarial services in support of the Rehabilitation Plan ("Plan") of Senior Health Insurance Company of Pennsylvania ("SHIP"). On January 29, 2020, SHIP was placed in rehabilitation by the Commonwealth Court of Pennsylvania. The Pennsylvania Insurance Commissioner, acting in her capacity of Statutory Rehabilitator, submitted an initial draft of the Plan on April 22, 2020, and an amended version of the Plan on October 21, 2020. The Plan is currently subject to comments from interested parties and future amendments.

SHIP's insurance business (the "Block") is entirely comprised of long-term care ("LTC") policies that were primarily issued in the 1990s. SHIP ceased issuing new policies in 2006. The Block consists of 44,673 in-force lives and $53 million of annualized premium as of December 31, 2019.

The Plan requires actuarial calculations that will be used for several purposes, including but not limited to the measurement of SHIP's current liabilities, those that may emerge under various Plan outcome scenarios, and the development of premium rates for the Plan Options that will be offered to policyholders. This report describes the current set of assumptions that we used to perform such calculations and the methods we used to develop them. These assumptions are reflected in all Plan calculations and liabilities as of June 30, 2020.

We developed first-principle assumptions from the Block's experience data over an exposure period of January 1, 2011 through December 31, 2019. All the assumptions presented in this report and its appendices represent our best estimates and contain no margin for potential future adverse deviation. Given the late age and high credibility of the underlying data, we did not see a need to supplement the data with external sources except for early duration lapses and cost of care inflation.

This report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries (the "Academy"). The professionals responsible for developing this report are members of the Academy and meet the Qualification Standards of the Academy to render the opinion contained herein.

This report and the information contained herein are furnished solely for the PID's internal use. They shall not be disclosed in whole or in part to any third party without Oliver Wyman's prior written consent.

The values and conclusions discussed in this report are subject to the reliances and limitations described in Section 5 of this report.

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2. SOURCE DATA, INTERPRETATIONS, AND EXPOSURE

We were provided policy exposure, coverage and claim payment data from SHIP for the purpose of setting actuarial assumptions for Plan calculations. We reviewed the data provided by SHIP for reasonableness and completeness and engaged in several conversations with SHIP's data team to ensure we were appropriately using and interpreting such data. Where necessary, we requested and were provided with supplemental data from SHIP. A complete list of the data files provided by SHIP is specified in Section 2.1.1.

We note that these assumptions were developed based on claims data predating the effects of COVID-19. We will consider the effects of COVID-19 when we update our actuarial assumptions in 2021.

2.1. Data files and data interpretations

The data files received from SHIP along with our interpretations of the data are described in this section.

2.1.1. Data files

We were provided with the following data files from SHIP for the purpose of setting assumptions:

Type of data	File name
Claim payment information	Condensed RFR Feed 12 31 2019v2.txt
Termination study	TermStudy_12_31_2019.txt
Policyholder coverage feed	Condensed Coverage Feed Dec 2019.txt
SHIP 10-year budget projection	10 Year Expenses _ CFT.xlsx
SHIP 5-year claims administration budget projection	Budget 2020-2025.xlsx

Exhibit 2.1: Listing of data files used for assumption setting

2.1.2. Data interpretations

When setting actuarial assumptions for long-term care blocks of business, we often have to make assumptions that relate to the interpretation of claims data. All key claims data interpretations are described in this section and are consistent with typical industry practice.

Claim incurrals

We applied the following approach for the identification of unique claim episodes and their estimated incurral dates:

1. **Identification of unique claims**: we defined a distinct claim to be a series of payments with claim service dates separated by no more than 180 days. If paid services halted and restarted again after 180 days, we treated the payments after the 180-day period as a new and subsequent claim.
2. **Identification of claim incurral dates**: we calculated the claim incurral date for a distinct claim as the first date for which benefits were paid, adjusted by the elimination period associated with the corresponding site of care.

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We applied this approach rather than relying on the incurral dates specified in the claims data provided by SHIP due to irregularities we often observe in long-term care claims data.

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Claim terminations

We applied the following approach to bifurcate claim terminations into disabled life deaths, benefit exhaustions and claim recoveries:

1. **Disabled life deaths**: we defined disabled life deaths to be claim terminations where (1) less than 90% of total available benefits had been paid out by the termination date and (2) the policy lapsed less than 180 days after the last claim payment. This methodology was used as a supplement to claim terminations categorized as disabled deaths in the data provided by SHIP.
2. **Benefit exhaustions**: we defined benefit exhaustions to be claim terminations where (1) more than 90% of total available benefits had been paid out by the termination and (2) the policy lapsed less than 180 days after the last claim payment. This methodology was used as a supplement to claim terminations categorized as benefit exhaustions in the data provided by SHIP.
3. **Claim recoveries**: we defined claim recoveries to be claim terminations occurring more than 180 days before the termination of a policy.

Sites of care

The claims data provided by SHIP includes approximately 60 different claim service descriptions. We allocated claims based on their claim service descriptions into one of the following three distinct categories.

1. Nursing Home Facility ("NHF")
2. Home Health Care ("HHC")
3. Assisted Living Facility ("ALF")

The allocation of claims by claim service description to the above three care setting categories was reviewed by SHIP's data team and deemed appropriate.

Data exclusions

We excluded a small number of claims from the assumption setting process due to irregularities within the claims data. The impact from excluding these claims is de minimis. A summary of the data exclusions is provided below.

Reason for data exclusion	Claim amount ($ millions)	Claim amount (% of total claims)
Claims associated with invalid sites of care	$17.9	0.23%
Claims from policyholders that do not exist in the coverage feed	$3.3	0.04%
Claims from policyholders with no issue date	$1.2	0.02%
Claims from policyholders with zero maximum daily benefit	$0.6	0.01%
Claims that began prior to the policyholder's issue date	$0.1	0.00%
Claims from policyholders with claims totaling less than $500	$3.8	0.05%
Other claims from policyholders with one or more claim exclusions	$0.4	0.01%
Total	**$27.4**	**0.35%**

Exhibit 2.2: Summary of claims data exclusions

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2.2. Source data exposure

This section summarizes the exposure periods that we used for setting actuarial assumptions. We generally used an exposure period of 2011 through 2018 with few exceptions. Exposures prior to 2011 were generally excluded due to data quality considerations.

2.2.1. Incidence

We studied active life exposures and claims for calendar years 2011 through 2018 to develop a claims incidence rate assumption. The following table summarizes the number of life years and claims included in the study period.

	Site of care	
	NHF and ALF	**HHC**
Number of life year exposures included in the study period	505,514	460,109
Number of claims included in the study period	23,146	14,227

Exhibit 2.3: Summary of incidence exposures and claims

2.2.2. Active life mortality

We studied active life exposures and deaths for calendar years 2011 through 2018 to develop an active life mortality assumption during the “ultimate” period (duration six and above). This exposure period was further restricted to lives above attained age 65 and above duration five. The study included 589,201 life year exposures and 31,577 deaths. For earlier durations, we analyzed experience dating back to 1995 to determine the active life mortality assumption during the “select” period (durations one through five).

2.2.3. Lapse

We studied active life exposures and lapses from calendar years 2011 through 2018 to develop a lapse assumption during the “ultimate” period (duration five and above). The study included 410,682 life year exposures and 8,853 lapses. We excluded paid-up policies from our study, starting from the year they became paid-up, whether due to survivorship waiver, nonforfeiture or limited-pay feature. We utilized experience dating back to 1995 in conjunction with industry data to determine the lapse assumption during the “select” period (durations one through four).

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2.2.4. Disabled life mortality

We studied disabled exposures and deaths from disabled policies with incurral years 2001 through 2018 to develop a disabled life mortality assumption. Because mortality rates are different between the initial period (claim months 0 through 24) and ultimate period (claim months 24 and above), we analyzed and set these rates separately. The following table summarizes the number of exposure months and disabled deaths included in the study period.

	Site of care	
	NHF and ALF	**HHC**
Number of exposure months included in the study period	1,708,161	990,585
Number of disabled deaths included in the study period	48,051	24,524

Exhibit 2.4: Summary of disabled life mortality exposures and deaths

2.2.5. Claim recovery

We studied disabled exposures and claim recoveries from calendar years 2011 through 2018 to develop a claim recovery assumption. For the base rates, we analyzed experience within the first year after incurral. Then, we graded the recovery rates to zero by claim month 48 for NHF/ALF claims and claim month 60 for HHC claims. The following table summarizes the number of exposure months and claim recoveries included in the study period.

	Site of care	
	NHF and ALF	**HHC**
Number of exposure months included in the study period	906,629	518,237
Number of claim recoveries included in the study period	13,267	19,180

Exhibit 2.5: Summary of claim recovery exposures and recoveries

2.2.6. Claim utilization

We studied claim payment experience from calendar years 2011 through 2018 and compared it to the maximum allowable benefits available as defined in SHIP's policy form provisions. We determined the maximum allowable benefits based on the site of care associated with the initial claim. The following table summarizes the claims paid and maximum allowable benefits available by site of care and coverage type within the study period.

	Site of care and coverage type			
	NHF only	**NHF and ALF other**	**HHC only**	**HHC other**
Claims paid ($ millions)	$699	$736	$241	$477
Maximum allowable benefits ($ millions)	$751	$795	$367	$603

Exhibit 2.6: Summary of claims paid and maximum allowable benefits

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3. ASSUMPTION DEVELOPMENT

This section describes the methodology we used to analyze SHIP's historical experience data in order to develop actuarial assumptions. We developed actuarial assumptions for incidence, active life mortality, lapse, disabled life mortality, claim recovery, claim utilization, expenses and commissions.

Unless otherwise noted, all historical data provided by SHIP is based on a snapshot as of December 31, 2019.

3.1. Incidence

3.1.1. Study approach

Historical claims data do not always accurately distinguish the classification of NHF and ALF claim incurrals. To remediate this data limitation, we combined morbidity assumptions for these two sites of care.

For policies with HHC coverage, the combined data includes policies with only HHC coverage, policies with comprehensive coverage (that includes NHF, ALF and HHC benefits), or policies with NHF and HHC coverage (which we refer to as "NHH coverage" in this report). We studied HHC only coverages separately from HHC experience from comprehensive policies and policies with NHF and HHC coverage, as they have a different experience profile given that they are the only site of care available. We refer to HHC experience from policies with coverages including other sites of care as "HHC other" to distinguish from HHC experience from policies with only HHC coverage ("HHC only").

We set base assumption curves for NHF/ALF and HHC coverages by fitting a fourth-degree polynomial to experience for attained ages 72 and above using 30-day elimination period experience. Finally, we performed manual smoothing and grading to ensure the base curve is continuous for all ages and does not contain any unintended noise associated with random variance in the experience.

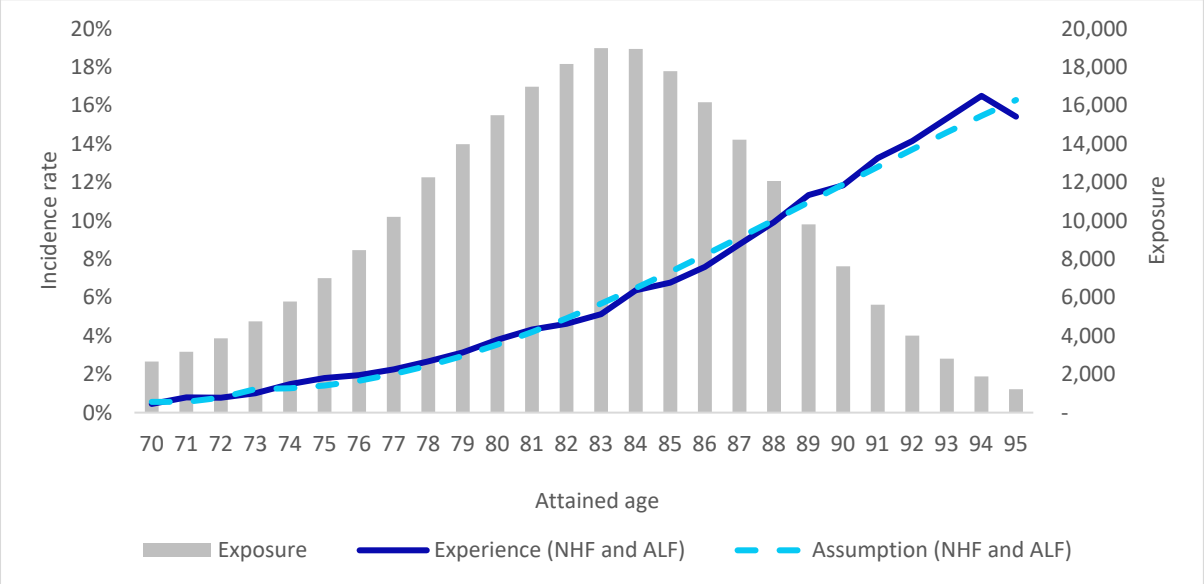


Exhibit 3.1: NHF and ALF incidence base curve

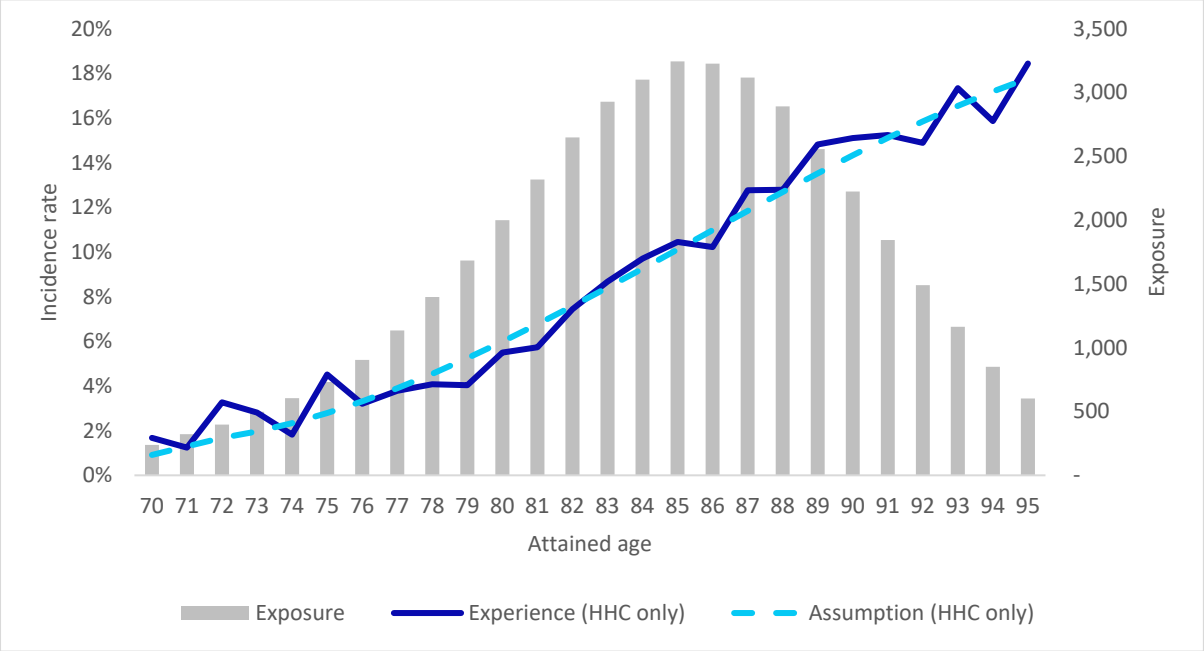


Exhibit 3.2: HHC only incidence base curve

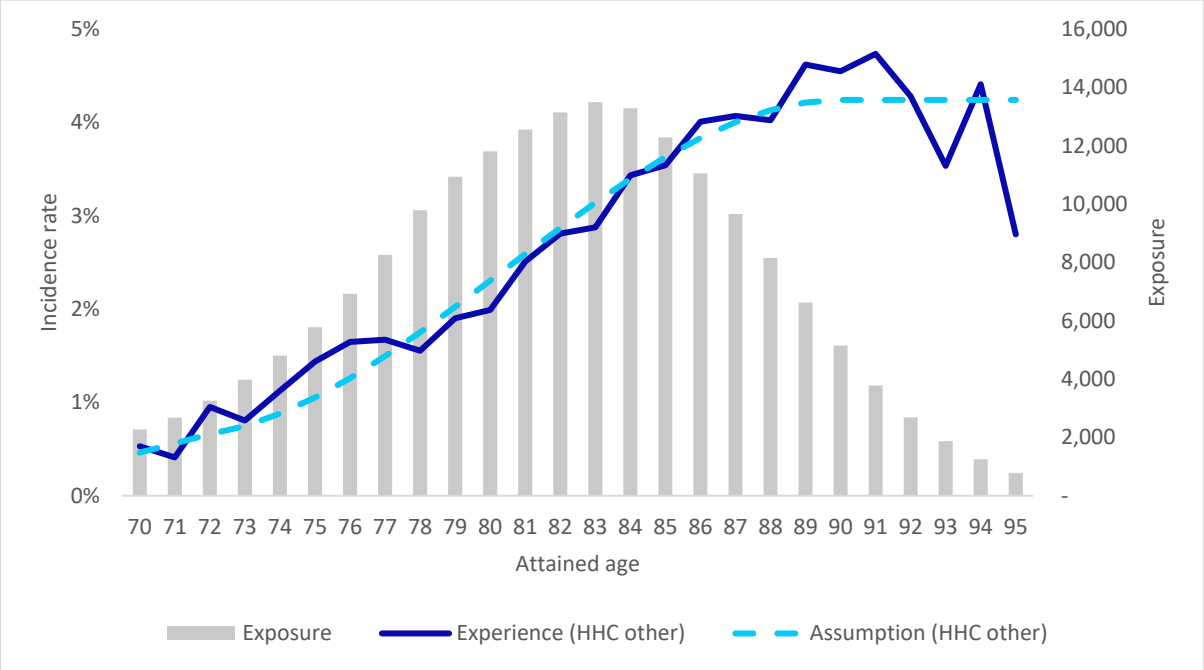


Exhibit 3.3: HHC other incidence base curve

We applied the base incidence curve to the study exposure and then compared it against experience split by all reasonable attributes that could potentially influence incidence through an actuals-to-expected analysis. We determined an adjustment factor for all attributes that exhibited a significant correlation with actual incidence experience. This process was repeated in successive order for all attributes. Ultimately, we applied adjustment factors for gender, elimination period, tax trigger, marital status, benefit period and nonforfeiture ("NFO") status.

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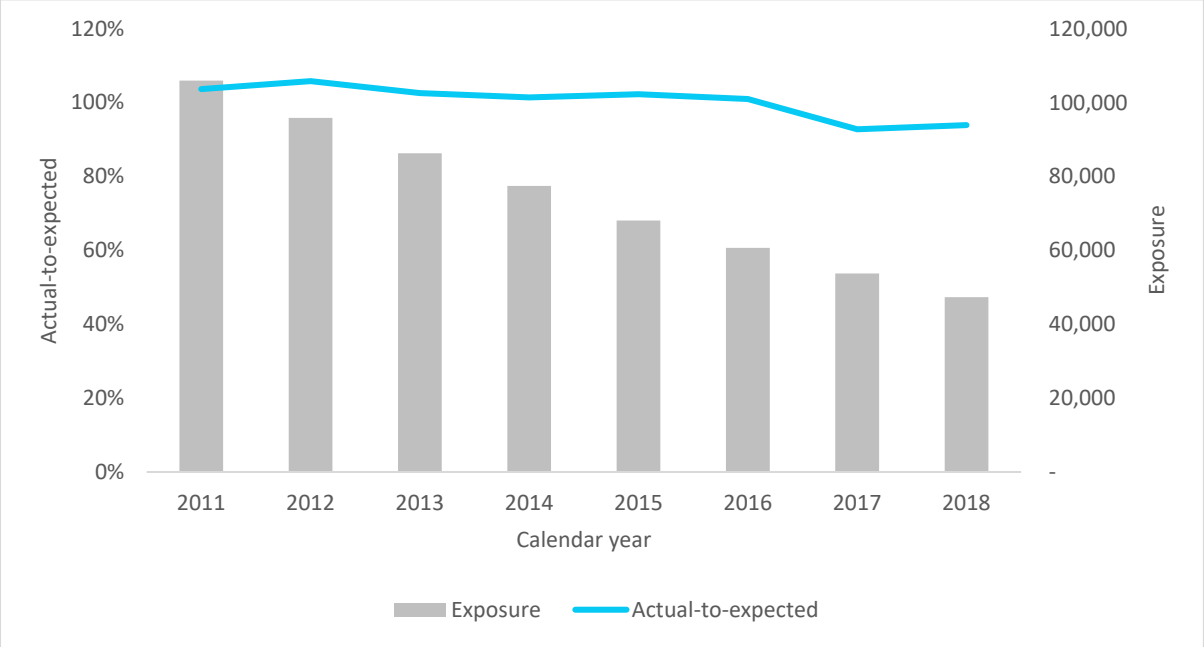


Exhibit 3.4: Aggregate actual-to-expected for incidence assumption

We note the presence of lower than expected new claims incidence in 2017 and 2018. The drivers behind the decrease in incidence rates are under review by Oliver Wyman and SHIP. We will be performing an updated actuarial experience study and assumption setting exercise in 2021, which will take the outcomes from the incidence rate review along with more recent claims experience data into consideration.

3.1.2. Assumption selection

The incidence assumption for each coverage type and site of care varies by gender, elimination period, tax trigger, marital status, benefit period and NFO status. Refer to Appendix A for tabular assumption values.

3.2. Active life mortality

3.2.1. Study approach

We developed the base active life mortality curve using SHIP's historical experience from durations six and above. We fitted attained ages with credible data to a percentage of the 2012 Individual Annuity Mortality table ("2012 IAM") which varies by gender. Finally, we performed manual smoothing and grading to ensure the base curve is continuous for all ages and does not contain any unintended noise associated with random variance in experience.

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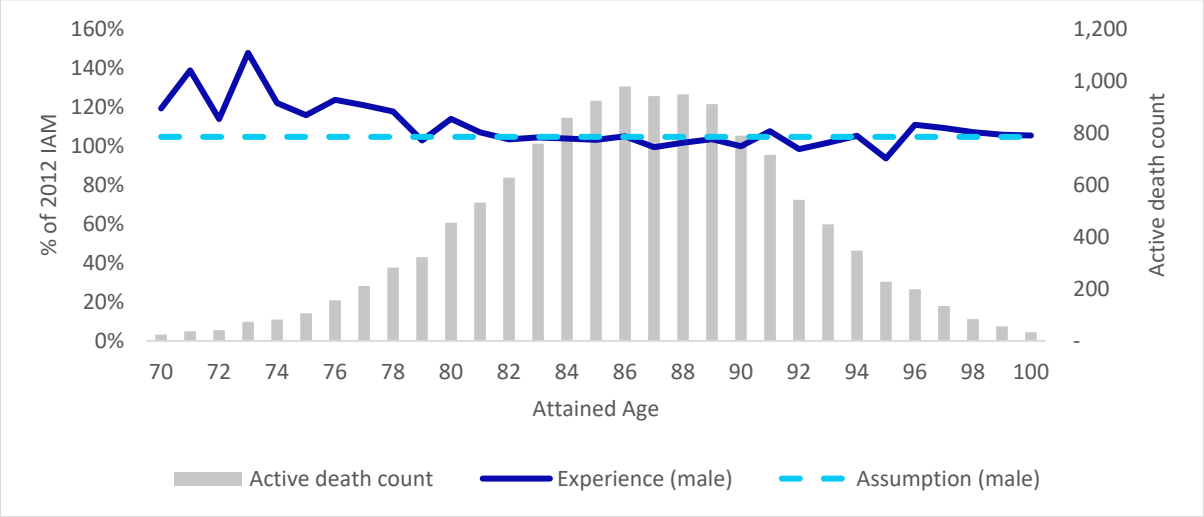


Exhibit 3.5: Active life mortality relative to the 2012 IAM mortality table (males)

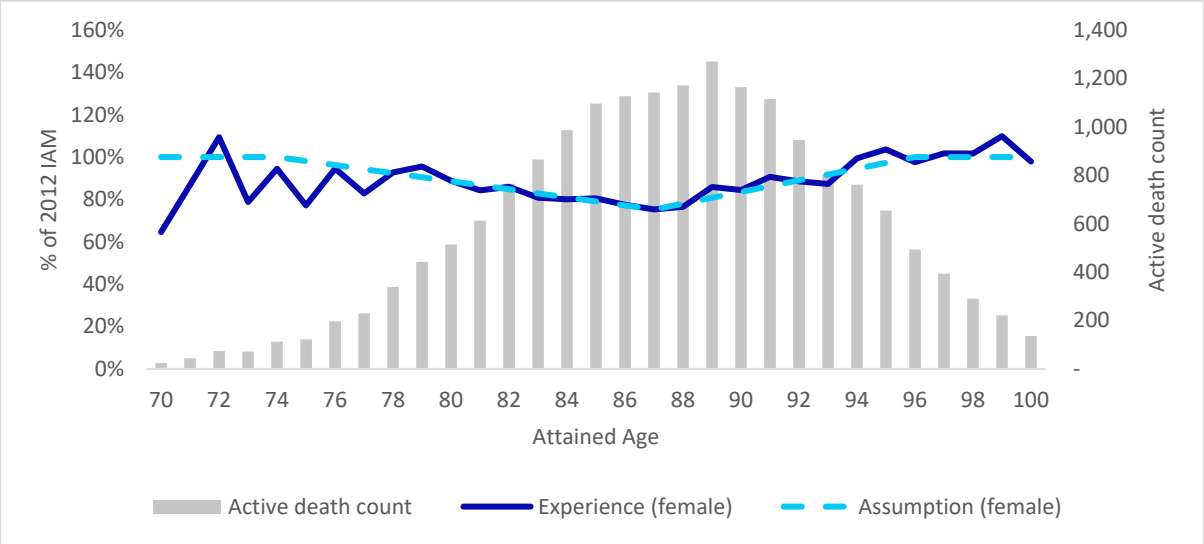


Exhibit 3.6: Active life mortality relative to the 2012 IAM mortality table (females)

We applied the 2012 IAM base mortality curve to the study exposure and then compared it against experience split by all reasonable attributes that could potentially influence mortality rates through an actual-to-expected analysis. We determined an adjustment factor for all attributes that exhibited a significant correlation with actual mortality experience. This process was repeated in successive order for all attributes. Ultimately, we applied adjustment factors to reflect differences in historical mortality experience by duration, company code and a true-up factor for recent experience. When analyzing the early duration impact of underwriting, we used experience data dating back to 1995, where available.

We then analyzed the historical experience by calendar year, which exhibited a small amount of mortality improvement (approximately 1% per annum). This is consistent with the G2 mortality improvement scale, which we applied starting in 2009.

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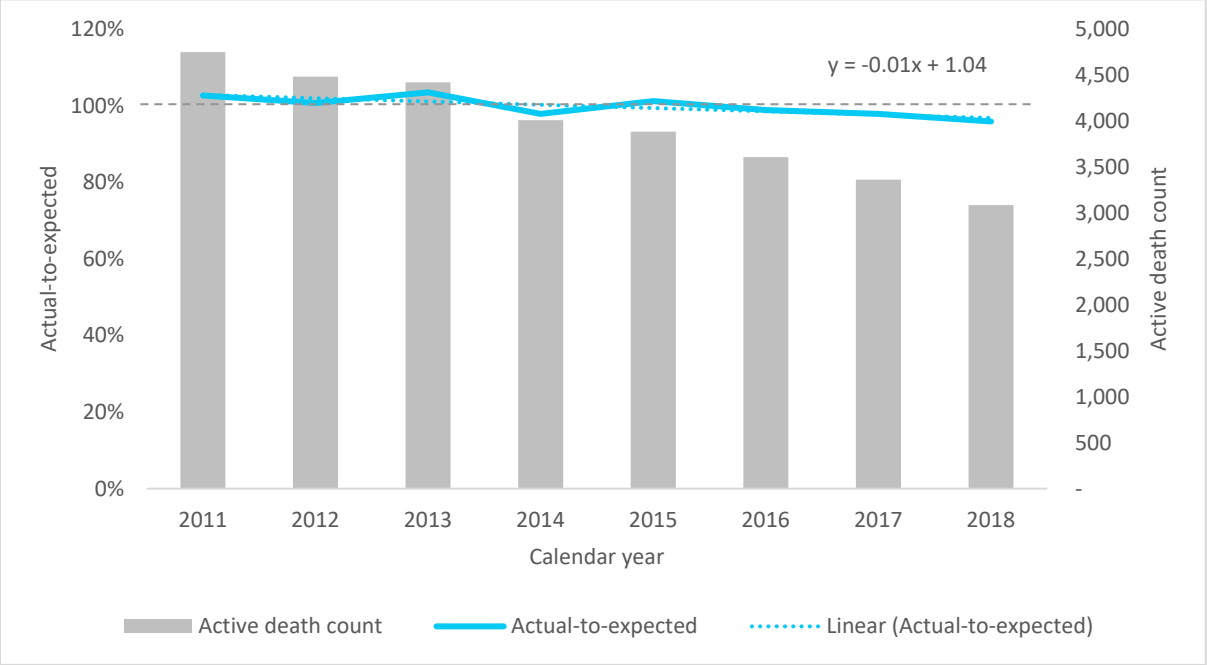


Exhibit 3.7: Aggregate actual-to-expected mortality without recent experience true-up

We then observed lowered mortality experienced in calendar years 2015 through 2018, which we accounted for with a true-up for recent experience.

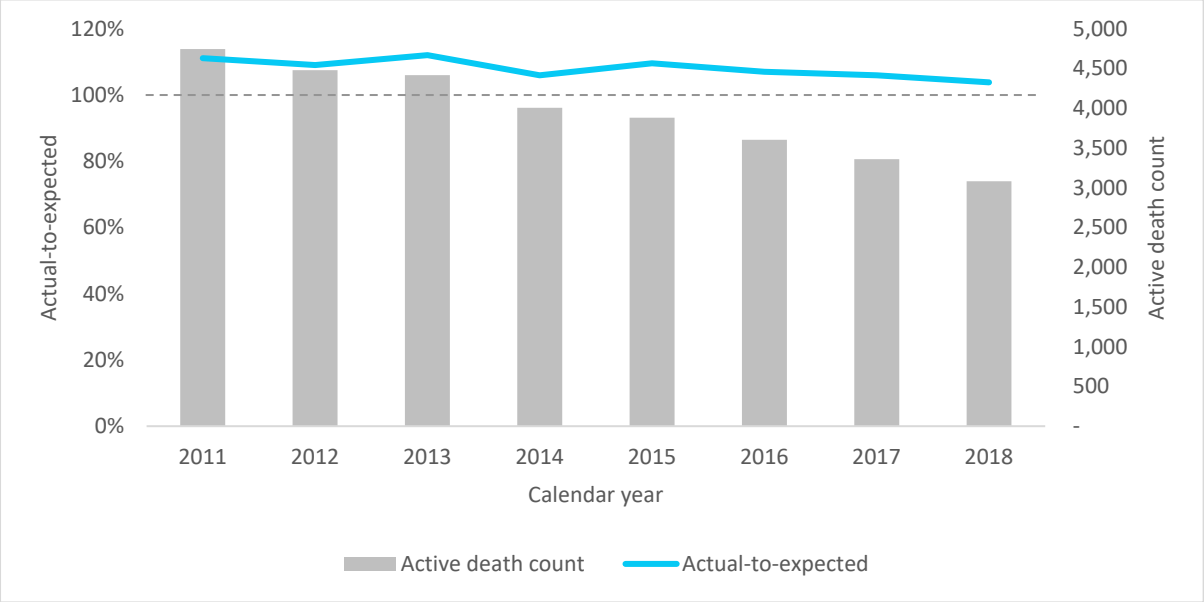


Exhibit 3.8: Aggregate actual-to-expected mortality with recent experience true-up

3.2.2. Assumption selection

The selected active life mortality assumption is based on the 2012 IAM industry mortality table with multiplicative adjustment factors varying by gender, attained age, duration, company code and a true-up factor for recent experience. In addition, we applied the G2 mortality improvement scale starting in 2009. Refer to Appendix A for tabular assumption values.

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3.3. Lapse

3.3.1. Study approach

We developed the base lapse curve based on SHIP's historical experience and industry sources. We developed an ultimate lapse assumption using SHIP's experience starting from duration 11, using experience data from calendar years 2011 through 2018.

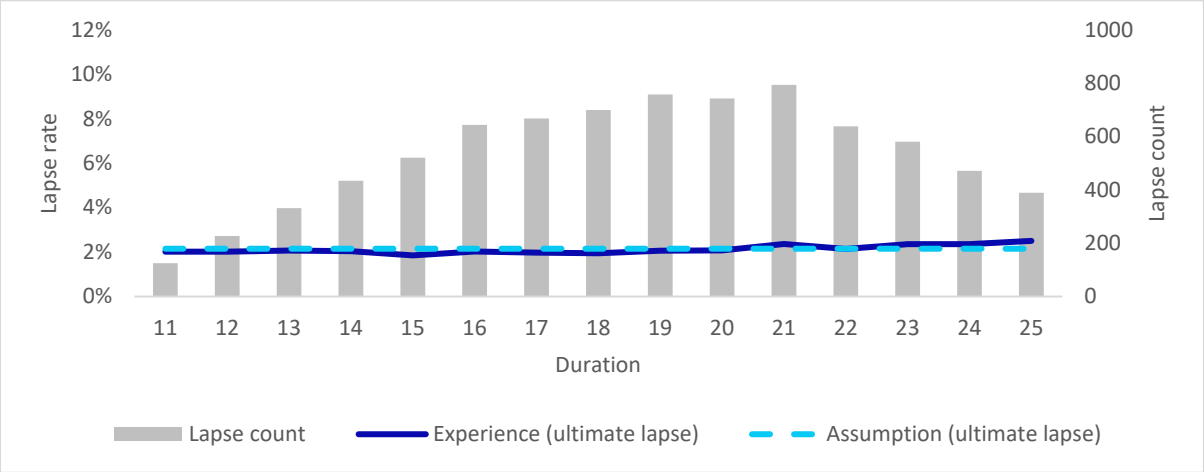


Exhibit 3.9: Ultimate lapse rates (duration 11 and above)

To study early duration lapse, we analyzed experience from calendar years 1995 through 2018. We observed significantly higher than expected lapses in early durations, including an abnormal spike in policy duration two. After review and discussing with SHIP's data team, we concluded that the high implied lapse rates were driven by data irregularities within the admin system. Thus, we instead decided to use industry data to establish an early duration lapse assumption. We developed the shape and level of the early duration base lapse curve based on the "U.S. Long Term Care Insurance Persistency (2008-2011 data)" study jointly published by LIMRA and the Society of Actuaries ("SOA").

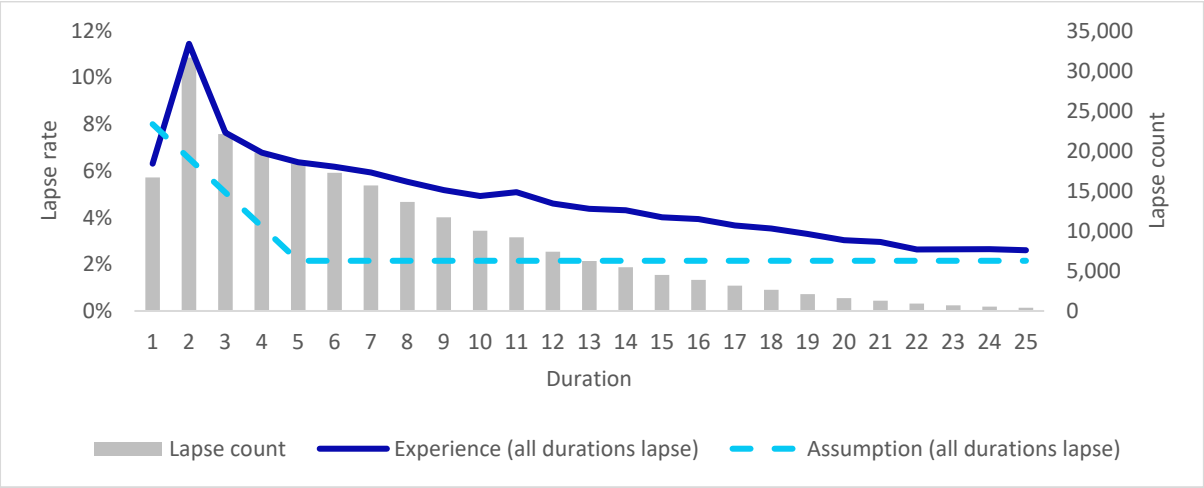


Exhibit 3.10: Lapse rates (all durations)

With the "U.S. Long Term Care Insurance Persistency (2008-2011 data)" study results, we adopted a lapse assumption with a shape consistent with the "SOA/LIMRA 2002-2004 experience" curve below,

beginning at 8% and grading down linearly to an ultimate lapse rate of approximately 2.2% by duration five.

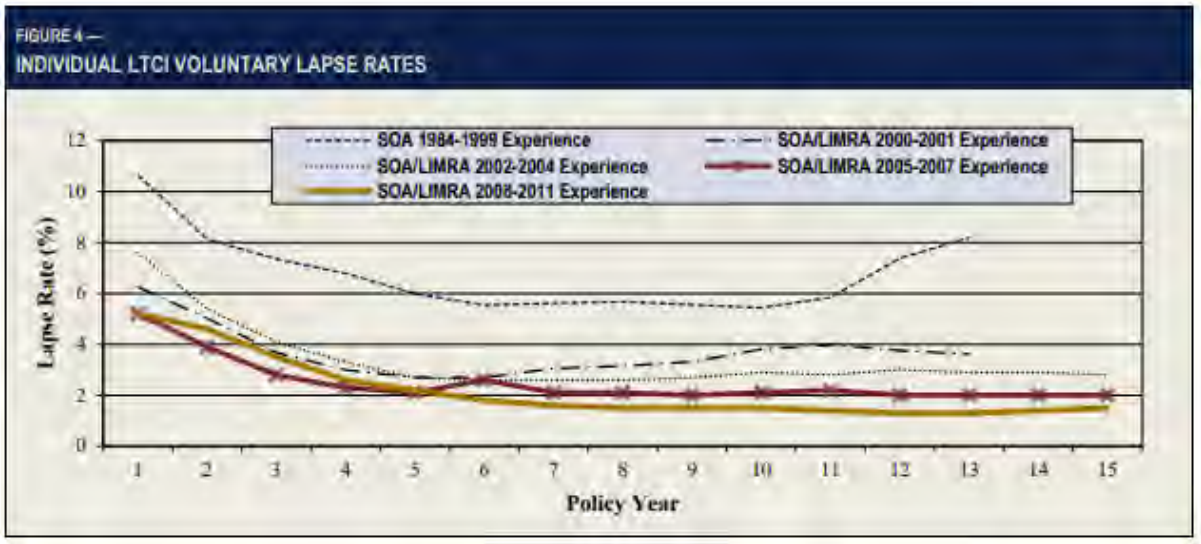


Exhibit 3.11: Individual LTCI voluntary lapse rates from the SOA and LIMRA study

We applied the base lapse curve to the study exposure and then compared it against experience split by all reasonable attributes that could potentially influence lapse rates through an actual-to-expected analysis. We determined an adjustment factor for all attributes that exhibited a significant correlation with actual lapse experience. This process was repeated in successive order for all attributes. Ultimately, we applied adjustment factors to reflect differences in historical lapse experience by company code, benefit period and inflation type. In general, we observed that policies with richer benefits experienced lower lapse rates (e.g., policies with longer benefit periods and higher inflation provisions).

After applying the above adjustment factors, we observed high actual-to-expected lapse rates in late durations. This is a common occurrence within LTC claims data as there is typically no incentive for policyholders' beneficiaries to report a death and instead allow the coverage to lapse. Thus, we did not apply any late duration lapse adjustment factors.

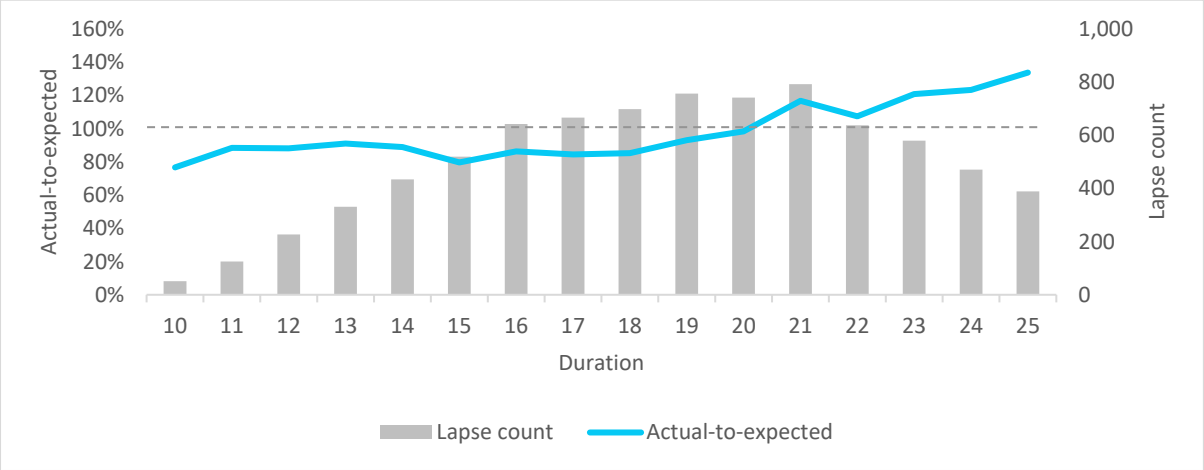


Exhibit 3.12: Aggregate actual-to-expected lapse

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3.3.2. Assumption selection

The selected lapse assumption is based on the 2002-2004 LIMRA/SOA study with multiplicative adjustment factors varying by duration, company code, benefit period and inflation type. In addition, the early duration lapse assumption was based on the "U.S. Long Term Care Insurance Persistency (2008-2011 data)" LIMRA/SOA study. Refer to Appendix A for tabular assumption values.

3.4. Disabled life mortality

3.4.1. Study approach

We set the disabled life mortality assumption in two segments due to material trend differences by claim duration. The first segment (which we refer to as the "initial period" in this report) includes the first 24 months since claim incurral. The second segment (which we refer to as the "ultimate period" in this report) begins on claim incurral month 13. The two segments are graded together by linearly interpolating from the initial period to the ultimate period from incurral months 13 to 24.

In the initial period (first 24 months since incurral), we derived a disabled life mortality assumption using SHIP's experience. For the ultimate period, we fitted actual-to-expected ratios by attained age to the 2012 IAM mortality table with base curves varying by site of care.

Disabled life mortality: initial period

For the initial period, experience exhibited a decreasing trend in the first 24 months since claim incurral. Setting an adjustment factor by claim duration for each site of care allows for recognition of this pattern. The pattern differs by incurral age, so we used decennial age bands to determine base curves for each site of care. We then linearly interpolated the curves to produce rates for each individual incurral age between the decennial age bands. We held rates constant for ages below 74 and above 94, only when credible experience data was lacking.

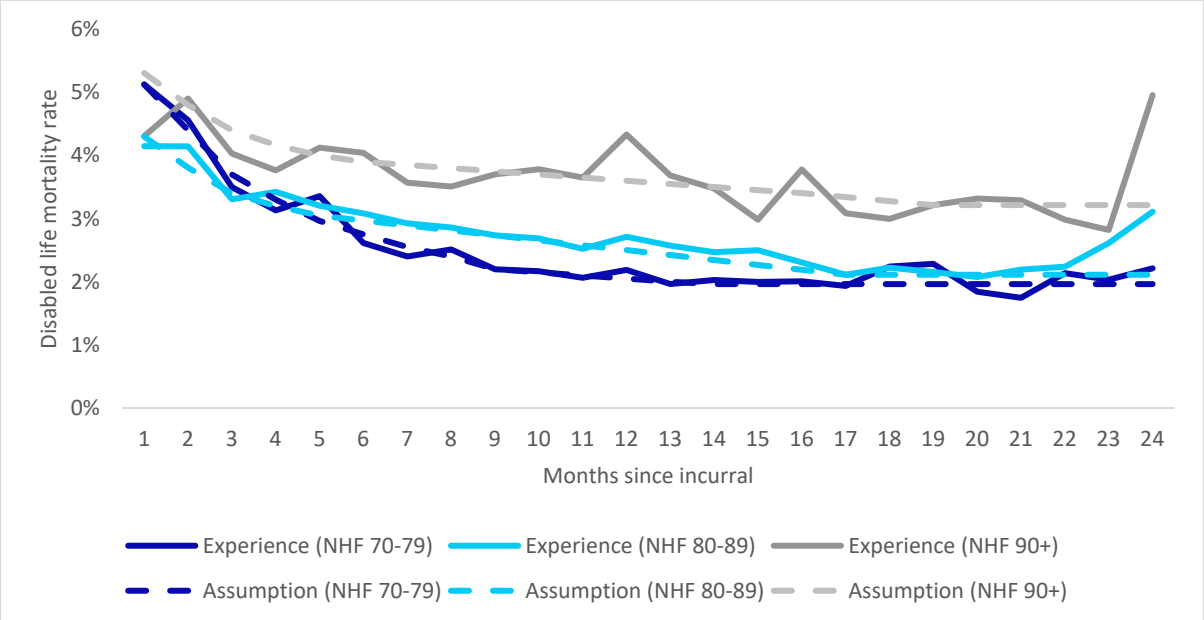


Exhibit 3.13: NHF disabled life mortality base curves (initial period)

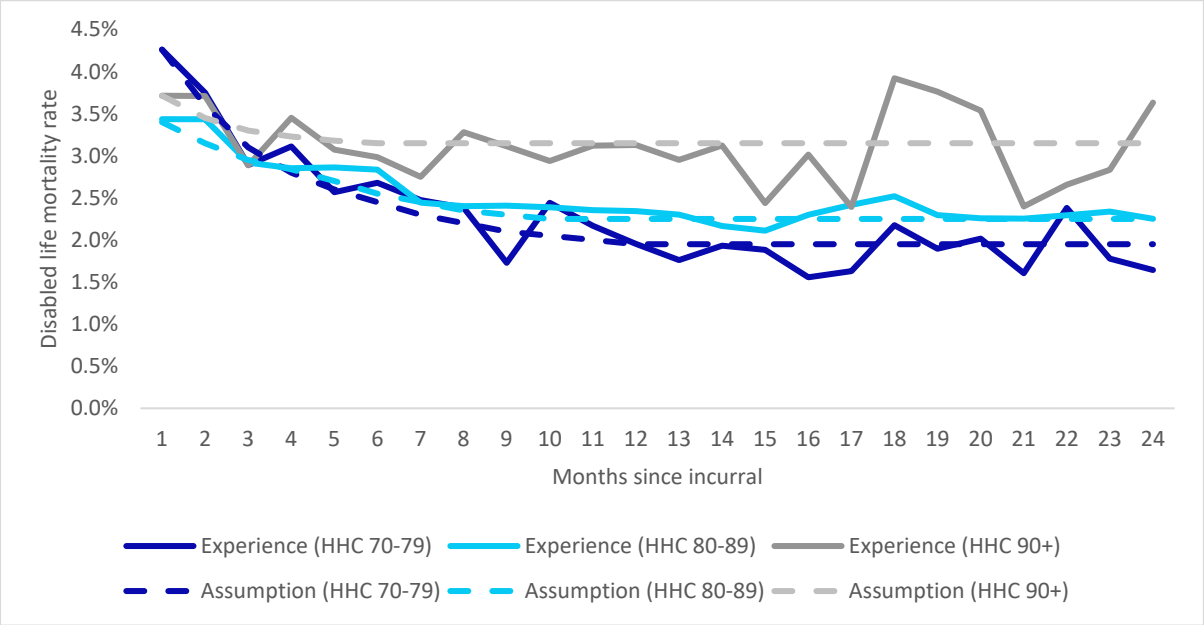


Exhibit 3.14: HHC disabled life mortality base curves (initial period)

We applied the initial period base disabled life mortality curve to the study exposure and then compared it against experience split by all reasonable attributes that could potentially influence disabled life mortality through an actual-to-expected analysis. We determined an adjustment factor for all attributes that exhibited a significant correlation with actual disabled life mortality experience. This process was repeated in successive order for all attributes. Ultimately, we applied adjustment factors to reflect differences in historical disabled life mortality experience by gender, coverage type and benefit period.

After reflecting the above adjustment factors, actual-to-expected experience fit well (nearing 100% A/E) except for NHF claims in incurral month 23 and 24. However, this has a de minimis impact as the grading from the initial period assumption to the ultimate period assumption is completed by incurral month 24.

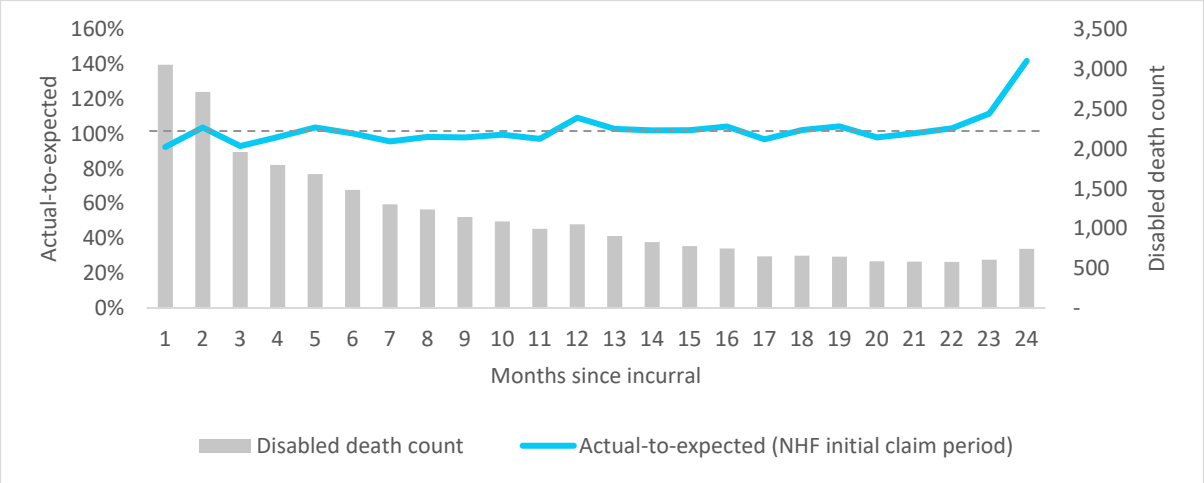


Exhibit 3.15: NHF disabled life mortality actual-to-expected (initial period)

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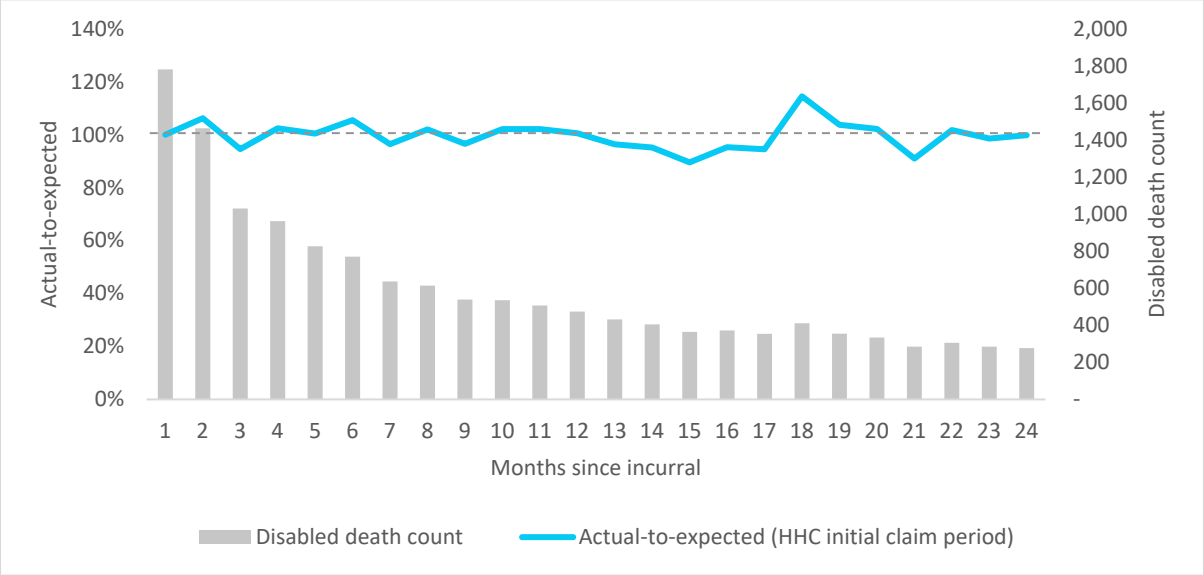


Exhibit 3.16: HHC disabled life mortality actual-to-expected (initial period)

Disabled life mortality: ultimate period

In the ultimate period, the disabled life mortality exhibited a decreasing trend (by attained age) relative to the 2012 IAM mortality table. We applied smoothing for ages below 75 and above 95 due to low credibility.

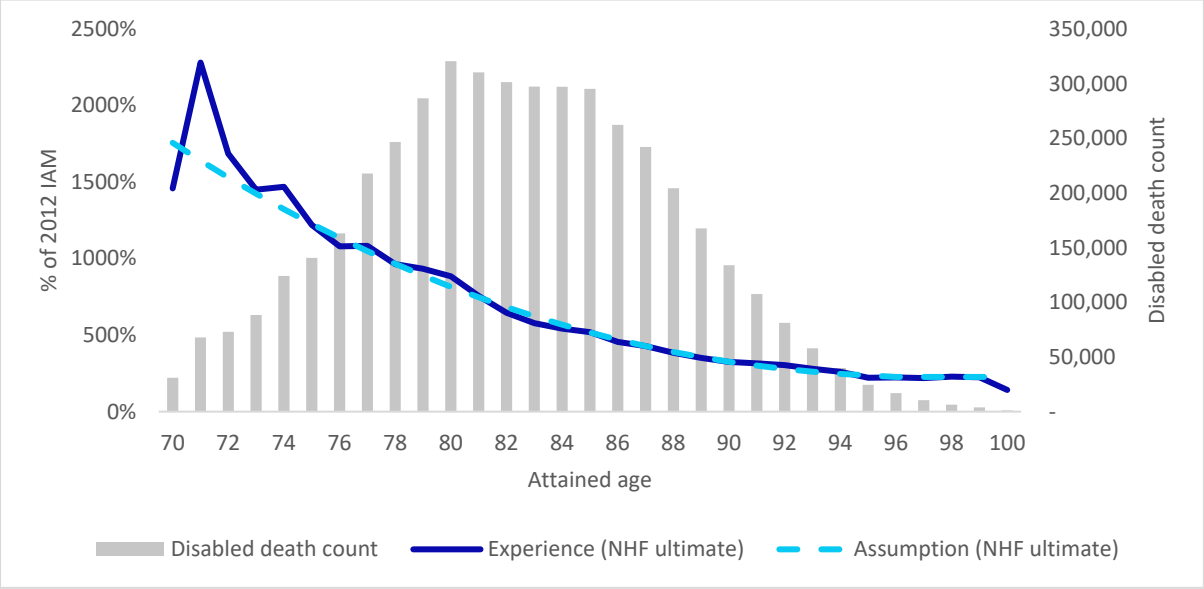


Exhibit 3.17: NHF disabled life mortality base curves (ultimate period)

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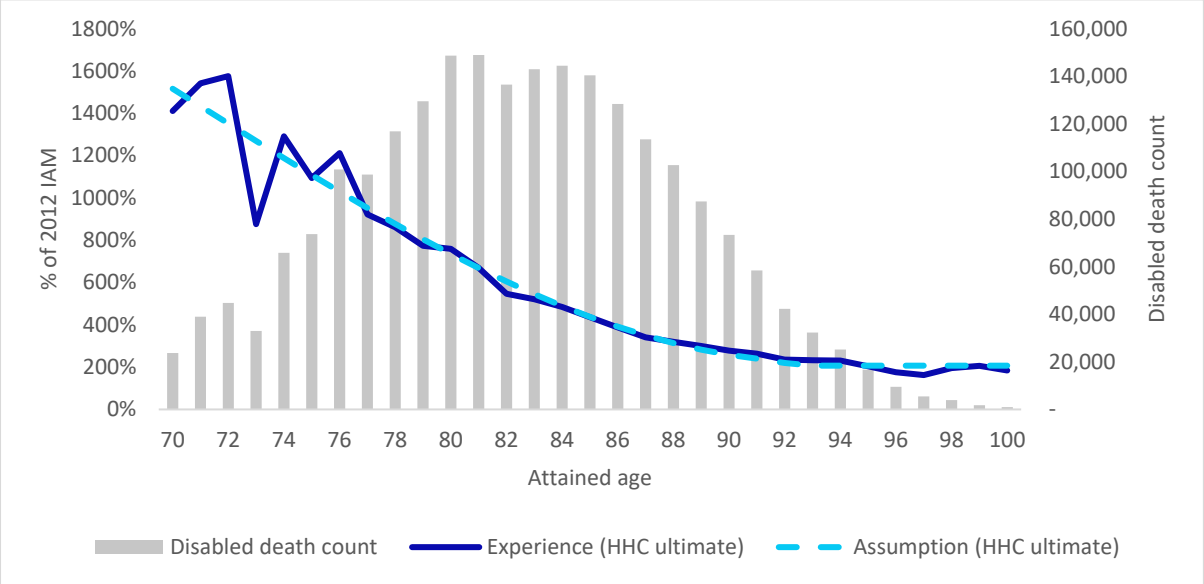


Exhibit 3.18: HHC disabled life mortality base curves (ultimate period)

We applied the ultimate base disabled life mortality curve to the study exposure and then compared it against experience split by all reasonable attributes that could potentially influence disabled life mortality through an actual-to-expected analysis. We determined an adjustment factor for all attributes that exhibited a significant correlation with actual disabled life mortality experience. This process was repeated in successive order for all attributes. Ultimately, we applied adjustment factors to reflect differences in historical disabled life mortality experience by gender, coverage type and benefit period.

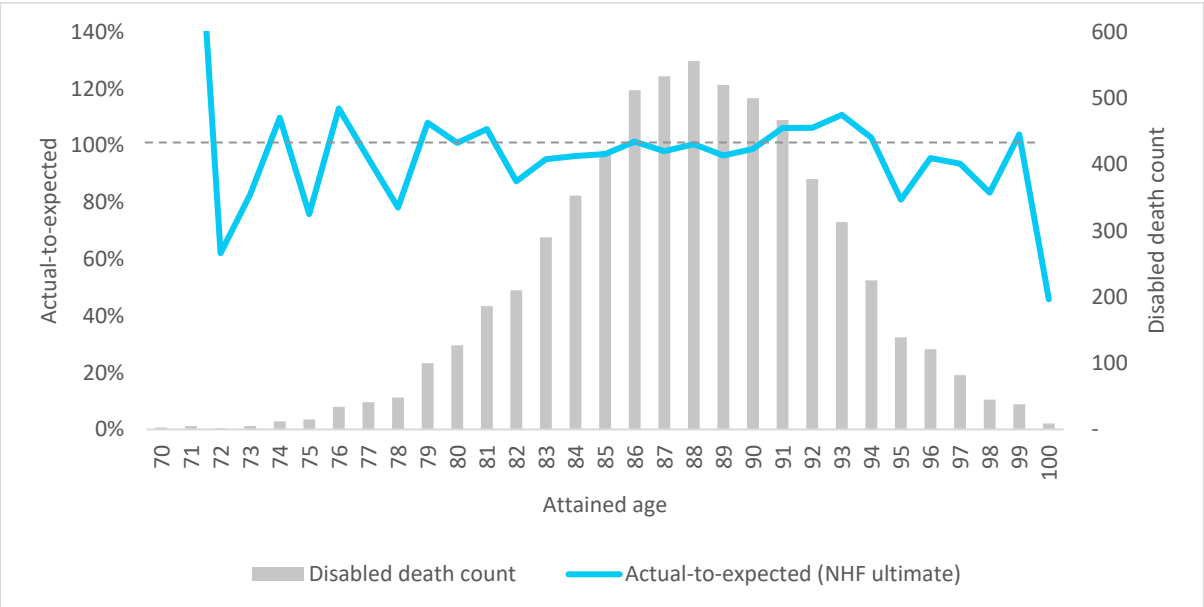


Exhibit 3.19: NHF disabled life mortality actual-to-expected (ultimate period)

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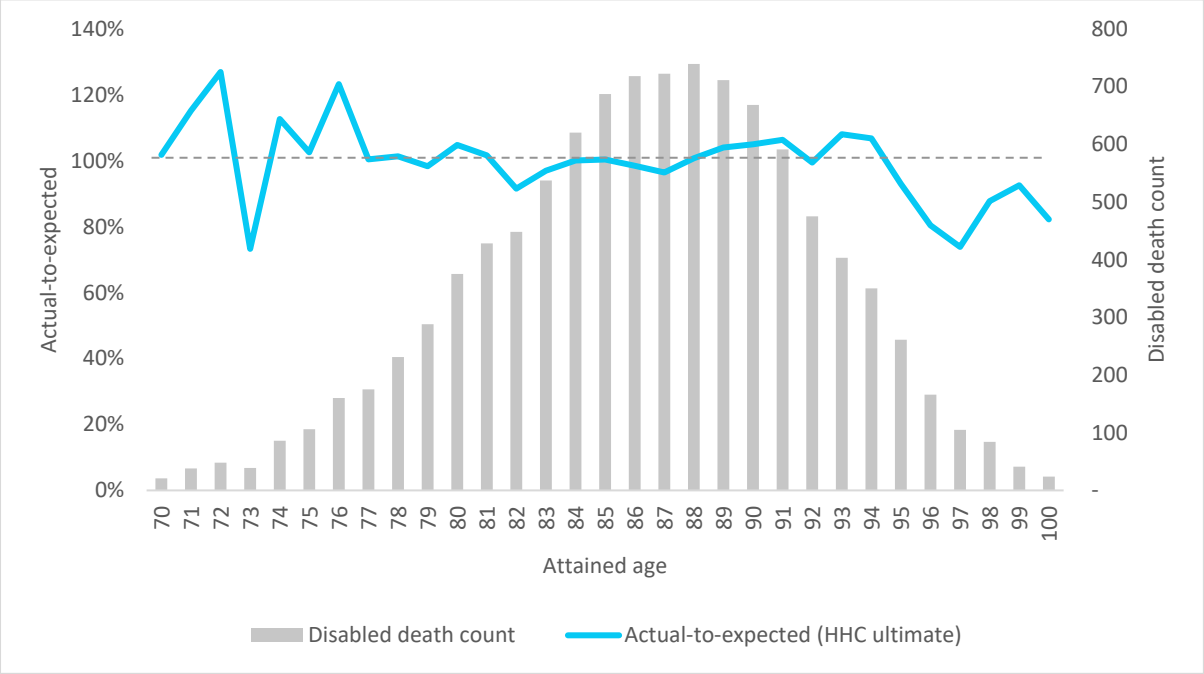


Exhibit 3.20: HHC disabled life mortality actual-to-expected (ultimate period)

3.4.2. Assumption selection

The selected disabled life mortality assumption contains two segments, an initial period segment (during the first 24 months since claim incurral) and an ultimate period segment (during months 13 and above since claim incurral). The two segments are graded together by linearly interpolating from the initial period to the ultimate period from incurral months 13 to 24.

The initial period disabled life mortality base curve was developed based on SHIP's experience, with multiplicative adjustment factors by gender, coverage type and benefit period. The ultimate period disabled life mortality assumption is based on the 2012 IAM mortality table, with multiplicative adjustment factors by gender, coverage type and benefit period. Refer to Appendix A for tabular assumption values.

3.5. Claim recovery

3.5.1. Study approach

We conducted a claim recovery study by analyzing SHIP's experience within 24 months of claim incurral to derive a base curve. We then graded the base curve from the last point where credible data exists, to zero claim recoveries by claim month 48 for NHF/ALF and claim month 60 for HHC.

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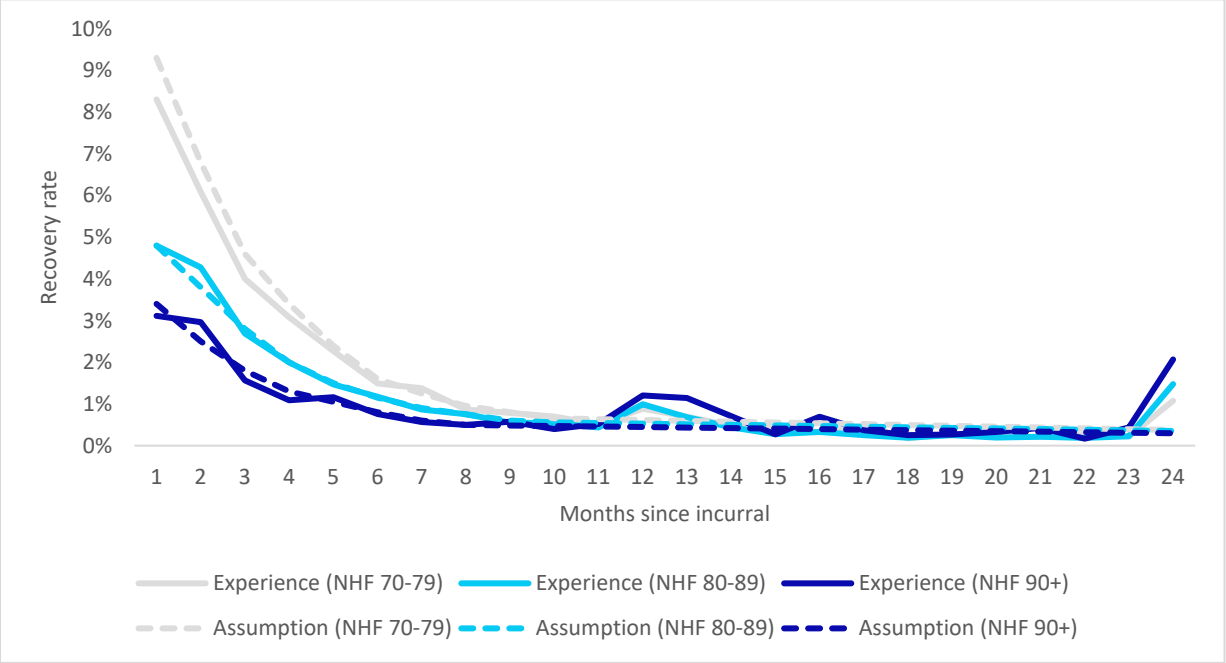


Exhibit 3.21: NHF and ALF claim recovery initial claim period base curves

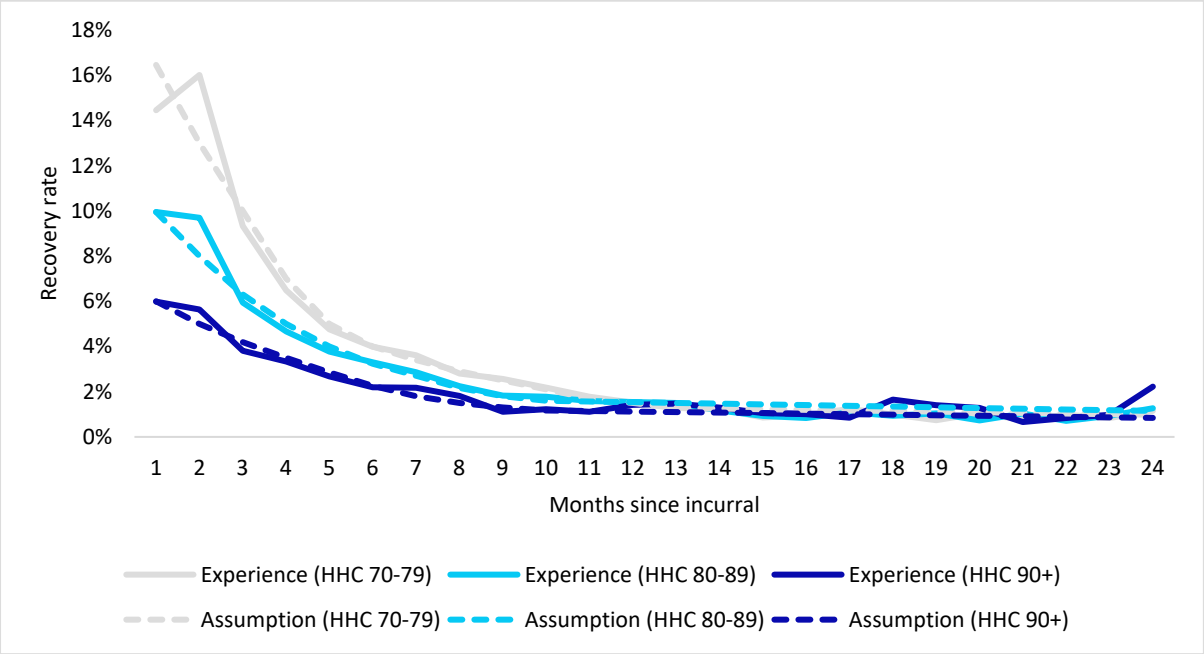


Exhibit 3.22: HHC claim recovery initial claim period base curves

We applied the base claim recovery curve to the study exposure and then compared it against experience split by all reasonable attributes that could potentially influence claim recoveries through an actual-to-expected analysis. We determined an adjustment factor for all attributes that exhibited a significant correlation with actual claim recovery experience. This process was repeated in successive order for all attributes. Ultimately, we applied adjustment factors to reflect differences in historical claim recovery experience by gender, coverage type and benefit period. The application of

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the adjustment factors achieved an actual-to-expected ratio of approximately 100% where credible data was available (particularly during the first 12 months since incurral).

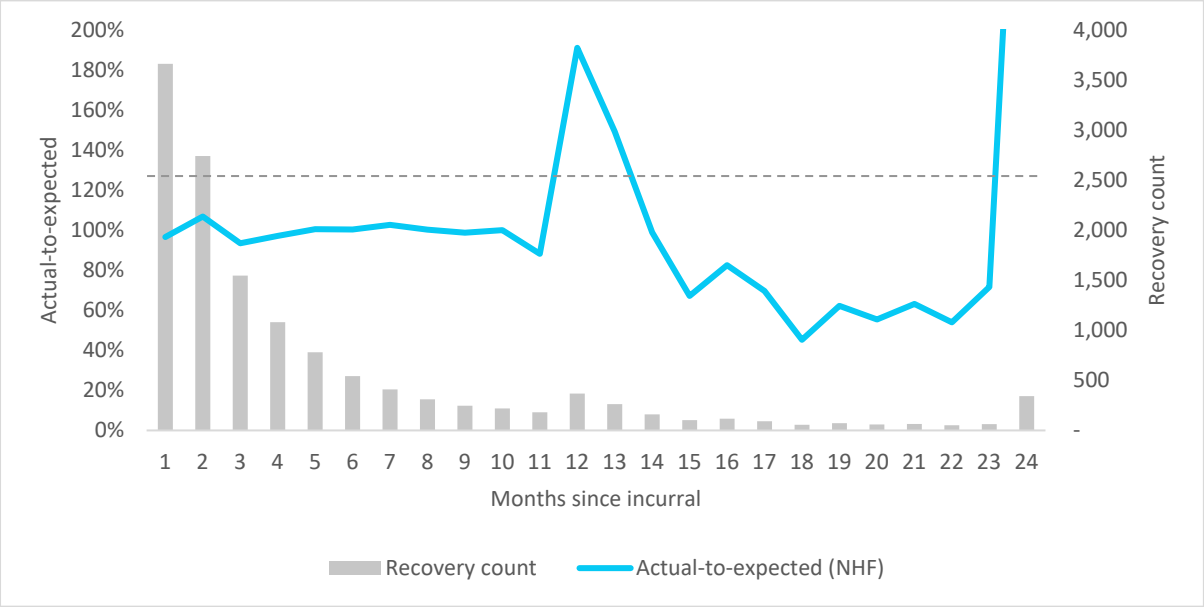


Exhibit 3.23: NHF claim recovery actual-to-expected

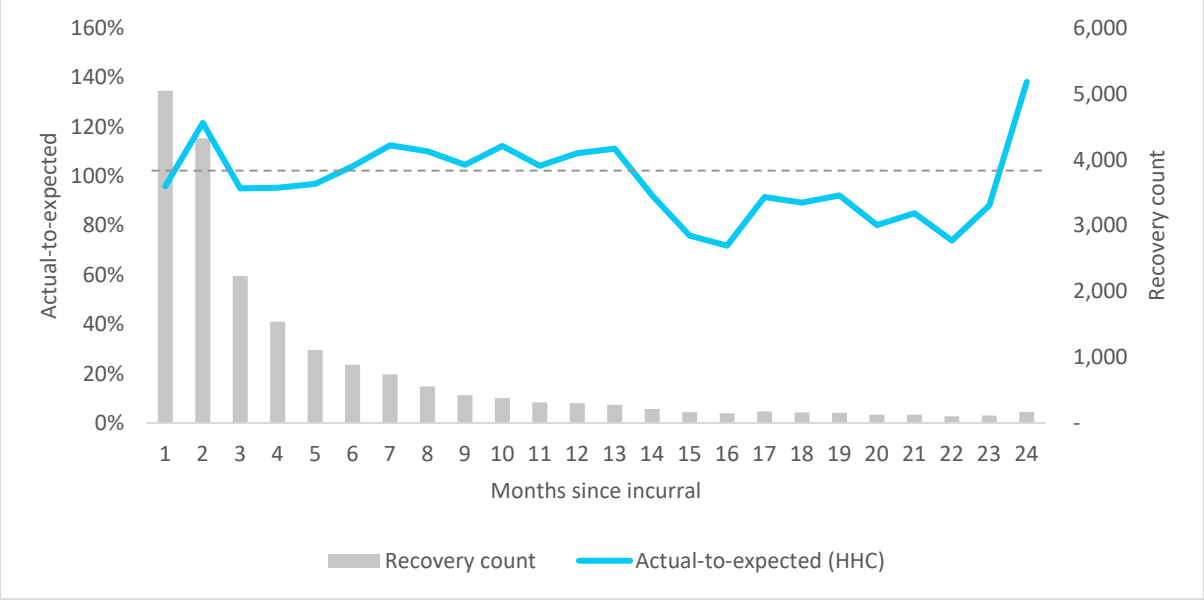


Exhibit 3.24: HHC claim recovery actual-to-expected

3.5.2. Assumption selection

The selected claim recovery assumption varies by site of care, gender, coverage type, benefit period and claim duration. The assumption assumes no recoveries occur after 48 months since claim incurral for NHF/ALF and after 60 months for HHC. All terminations subsequent to these durations are assumed to be due to disabled life mortality or benefit exhaustions. Refer to Appendix A for tabular assumption values.

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3.6. Claim utilization

3.6.1. Study approach

Given the dissimilar nature of each site of care under different coverage types, we defined base utilization curves for the following four coverage combinations:

1. HHC only (i.e., HHC utilization for HHC only coverages)
2. HHC other (i.e., HHC utilization for coverages containing HHC among other sites of care)
3. NHF only (i.e., NHF utilization for NHF only coverages)
4. NHF and ALF other (i.e., NHF and ALF utilization for coverages containing NHF and ALF sites of care)

For policies with HHC coverage, they may either have a policy with only HHC coverage, a policy with comprehensive coverage (that includes NHF, ALF and HHC benefits) or a policy with NHF and HHC coverage (which we refer to as "NHH coverage" in this report). We studied HHC only coverages separately from HHC experience from comprehensive policies and policies with NHF and HHC coverage, as they have a different experience profile given that they are the only site of care available. We refer to HHC experience from policies with coverages including other sites of care as "HHC other" to distinguish from HHC experience from policies with only HHC coverage ("HHC only"). Similarly, we analyzed policies with NHF only coverage separately from policies with NHF and ALF coverage (which we refer to as "NHA coverage" in this report) and comprehensive coverage.

Claim utilization: indemnity

For policies with indemnity benefits, utilization is generally stable and close to 100% as benefits are paid at the full maximum daily benefit ("MDB"). SHIP's experience supported a flat utilization assumption, varying by site of care and coverage type.

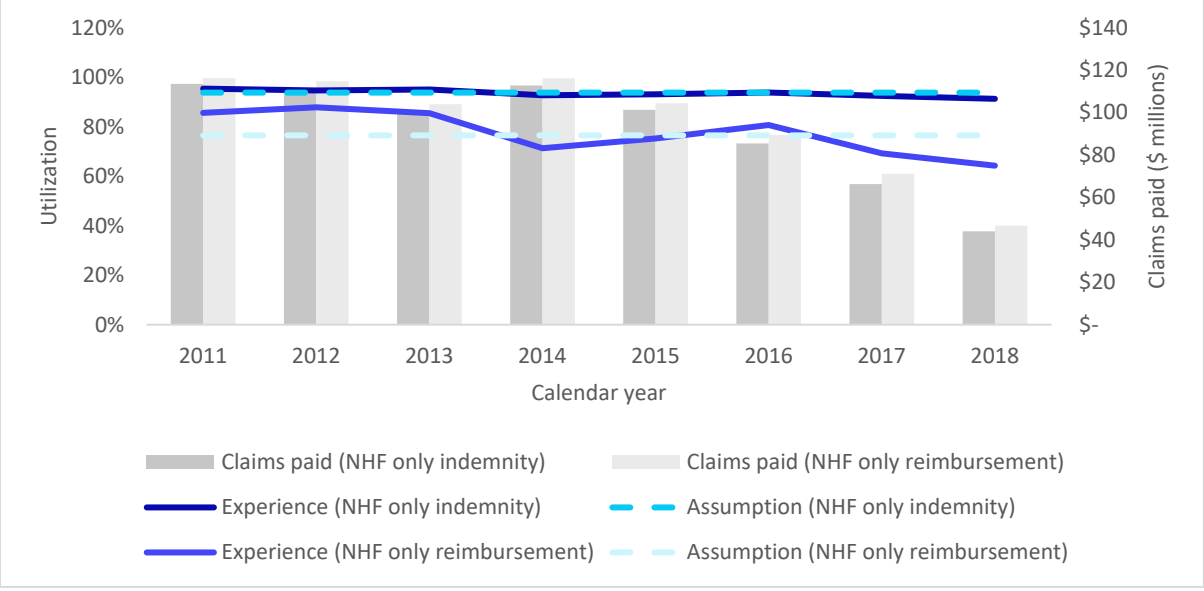


Exhibit 3.25: NHF only utilization by reimbursement type (NHF only policies)

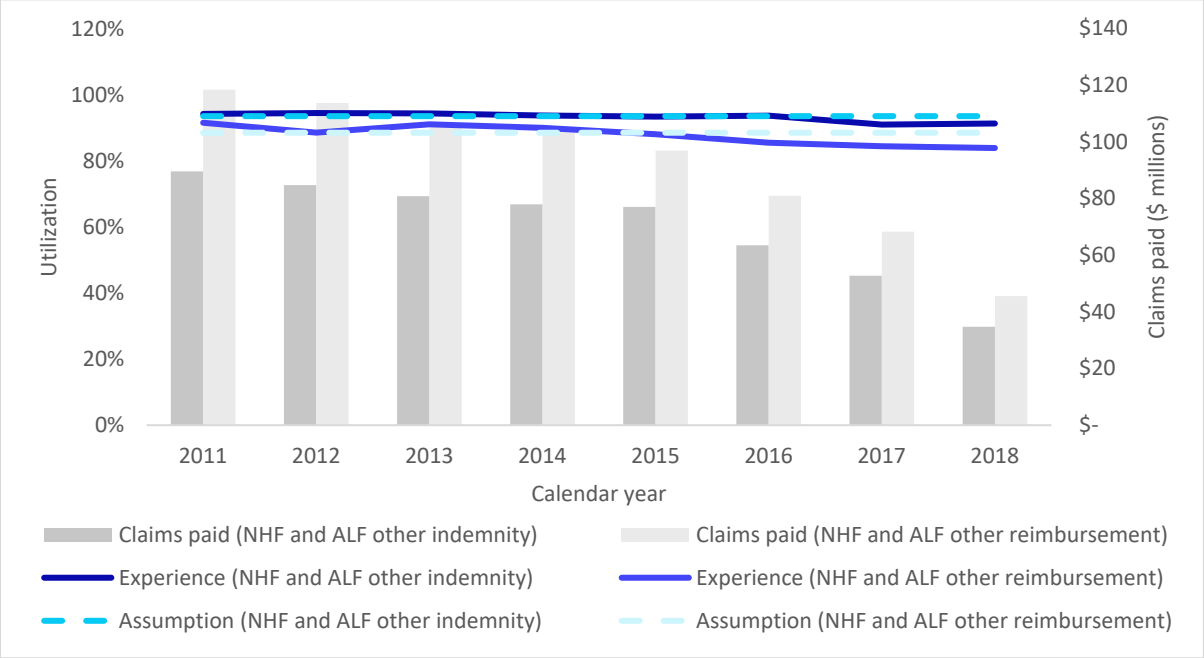


Exhibit 3.26: NHF and ALF other utilization by reimbursement type (NHA and comprehensive policies)

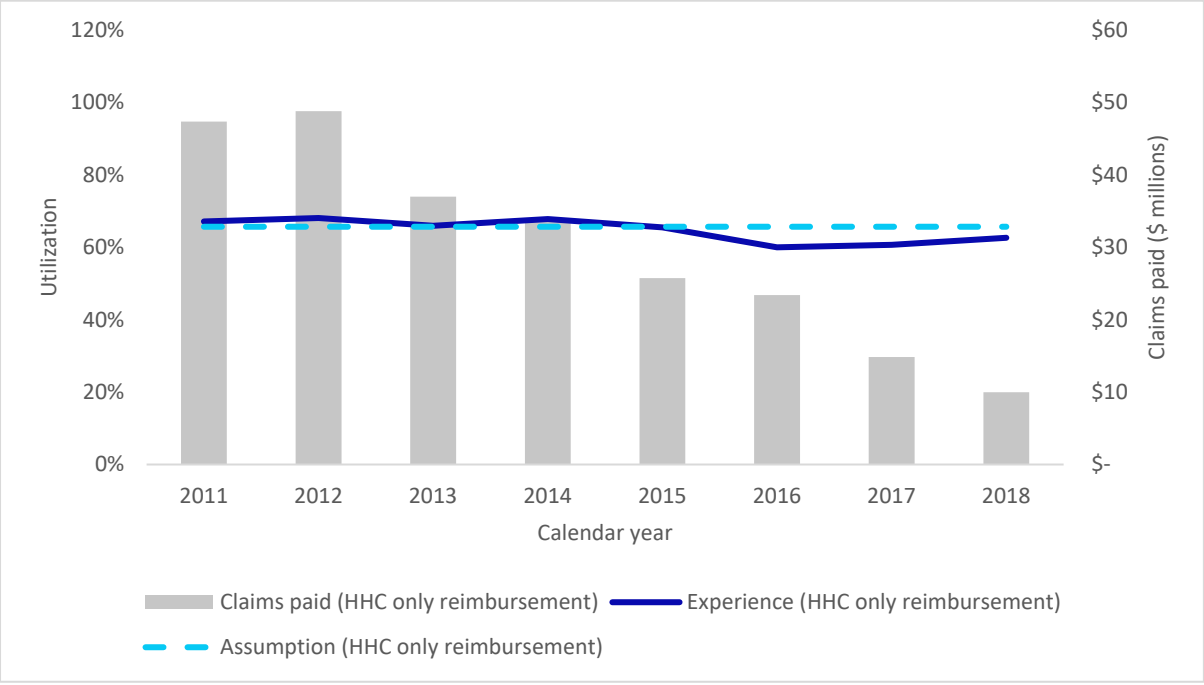


Exhibit 3.27: HHC only utilization by reimbursement type (HHC only policies, only reimbursement)

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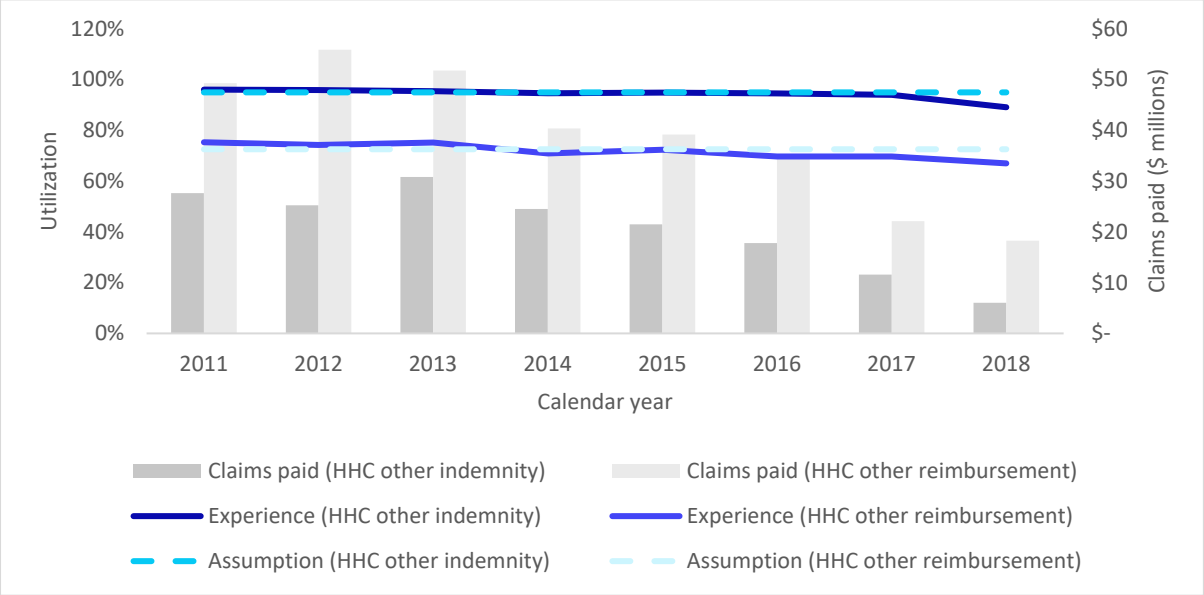


Exhibit 3.28: HHC other utilization base levels by reimbursement type (NHH and comprehensive policies)

Claim utilization: reimbursement

For reimbursement policies, we developed a base utilization curve in increments of $25 MDBs, based on SHIP's claims experience. For coverages with MDBs above $350, we assumed their expected daily benefit amount utilized (in dollars) is the same as a coverage with a $350 MDB. The rationale being that service amounts tend to not increase proportionately and instead stabilize as MDBs increase beyond a certain threshold. The expected maximum reimbursement amount for a $350 MDB policy is $217 for HHC only policies and $197 for other sites of care and coverage types.

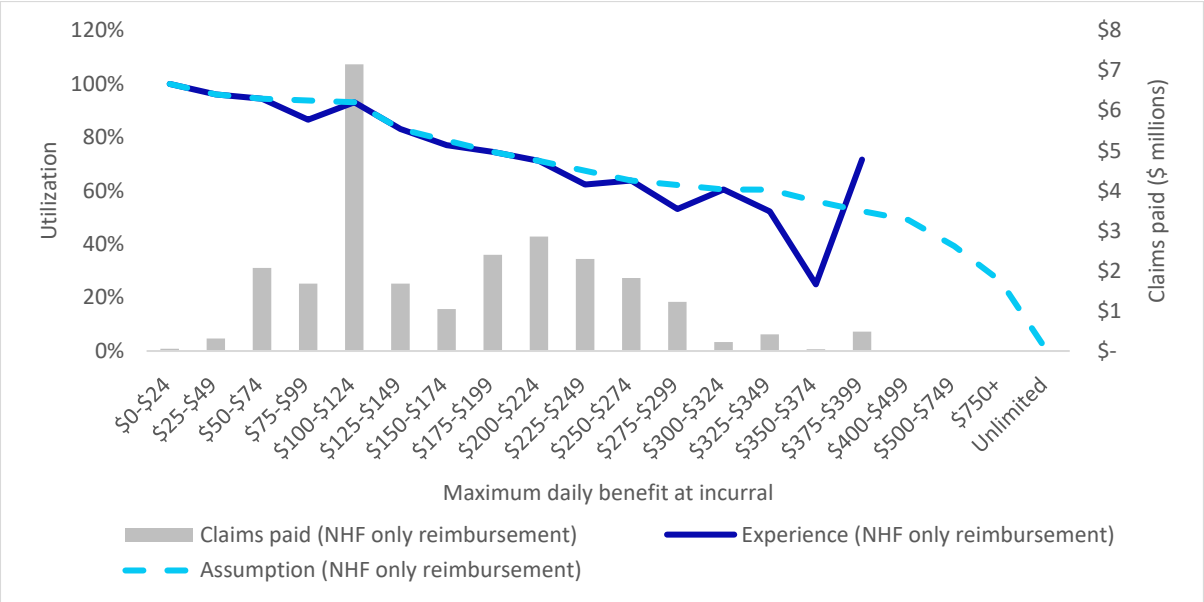


Exhibit 3.29: NHF only reimbursement base curve by MDB (NHF only policies)

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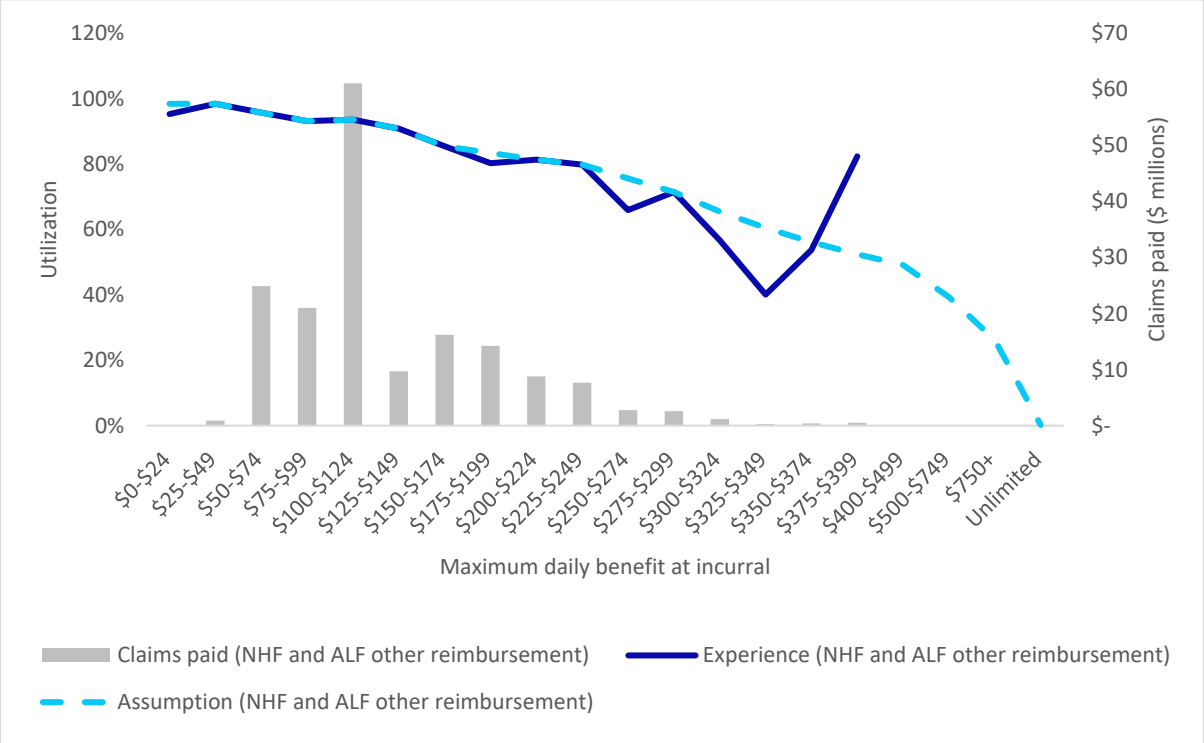


Exhibit 3.30: NHF and ALF other reimbursement base curve by MDB (NHA and comprehensive policies)

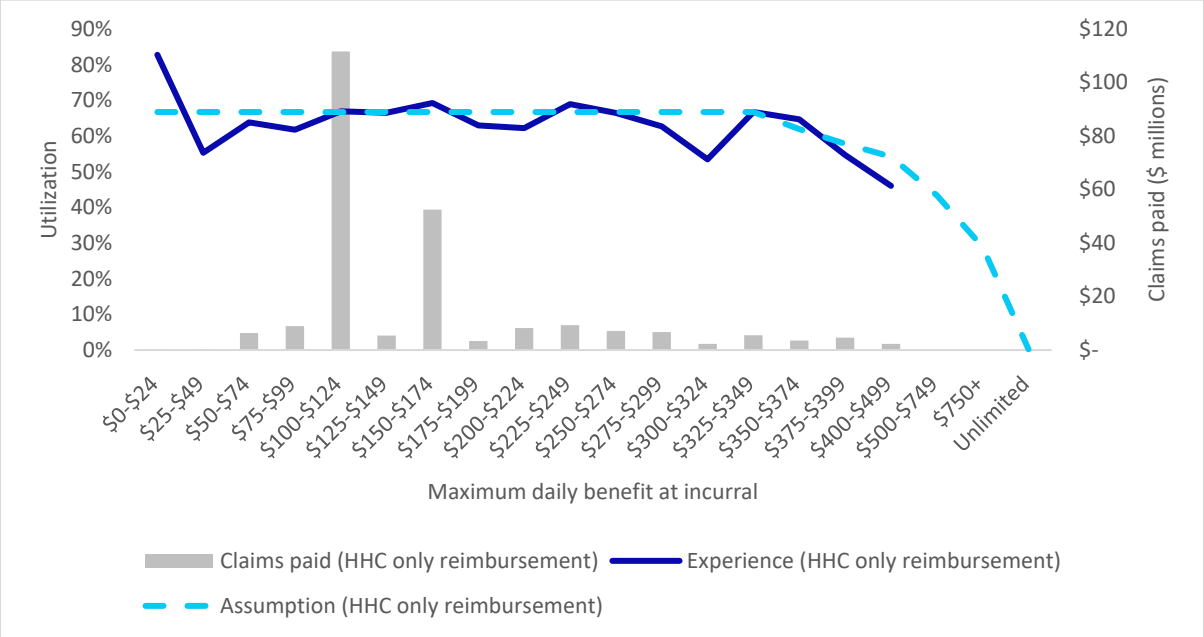


Exhibit 3.31: HHC only reimbursement base curve by MDB (HHC only policies)

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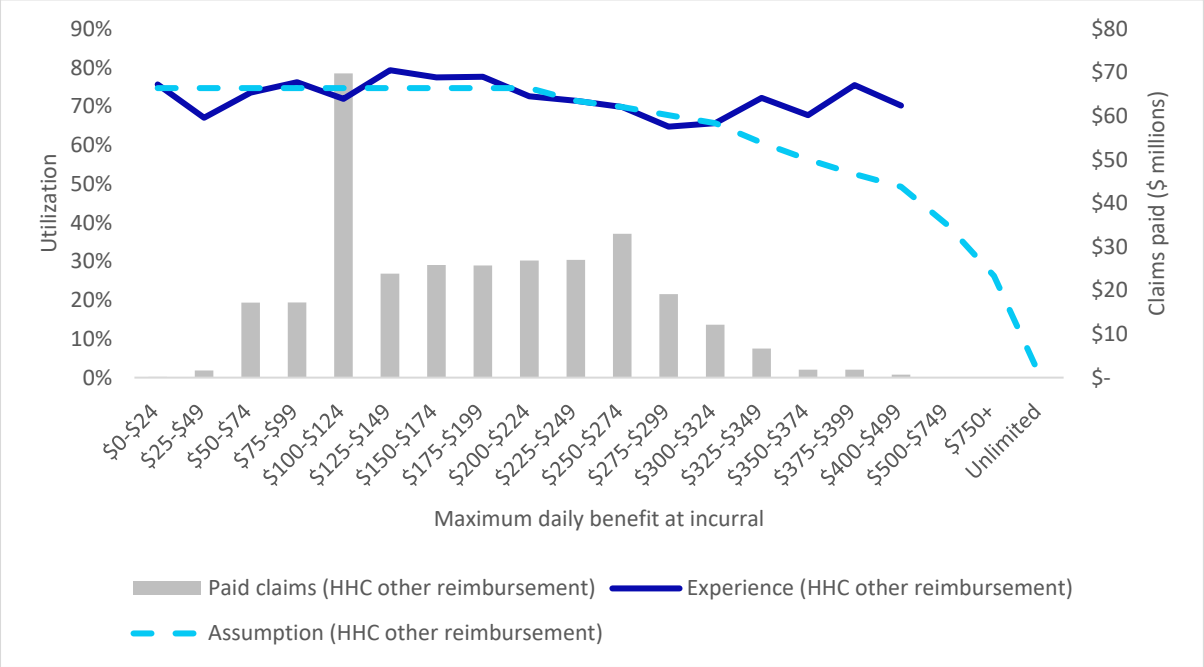


Exhibit 3.32: HHC other reimbursement base curve by MDB (NHH and comprehensive policies)

We applied the ultimate base utilization curve to the study exposure and then compared it against experience split by all reasonable attributes that could potentially influence utilization rates through an actual-to-expected analysis. We determined an adjustment factor for all attributes that exhibited a significant correlation with actual utilization experience. This process was repeated in successive order for all attributes. Ultimately, we applied adjustment factors to reflect differences in historical utilization experience by benefit period. The application of the adjustment factors achieved an actual-to-expected ratio of approximately 100% where credible data was available.

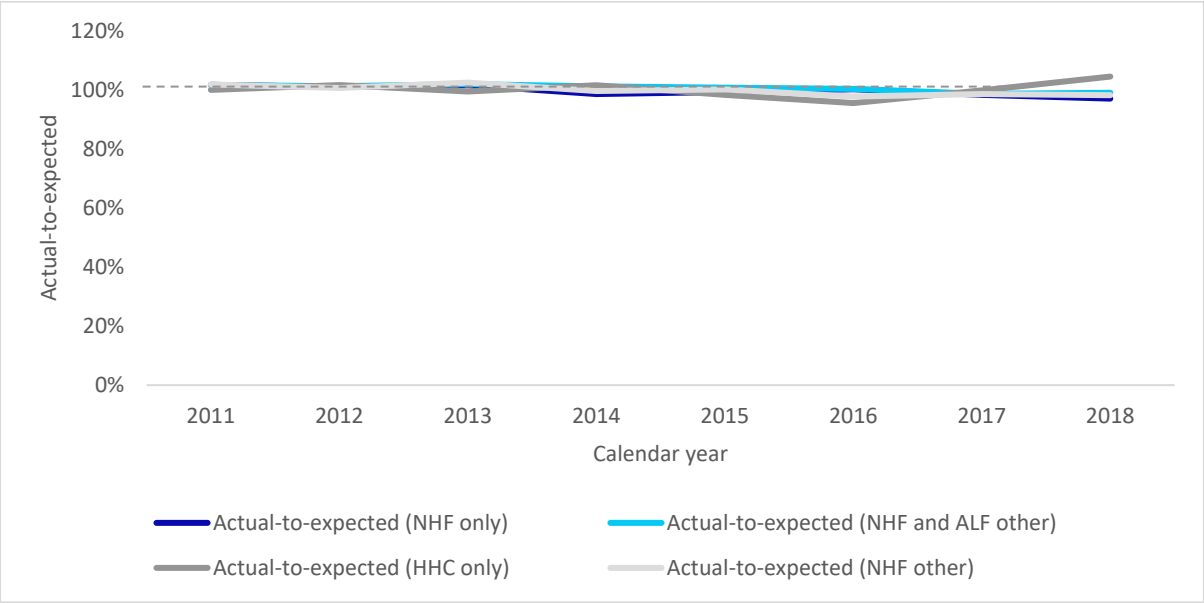


Exhibit 3.33: Actual-to-expected utilization

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3.6.2. Assumption selection

The selected utilization assumption for reimbursement policies is based on a maximum daily amount at incurral, with caps applied at $217 for HHC only policies and $197 for other sites of care and coverage types. In addition, we applied adjustments by indemnity type, daily benefit amount and benefit period. We also included a 3% future cost of care inflation assumption, which is consistent with the Genworth and John Hancock industry surveys. Refer to Appendix A for tabular assumption values.

			Benchmarks	
Site of care	**Selected assumption**	**Site of care type**	**Genworth[1]**	**John Hancock[2]**
NHF	3.0%	Private room	3.1%	3.1%
		Semi-private room	3.1%	3.2%
ALF	3.0%	Assisted living facility	3.0%	2.1%
HHC	3.0%	Adult day care	2.9%	1.5%
		Home health aide	3.1%	1.5%
		Homemaker	3.4%	n/a

Exhibit 3.34: Cost of care inflation assumption and industry benchmarks

3.7. Expenses

We were provided a forecast of SHIP's expense budget from 2020 to 2029. In addition, we were provided a forecast of SHIP's claims administration budget from 2020 to 2025. The claims administration budget is based on a fee schedule and projection provided by SHIP's claims administrator (Long Term Care Group or "LTCG"). We adopted the claims administration fee schedule for 2020 through 2025 by allocating the fees into three distinct categories and then calculated an average cost per unit. For calendar years 2025 through 2029, we extrapolated the expense assumption based on the implied inflationary trend factor from 2024 to 2025. A 3% inflation factor was assumed from 2030 and beyond.

We confirmed that the expense projection produced by our actuarial model reconciled in aggregate with SHIP's ten-year budget forecast. Refer to Appendix A for tabular assumption values.

		Calendar year	
Expense category	**Description**	**2020**	**2029**
Per active policy, per month	Fees associated with policyholder administration and all other expenses reflected in SHIP's budget forecast	$49	$103
Per incurred claim	Fees associated with initial claim evaluation and establishment	$520	$942
Per open claim, per month	Fees associated with ongoing claim management	$107	$194

Exhibit 3.35: Expense assumption by expense category

[1] Historical inflation 2014-2019, 2019 Genworth Cost of Care Survey

[2] Historical inflation 2008-2016, 2016 John Hancock Cost of Care Survey

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3.8. Commissions

We were provided SHIP's commission rates, as a percentage of collected premium, for each issuing company code. The commission rates are summarized in the exhibit below.

Company code	Commission rate (% of premium)
ATL, JCL, JCP, UGL	7.8%
TPM	2.2%
ALI, CLI, PLI, TLI	14.2%

Exhibit 3.36: Commission assumption by company code

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5. RELIANCES AND LIMITATIONS

5.1. Data verification

In developing this report, Oliver Wyman relied upon data and information supplied by SHIP and its third-party administrator Fuzion Analytics. We relied upon the general accuracy of this data and information without independent verification. However, we did review the data for reasonableness and consistency with our knowledge of the business. To the extent any material errors exist in the data and information supplied by SHIP and Fuzion Analytics, the results of our analysis may be impacted.

Information relied upon includes, but is not necessarily limited to:

- Seriatim policyholder data as of December 31, 2019;
- Historical experience including policy exposure, coverage, claim payment data, and associated information (e.g., care setting and incurred date)
- Policy information including benefit characteristics and effective and termination dates.
- SHIP 10-year expense budget projection
- SHIP 5-year claims administration budget projection

5.2. Supplemental data

Where historical data of SHIP was either not available, not appropriate or not sufficiently credible to develop our actuarial assumptions, we supplemented it with external information, as we deemed appropriate. Although we believe these external sources may be more predictive of future experience of SHIP than any other data of which we are aware, the use of external data adds to the uncertainty associated with our projections.

5.3. Unanticipated changes

We developed our conclusions based on an analysis of data from the client named herein and on the estimation of the outcome of many contingent events. We developed our estimates from the historical claim experience and covered exposure, with adjustments for anticipated changes. Our estimates make no provision for extraordinary future emergence of new types of losses not sufficiently represented in historical databases or which are not yet quantifiable.

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The findings contained in this report contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. Oliver Wyman accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. No obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

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APPENDIX A. INVENTORY OF ACTUARIAL ASSUMPTIONS

Refer to the accompanying Microsoft Excel workbook ("*Appendix A – inventory of actuarial assumptions 2021 01 22.xlsx*").

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REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 18

OLIVER WYMAN

Pennsylvania Insurance Department

SENIOR HEALTH INSURANCE CO. OF PA

Phase I Rehabilitation Plan: Cumulative Excess Benefits Analysis

March 24, 2021

CONFIDENTIALITY

Our clients' industries are extremely competitive, and the maintenance of confidentiality with respect to our clients' plans and data is critical. Oliver Wyman rigorously applies internal confidentiality practices to protect the confidentiality of all client information.

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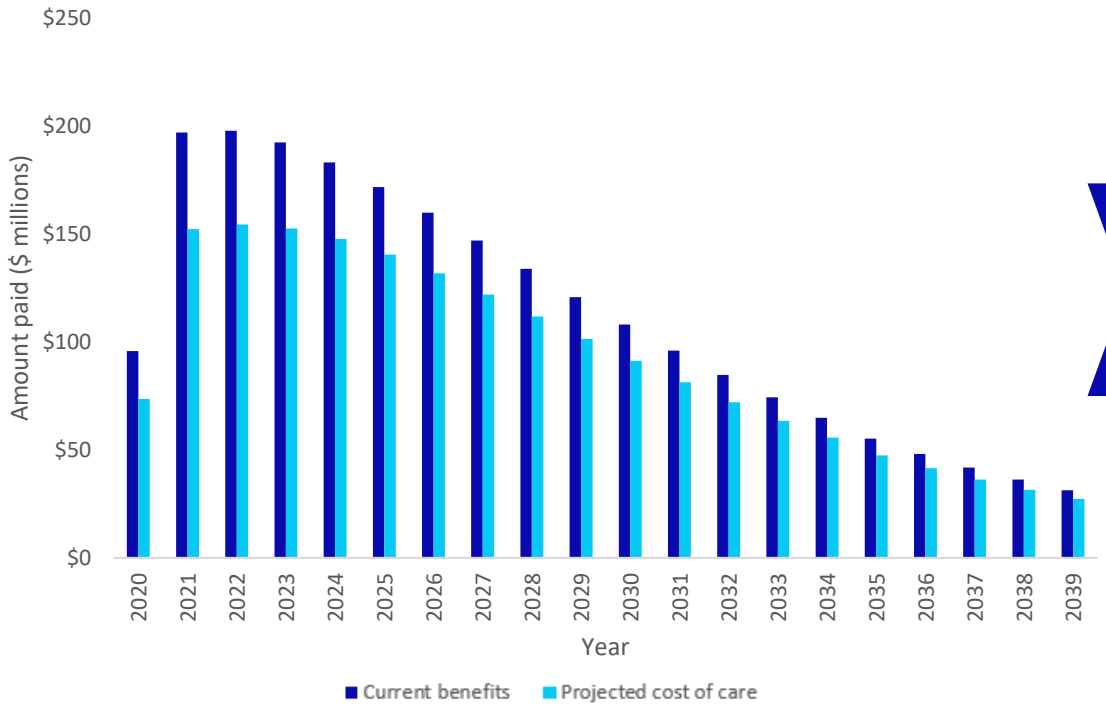
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CUMULATIVE EXCESS BENEFITS ANALYSIS (AS OF 6/30/2020)

The following exhibits illustrate the projected amount of “excess benefits” associated with policyholders with compound inflation benefits

Excess benefits = [present value of projected benefit payments] *less* [present value of projected cost of care]

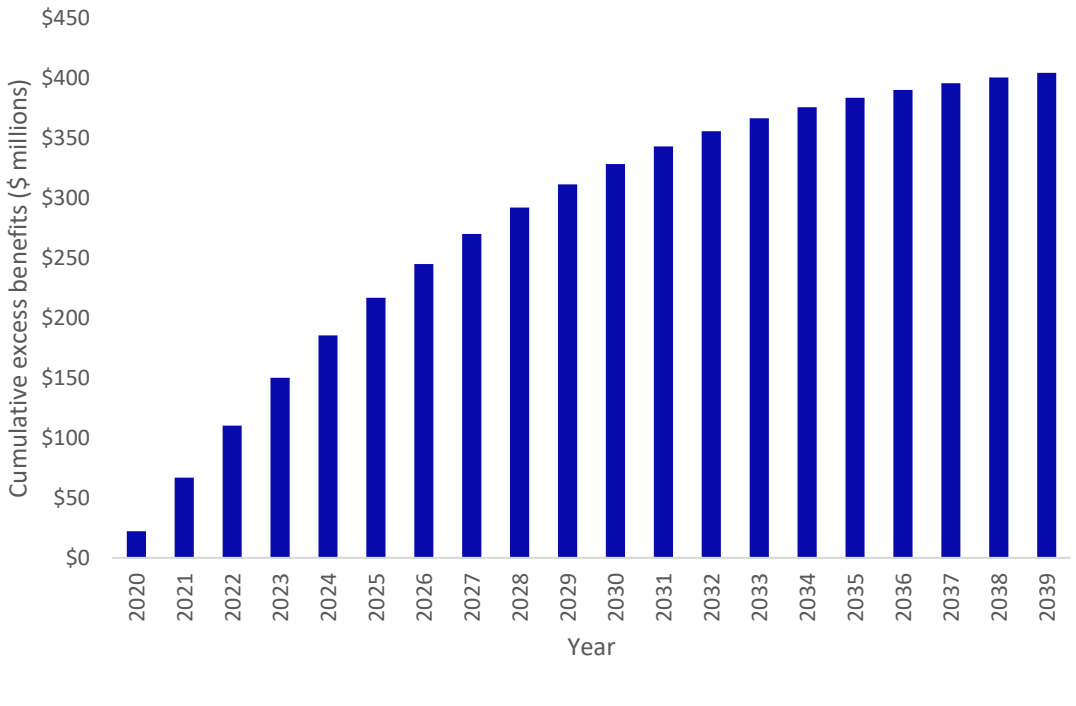
Exhibit 1: Projection of benefit payments ($ millions)



Description

- Exhibit 1 contains a projection of benefit payments for SHIP policyholders with compound inflation coverage.
- The dark blue bars represent a projection of current benefit payments without modification.
- The light blue bars represent a projection of the average cost of care (including cost of care inflation) for SHIP’s policyholders.
- The projection of the average cost of care was developed by studying SHIP specific payment data.
- Figures exclude return of premium benefits.

Exhibit 2: Projection of cumulative excess benefits ($ millions)



Description

- Exhibit 2 contains a projection of cumulative excess benefits for SHIP policyholders with compound inflation coverage.
- The excess benefits for policies with "reimbursement" coverage is assumed to be zero because they are reimbursed at their exact cost of care (subject to coverage limitations).
- Figures exclude return of premium benefits. The cumulative excess benefit amounts are only forward looking, starting from 6/30/2020.

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OLIVER WYMAN

Received 4/5/2021 11:51:38 PM Commonwealth Court of Pennsylvania

REHABILITATOR'S PRE-HEARING MEMORANDUM

Filed 4/5/2021 11:51:00 PM Commonwealth Court of Pennsylvania
1 SHP 2020

PROPOSED

EXHIBIT 20

OLIVER WYMAN

Pennsylvania Insurance Department

SENIOR HEALTH INSURANCE CO. OF PA

Phase I Rehabilitation Plan Funding Gap Exhibits (as of 6/30/2020)

April 2, 2021

CONFIDENTIALITY

Our clients' industries are extremely competitive, and the maintenance of confidentiality with respect to our clients' plans and data is critical. Oliver Wyman rigorously applies internal confidentiality practices to protect the confidentiality of all client information.

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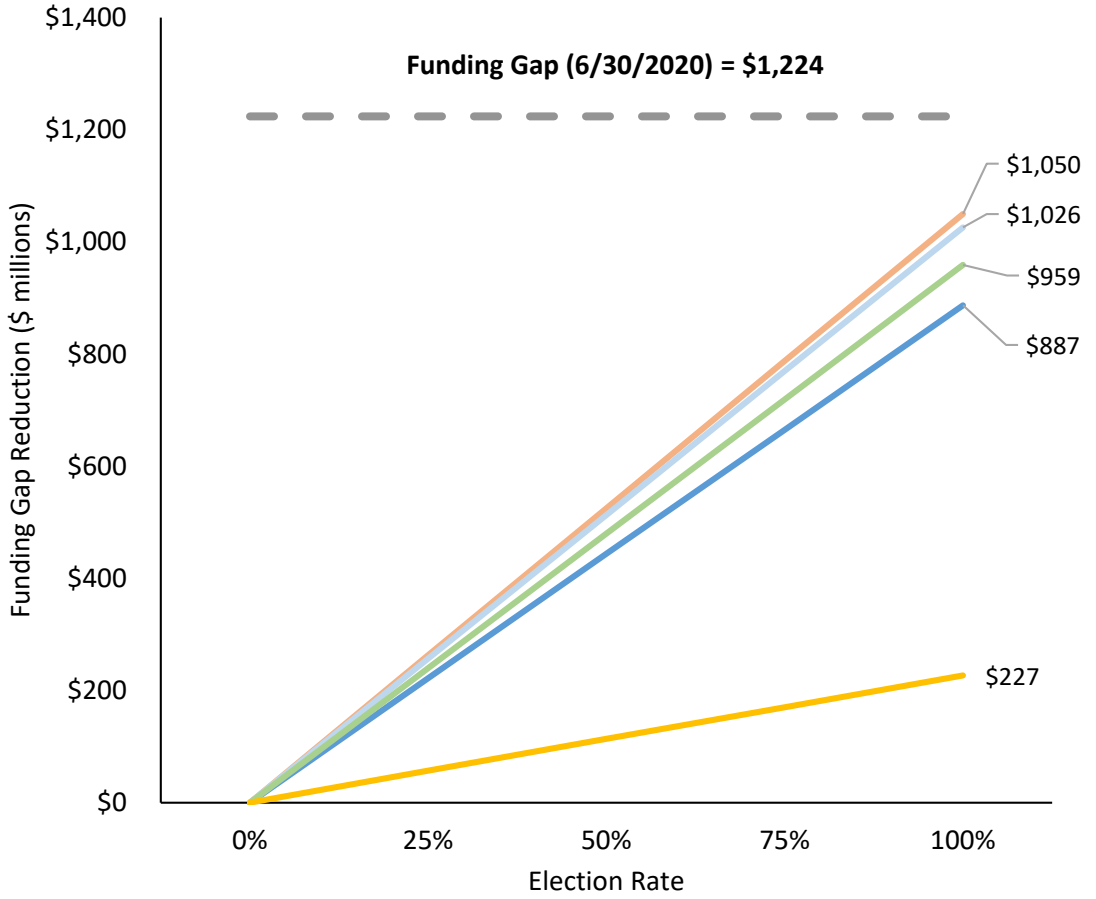
PHASE I FUNDING GAP REDUCTION: AS A FUNCTION OF PLAN OPTION ELECTION RATES

The following exhibits illustrate the amount of Funding Gap eliminated under each Plan Option as a function of the associated election rate

Funding Gap = expected benefits + expected expenses – expected premium (incl. differential premium) – current asset value

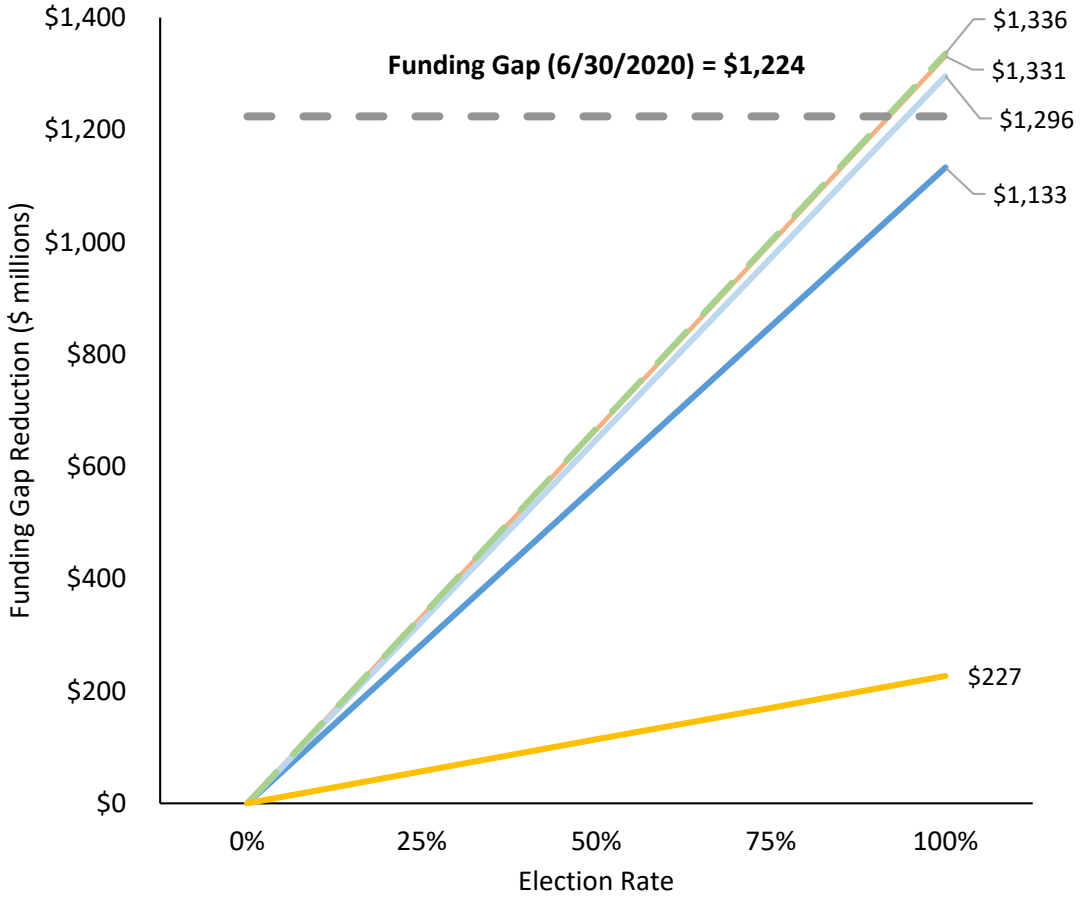
Methodology 1

- Active policyholders select the Options noted in the legend of the exhibit below
- Disabled policyholders select Option 4 (**conservative assumption**)



Methodology 2

- Active policyholders select the Options noted in the legend of the exhibit below
- Disabled policyholders select the Options noted in the legend of the exhibit below (**optimistic assumption**)



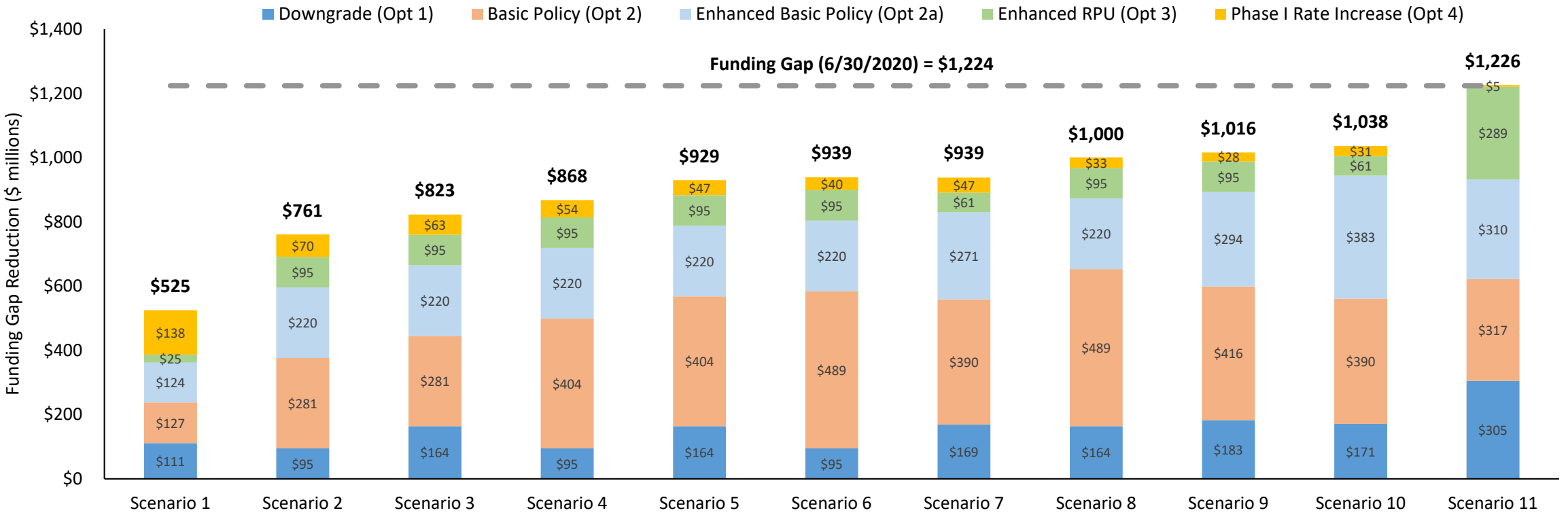
Downgrade (Opt 1) Basic Policy (Opt 2) Enhanced Basic Policy (Opt 2a) Enhanced RPU (Opt 3) Phase I Rate Increase (Opt 4)

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PHASE I FUNDING GAP REDUCTION: ILLUSTRATIVE ELECTION RATE SCENARIOS

The following exhibit illustrates the amount of Funding Gap eliminated under a range of Plan probability-weighted election rate scenarios

Funding Gap = expected benefits + expected expenses – expected premium (incl. differential premium) – current asset value



Assumed Election Rate by Policyholder Status and Plan Option

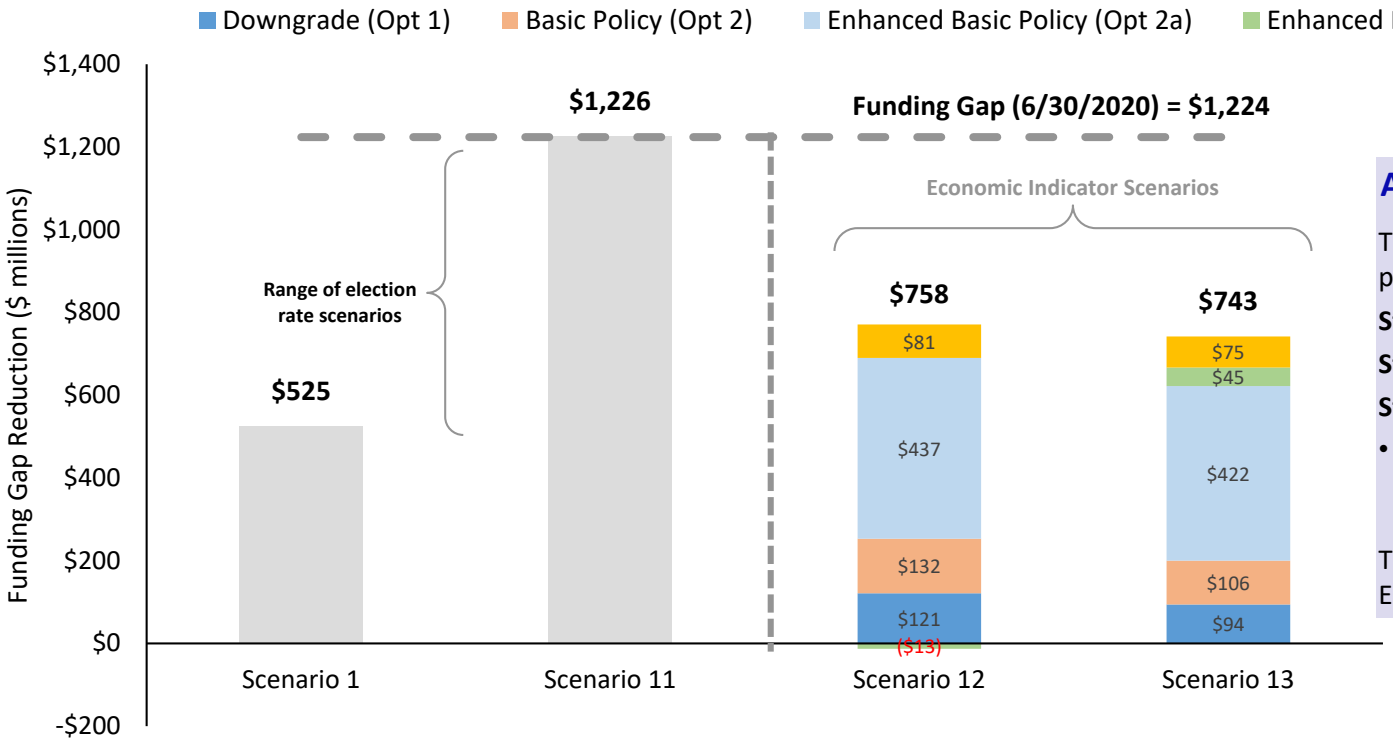
		Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7	Scenario 8	Scenario 9	Scenario 10	Scenario 11
Active policyholders	Opt 1	7%	10%	10%	10%	10%	10%	15%	10%	15%	5%	5%
	Opt 2	4%	10%	10%	30%	30%	50%	30%	50%	35%	30%	31%
	Opt 2a	4%	10%	10%	10%	10%	10%	20%	10%	25%	40%	31%
	Opt 3	4%	10%	10%	10%	10%	10%	5%	10%	10%	5%	31%
	Opt 4	81%	60%	60%	40%	40%	20%	30%	20%	15%	20%	2%
Disabled policyholders	Opt 1	0%	0%	25%	0%	25%	0%	25%	25%	30%	35%	96%
	Opt 4	100%	100%	75%	100%	75%	100%	75%	75%	70%	65%	4%

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PHASE I FUNDING GAP REDUCTION: ECONOMIC INDICATOR BASED SCENARIOS

The following exhibit illustrates the amount of Funding Gap eliminated under a range of Economic Indicator based scenarios

Funding Gap = expected benefits + expected expenses – expected premium (incl. differential premium) – current asset value



About the Economic Indicator scenarios…

The following steps were performed in sequential order to allocate each policyholder to one of the five Rehabilitation Plan Options:

Step 1: Policies on premium waiver or on claim elect **Option 4**

Step 2: Policies with a "relatively rich" Enhanced RPU elect **Option 3**

Step 3: All other policies elect the Option with the highest **Economic Indicator**

- **Economic Indicator** is defined as the present value of projected benefits divided by annualized premium

The table below describes the test used to identify a "relatively rich" Enhanced RPU

Economic Indicator Scenarios

Scenario	Test for "relatively rich" Option 3
12	$\frac{Option\ 3\ (PV\ benefits)}{Current\ (PV\ benefits)} > 75\%$
13	$\frac{Option\ 3\ (PV\ benefits)}{Current\ (PV\ benefits)} > 50\%$

Assumed[1] Election Rate by Policyholder Status and Plan Option

Active policyholders	Opt 1	7%	5%	12%	7%
	Opt 2	4%	31%	28%	14%
	Opt 2a	4%	31%	16%	13%
	Opt 3	4%	31%	12%	39%
	Opt 4	81%	2%	32%	27%
Disabled policyholders	Opt 1	0%	96%	0%	0%
	Opt 4	100%	4%	100%	100%

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1. Election rates for Scenarios 12 and 13 are not assumed, but rather the result of election methodology for Economic Indicator scenarios

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REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 22

Senior Health Insurance Company of Pennsylvania In Rehabilitation

Policies, Premiums, and Reserves as of December 31, 2020

Breakout Exhibit by Product ID

Product ID	Number of Members **(1)**	Annualized Premium **(2)**	Total Reserve **(3)**
TPM	916	$ 3,014,946	$ 51,234,753
10770/10853	1,250	1,155,347	38,884,784
10955/11001	6,910	13,502,855	919,332,831
FQ_Preference	9,313	13,601,207	515,754,215
HHC	4,128	2,498,435	128,316,755
LTC-1	3,919	7,578,841	128,362,824
LTC-3	2,663	3,516,218	202,439,632
LTC-6	8,476	11,855,415	515,425,144
Other ATL	1,237	1,284,142	29,809,804
Other_TLI	336	116,303	7,996,979
Grand Total	39,148	$ 58,123,709	$ 2,537,557,721

(1) Includes paid up policies: NFO or lifetime waiver

(2) Includes policies on waiver of premium

(3) Includes active life reserves, claim reserves, and premium deficiency reserves, gross unearned premium reserves

Senior Health Insurance Company of Pennsylvania in Rehabilitation

LTC In force by Resident State

December 31, 2020

Resident State	Number of Members (1)	Premium (2)
Alabama	93	$ 127,091
Alaska	27	25,894
Arizona	985	1,322,926
Arkansas	220	285,669
California	3,183	5,277,535
Canada	7	8,335
Colorado	422	701,244
Connecticut	86	139,014
Delaware	109	139,231
District of Columbia	24	30,292
Florida	4,040	4,998,682
Georgia	742	1,127,784
Hawaii	100	128,868
Idaho	125	123,787
Illinois	1,753	3,562,625
Indiana	967	1,610,819
Iowa	916	1,352,607
Kansas	829	1,124,897
Kentucky	583	735,100
Louisiana	310	391,035
Maine	316	426,248
Maryland	878	1,559,287
Massachusetts	296	530,502
Michigan	924	1,084,712
Minnesota	540	810,814
Mississippi	183	363,424
Missouri	984	1,497,207
Montana	198	$ 258,476
Nebraska	432	$ 674,242
Nevada	147	$ 169,348
New Hampshire	62	$ 109,037
New Jersey	660	$ 1,199,668
New Mexico	157	$ 243,298
New York	388	$ 422,877
North Carolina	1,175	$ 2,081,859
North Dakota	358	$ 635,090
Ohio	1,520	$ 2,593,057
Oklahoma	864	$ 1,023,595
Oregon	293	$ 323,342
Other	10	$ 35,794
Pennsylvania	3,862	$ 7,119,488
Puerto Rico	-	$ -
Rhode Island	18	$ 34,399
South Carolina	395	$ 714,562
South Dakota	243	$ 496,900
Tennessee	613	$ 967,561
Texas	4,960	$ 5,551,266
Utah	317	$ 348,962
Vermont	23	$ 30,682
Virginia	732	$ 1,317,667
Washington	1,287	$ 1,336,270
West Virginia	70	$ 99,194
Wisconsin	682	$ 799,146
Wyoming	40	$ 52,301
Total	39,148	$ 58,123,709

(1) Number of members inforce

(2) Annualized premiums inforce

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 24

Senior Health Insurance Company of Pennsylvania in Rehabilitation
Balance Sheet
Proforma adjusted for removal of reinsurance assumed business
($ in thousands)

	YTD 09/30/2020	Reinsurance 09/30/2020	Proforma 09/30/2020
Assets			
Bonds	$ 1,548,916	$ (305,251)	$ 1,243,665
Preferred stock	79,903	-	79,903
Common stock	4,264	-	4,264
Mortgage loans	11,967	-	11,967
Cash and short term investments	47,736	(17,782)	29,954
Other invested assets	9,263	(1,601)	7,662
Receivable for securities	-	-	-
Total invested assets	1,702,049	(324,634)	1,377,415
Investment income due and accrued	10,852	(1,126)	9,726
Uncollected premiums	879	(46)	833
Federal income tax recoverable	2,581	-	2,581
Guaranty funds receivable	1,220	-	1,220
Reimbursement from insurance carrier	1,497	-	1,497
Other	127	(5)	122
		-	
Total Assets	$ 1,719,205	$ (325,811)	$ 1,393,394
Liabilities and Capital and Surplus			
Liabilities			
Active life reserves	$ 1,141,574	$ (58,406)	$ 1,083,168
Premium deficiency reserves	732,659	(47,804)	684,855
Claim reserves	885,098	(58,226)	826,872
Premiums paid in advance	1,214	(49)	1,165
Interest maintenance reserve	5,849	-	5,849
Accounts payable and other liabilites*	23,188	(256)	22,932
Total Liabilities	$ 2,789,582	$ (164,741)	$ 2,624,841
Capital and Surplus			
Common stock	$ 2,500	$ -	$ 2,500
Preferred capital stock	5,000	-	5,000
Surplus notes	50,000	-	50,000
Unassigned surplus	(1,127,877)	(161,070)	(1,288,947)
Total Capital and Surplus	$ (1,070,377)	$ (161,070)	$ (1,231,447)
Total Liabilities and Capital and Surplus	$ 1,719,205	$ (325,811)	$ 1,393,394

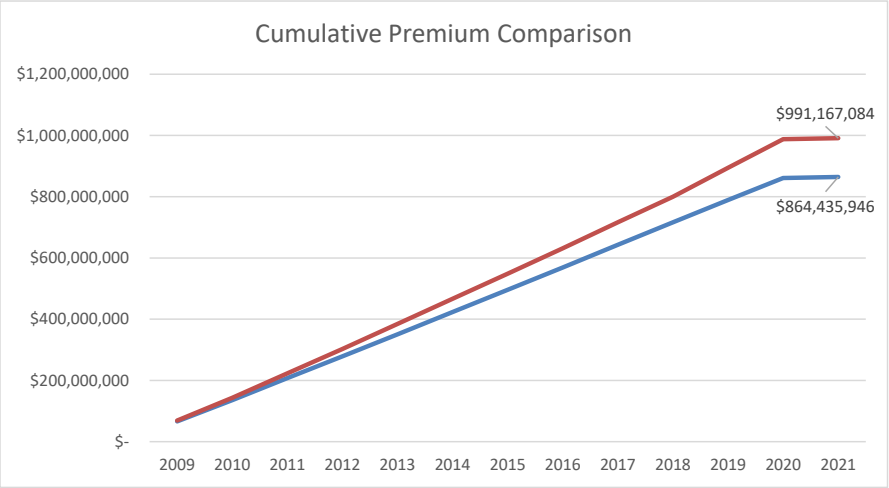
REHABILITATOR'S PRE-HEARING MEMORANDUM

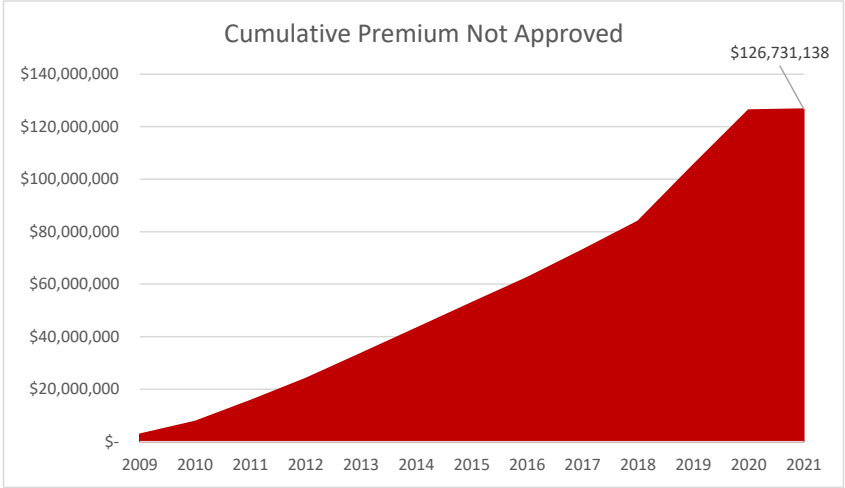
PROPOSED

EXHIBIT 27

State	All States	State Approval Ratio	.61	Company Approval Ratio	.62
Status	In Force				

Year Requested	Average Percent Requested	Average Percent Approved	Percent Approved Ratio	Percentage of Population Impacted
2009	24%	15%	.61	12%
2010	29%	14%	.48	36%
2011	33%	14%	.41	27%
2012	22%	14%	.64	12%
2013	22%	22%	1.00	1%
2014	0%	0%	N/A	0%
2015	0%	0%	N/A	0%
2016	40%	29%	.71	7%
2017	40%	16%	.39	2%
2018	23%	16%	.69	4%
2019	51%	0%	.00	28%
2020	0%	0%	N/A	0%





* SHIP Only, excludes reinsurance
** figures do not consider billing mode changes or benefit buy downs

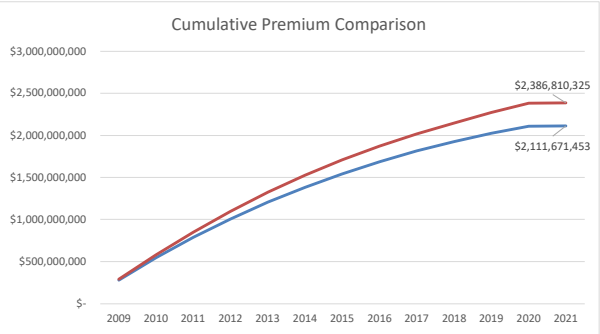
REHABILITATOR'S PRE-HEARING MEMORANDUM

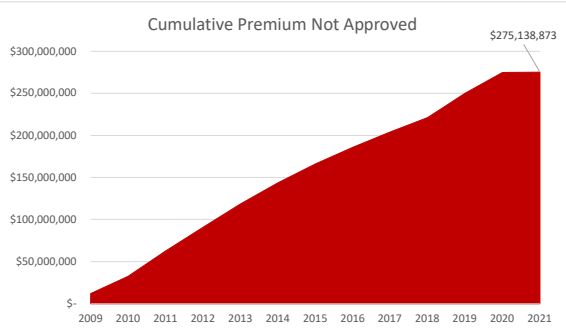
PROPOSED

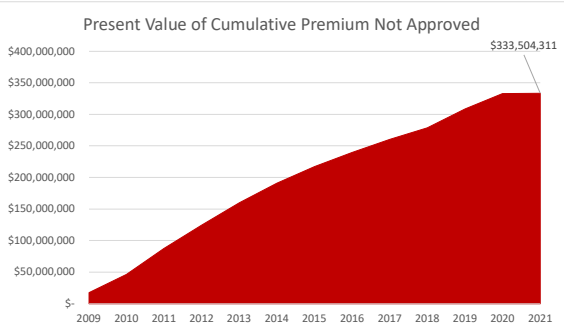
EXHIBIT 28

State	All States	State Approval Ratio	.62	Company Approval Ratio	.62
Status	All Historical				

Year Requested	Average Percent Requested	Average Percent Approved	Percent Approved Ratio	Percentage of Population Impacted
2009	24%	14%	.59	10%
2010	32%	12%	.37	33%
2011	33%	12%	.36	27%
2012	22%	13%	.59	10%
2013	20%	20%	1.00	1%
2014	0%	0%	N/A	0%
2015	0%	0%	N/A	0%
2016	40%	29%	.74	6%
2017	40%	16%	.39	2%
2018	23%	16%	.69	4%
2019	51%	0%	.00	28%
2020	0%	0%	N/A	0%







* SHIP Only, excludes reinsurance
** figures do not consider billing mode changes or benefit buy downs

*assumes a flat 3.5% interest rate

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 31

Received 3/31/2021 11:37:47 PM Commonwealth Court of Pennsylvania

Filed 3/31/2021 11:37:47 PM Commonwealth Court of Pennsylvania
1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

NOTICE OF FILING OF QUARTERLY REPORT

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as the Statutory Rehabilitator ("Rehabilitator") of Senior Health Insurance Company of Pennsylvania ("SHIP"), hereby gives notice to all interested persons currently on the Master Service List that on March 31, 2021, she has filed her Quarterly Report on the Status of the Rehabilitation of SHIP. An electronic copy of this filing will be available on the Court Documents page of the web site for SHIP in Rehabilitation, https://www.shipltc.com/. Paper copies will be distributed to the parties who requested and received placement on the hard copy service list.

Dated: March 31, 2021

Respectfully submitted,

/s/ Michael J. Broadbent
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Counsel for Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, as Statutory Rehabilitator of SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

Received 3/31/2021 11:37:47 PM Commonwealth Court of Pennsylvania

Filed 3/31/2021 11:37:47 PM Commonwealth Court of Pennsylvania
1 SHP 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

QUARTERLY REPORT OF THE REHABILITATOR ON THE STATUS OF THE REHABILITATION OF SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as the Statutory Rehabilitator ("Rehabilitator") of Senior Health Insurance Company of Pennsylvania ("SHIP"), hereby submits this quarterly report on the status of the rehabilitation of SHIP.

I. INTRODUCTION

SHIP was placed in rehabilitation by Order of this Court on January 29, 2020. On April 22, 2020, the Rehabilitator filed a Rehabilitation Plan and provided notice to all policyholders and interested parties of the filing that plan. There followed a period for formal and informal comments and objections. The chief insurance regulators from the states of Maine, Massachusetts and Washington applied for and were granted leave to intervene, as were a group of agents and brokers, certain insurers that had ceded insurance business to SHIP, the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA"), certain Health Insurers, and two individual policyholders (collectively, the "Intervenors"). After considering the positions articulated by the Intervenors, the formal and informal

comments, and the Rehabilitator's own continuing analysis, on October 21, 2020, the Rehabilitator filed the Amended Rehabilitation Plan. On February 25, 2021, the Court entered a Scheduling Order, *inter alia*, setting a hearing on the rehabilitation plan for May 17, 2021.

This report is intended to inform the Court about SHIP's current financial condition and certain collateral matters that may be of interest to the Court. For the information of the Court, the Special Deputy Rehabilitator ("SDR") has summarized information from several sources in this report. The descriptions of several matters are necessarily brief and may be incomplete. This report is not intended, and should not be interpreted, as a complete description of those matters. Its sole purpose is to advise the Court of significant developments in SHIP's rehabilitation proceeding. The SDR stands ready to respond to the Court's request for additional information regarding any of these matters.

II. REPORT

A. FINANCIAL STATUS

Attached as Exhibit A is a financial package prepared for the Court ("Financial Package") by SHIP and the SDR containing a detailed summary of the financial status of SHIP as of December 31, 2020. In summary, and as set forth in detail in the Financial Package, as of December 31, 2020, the total value of SHIP's assets is $1,369,908,000, and the total value of SHIP's liabilities is $2,592,415,000.

SHIP's total adjusted capital as of December 31, 2020, is $1,220,692,000. (Ex. A, Financial Package at 5.) The Financial Package includes financial reporting, trend tracking, professional and consulting fees, and an analytics dashboard for SHIP. The Notes set forth on page four and throughout the Financial Package should be included in any review of the information contained therein.

B. COVID-19

In December 2019, a new virus emerged in Wuhan, China, identified in due course as severe acute respiratory syndrome coronavirus 2, resulting in a pandemic of coronavirus disease 2019 ("COVID-19"). As of the filing of this report, at least 128 million people have been infected worldwide, resulting in at least 2.8 million deaths. In the United States, the first cases were reported in January 2020, with total estimates now exceeding thirty million and fatalities exceeding 550,000. COVID-19 is particularly threatening to the elderly and those with impaired respiratory systems or other underlying health conditions. While intense work continues around the globe, no effective cure has yet emerged. There has been substantial progress in efforts to develop and distribute several effective vaccines. At this time, about 16% of the U.S. population has been fully vaccinated. The implications of COVID-19 for the Plan fall in three major areas.

Case Management: Restrictions on travel and personal contact imposed as preventive measures have caused SHIP to revise, at least temporarily, the manner in which it conducts its business and, specifically, how it confirms eligibility for benefits and other aspects of case management. The vast majority of staff for SHIP

and its subsidiary Fuzion have been working from home during the last year. The transition was successful with no material loss in productivity. Although current protocols, which have now been in effect for about a year, emphasize means of communication other than in-person visits, the Company remains attentive to the needs of its insureds as well as to the important function of preventing fraud, waste and abuse. At this juncture, these changes are not expected to have a material effect on the Plan or on the options it will offer to eligible policyholders.

Mortality and Morbidity: Although sufficient reliable data is not yet available, preliminary data indicates that COVID-19 may be causing a decrease in the number of SHIP insureds filing claims and an increase in the number of deaths among the aging population insured by SHIP. While these unfortunate developments may combine to reduce slightly SHIP's deficit, it is possible that, at least in part, they are temporary. The Rehabilitator cannot yet project what, if any, permanent impact these consequences will have on the Plan.

Suspension of Premium Payments: Many SHIP policyholders have delayed making their required premium payment. While SHIP delayed lapsing or cancelling policies for non-payment of premiums because of the exceptional circumstances, protracted delays in making these payments may aggravate SHIP's financial difficulties. These delays are waning gradually. Some regulatory agencies have requested or required that insurers (including SHIP) accommodate some premium deferrals, but many of these deferrals are also expiring or will soon expire. Continued non-payment of premium beyond the expiration of the deferral period is expected to result in an increased number of policy terminations. The Rehabilitator has already observed a slight increase in the number of policy terminations that appear not to be the result of increased insured mortality. However, in the aggregate they are not expected to be material to the Plan.

C. REINSURANCE ASSUMED

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 Travellers 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.

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 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 insurance policies only.

On 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 ("AH&L")

long-term care insurance 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.

The insurance policies for which SHIP became responsible from Transamerica, Primerica and AH&L or their predecessors (the "ceding companies") are what is generally referred to in the industry as "reinsurance assumed." All of these assumed LTCI policies have historically been treated by SHIP for administrative purposes in a manner very similar to those issued directly by SHIP. However, communications with policyholders and regulators properly identified them as policies of the ceding companies.

It is important to note that while these policies have been reinsured by SHIP, they were never novated as part of the transactions. Thus, the policyholders retained, and continue to retain, their contractual rights against the ceding companies or their successors. In turn, the ceding companies retain contractual rights against SHIP.

The preliminary plan of rehabilitation filed on April 22, 2020, proposed to treat Direct Business and Reinsurance Assumed in the same way under the Plan. The Rehabilitator believed that this would be most advantageous to the affected policyholders. However, this proposal resulted in a number of objections from insurance regulators around the country, asserting that it departs from established

custom and practice and is unsupported by applicable law. In response to these objections, the Rehabilitator changed that provision of the preliminary plan of rehabilitation. The Amended Plan proposes to treat the reinsurance assumed differently from the policies issued directly by SHIP and its predecessors. As a result of this change, if the Plan is approved as proposed: (1) the reinsurance assumed policies will not be modified under the Plan and the policyholders will not be asked (or have the ability) to make elections under the Plan; (2) SHIP will not be financially responsible for claims and commissions owed under these policies and will not have the right to treat premiums paid by these policyholders as assets of SHIP; and (3) if SHIP is placed in liquidation, the terms of these policies will remain unchanged and the policyholders will not receive benefits from any life and health insurance Guaranty Association. Instead, in that case, the ceding companies (or their successors) will remain fully responsible for these policies and any claims and commissions owed under these policies.

Consistent with this change in the Plan, Transamerica and SHIP entered into a Recapture Agreement though which Transamerica assumed complete responsibility for the LTC insurance policies its predecessors had ceded to SHIP's predecessors. This Agreement was approved by the Court on December 29, 2020, and made effective October 1, 2020,.

D. KINGDOM ENERGY LOAN

In June 2016, SHIP entered into a Secured Term Note loaning $4.2 million to Kingdom Energy Resources, LLC; DDB Energy Resources, LLC; Montana Bakken, LLC; Little Creek Coal Co., Inc.; Green Equity Partners, LLC; and KEP-RMA, LLC (collectively, the "Borrowers"). At the same time, Conseco subsidiaries BRe BCLIC Primary and BRe WNIC 2013 LTC Primary loaned the Borrowers $11.8 million and $6 million, respectively. Collectively, SHIP and the Conseco subsidiaries loaned the Borrowers $22 million (the "Loan"). In November 2016, the Conseco subsidiaries assigned their interests in the Loan to Washington National Insurance Company ("WNIC") and Bankers Conseco Life Insurance Company ("BCLIC"; together, the "Conseco Lenders") respectively. As a result, WNIC and BLIC had 27.273% and 53.636% interests in the Loan, respectively, with the remaining 19.091% being SHIP's portion.

The Loan has been in default since late 2016. The current balance, including accrued and unpaid interest and fees, approximates $40 million, secured by approximately 19,500 acres of land located in Harlan and Bell Counties in southeastern Kentucky known as Pathfork, Left Fork, and Brookside (the "Collateral"). In August 2020, the Rehabilitator requested authority from this Court to purchase the Conseco Lenders' interests in the Loan for four million dollars ($4,000,000.00), for reasons more fully explained in her August 14, 2020, verified

Application. The Court granted the Application on September 25, 2020, and SHIP now owns the entire Loan.

Since acquiring the Conseco Lenders' interest in the Loan, SHIP has been exploring ways to maximize recovery, including negotiations with the Borrowers. Recognizing that foreclosure on the loan and obtaining the collateral may be necessary to effect a reasonable recovery, SHIP has engaged in due diligence on the Collateral. Also, anticipating the steps necessary to foreclose, SHIP has formed a Delaware limited liability company (HBKY, LLC) to serve as a special purpose entity that would hold the loan and the collateral, insulating SHIP from any associated potential liabilities.

As of the date of this report, SHIP is preparing to convey the loan to HBKY, LLC while continuing negotiations with the borrowers and related parties. If those negotiations prove fruitless, the Rehabilitator anticipates that HBKY, LLC will foreclose on the loan, secure the collateral, and attempt to dispose of it on the best terms possible.

E. COLLATERAL LITIGATION

There are very few pending litigation matters to which SHIP is a party. One is the remainder of the Beechwood litigation described below. Two are regulatory challenges to the Proposed Rehabilitation Plan, and the last is a small claim case.

1. Beechwood Litigation

Beginning in 2014 SHIP began investing what eventually became $320 million with Beechwood Capital Group, LLC and its affiliates ("Beechwood"). The relationship became complex and by 2016 it became evident that Beechwood had become embroiled in the collapse of the Platinum Partners Credit Opportunities Fund ("Platinum") and its affiliates. Seeking to recover losses under the Beechwood Investment Management Agreements, SHIP eventually joined in pending litigation by other Platinum and Beechwood clients. SHIP then became the target of a number of cross claims and counterclaims. SHIP was able to recover most of its defense costs for these proceedings from its liability insurers. In addition, SHIP recovered about $84 million of assets from the investment program. In due course, the SDR oversaw the wind-down of all but one aspect (discussed below) of the Beechwood litigation. The final piece was an agreement to settle the claims of the receiver appointed for Platinum by the United States Securities and Exchange Commission (SEC) against SHIP and SHIP's claims against Platinum (except as noted below), which resulted in an additional $9.5 million payment to SHIP with a possible additional $4.5 million recovery as the Platinum receivership winds down.

Remaining open are the claims related to the liquidation in the Cayman Islands of Platinum's affiliate, Platinum Partners Value Arbitrage Fund ("PPVA"). The claims in this proceeding (now pending in Delaware Chancery Court) include

competing claims by SHIP and PPVA's Joint Official Liquidators ("JOL") to certain collateral underlying Beechwood investments and claims by the JOL against SHIP for losses suffered by PPVA investors in a complicated transaction partially funded by SHIP under the Beechwood program but outside the Investment Management Agreements. That matter is currently the subject of a mediation proceeding.

2. Regulatory Challenges to the Proposed Plan

The proposed plan of rehabilitation provides policyholders with multiple options by which they can change the premiums and benefits of their existing insurance policy, avoiding certain future losses to SHIP by allowing policyholders to align their future coverage with their potential needs and ability to pay. The state insurance regulators of Louisiana and South Carolina have filed complaints in other jurisdictions to prevent this Court from considering such a plan and to prevent the Rehabilitator from implementing it.[1]

a. Louisiana

On September 11, 2020, James J. Donelon, in his capacity as the Commissioner of Insurance for the State of Louisiana, filed a Complaint in the United States District Court for the Middle District of Louisiana, naming as a defendant Commissioner Altman in her capacity as Rehabilitator of SHIP. *Donelon v. Altman*, Case No. 3:20-cv-00604 (M.D. La.). In the Complaint, Commissioner

[1] The insurance regulators of Louisiana and South Carolina elected not to intervene in this action.

Donelon seeks a declaratory judgment that the Rehabilitator cannot impose rate and benefit modifications on Louisiana policies without complying with Louisiana's laws and regulations, and seeks as well a permanent injunction against implementation or enforcement of the proposed plan if approved. The Rehabilitator disagrees strongly with the allegations in the Complaint and, should further litigation be necessary, will defend vigorously her ability to offer the policyholder choices provided by the Plan and Amended Plan.

On November 24, 2020, the Rehabilitator filed a Motion to Dismiss the Complaint on numerous grounds—specifically, the lack of case or controversy; the absence of personal jurisdiction; the Anti-Injunction Act's bar against the requested relief; Commissioner Donelon's failure to state a claim; and various federal court abstention doctrines. That motion is fully briefed and the parties are awaiting a decision from the Court. All proceedings are stayed pending a decision on the Motion to Dismiss. If the Court rules in favor of the Rehabilitator, the matter will be dismissed and terminated.

b. South Carolina

On December 10, 2020, Plaintiffs Raymond G. Farmer, in his capacity as Director of the South Carolina Department of Insurance, and the South Carolina Department of Insurance filed a Complaint naming as defendants Commissioner Altman, in her capacity as Rehabilitator of SHIP, Patrick Cantilo, in his capacity as

Special Deputy Rehabilitator of SHIP, and SHIP in rehabilitation. That Complaint was filed in South Carolina state court, in the Court of Common Pleas for the Fifth Judicial Circuit, Richland County. *Farmer v. Altman*, No. 2020-CP-4005802 (S.C. C.C.P.). On January 11, 2021, Defendants removed the matter to the United States District Court for the District of South Carolina where it is currently pending. *Farmer v. Altman*, Case No. 3:21-cv-00097 (D.S.C.).

In the Complaint, Commissioner Farmer and the South Carolina Department of Insurance seek a declaratory judgment that the proposed plan is invalid and unenforceable to the extent it does not comply with South Carolina's regulatory authority to set rates and benefits. Plaintiffs also seek a permanent injunction against implementing or enforcing the plan coupled with certain financial penalties for any act in violation of that injunction. As with the Louisiana litigation, the Rehabilitator disagrees strongly with the allegations in the Complaint. The proposed Plan and Amended Plan comport with all applicable laws, and South Carolina's decision to pursue collateral litigation is inappropriate.

Two motions are pending in South Carolina federal court. On January 19, 2021, Defendants filed a Motion to Dismiss on numerous grounds—specifically, the lack of case or controversy; the Anti-Injunction Act's bar against the requested relief; Plaintiffs failure to state a claim; the absence of personal jurisdiction; and various federal court abstention doctrines. That motion is fully briefed. On February

10, 2021, Plaintiffs filed a Motion to Remand, asking the federal court to remand the case to state court rather than dismiss it outright. That motion is fully briefed as well, and the parties are awaiting decisions on both motions. At present, all proceedings are stayed, including discovery, pending a decision on the Motion to Dismiss and Motion to Remand. If the Court rules in favor of the SHIP defendants, the matter will be dismissed and terminated. If the Court rules in favor of the South Carolina Plaintiffs, the matter will be remanded to state court, and the SHIP defendants will file a new Motion to Dismiss addressed to the procedural and substantive defects in the Complaint.

3. Anthony vs. SHIP

On July 27, 2020, Wayne L. Anthony sued SHIP in the Court of Common Pleas in Lancaster, Pennsylvania, for the cancellation of his policy for non-payment of premiums. SHIP believes strongly that the claim is without merit and does not believe that its result will be material to SHIP's financial condition or rehabilitation.

F. OTHER MATTERS

With the help of counsel, the SDR continues to investigate and assess all potential avenues for asset recovery, including but not limited to claims against third parties where necessary. Those investigations are ongoing, and the Rehabilitator and the SDR will advise the Court of any recovery made or litigation filed as a result.

Dated: March 31, 2021

Respectfully submitted,

/s/ Michael J. Broadbent

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EXHIBIT A

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Senior Health Insurance Company of Pennsylvania In Rehabilitation ("SHIP")

Court Reporting Package

December 31, 2020

SHIP Reporting Package
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SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

SHIP Reporting Package

Financial Reporting Package
As of December 31, 2020

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SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Monthly Financial Reporting Package
Notes
As of December 2020

1	Policyholder liabilities are not being adjusted in interim months between quarters. Liabilities are being reported based on the most recent quarter-end balance.
2	Provisions for income tax are not computed in interim months between quarters. The overall impact to the Company is immaterial given Company NOLs. In 2020, the Company reported a $273 thousand tax benefit resulting from its tax sharing agreement with its subsidiary Fuzion. On a consolidated basis, this benefit is offset by tax expense allocated to Fuzion.
3	Legal expenses related to investments (i.e. Beechwood litigation) were reclassed from investment expense to general expense in 2020.
4	Asset valuation reserve is not adjusted in interim months between quarters. The reserve reported is based on the most recent quarter-end balance. During Q3 2020, an increase in the reserve was due to the Company realizing $8 million in gains which included $6 million from Beechwood assets. The reduction in the Asset valuation reserve in Dec 2020 primarily relates to the Transamerica recapture.
5	Common stock balance for Q3 2019 onward includes the equity balance of the Company's wholly-owned subsidiary Fuzion. The balance of Fuzion is updated monthly based on the prior month's equity balance.
6	Various general expense items include rehabilitation expenses totaling $10.2 million from January through December 2020.
7	The Company has insurance against certain litigation costs. The amount receivable from this policy is recorded monthly under Insurance Carrier Receivable. Discussions continue with insurance carriers to push the reimbursement level from 65% to 100%; however, the financials currently reflect recovery at 65%. In November, the Company received $2.6 million payment based on an expected maximum benefit of $10 million from one of the carriers.
8	Taxes, Licenses & Fees includes $232 thousand in tax refunds received from the State of Florida and State of Illinois, as well as a $40 thousand true up of premium taxes accrued over 2019 that were filed and paid during Q1 2020. Additionally, costs related to rehabilitation were included in insurance department exam fees for FY2019 but moved to general expenses for FY2020. In November 2020, a credit of $44 thousand was recorded to Interest and Penalty expense as a result of interest from an IRS tax refund.
9	During Q1 2020, Oliver Wyman transitioned as the Company's actuaries and recognized higher premium deficiency reserves of $30 million due to no morbidity improvement and adjusting lapse rates. During Q2 2020, Oliver Wyman updated their model for lower new money rates as the portfolio turns over and increasing claim liability on certain policies that were not built into past models. These adjustments increased the premium deficiency reserves by another $80 million.
10	Remittance Items Not Allocated at the end of Q2 2020 includes proceeds from the sale of investments totaling $3.3 million that were recorded to the suspense account at June 30 and posted to the proper cash account as of July 1 by the Company's investment management firm. Investment income is not affected by this timing difference. Included in December 2020 is a Transamerica payable of $21.1 million which will be part of the settlement related to the recapture noted below in note #16.
11	The PPCO lawsuit was settled in August 2020. This included a cash settlement of $9.5 million of which $3.3 million reduced Other Invested Assets and $6.2 million was recorded as a realized gain. An additional $4.5 million was received in a Trust until the PPVA litigation is settled. This amount is not recorded in the financial statements due to uncertainty of receipt.
12	During Q3 2020, there were favorable underwriting results from higher than expected active life lapses. From March 2020 through August 2020, policies with past due premiums over 90 days were not cancelled due to coronavirus; in September, 238 of these policies were lapsed. On average, pre-coronavirus lapse activity was 30 to 40 lapses per month. All lapses have been caught up except in 4 states that have extended the COVID 19 regulation.
13	During Q3 2020, new claims were fewer than expected, resulting in $6 million favorability from 156 policies.
14	During Q3 2020, recoveries and exhautions on disabled life reserves were higher than expected, resulting in a favorable variance of $12 million from 239 policies, 136 due to deaths.
15	In November 2020, the increase in Other Investment Assets is due to the Company purchasing 100% of the interest in Kingdom Energy from CNO Financial Group (WNIC and BCLIC) for $4 million. Additionally the company wrote down its original investment in Kingdom, resulting in OTTI of $930 thousand. In December 2020, the Kingdom investment of $4 million was non-admitted.
16	Effective October 1st, Transamerica recaptured their block of business primarily resulting in a transfer of assets (primarily bonds), reserves and other liabilities and assets such as commission payable. The recapture resulted in a loss of $169 million.

Senior Health Insurance Company of Pennsylvania In Rehabilitation

Financial Summary

As of December 2020

(in 000s)

	Prior Year				Current Year					
	Q1-FY19	**Q2-FY19**	**Q3-FY19**	**Q4-FY19**	**Q1-FY20**	**Q2-FY20**	**Q3-FY20**	**Oct-2020**	**Nov-2020**	**Dec-2020**
Assets										
Invested Assets	2,120,050	2,053,850	1,949,842	1,886,939	1,808,648	1,744,218	1,702,048	1,683,373	1,658,356	1,351,105
Other Assets	17,360	18,350	19,994	20,242	20,120	17,488	17,157	15,959	14,822	18,803
Total Assets	**2,137,410**	**2,072,200**	**1,969,836**	**1,907,181**	**1,828,768**	**1,761,706**	**1,719,205**	**1,699,332**	**1,673,178**	**1,369,908**
Liabilities										
Policyholder Liabilities	2,597,561	2,547,356	2,498,460	2,805,641	2,808,630	2,835,523	2,760,544	2,760,544	2,760,544	2,544,157
Other Liabilities	21,120	21,084	12,216	17,639	16,505	13,912	29,037	29,490	20,694	48,258
Total Liabilities	2,618,680	**2,568,440**	**2,510,676**	**2,823,279**	**2,825,135**	**2,849,435**	**2,789,582**	**2,790,035**	**2,781,238**	**2,592,415**
Net Income YTD	**(13,083)**	**(26,817)**	**(80,074)**	**(462,034)**	**(80,262)**	**(170,654)**	**(150,121)**	**(170,108)**	**(188,333)**	**(305,847)**
Capital and Surplus	**(481,271)**	**(496,240)**	**(540,840)**	**(916,098)**	**(996,368)**	**(1,087,729)**	**(1,070,377)**	**(1,090,703)**	**(1,108,060)**	**(1,222,507)**
Total Adjusted Capital										
Capital and Surplus (Rollup)	(481,271)	(496,240)	(540,840)	(916,098)	(996,368)	(1,087,729)	(1,070,377)	(1,090,703)	(1,108,060)	(1,222,507)
Asset Valuation Reserve	1,839	3,319	47	206	600	1,934	5,801	5,801	5,801	1,816
Total Adjusted Capital	**(479,431)**	**(492,920)**	**(540,793)**	**(915,892)**	**(995,768)**	**(1,085,795)**	**(1,064,576)**	**(1,084,902)**	**(1,102,260)**	**(1,220,692)**
Member Count - Non NFO	41,066	39,692	38,526	37,281	35,869	34,794	33,706	32,925	32,444	31,693
Claim Count - Non NFO	6,272	6,185	6,122	5,997	5,783	5,617	5,422	5,233	5,169	4,971
** NFO members removed due to the limited liability with an average reserve at ~$4k*										
Invested Assets per Member	51.63	51.74	50.61	50.61	50.42	50.13	50.50	51.13	51.11	42.63
Policyholder Liabilities per Member	63.25	64.18	64.85	75.26	78.30	81.49	81.90	83.84	85.09	80.28

Senior Health Insurance Company of Pennsylvania In Rehabilitation

Monthly Financial Results - Balance Sheet

As of December 2020

(in 000s)

	Prior Year				Current Year					
	Q1-FY19	Q2-FY19	Q3-FY19	Q4-FY19	Q1-FY20	Q2-FY20	Q3-FY20	Oct-2020	Nov-2020	Dec-2020
Assets										
Bonds (16)	1,955,374	1,891,464	1,810,655	1,721,888	1,657,498	1,604,419	1,548,916	1,534,770	1,513,531	1,201,083
Preferred Stocks	109,433	109,433	86,271	86,271	86,271	79,903	79,903	79,903	79,903	77,608
Common Stocks (5)	613	937	3,336	3,578	3,957	4,153	4,264	4,327	4,507	4,735
Mortgage Loans	17,277	17,002	16,722	12,682	12,454	12,212	11,967	11,884	11,800	11,717
Cash and Short Term Investments	21,035	23,642	20,027	46,682	17,209	30,918	47,736	43,627	36,686	46,100
Other Invested Assets (11) (15)	11,818	11,372	12,739	15,701	14,732	12,612	9,263	8,863	11,928	9,862
Receivables for Securities	4,500	0	90	136	16,525	0	0	0	0	0
Insurance Carrier Recoverable (7)	0	0	2,334	3,588	3,324	1,006	1,497	1,565	0	421
Investment Income Due	15,125	14,039	13,132	12,082	12,189	11,720	10,852	11,201	11,578	9,363
Uncollected Premiums	930	879	758	928	880	862	879	564	567	961
Reinsurance Recoverable	55	49	25	22	83	178	52	12	38	59
Prepaid Expenses	0	0	0	0	0	0	18	18	46	42
Federal Tax Recoverable (2)	(121)	2,036	2,364	2,364	2,364	2,364	2,581	1,323	1,323	1,380
Guaranty Funds Recoverable	1,311	1,314	1,314	1,209	1,218	1,218	1,220	1,220	1,220	1,135
Transamerica Receivable (16)	0	0	0	0	0	0	0	0	0	5,408
Receivable from Affiliate	60	34	67	50	62	139	56	56	49	35
Total Assets	**2,137,410**	**2,072,200**	**1,969,836**	**1,907,181**	**1,828,768**	**1,761,706**	**1,719,205**	**1,699,332**	**1,673,178**	**1,369,908**
Liabilities										
Active Life Reserves (1) (12) (16)	1,283,062	1,257,168	1,232,067	1,234,831	1,202,619	1,177,017	1,141,574	1,141,574	1,141,574	1,047,770
Active Life Reserves - PDR (1) (9) (16)	291,202	277,403	263,605	590,807	640,834	720,935	695,282	695,282	695,282	728,008
Active Life Reserves - PDR (IMR Release) (1)	63,280	57,430	51,580	45,730	42,946	40,161	37,377	37,377	37,377	34,592
Disabled Life Reserves (1) (13) (14) (16)	958,260	953,835	949,653	932,811	920,835	896,046	885,098	885,098	885,098	732,814
Advanced Premiums (1) (16)	1,757	1,519	1,555	1,462	1,397	1,365	1,214	1,214	1,214	972
Reinsurance Payable	20	35	34	18	18	(39)	16	14	15	16
Interest Maintenance Reserve (16)	1,936	2,303	3,317	4,746	5,293	5,525	5,849	5,885	5,757	18,457
Commissions Due (16)	716	491	496	581	592	579	527	872	1,223	433
General Expenses Due	4,765	3,626	3,628	6,630	4,813	3,544	3,512	3,700	4,440	2,965
Taxes, licenses and fees Due	434	497	538	414	430	491	552	547	581	480
Federal Income Tax Due (2)	(2,051)	0	0	0	0	0	0	0	0	0
Remittance Items Not Allocated (10) (16)	249	233	205	330	459	(3,147)	233	276	301	21,539
Payable to Affiliate	(9)	0	140	0	0	0	0	3	0	0
Asset Valuation Reserve (4)	1,839	3,319	47	206	600	1,934	5,801	5,801	5,801	1,816
Payable for securities	10,531	8,000	1,110	1,976	1,543	2,553	9,929	9,874	0	0
Unclaimed Property (16)	2,689	2,579	2,702	2,738	2,758	2,472	2,618	2,518	2,577	2,553
Total Liabilities	**2,618,680**	**2,568,440**	**2,510,676**	**2,823,279**	**2,825,135**	**2,849,435**	**2,789,582**	**2,790,035**	**2,781,238**	**2,592,415**
Capital and Surplus										
Common and Preferred Stock	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500
Surplus Note	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Paid In Capital	1,196,326	1,196,326	1,198,824	1,198,824	1,198,824	1,198,824	1,198,824	1,198,824	1,198,824	1,198,824
Unassigned Surplus	(1,720,699)	(1,720,699)	(1,720,699)	(1,720,699)	(2,172,422)	(2,172,422)	(2,172,422)	(2,172,422)	(2,172,422)	(2,172,422)
Net Income Current Year	(13,083)	(26,817)	(80,074)	(462,034)	(80,262)	(170,654)	(150,121)	(170,108)	(188,333)	(305,847)
Unrealized Gain/Loss	442	698	599	842	379	878	1,428	1,097	1,960	2,188
Change in Nonadmitted Assets	24	14	2,999	9,617	8	(127)	9	1	6	(1,140)
Change in Asset Valuation Reserve (4)	(1,781)	(3,261)	11	(148)	(394)	(1,728)	(5,595)	(5,595)	(5,595)	(1,610)
Total Capital and Surplus	**(481,271)**	**(496,240)**	**(540,840)**	**(916,098)**	**(996,368)**	**(1,087,729)**	**(1,070,377)**	**(1,090,703)**	**(1,108,060)**	**(1,222,507)**
Liabilities, Capital and Surplus	**2,137,410**	**2,072,200**	**1,969,836**	**1,907,181**	**1,828,768**	**1,761,706**	**1,719,205**	**1,699,332**	**1,673,178**	**1,369,908**

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Monthly Financial Results - Income Statement
As of December 2020
(in 000s)

	Prior Year					Current Year					
	Q1-FY19	Q2-FY19	Q3-FY19	Q4-FY19	FY2019	Q1-FY20	Q2-FY20	Q3-FY20	Oct-2020	Nov-2020	Dec-2020
Investment Income											
Investment income, gross without IMR	20,897	20,859	20,354	18,483	80,593	19,353	17,590	15,670	5,417	4,866	5,024
Amortization of IMR (16)	60	54	107	277	497	197	108	220	84	64	1,826
Net Realized Capital Gains (Losses) (11) (15) (16)	350	541	(35,189)	(4,251)	(38,549)	(13,511)	402	6,829	155	(1,746)	18,390
Gains/(Losses) transferred to IMR (16)	(430)	(421)	(1,121)	(1,706)	(3,679)	(744)	(340)	(545)	(120)	64	(14,526)
Investment Expenses (3) (16)	(2,314)	(3,262)	(2,082)	(3,037)	(10,695)	471	(997)	(269)	(90)	(90)	(78)
Other Income	0	0	0	0	0	0	0	0	0	0	0
Total Investment Income	**18,562**	**17,771**	**(17,930)**	**9,765**	**28,168**	**5,766**	**16,763**	**21,906**	**5,446**	**3,159**	**10,636**
Management Income	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**144**
Underwriting Income											
Premiums - Collected and Waived (16)	21,500	19,880	18,899	18,197	78,476	18,014	16,964	15,459	4,909	4,977	3,808
Premium Accruals (16)	(233)	626	886	917	2,196	256	395	1,130	(307)	3	1,375
Claims Paid and Waived (16)	(90,528)	(92,348)	(93,820)	(92,930)	(369,626)	(90,344)	(88,588)	(82,797)	(26,655)	(23,793)	(21,024)
Claims - Change in Reserves (1) (13) (14) (16)	692	4,414	4,167	16,830	26,104	11,957	24,771	10,917	0	0	95,663
Change in ALR (1) (12) (16)	28,572	25,470	24,069	(3,404)	74,708	31,991	25,375	34,377	0	0	37,339
Change in Premium Deficiency Reserve (1) (9) (16)	13,798	13,798	13,798	(327,202)	(285,807)	(50,028)	(80,100)	25,653	0	0	(77,438)
Change in PDR (IMR Release) (1) (16)	5,343	5,850	5,850	5,850	22,892	2,785	2,785	2,785	0	0	2,785
Reinsurance Activity (16)	0	0	0	0	0	0	0	0	0	0	(168,507)
Total Underwriting Income	**(20,855)**	**(22,309)**	**(26,151)**	**(381,742)**	**(451,057)**	**(75,369)**	**(98,400)**	**7,523**	**(22,053)**	**(18,813)**	**(125,997)**
Expenses											
Commissions (16)	1,540	1,399	1,308	1,408	5,654	1,303	1,265	1,083	346	347	278
General Insurance Expense (3) (6) (7)	7,923	7,071	7,374	7,028	29,396	9,270	7,194	7,690	2,973	2,170	2,010
Insurance Taxes, Licenses & Fees (8)	794	726	823	1,547	3,890	85	296	340	60	54	65
Total Expenses	**10,256**	**9,196**	**9,505**	**9,983**	**38,940**	**10,658**	**8,755**	**9,113**	**3,380**	**2,570**	**2,353**
Net Gain (Loss) from Operations	**(12,549)**	**(13,734)**	**(53,586)**	**(381,960)**	**(461,829)**	**(80,262)**	**(90,392)**	**20,316**	**(19,987)**	**(18,225)**	**(117,571)**
**Investment Income plus Underwriting less Expenses*											
Federal Income Tax Expense (Benefit) (2)	534	0	(329)	0	205	0	0	(217)	0	0	(57)
Net Income	**(13,083)**	**(13,734)**	**(53,257)**	**(381,960)**	**(462,034)**	**(80,262)**	**(90,392)**	**20,533**	**(19,987)**	**(18,225)**	**(117,514)**

Senior Health Insurance Company of Pennsylvania In Rehabilitation

Monthly Financial Results - Expenses

As of December 2020

(In 000s)

	Prior Year					Current Year					
	Q1-FY19	Q2-FY19	Q3-FY19	Q4-FY19	FY2019	Q1-FY20	Q2-FY20	Q3-FY20	Oct-2020	Nov-2020	Dec-2020
General Insurance Expense											
Service/Administration Fee	3,195	3,195	3,195	3,195	12,779	3,195	3,161	3,179	1,060	1,060	1,060
LTCG Fees (6)	2,736	2,744	2,732	2,650	10,862	2,726	2,502	2,405	790	745	941
Actuarial Fees - Valuation (6)	1,289	970	867	959	4,085	2,299	1,708	1,151	408	342	125
Legal Fees (3) (6) (7)	2,446	3,017	2,050	2,800	10,313	(111)	(1,105)	(391)	313	(600)	(475)
Portfolio Management Fees	297	254	277	271	1,100	238	260	258	86	85	75
Mortgage Loans Service Fees	15	13	12	11	51	9	8	10	4	5	3
Audit Fees - External	105	80	21	-	206	107	92	-	-	-	-
Software Development	68	48	33	30	178	3	155	267	90	94	-
Appl Software Lic and Fees	-	(60)	15	-	(45)	-	-	-	-	-	-
Bank Service Charges	-	0	-	-	-	-	-	-	-	-	-
Claim Cost Containment	41	28	34	26	130	15	20	20	7	1	9
Consulting (6)	8	29	173	67	276	307	1,125	982	259	405	268
Legal Fees - Claim Settlement	-	-	2	-	2	-	-	-	-	-	-
Medical Reports	-	-	-	3	3	-	-	-	-	-	-
Miscellaneous Expenses	8	0	15	13	36	-	-	-	(1)	-	(8)
Postage and Printing (6)	4	0	6	2	13	1	232	72	2	67	17
Election Package	-	-	-	-	-	-	-	-	23	23	71
Tax Consultation Fees	19	11	16	32	77	5	24	-	45	30	3
Employee Medical	6	3	6	5	21	3	6	6	-	2	2
Agents' Balances Charged Off	0	(0)	1	2	3	3	-	-	-	-	-
Investment Expense - Reclass	(2,314)	(3,262)	(2,082)	(3,037)	(10,695)	471	(997)	(269)	(90)	(90)	(78)
Total General Insurance Expense	**7,923**	**7,071**	**7,374**	**7,028**	**29,396**	**9,270**	**7,194**	**7,690**	**2,973**	**2,170**	**2,010**
Investment Expense - Reclass	(2,314)	(3,262)	(2,082)	(3,037)	(10,695)	471	(997)	(269)	(90)	(90)	(78)
Total General Insurance Expense before Reclass	**10,237**	**10,333**	**9,456**	**10,065**	**40,090**	**8,799**	**8,190**	**7,959**	**3,064**	**2,260**	**2,088**
Insurance Taxes, Licenses & Fees											
General Assessments	17	8	14	2	42	5	5	2	-	1	-
Guaranty Assoc Assessments	205	1	3	42	250	1	2	1	10	18	(15)
Insurance Dept Exam Fees (8)	273	315	496	1,213	2,297	-	-	-	-	-	-
Interest & Penalties Fees (8)	0	1	2	0	3	1	1	-	-	(44)	1
Licenses and Fees	12	20	15	15	62	49	21	14	-	4	4
Municipal Taxes	(12)	7	12	0	7	12	6	10	-	-	-
Premium Taxes	298	376	280	277	1,231	249	261	313	49	75	75
State Taxes (8)	-	(1)	-	(1)	(3)	(232)	-	-	-	-	-
Other Taxes	-	-	-	-	-	1	-	-	-	-	
Total Insurance Taxes, Licenses & Fees	**794**	**726**	**823**	**1,547**	**3,890**	**85**	**296**	**340**	**60**	**54**	**65**

SHIP Reporting Package

Trend Tracking

As of December 31, 2020

Contents:

i. 2018-2020 Numbers
ii. Net Investment Income
iii. Collected Premium and Paid Claims
iv. Change in Claim Reserves
v. Change in Active Life Reserves (“ALR”)
vi. Change in Premium Deficiency Reserves
vii. General Expenses

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Senior Health Insurance Company of Pennsylvania In Rehabilitation
December 31, 2020
in 000s

	Jan-2020	Feb-2020	Mar-2020	Apr-2020	May-2020	Jun-2020	Jul-2020	Aug-2020	Sep-2020	Oct-2020	Nov-2020	Dec-2020
Investment Income Collected	$ 7,093	$ 6,024	$ 6,790	$ 5,848	$ 6,129	$ 6,270	$ 5,522	$ 5,278	$ 5,566	$ 5,674	$ 5,657	$ 5,219
Change in Investment Due and Accrued	(192)	(162)	(200)	(205)	(238)	(214)	(259)	(216)	(221)	(256)	(790)	(194)
Net Investment Income	6,900	5,862	6,590	5,643	5,891	6,056	5,263	5,062	5,345	5,417	4,866	5,024
Realized Gains/(Losses)	69	520	(14,101)	(2)	391	12	(44)	6,239	634	155	(1,746)	18,390
Gains/Losses Transf to IMR	(54)	(367)	(323)	1	(309)	(32)	(272)	(80)	(192)	(120)	64	(14,526)
Amortization of IMR	60	67	70	(18)	70	56	78	54	88	84	64	1,826
Investment General Expenses	(549)	(333)	1,353	(816)	(93)	(87)	(88)	(91)	(89)	(90)	(90)	(78)
Premiums Collected & Waived	6,192	5,861	5,961	5,795	5,515	5,654	5,325	5,245	4,889	4,909	4,977	3,808
Premiums Accrued	(391)	(538)	1,185	(0)	(150)	545	(112)	73	1,168	(307)	3	1,375
Earned Premium	5,801	5,323	7,146	5,795	5,365	6,199	5,214	5,318	6,057	4,602	4,980	5,184
Claims Paid and Waived	(31,274)	(29,010)	(30,060)	(29,643)	(29,021)	(29,924)	(28,154)	(27,615)	(27,028)	(26,655)	(23,793)	(21,024)
Change in Claim Reserves	0	-	11,957	0	-	24,770	0	-	10,917	-	-	95,663
Change in Active Life Reserves	0	-	31,991	(0)	-	25,375	(0)	-	34,377	-	-	37,339
Change in Premium Deficiency Reserves	0	-	(50,028)	0	-	(80,100)	0	-	25,653	-	-	(77,438)
Change in PDR (IMR Release)	(0)	-	2,785	0	-	2,785	0	-	2,785	-	-	2,785
Incurred Claims	(31,274)	(29,010)	(33,355)	(29,643)	(29,021)	(57,094)	(28,154)	(27,615)	46,703	(26,655)	(23,793)	37,325
Reinsurance Activity	-	-	-	-	-	-	-	-	-	-	-	(168,507)
Management Income	-	-	-	-	-	-	-	-	-	-	-	144
Commissions	432	426	445	438	408	418	377	379	327	346	347	278
G&A Expenses (excluding Inv Exp Reclass)	3,595	3,430	1,774	1,480	3,989	2,722	2,451	2,832	2,676	3,064	2,260	2,088
G&A Expenses (including Inv Exp Reclass)	3,045	3,098	3,127	663	3,896	2,634	2,362	2,741	2,586	2,973	2,170	2,010
Taxes, Licenses and Fees	133	212	(28)	98	90	108	184	113	43	60	54	65
Federal and State Taxes	0	0	(232)	-	-	-	0	-	(217)	0	-	(57)
Net Income	$ (22,658)	$ (21,672)	$ (35,932)	$ (20,240)	$ (22,100)	$ (48,052)	$ (20,927)	$ (14,347)	$ 55,807	$ (19,987)	$ (18,225)	$ (117,514)

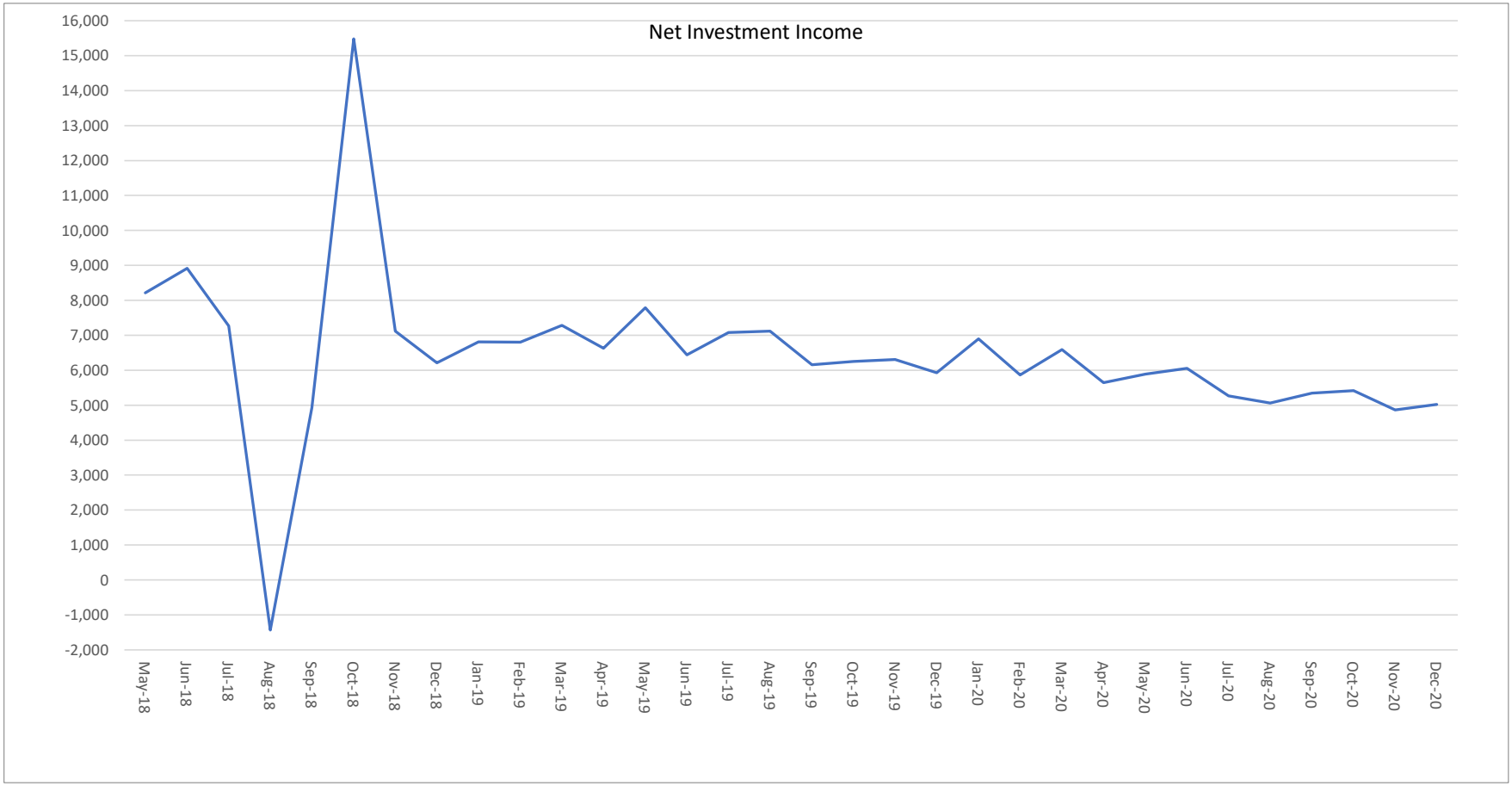
Senior Health Insurance Company of Pennsylvania In Rehabilitation
December 31, 2019
in 000s

	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019
Investment Income Collected	$ 6,954	$ 6,961	$ 7,397	$ 6,773	$ 7,944	$ 6,608	$ 7,258	$ 7,309	$ 6,354	$ 6,495	$ 6,878	$ 6,171
Change in Investment Due and Accrued	(140)	(160)	(116)	(143)	(159)	(164)	(180)	(190)	(197)	(246)	(575)	(240)
Net Investment Income	6,814	6,801	7,281	6,630	7,784	6,444	7,078	7,119	6,157	6,249	6,304	5,931
Realized Gains/(Losses)	(179)	209	320	403	235	(97)	53	741	(35,982)	455	493	(5,200)
Gains/Losses Transf to IMR	(10)	(167)	(253)	(312)	(186)	76	(42)	(585)	(494)	(360)	(389)	(958)
Amortization of IMR	13	3	44	6	27	21	24	37	46	60	81	136
Investment General Expenses	(931)	(974)	(409)	(793)	(884)	(1,585)	(1,314)	(653)	(115)	(1,189)	(1,531)	(317)
Premiums Collected & Waived	7,284	7,035	7,181	6,879	6,589	6,412	6,655	6,016	6,228	6,053	5,349	6,795
Premiums Accrued	118	49	(400)	201	29	396	286	(230)	830	(134)	636	415
Earned Premium	7,402	7,084	6,781	7,080	6,618	6,808	6,941	5,786	7,058	5,919	5,985	7,210
Claims Paid and Waived	(31,166)	(30,515)	(28,848)	(32,198)	(31,578)	(28,572)	(32,551)	(31,768)	(29,501)	(31,808)	(30,968)	(30,154)
Change in Claim Reserves	702	1,218	(1,228)	1,608	2,107	700	2,497	3,472	(1,802)	4,809	4,809	7,213
Change in Active Life Reserves	9,462	9,462	9,649	10,417	10,417	4,636	9,018	9,018	6,034	10,054	10,054	(23,513)
Change in Premium Deficiency Reserves	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	(336,401)
Change in PDR (IMR Release)	1,908	1,908	1,528	1,950	1,950	1,950	1,950	1,950	1,950	1,950	1,950	1,950
Incurred Claims	(14,495)	(13,328)	(14,300)	(13,624)	(12,505)	(16,687)	(14,486)	(12,729)	(18,720)	(10,396)	(9,555)	(380,905)
Commissions	486	532	522	493	469	438	428	439	440	409	417	582
G&A Expenses (excluding Inv Exp Reclass)	3,550	3,717	2,970	3,285	3,471	3,577	3,942	3,209	2,305	3,577	3,870	2,617
G&A Expenses (including Inv Exp Reclass)	2,619	2,744	2,560	2,492	2,587	1,992	2,628	2,556	2,190	2,388	2,339	2,301
Taxes, Licenses and Fees	185	231	378	185	364	179	285	199	338	568	436	544
Federal and State Taxes	-	-	534	(1)	-	-	-	-	(329)	0	-	(2)
Net Income	$ (4,674)	$ (3,877)	$ (4,531)	$ (3,777)	$ (2,329)	$ (7,628)	$ (5,088)	$ (3,478)	$ (44,691)	$ (2,626)	$ (1,807)	$ (377,527)

Senior Health Insurance Company of Pennsylvania In Rehabilitation
December 31, 2018
in 000s

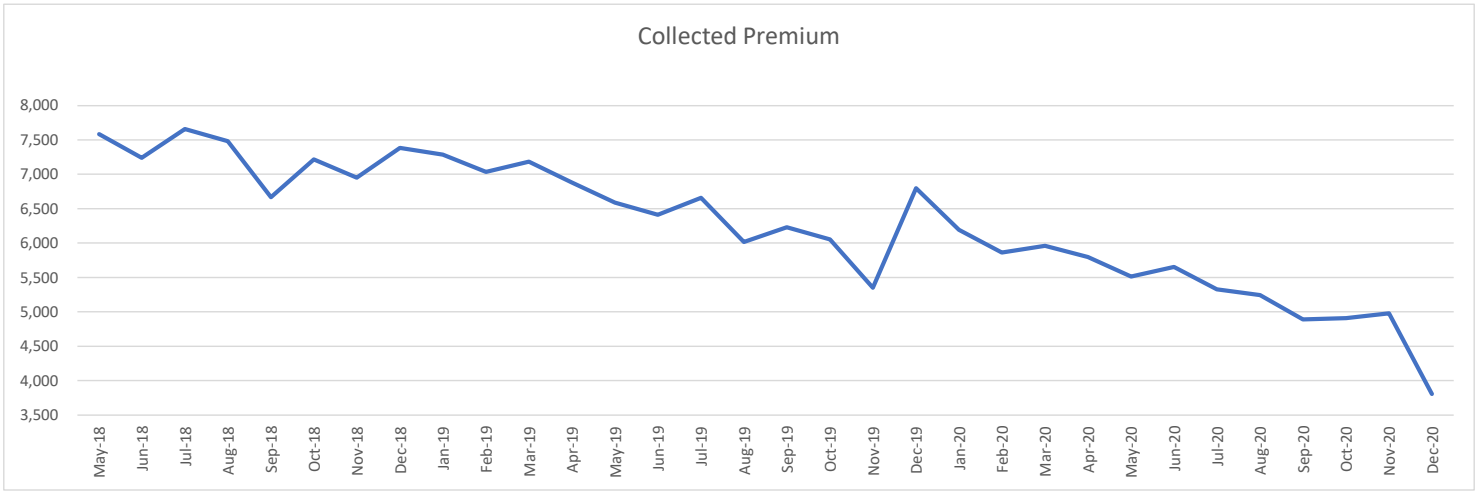
	May-2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct-2018	Nov-2018	Dec-2018
Investment Income Collected	$ 8,390	$ 9,098	$ 7,449	$ 129	$ 5,102	$ 15,629	$ 7,153	$ 6,385
Change in Investment Due and Accrued	(177)	(184)	(184)	(1,565)	(172)	(153)	(36)	(178)
Net Investment Income	8,213	8,914	7,265	(1,436)	4,930	15,476	7,117	6,208
Realized Gains/(Losses)	(925)	(225)	222	(102)	(18,326)	(0)	61	(150,232)
Gains/Losses Transf to IMR	(285)	(2)	57	78	(436)	13	(154)	610
Amortization of IMR	198	48	75	45	128	56	54	(431)
Investment General Expenses	(167)	(141)	(179)	(201)	(308)	(139)	43	(3,347)
Premiums Collected & Waived	7,584	7,237	7,657	7,478	6,664	7,213	6,951	7,383
Premiums Accrued	16	402	361	62	916	(188)	530	536
Earned Premium	7,600	7,639	8,018	7,540	7,580	7,025	7,482	7,919
Claims Paid and Waived	(32,222)	(29,841)	(32,872)	(32,497)	(28,714)	(28,618)	(30,220)	(30,187)
Change in Claim Reserves	1,455	6,353	1,388	1,918	(32,758)	3,320	3,320	(29,131)
Change in Active Life Reserves	12,803	7,387	12,319	12,319	352	11,238	11,238	5,052
Change in Premium Deficiency Reserves	625	625	625	625	625	625	625	(296,875)
Change in PDR (IMR Release)	4,281	4,281	4,281	4,281	4,281	4,281	4,281	4,281
Incurred Claims	(13,058)	(11,194)	(14,259)	(13,354)	(56,214)	(9,154)	(10,756)	(346,860)
Commissions	547	594	514	531	522	486	531	(400)
G&A Expenses (excluding Inv Exp Reclass)	3,439	3,158	3,524	3,635	3,207	3,344	2,752	3,347
G&A Expenses (including Inv Exp Reclass)	3,272	3,017	3,345	3,435	2,898	3,205	2,794	0
Taxes, Licenses and Fees	772	223	270	214	60	147	149	(14)
Federal and State Taxes	-	(218)	-	-	(115)	5	-	(146)
Net Income	$ (3,014)	$ 1,422	$ (2,932)	$ (11,609)	$ (66,011)	$ 9,435	$ 371	$ (485,572)

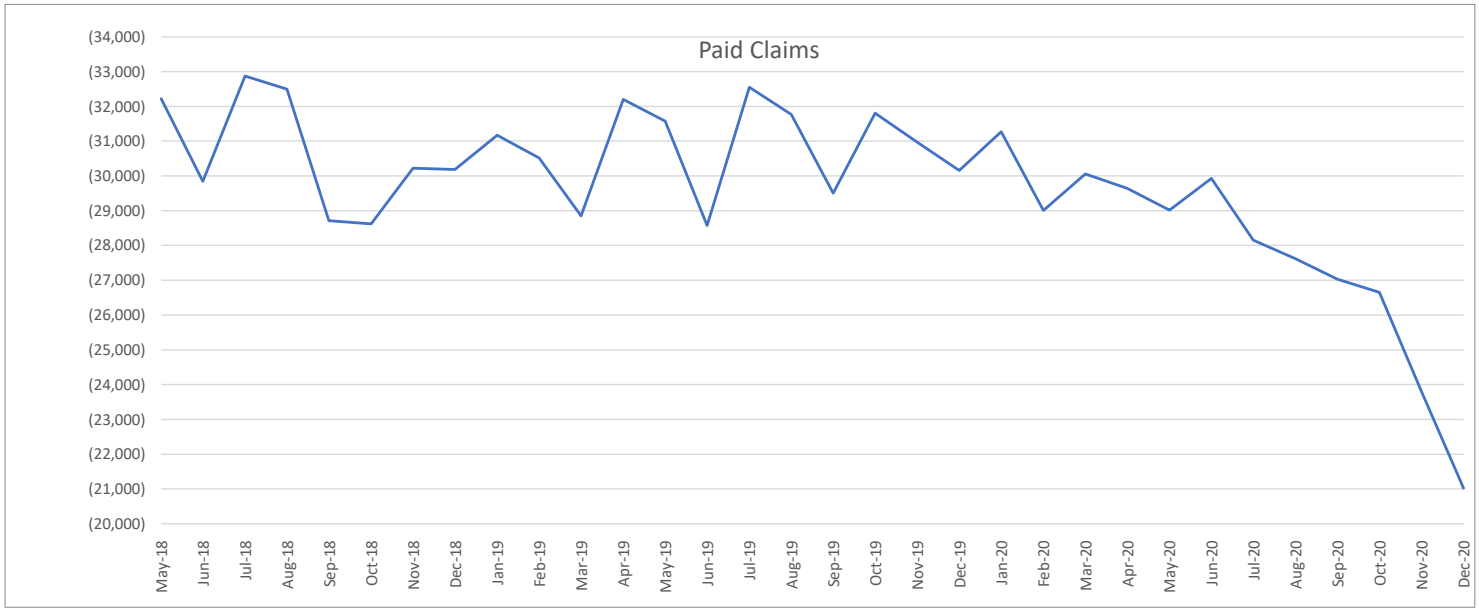
Senior Health Insurance Company of Pennsylvania In Rehabilitation
Trended Net Investment Income
December 31, 2020
in 000s



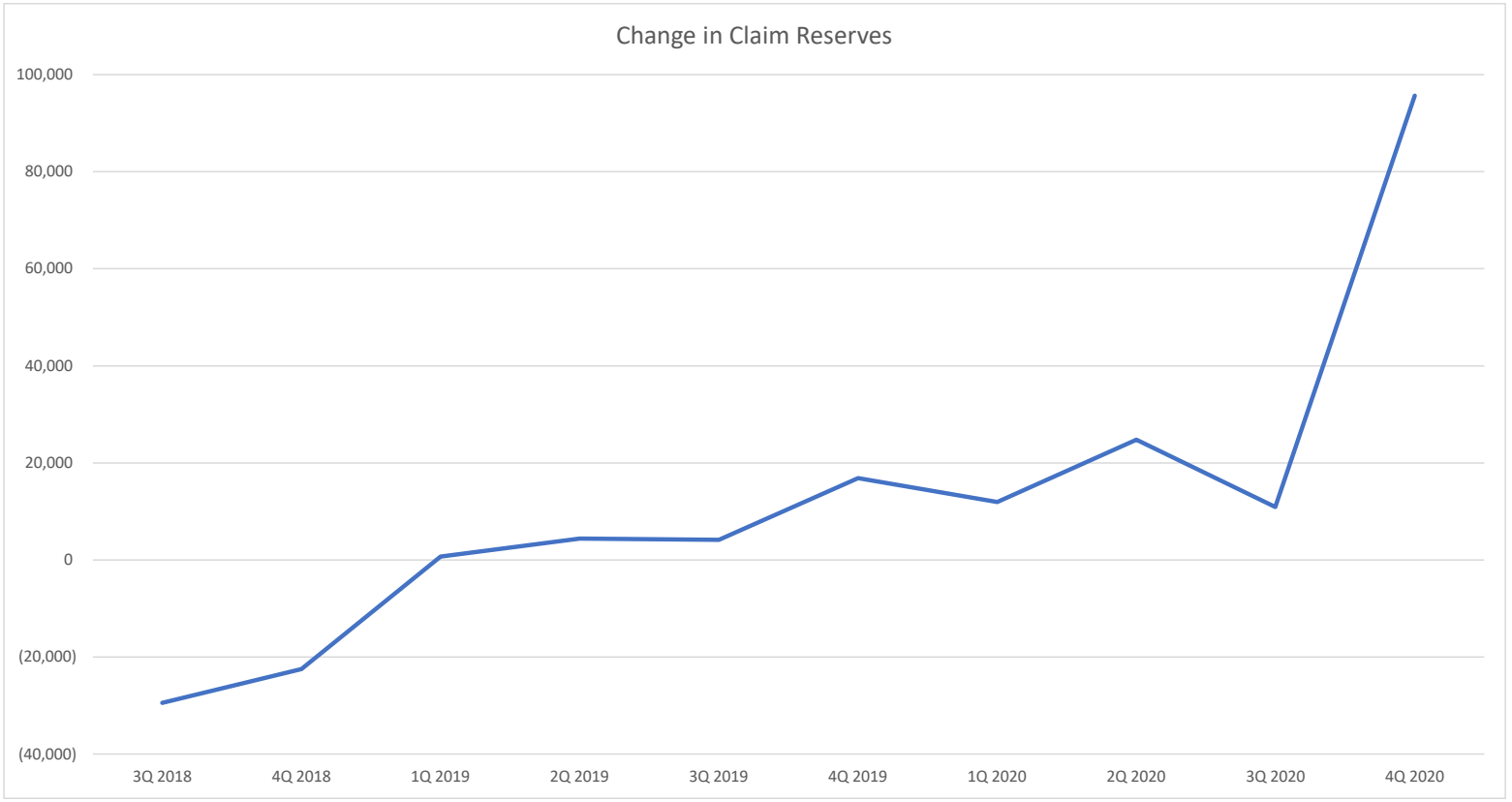
The Company wrote off interest of $9.3 million related to certain Beechwood assets in August 2018 due to expectations of not receiving the interest. In October 2018, the Company received a distribution of $7.4 million from Equipment Finance V, a Beechwood asset.

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Trended Collected Premium and Paid Claims
December 31, 2020
in 000s

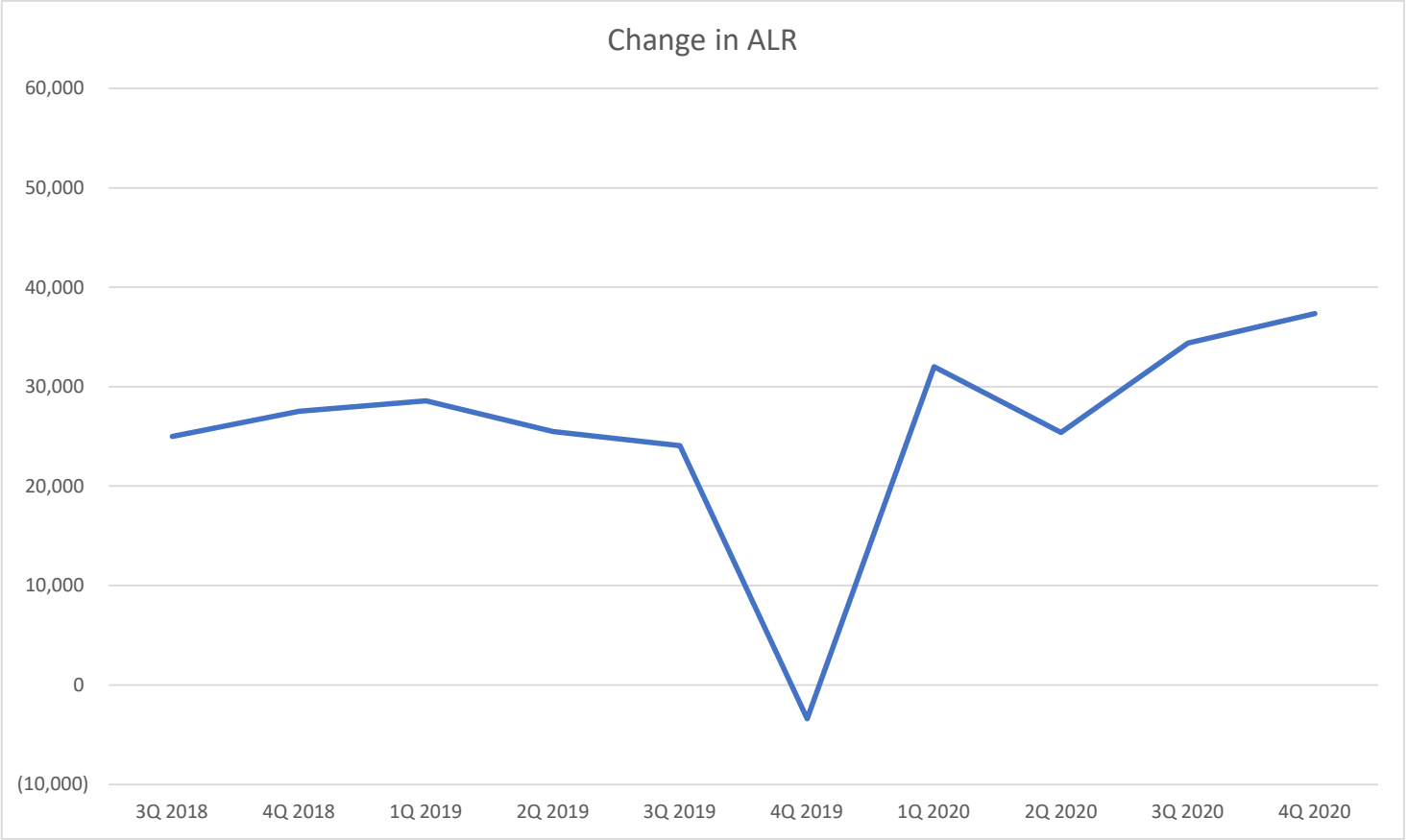




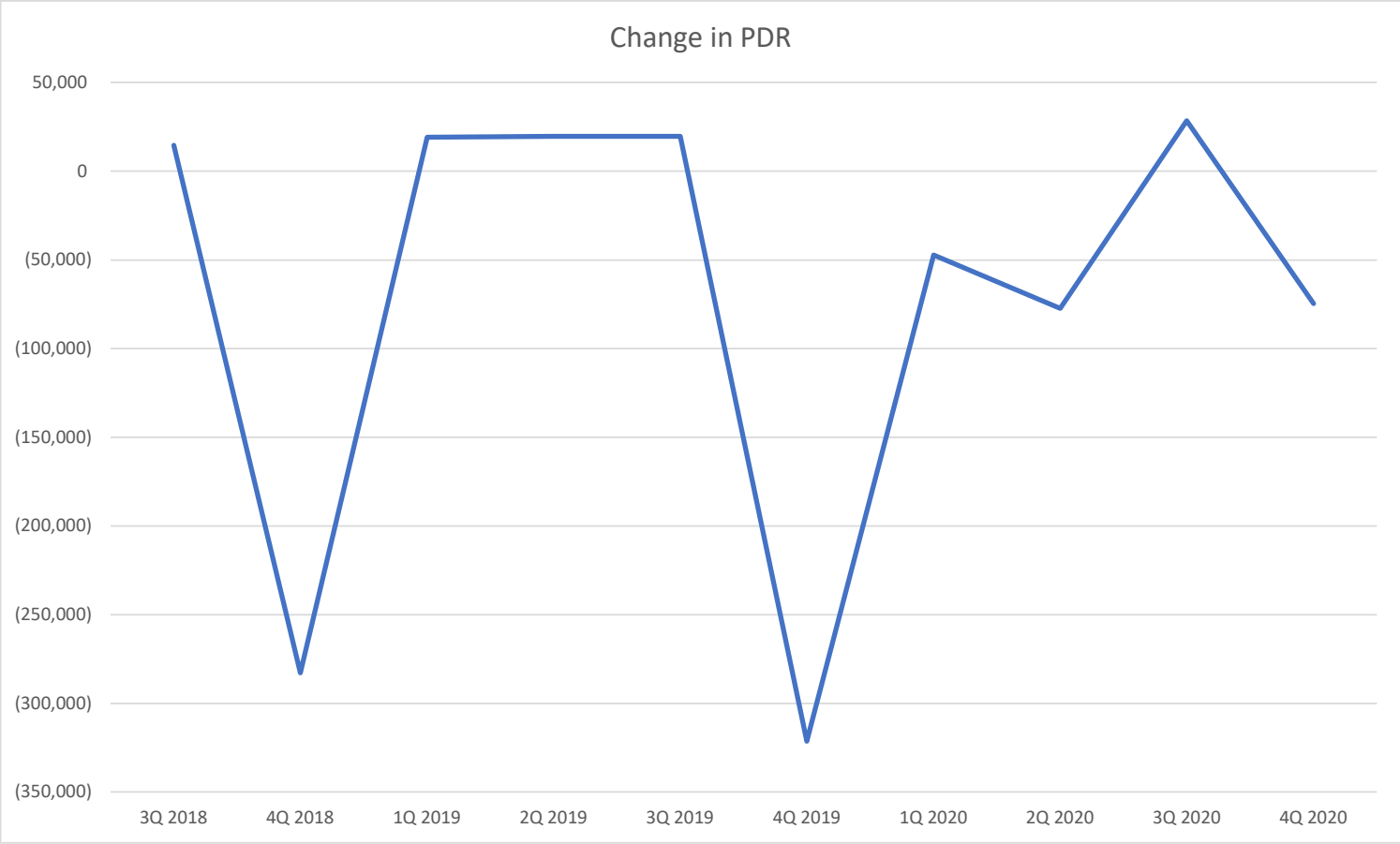
Senior Health Insurance Company of Pennsylvania In Rehabilitation
Quarterly Trended Change in Claim Reserves
December 31, 2020
in 000s



Senior Health Insurance Company of Pennsylvania In Rehabilitation
Quarterly Trended Change in ALR
December 31, 2020
in 000s



Senior Health Insurance Company of Pennsylvania In Rehabilitation
Quarterly Trended Change in PDR
December 31, 2020
in 000s



Senior Health Insurance Company of Pennsylvania In Rehabilitation
Trended General Expenses Excluding Investment Expense Legal Litigation
December 31, 2020
in 000s



SHIP Reporting Package

Professional and Consulting Fees
As of December 31, 2020

Contents:

i. SHIP Rehabilitation Expenses since Rehabilitation Order

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Rehabilitation Expenses after Rehabilitation Order
Period Ending December 31, 2020

Vendor	Inception (Feb 2020 to date)	2020	
		YTD	Dec-20
Legal Fees			
Cozen O'Connor	$ 951,846	$ 951,846	$ (242,244)
Scribner Hall	27,532	27,532	-
Total Rehabilitation Legal Fees	979,378	979,378	(242,244)
Actuarial Fees			
Milliman	20,789	20,789	-
Oliver Wyman	4,229,759	4,229,759	120,214
Total Rehabilitation Actuarial Fees	4,250,548	4,250,548	120,214
Outsourced Services			
E-gineering	260,314	260,314	21,313
LTCG	751,769	751,769	170,405
Priority Press	179,124	179,124	16,625
TPG Direct	69,650	69,650	69,650
Kinsella Media	1,775	1,775	1,775
William J Mansfield	209,145	209,145	-
Zeldis	39,700	39,700	(1,000)
Total Rehabilitation Outsourced Services	1,511,477	1,511,477	278,768
Estate Management Expense			
Cantilo & Bennett	1,916,418	1,916,418	180,000
RLR Management Services	609,223	609,223	62,500
Statutory Rehabilitator	342,248	342,248	3,914
Total Rehabilitation Estate Management Expense	2,867,889	2,867,889	246,414
Total Rehabilitation Expenses	**$ 9,609,292**	**$ 9,609,292**	**$ 403,152**

SHIP Reporting Package

Analytics Dashboard
As of December 31, 2020

Contents:

i. Financial Highlights
ii. Policies, Premiums and Reserves by Product and Company
iii. Inforce Policy Persistency Ratio
iv. LTC Inforce Business by Resident State
v. LTC Lapse/Cancel Summary
vi. Claims Analysis
vii. Complaints Analysis

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard

4th Quarter Dashboard
December 31, 2020

Financial Highlights ($000s)

Balance Sheet	Q4-FY19	Q1-FY20	Q2-FY20	Q3-FY20	Q4-FY20
	12/31/2019	3/31/2020	6/30/2020	9/30/2020	12/31/2020
SHIP Invested Assets	1,589,886	1,509,551	1,442,341	1,400,864	1,351,105
Transamerica Trust	297,053	299,097	301,877	301,184	-
Total Admitted Assets	1,907,181	1,828,768	1,761,706	1,719,205	1,369,908
Reserves	2,805,641	2,808,630	2,835,523	2,760,544	2,544,157
Total Liabilities	2,823,279	2,825,135	2,849,435	2,789,582	2,592,415
Capital and Surplus	(916,098)	(996,368)	(1,087,729)	(1,070,377)	(1,222,507)

Statement of Operations	Q4-FY19		Q1-FY20		Q2-FY20		Q3-FY20		Q4-FY20	
	QTR	YTD	QTR	YTD	QTR	YTD	QTR	YTD	QTR	YTD
Premiums	19,114	80,672	18,270	18,270	17,358	35,628	16,589	52,217	14,765	66,982
Investment Income	18,760	81,091	19,550	19,550	17,698	37,247	15,890	53,138	17,281	70,419
Investment Expense	(3,037)	(10,695)	471	471	(997)	(526)	(269)	(794)	(258)	(1,053)
Gain/Loss Transferred to IMR	(1,706)	(3,679)	(744)	(744)	(340)	(1,084)	(545)	(1,629)	(14,581)	(16,210)
Realized Gains/(Losses)	(4,251)	(38,549)	(13,511)	(13,511)	402	(13,110)	6,829	(6,281)	16,799	10,518
Management Fees	-	-	-	-	-	-	-	-	144	144
Benefits Paid	92,930	369,626	90,344	90,344	88,588	178,932	82,797	261,729	71,472	333,201
Change in Claim Reserves	(16,830)	(26,104)	(11,957)	(11,957)	(24,771)	(36,727)	(10,917)	(47,644)	(95,663)	(143,307)
Change in ALR	3,404	(74,708)	(31,991)	(31,991)	(25,375)	(57,366)	(34,377)	(91,744)	(37,339)	(129,083)
Change in PDR Reserves	321,352	262,914	47,243	47,243	77,316	124,559	(28,437)	96,122	74,653	170,775
Loss on Transamerica Recapture	-	-	-	-	-	-	-	-	168,507	168,507
Commissions	1,408	5,654	1,303	1,303	1,265	2,568	1,083	3,651	971	4,622
Operating Expenses	7,028	29,396	9,270	9,270	7,194	16,464	7,690	24,153	7,153	31,306
Taxes/Licenses/Fees	1,549	3,893	316	316	296	613	340	953	179	1,132
Federal & State Income Taxes	(1)	203	(232)	(232)	-	(232)	(217)	(449)	(56)	(505)
Net (loss) income	(381,960)	(462,034)	(80,261)	(80,261)	(90,392)	(170,654)	20,533	(150,121)	(155,726)	(305,847)

Ratios	Q4-FY19		Q1-FY20		Q2-FY20		Q3-FY20		Q4-FY20	
	QTR	YTD	QTR	YTD	QTR	YTD	QTR	YTD	QTR	YTD
Paid Claims Ratio (1)	486.19%	458.18%	494.50%	494.50%	510.36%	502.22%	499.11%	501.23%	484.05%	497.45%
Incurred Claims Ratio (2)	398.14%	425.82%	429.05%	429.05%	367.65%	399.14%	433.30%	409.99%	-163.84%	283.50%
Loss Ratio(3)	2097.18%	659.12%	512.53%	512.53%	666.88%	587.73%	54.65%	418.38%	88.87%	345.74%
Operating Expense Ratio (4)	36.77%	36.44%	50.74%	50.74%	41.44%	46.21%	46.35%	46.26%	48.44%	46.74%
Commission Ratio (5)	7.37%	7.01%	7.13%	7.13%	7.29%	7.21%	6.53%	6.99%	6.58%	6.90%

(1) Benefits Paid divided by premiums
(2) Includes benefits paid and change in claim reserves divided by premiums
(3) Includes benefits paid, change in claim reserves, change in ALR and change in PDR reserves divided by premiums
(4) Operating expenses divided by premiums
(5) Commissions divided by premiums

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard

4th Quarter Dashboard
December 31, 2020

Policies, Premiums, and Reserves as of December 31, 2020
Breakout Exhibit by Product ID

Product ID	Number of Members **(1)**	Annualized Premium **(2)**	Total Reserve **(3)**
TPM	916	$ 3,014,946	$ 51,234,753
10770/10853	1,250	1,155,347	38,884,784
10955/11001	6,910	13,502,855	919,332,831
FQ_Preference	9,313	13,601,207	515,754,215
HHC	4,128	2,498,435	128,316,755
JCP	1,862	3,634,975	97,789,066
LTC-1	3,919	7,578,841	128,362,824
LTC-3	2,663	3,516,218	202,439,633
LTC-6	8,476	11,855,415	515,425,144
Other ATL	1,237	1,284,142	29,809,804
Other_TLI	407	166,947	15,556,110
Grand Total	41,081	$ 61,809,328	$ 2,642,905,919

(1) Includes paid up policies: NFO or lifetime waiver

(2) Includes policies on waiver of premium

(3) Includes active life reserves, claim reserves, premium deficiency reserves, and gross unearned premium reserves

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard

4th Quarter Dashboard
December 31, 2020

Inforce Policy Persistency Ratio (1)		
Value Date	**Annualized Plan (2)**	**Actual**
Q1 2015	89.9%	88.2%
Q2 2015	89.7%	89.1%
Q3 2015	89.7%	90.1%
Q4 2015	89.6%	90.1%
Q1 2016	89.2%	88.6%
Q2 2016	89.0%	89.0%
Q3 2016	89.0%	89.5%
Q4 2016	89.0%	89.2%
Q1 2017	89.1%	87.3%
Q2 2017	88.8%	87.6%
Q3 2017	88.6%	86.6%
Q4 2017	88.6%	88.8%
Q1 2018	88.6%	87.0%
Q2 2018	88.3%	87.4%
Q3 2018	88.1%	88.5%
Q4 2018	88.0%	88.3%
Q1 2019	88.8%	87.7%
Q2 2019	88.3%	87.8%
Q3 2019	87.8%	88.0%
Q4 2019	87.6%	86.5%
Q1 2020	85.6%	85.7%
Q2 2020	85.0%	87.8%
Q3 2020	86.5%	83.4%
Q4 2020	86.6%	83.7%

(1) Percent of members who remain inforce
(2) Source - Milliman CFT

Senior Health Insurance Company of Pennsylvania in Rehabilitation
Analytic Dashboard
LTC In force by Resident State

4th Quarter Dashboard
December 31, 2020

Resident State	Number of Members (1)	Premium (2)
Alabama	97	$ 131,553
Alaska	27	25,894
Arizona	1,026	1,378,941
Arkansas	225	293,691
California	3,243	5,369,645
Canada	7	8,335
Colorado	460	773,500
Connecticut	86	139,014
Delaware	109	139,231
District of Columbia	25	32,511
Florida	4,117	5,106,727
Georgia	786	1,190,020
Hawaii	101	130,190
Idaho	127	123,787
Illinois	1,782	3,624,068
Indiana	1,149	1,957,671
Iowa	967	1,428,260
Kansas	837	1,153,140
Kentucky	677	896,052
Louisiana	312	394,453
Maine	319	428,736
Maryland	886	1,577,769
Massachusetts	300	540,017
Michigan	930	1,096,441
Minnesota	542	816,285
Mississippi	187	367,614
Missouri	1,231	2,051,813
Montana	200	$ 260,050
Nebraska	544	$ 947,162
Nevada	153	$ 179,502
New Hampshire	62	$ 109,037
New Jersey	703	$ 1,286,167
New Mexico	163	$ 254,184
New York	393	$ 433,904
North Carolina	1,210	$ 2,136,541
North Dakota	358	$ 635,090
Ohio	1,610	$ 2,798,256
Oklahoma	924	$ 1,098,296
Oregon	296	$ 330,954
Other	10	$ 35,794
Pennsylvania	3,963	$ 7,310,100
Puerto Rico	2	$ 1,558
Rhode Island	18	$ 34,399
South Carolina	403	$ 727,082
South Dakota	245	$ 500,830
Tennessee	631	$ 987,230
Texas	5,403	$ 6,432,519
Utah	321	$ 353,161
Vermont	23	$ 30,682
Virginia	779	$ 1,411,532
Washington	1,296	$ 1,348,839
West Virginia	87	$ 132,302
Wisconsin	687	$ 802,584
Wyoming	42	$ 56,218
Total	41,081	$ 61,809,328

(1) Number of members inforce
(2) Annualized premiums inforce

4Q Quarter Dashboard
December 31, 2020
Status on LTC Lapse/Cancel/Death (1)

4th Quarter Dashboard
December 31, 2020

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total YTD	Avg YTD
Premium Paying	25,892	25,490	25,109	24,815	24,535	24,233	23,954	23,673	23,138	22,827	22,437	21,875	21,875	23,998
Claim Waiver / Lifetime Waiver	10,986	10,902	10,768	10,672	10,579	10,569	10,478	10,433	10,231	10,106	10,015	9,826	9,826	10,464
Nonforfeiture	10,382	10,350	10,204	10,103	9,968	9,871	9,750	9,624	9,453	9,360	9,404	9,380	9,380	9,821
Lapse	60	33	25	-	-	-	-	-	238	87	57	71	571	48
Cancel	32	27	60	44	45	32	33	42	27	28	29	53	452	38
Death	411	427	560	426	443	347	438	381	629	387	321	634	5,404	450
OTHER TERMINATIONS														
Maxed Benefits	31	34	21	28	23	32	29	31	23	35	35	22	344	29
Other Terminations	1	-	1	-	-	-	-	-	-	-	-	-	2	0
Reinstatements	(10)	(3)	(6)	(7)	(3)	(2)	(9)	(2)	(9)	(8)	(5)	(5)	(69)	(6)
Nonforfeiture Conversion	1	78	5	6	5	1	2	-	1	10	148	125	382	32
Lapse/Cancel	92	60	85	44	45	32	33	42	265	115	86	124	1,023	85
Death	411	427	560	426	443	347	438	381	629	387	321	634	5,404	450
Other Terminations	33	112	27	34	28	33	31	31	24	45	183	147	728	61
Policies In Force	47,260	46,742	46,081	45,590	45,082	44,673	44,182	43,730	42,822	42,293	41,856	41,081	41,081	44,283
Lapse / Cancel Term Rate	0.19%	0.13%	0.18%	0.10%	0.10%	0.07%	0.07%	0.10%	0.61%	0.27%	0.20%	0.30%	N/A	0.19%
Annualized Lapse / Cancel Term Rate	2.31%	1.52%	2.18%	1.15%	1.18%	0.85%	0.89%	1.14%	7.27%	3.22%	2.44%	3.56%	N/A	2.31%
Death & Other Term Rate	0.93%	1.14%	1.26%	1.00%	1.03%	0.84%	1.05%	0.93%	1.49%	1.01%	1.19%	1.87%	N/A	1.15%
Annualized Death & Other Term Rate	11.15%	13.69%	15.07%	11.98%	12.40%	10.11%	12.60%	11.19%	17.92%	12.11%	14.30%	22.39%	N/A	13.74%
Annualized Total Term Rate	13.46%	15.21%	17.25%	13.12%	13.58%	10.97%	13.48%	12.33%	25.19%	15.33%	16.74%	25.95%	N/A	16.05%

(1) Termination status is based on the reporting month's coverage file and what was known at that point in time. Actual termination reasons may vary due to additional information provided at a later date.

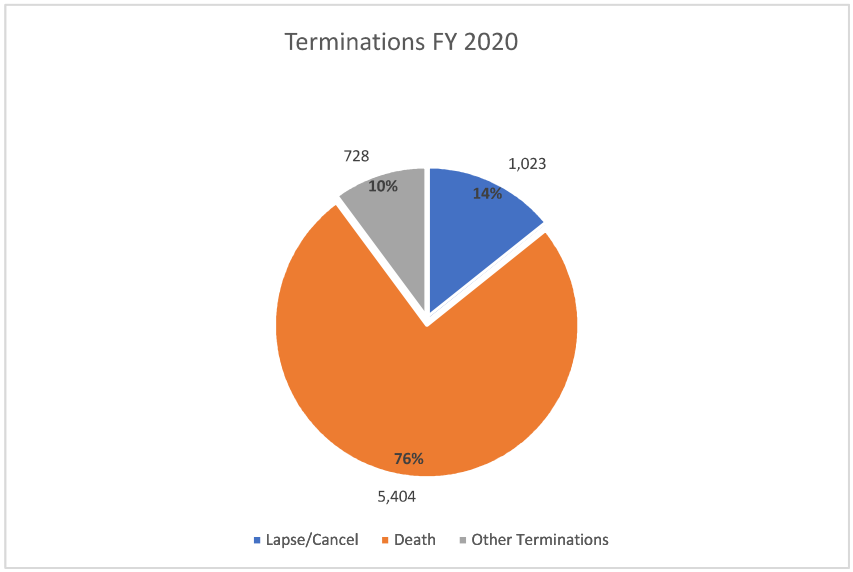
Senior Health Insurance Company of Pennsylvania In Rehabilitation

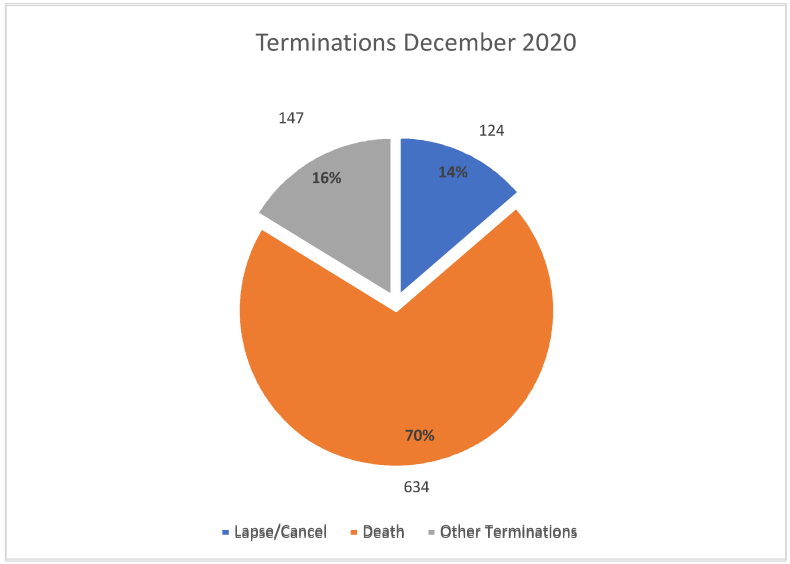
Analytic Dashboard

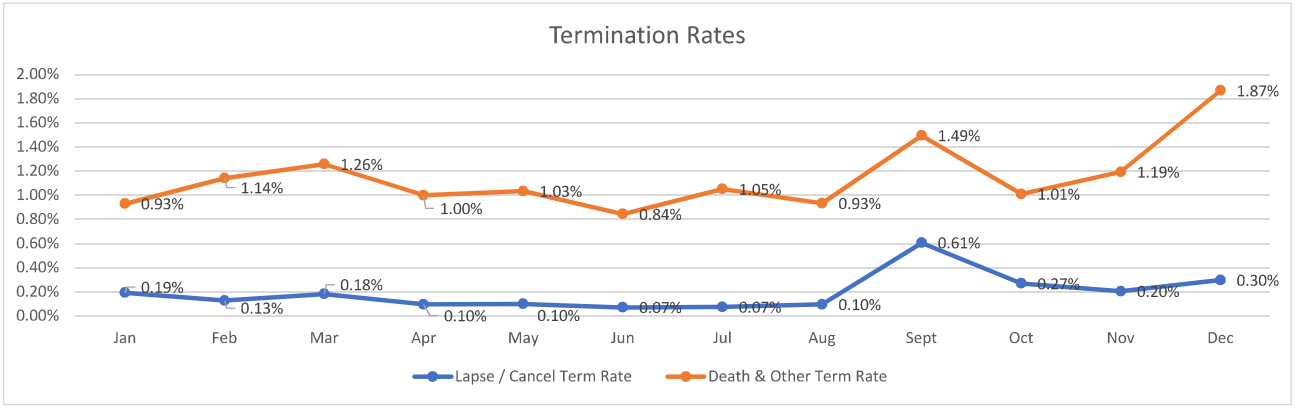
Status on LTC Lapse/Cancel/Death

Policies inforce as of December 31, 2020 is 41,081

4th Quarter Dashboard
December 31, 2020

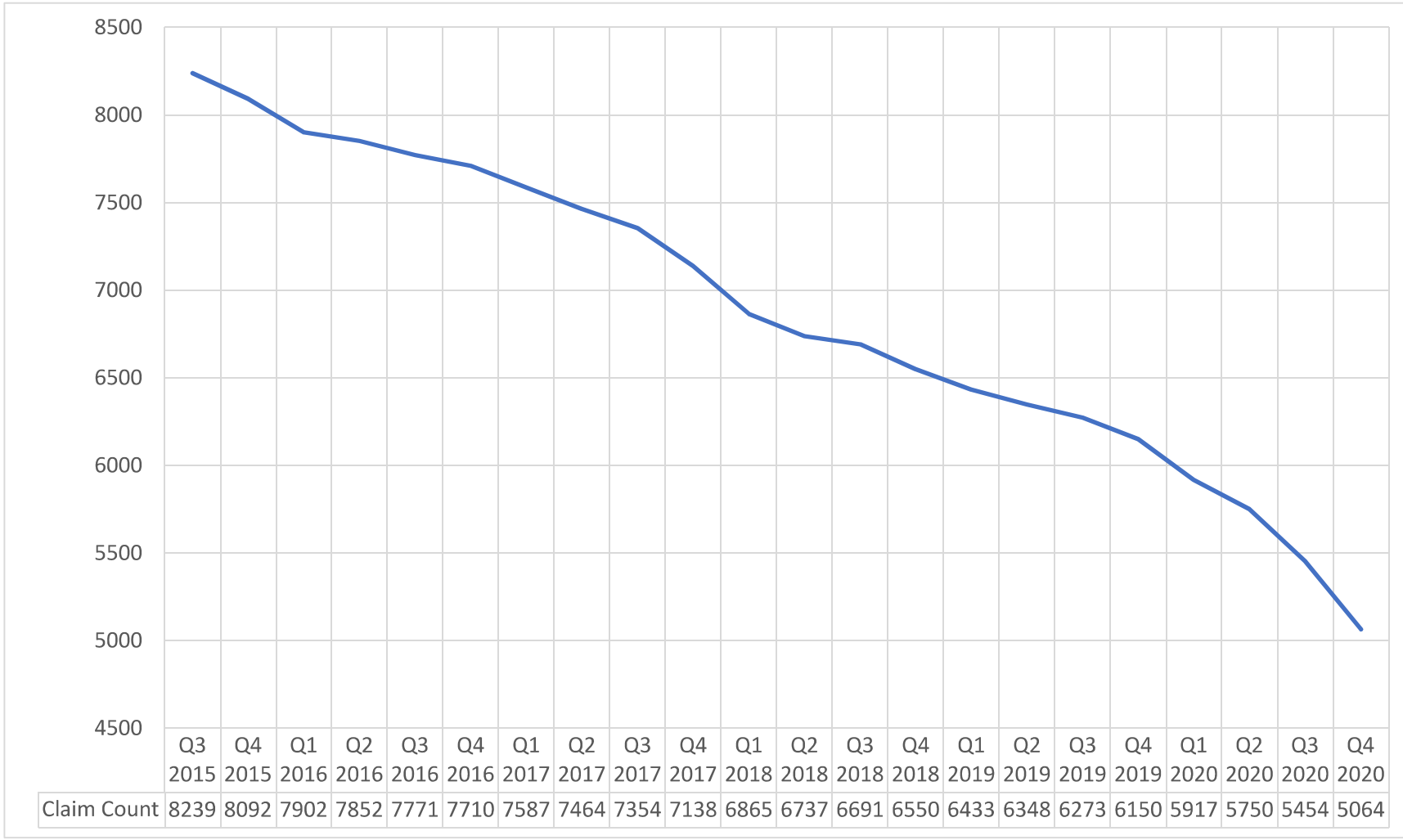






Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard
Total Open Claims (1)

4th Quarter Dashboard
December 31, 2020

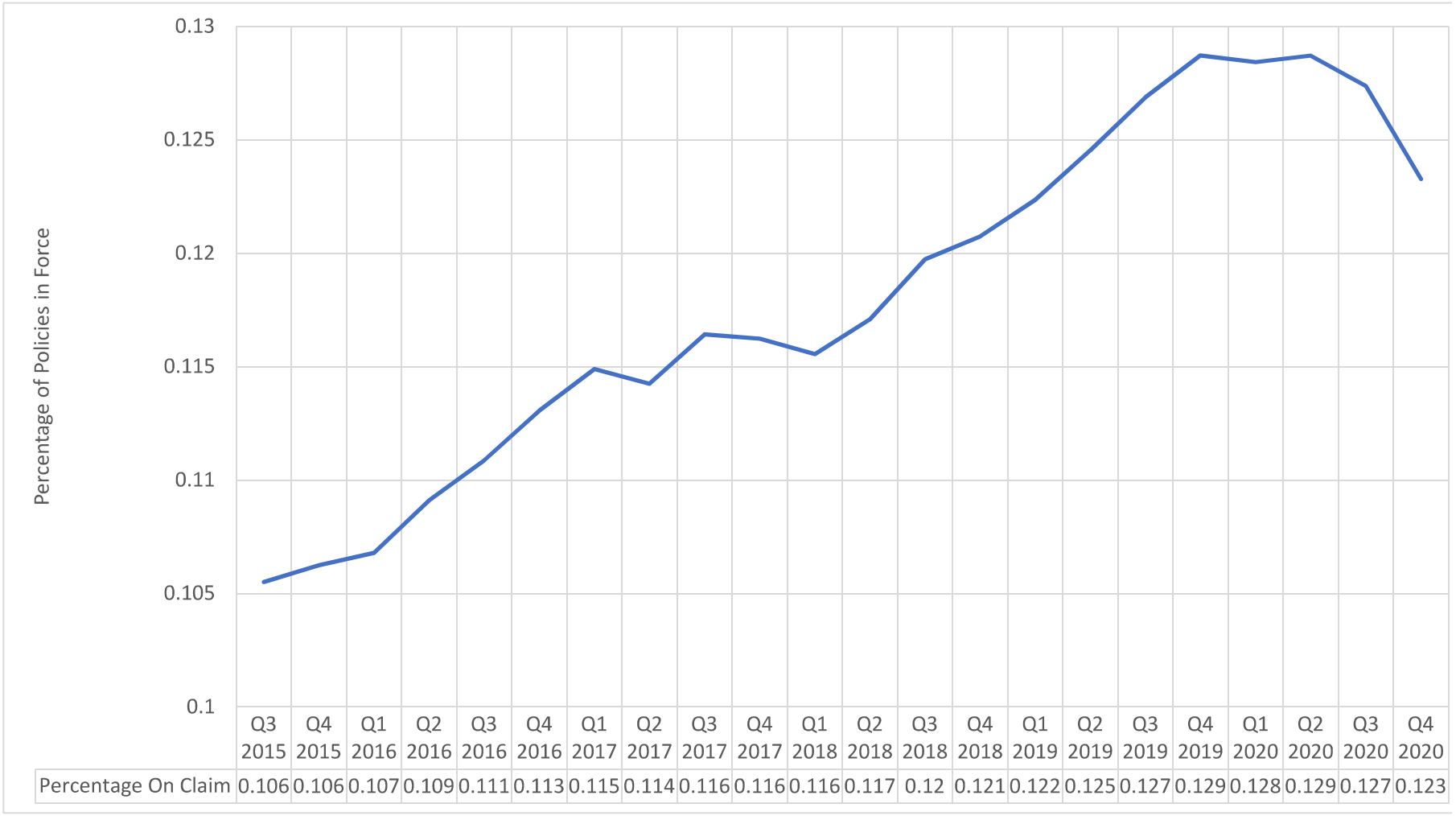


	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Claim Count	8239	8092	7902	7852	7771	7710	7587	7464	7354	7138	6865	6737	6691	6550	6433	6348	6273	6150	5917	5750	5454	5064

(1) Open Claims are those that have had a payment

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard
Percentage of Inforce on Claim

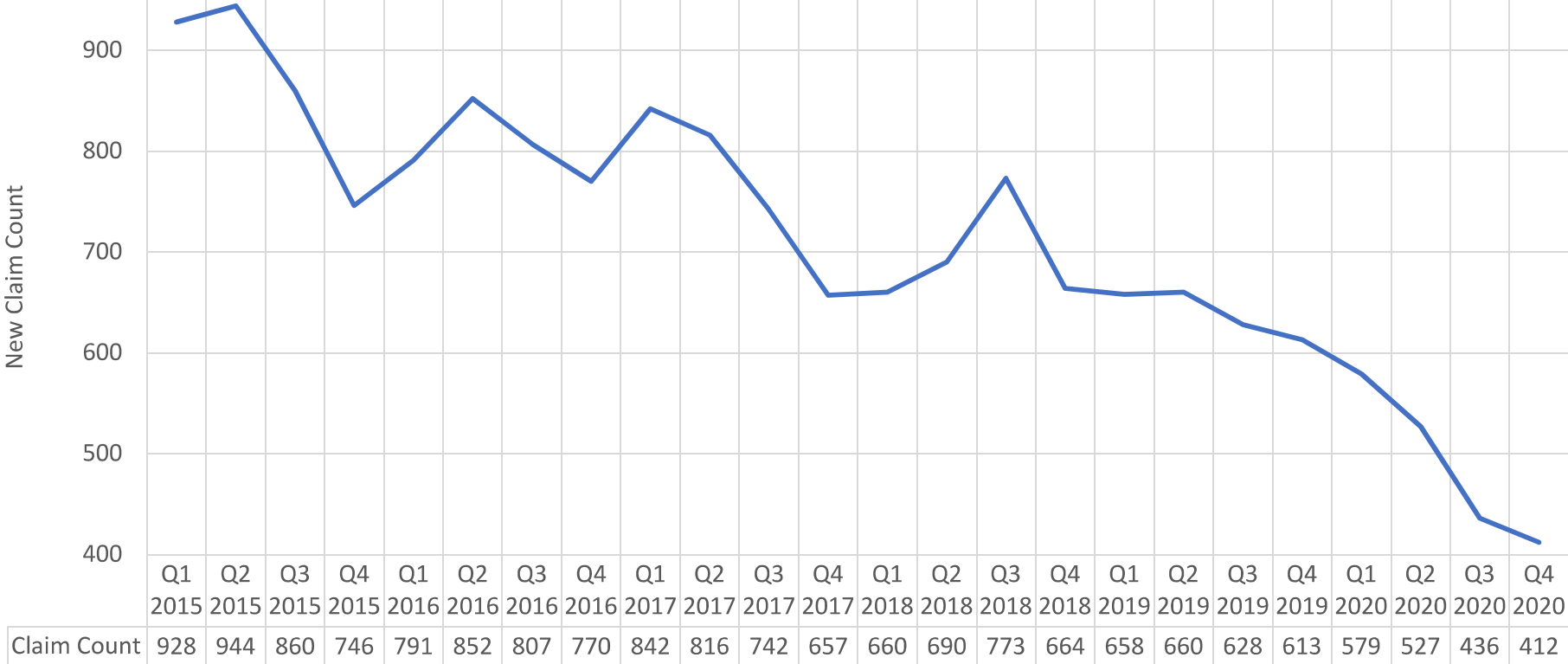
4th Quarter Dashboard
December 31, 2020



	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Percentage On Claim	0.106	0.106	0.107	0.109	0.111	0.113	0.115	0.114	0.116	0.116	0.116	0.117	0.12	0.121	0.122	0.125	0.127	0.129	0.128	0.129	0.127	0.123

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard
New Claim Trend

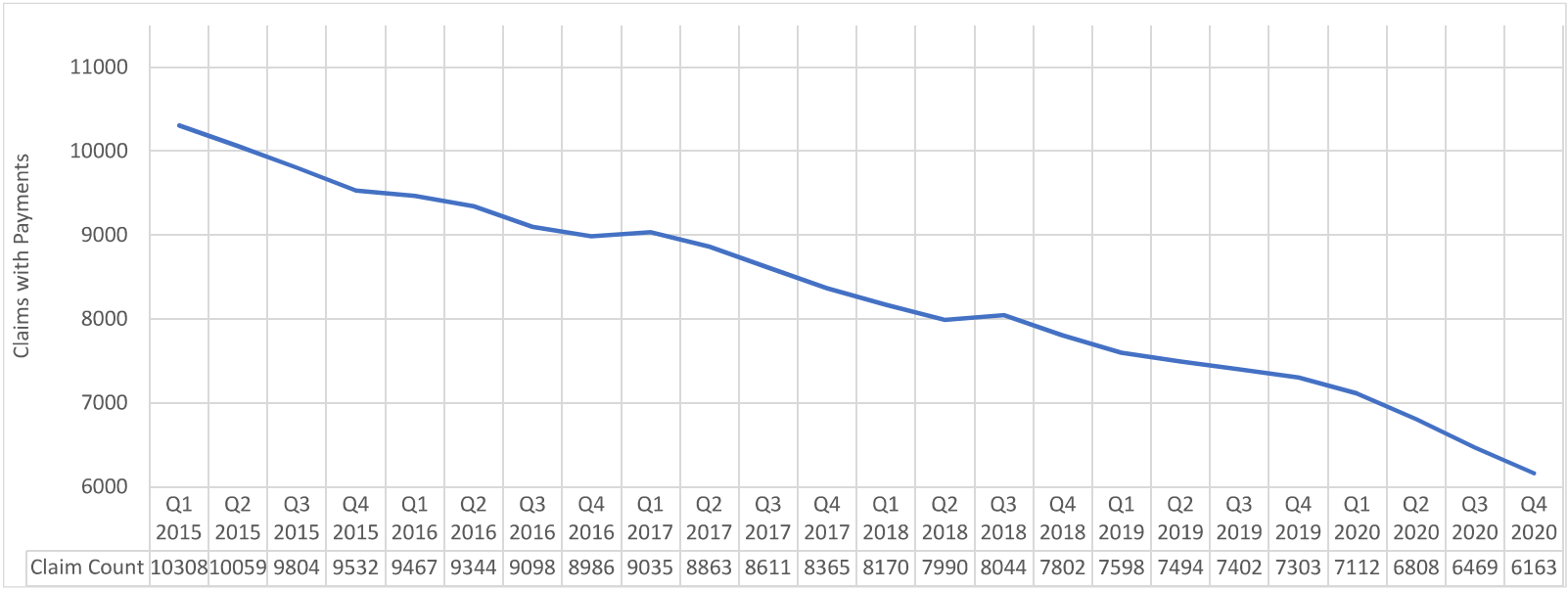
4th Quarter Dashboard
December 31, 2020



	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Claim Count	928	944	860	746	791	852	807	770	842	816	742	657	660	690	773	664	658	660	628	613	579	527	436	412

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard
Claims with Payments

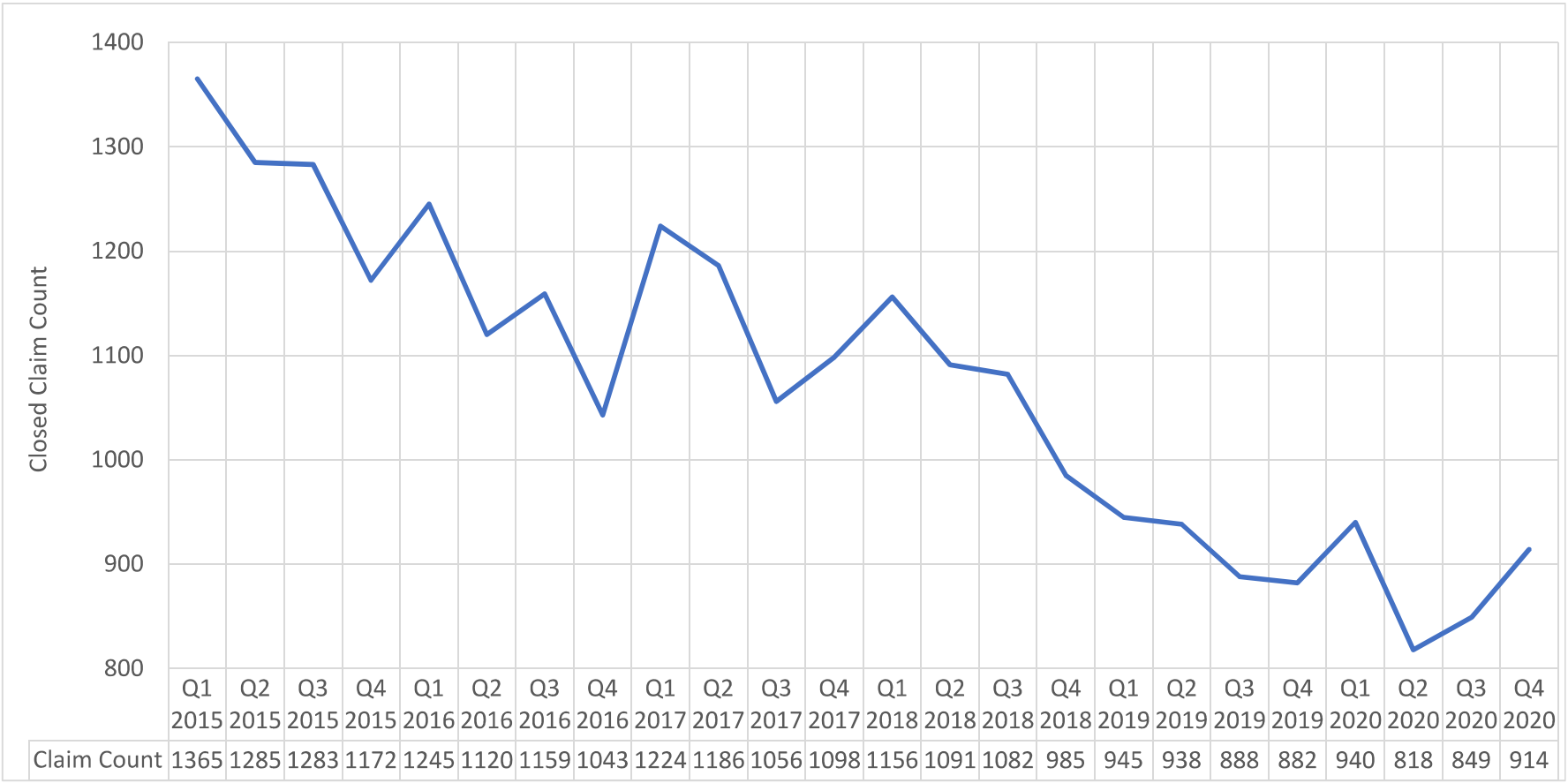
4th Quarter Dashboard
December 31, 2020



	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Claim Count	10308	10059	9804	9532	9467	9344	9098	8986	9035	8863	8611	8365	8170	7990	8044	7802	7598	7494	7402	7303	7112	6808	6469	6163

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard
Closed Claims Trend

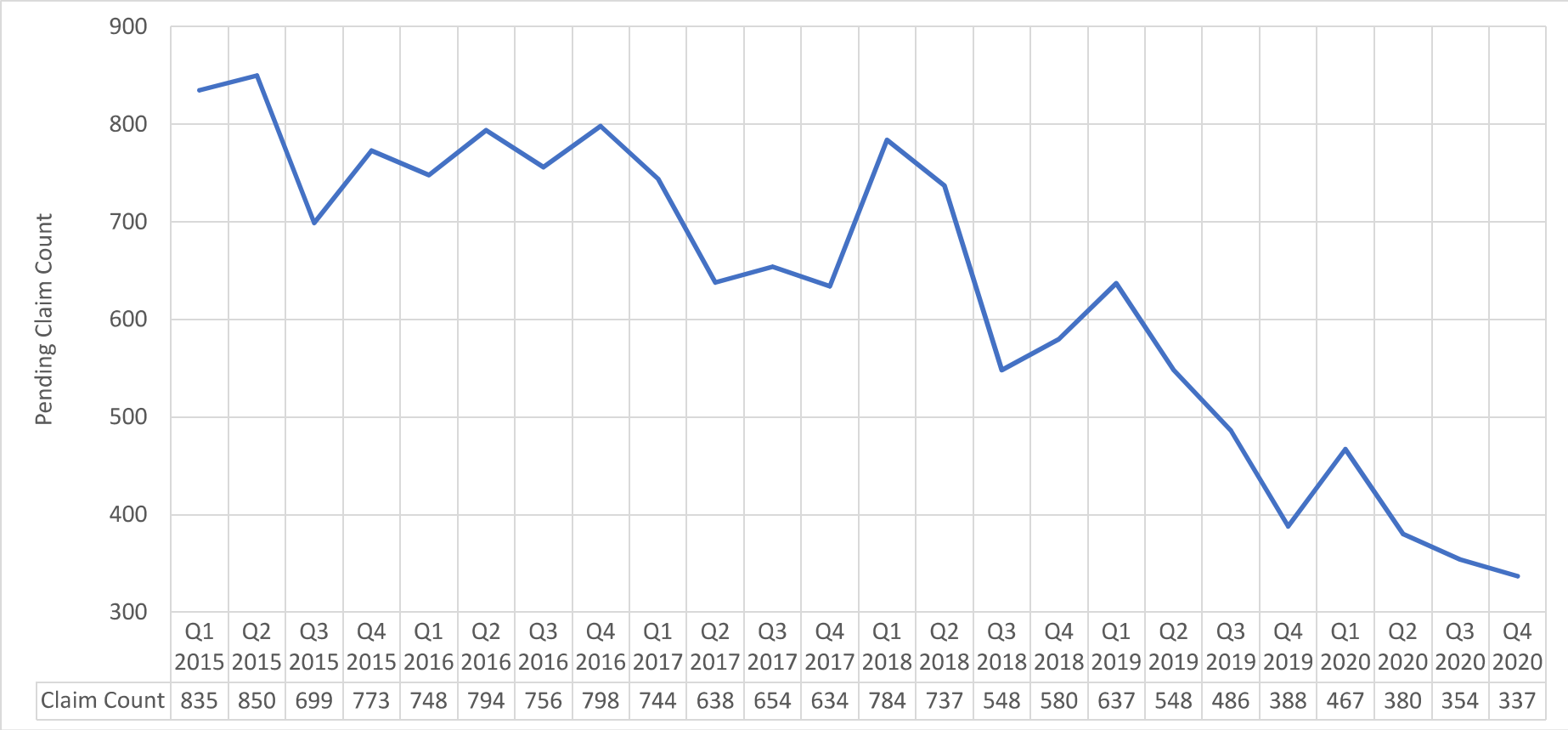
4th Quarter Dashboard
December 31, 2020



	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Claim Count	1365	1285	1283	1172	1245	1120	1159	1043	1224	1186	1056	1098	1156	1091	1082	985	945	938	888	882	940	818	849	914

Senior Health Insurance Company of Pennsylvania in Rehabilitation
Analytic Dashboard
Pending Claims Trend

4th Quarter Dashboard
December 31, 2020



	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Claim Count	835	850	699	773	748	794	756	798	744	638	654	634	784	737	548	580	637	548	486	388	467	380	354	337

Senior Health Insurance Company of Pennsylvania In Rehabilitation
Analytic Dashboard
Complaint Analysis

4th Quarter Dashboard
December 31, 2020

Month	Total Complaints	Total Justified	Outcome Pending	Claims	Claims DOI	Claims PH	Claims Other	PHS	PHS DOI	PHS PH	PHS Other	MISC	MISC DOI	MISC PH	MISC Other
JAN	24	2	0	17	5	7	5	7	4	3	0	0	0	0	0
FEB	0	0	0	21	9	10	2	6	3	3	0	0	0	0	0
MAR	39	2	0	26	15	10	1	8	2	6	0	5	0	5	0
1st Quarter Totals	63	4	0	64	29	27	8	21	9	12	0	5	0	5	0
APR	31	3	0	19	10	8	1	8	3	5	0	4	2	2	0
MAY	24	2	0	18	8	10	0	4	2	2	0	2	1	1	0
JUNE	23	3	0	19	9	8	2	3	1	2	0	1	0	1	0
2nd Quarter Totals	78	8	0	56	27	26	3	15	6	9	0	7	3	4	0
JULY	22	3	0	14	5	8	1	6	4	2	0	2	0	2	0
AUGUST	27	0	0	16	10	6	0	2	2	0	0	9	2	7	0
SEPTEMBER	16	1	0	8	7	1	0	4	3	1	0	4	2	2	0
3rd Quarter Totals	65	4	0	38	22	15	1	12	9	3	0	15	4	11	0
OCTOBER	10	2	0	6	2	3	1	3	1	2	0	1	0	1	0
NOVEMBER	14	2	0	6	2	4	0	5	2	3	0	3	1	2	0
DECEMBER	16	0	0	7	5	1	1	0	0	0	0	9	3	6	0
4th Quarter Totals	40	4	0	19	9	8	2	8	3	5	0	13	4	9	0

Year Total	246	20	-	177	87	76	14	56	27	29	-	40	11	29	-

Received 3/31/2021 11:37:47 PM Commonwealth Court of Pennsylvania

Filed 3/31/2021 11:37:47 PM Commonwealth Court of Pennsylvania
1 SHP 2020

CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that on March 31, 2021, I served the foregoing Notice of Filing of Quarterly Report and the Quarterly Report of the Rehabilitator on the Status of the Rehabilitation of Senior Health Insurance Company of Pennsylvania filed concurrently therewith on all parties listed on the Master Service List by electronic mail, and I further certify that an electronic copy of the foregoing documents will be posted on SHIP's website at https://www.shipltc.com/court-documents.

/s/ Michael J. Broadbent

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 33

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

SHIP in Rehabilitation

Policy and Product Overview

Policyholder Demographics
Benefits & Premium
Product Pricing Comparison
Rate Increases

Confidential

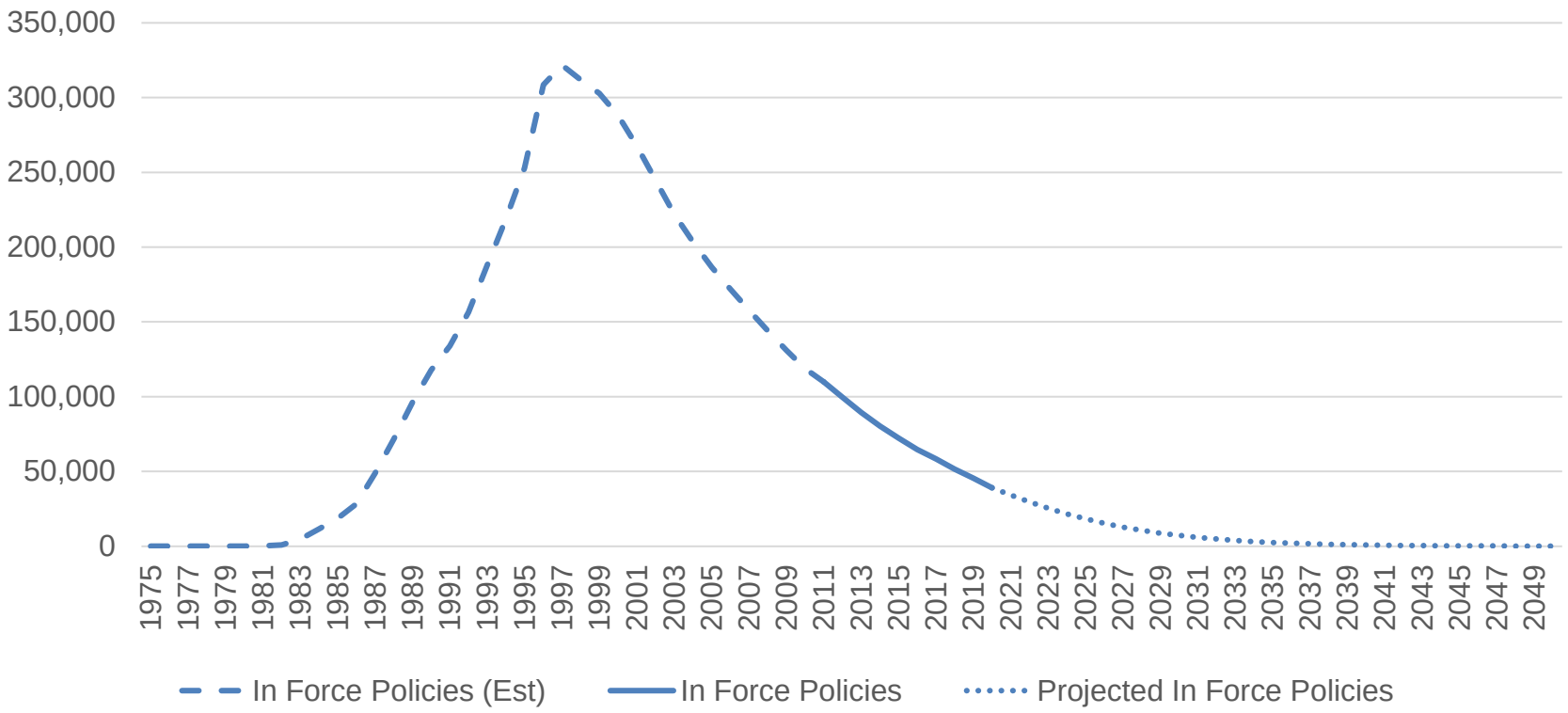
POLICYHOLDER DEMOGRAPHICS

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Policies in Force

As of Year End 2020

Over 646,000 policies were ever issued and only 39,148 remain in force as of December 31, 2020



SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

Policies in Force

As of Year End 2020

	SHIP
Not On Claim	34,058
On Claim	4,771
Pending Claim	319
Total Policies	**39,148**

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Policyholder & Claimant Age



1% of policyholders

< 1% of claimants

are in their

60s



10% of policyholders

2% of claimants

are in their

70s



50% of policyholders

40% of claimants

are in their

80s



37% of policyholders

57% of claimants

are in their

90s

1% of policyholders

1% of claimants

are

100+

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

Gender



71% Female

29% Male



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(IN REHABILITATION)

BENEFITS & PREMIUM

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Coverage Types

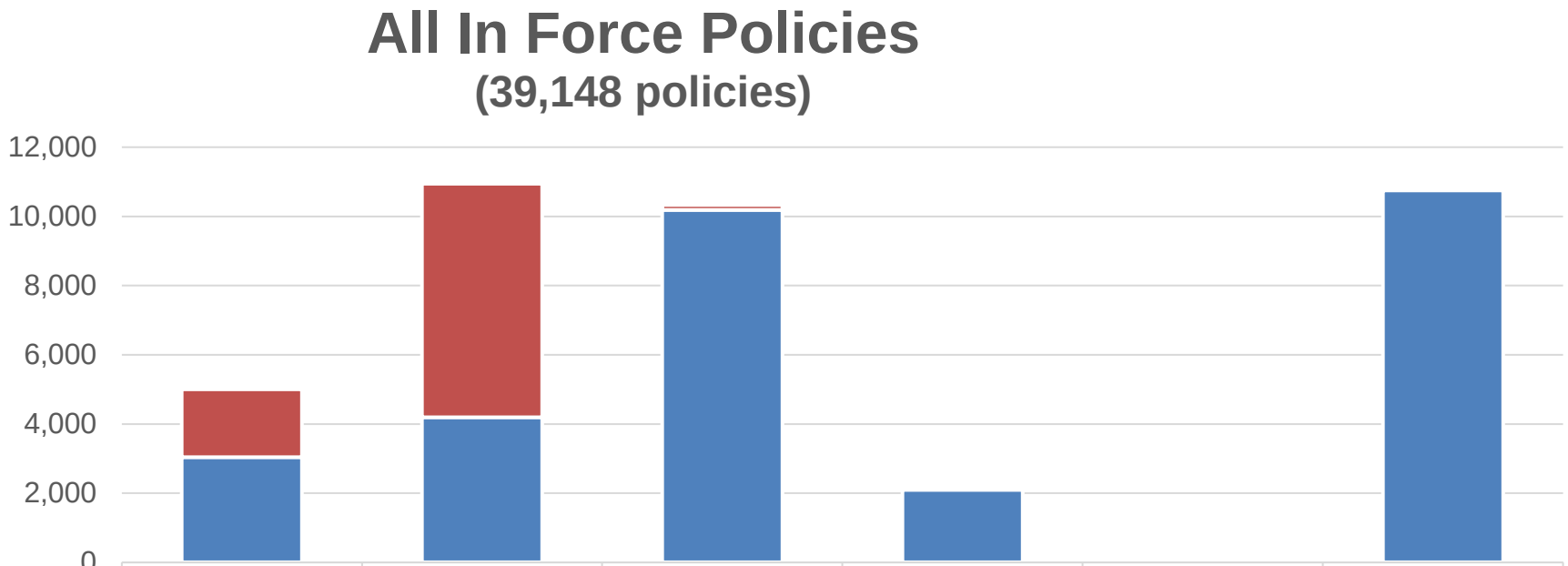
70% Comprehensive

17% Nursing Home Only

13% Home Health Care Only

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(IN REHABILITATION)

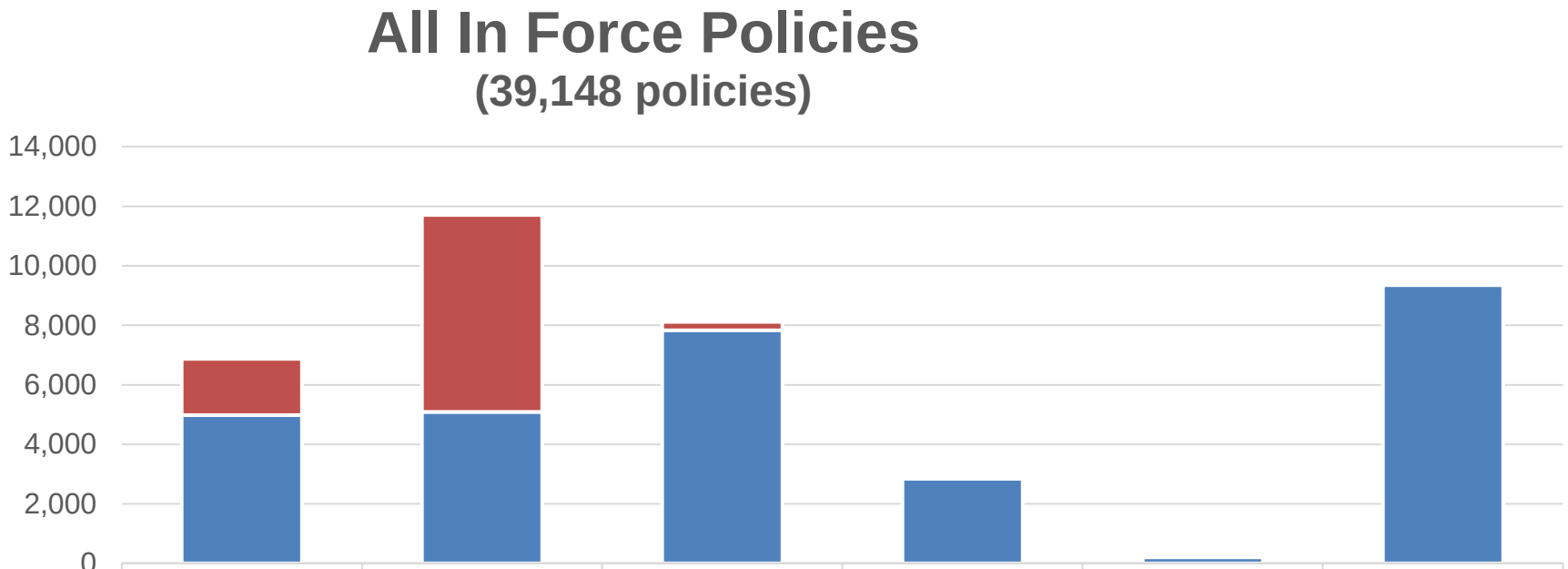
Facility Coverage Benefit Period for In Force Policies



	No Facility Coverage	0-2 Years	2-4 Years	4-6 Years	6+ Years (Non-Lifetime)	Lifetime
NFO In Force Policies	1,961	6,741	140	5	0	0
Non-NFO In Force Policies	3,045	4,198	10,187	2,098	22	10,751
Total In Force Policies	5,006	10,939	10,327	2,103	22	10,751
% of In Force Policies	13%	28%	26%	5%	0%	27%

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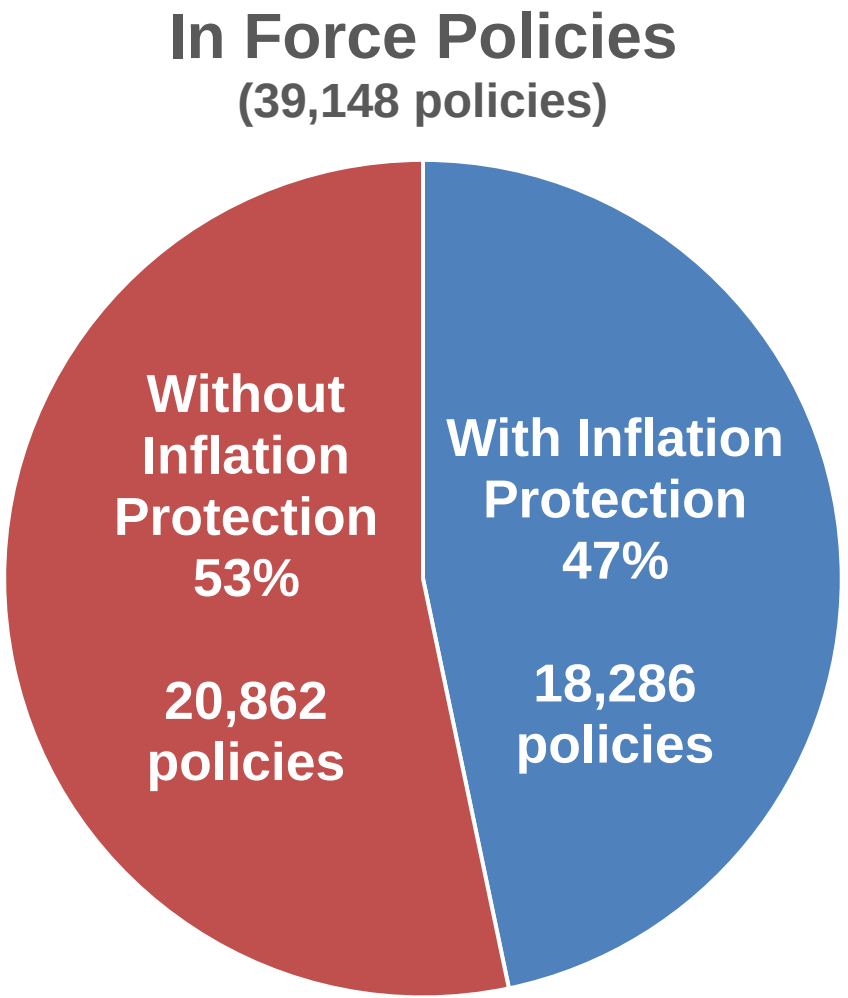
HHC Benefit Period for In Force Policies



	No HHC Coverage	0-2 Years	2-4 Years	4-6 Years	6+ Years (Non-Lifetime)	Lifetime
NFO In Force Policies	1,891	6,616	284	47	9	0
Non-NFO In Force Policies	4,982	5,087	7,830	2,847	204	9,351
Total In Force Policies	6,873	11,703	8,114	2,894	213	9,351
% of In Force Policies	18%	30%	21%	7%	1%	24%

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Inflation Protection



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Claims Paid

Number of In Force policies that have received claim payments:

8,537

(22%)

Total claims paid on these In Force policies over their lifetime:

$837 million

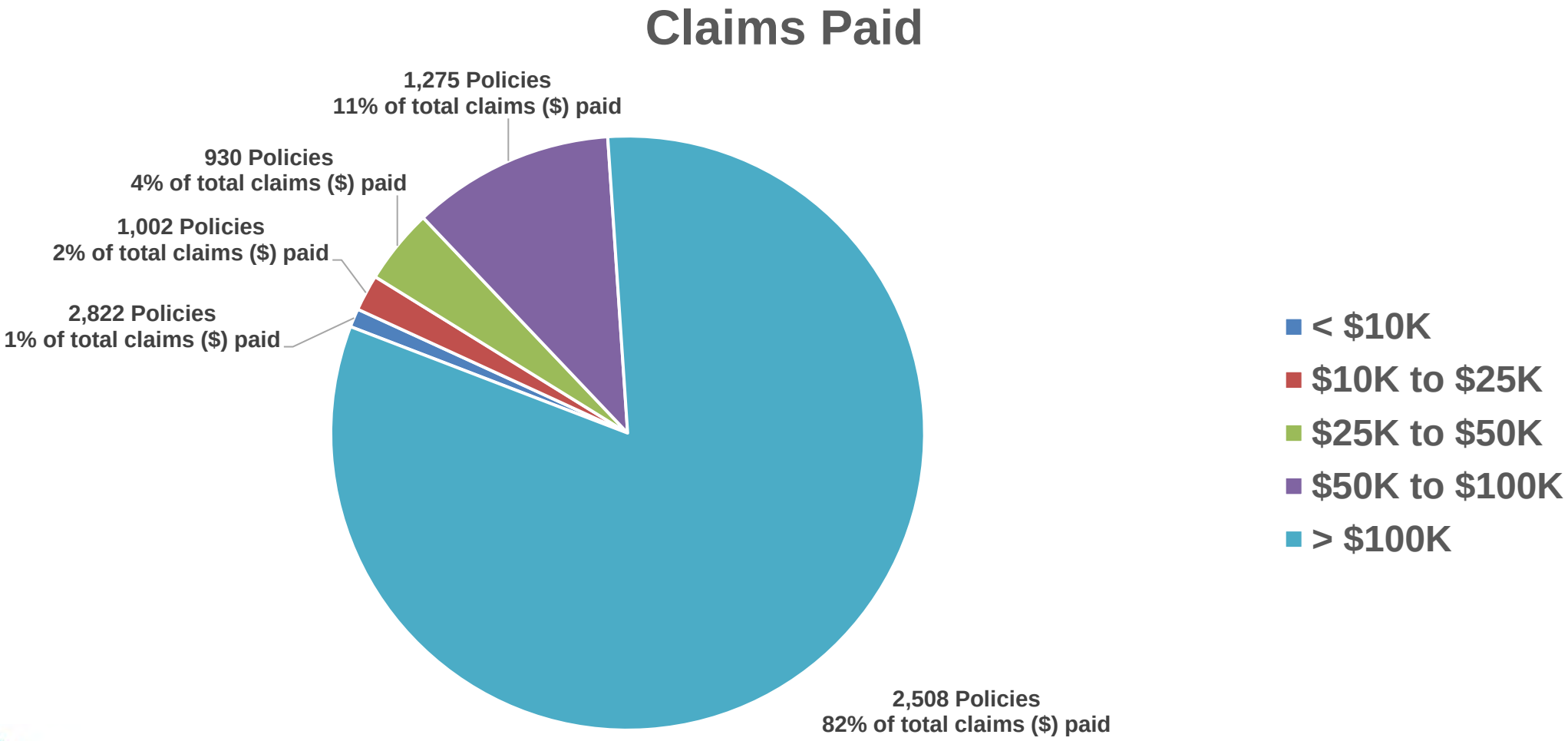
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Claims Paid over Life of Policy for In Force Policies

	Percent of Claims Paid	In Force Policy Count	Percentage of Policies with Claims	Total Claims Paid	Average Claim Paid Per Policy
< $10K	1%	2,822	34%	$8M	$2,996
$10K to $25K	2%	1,002	13%	$17M	$16,505
$25K to $50K	4%	930	11%	$34M	$36,786
$50K to $100K	11%	1,275	14%	$92M	$73,303
> $100K	82%	2,508	29%	$685M	$273,214
Total	100%	8,537	100%	$837M	$97,998

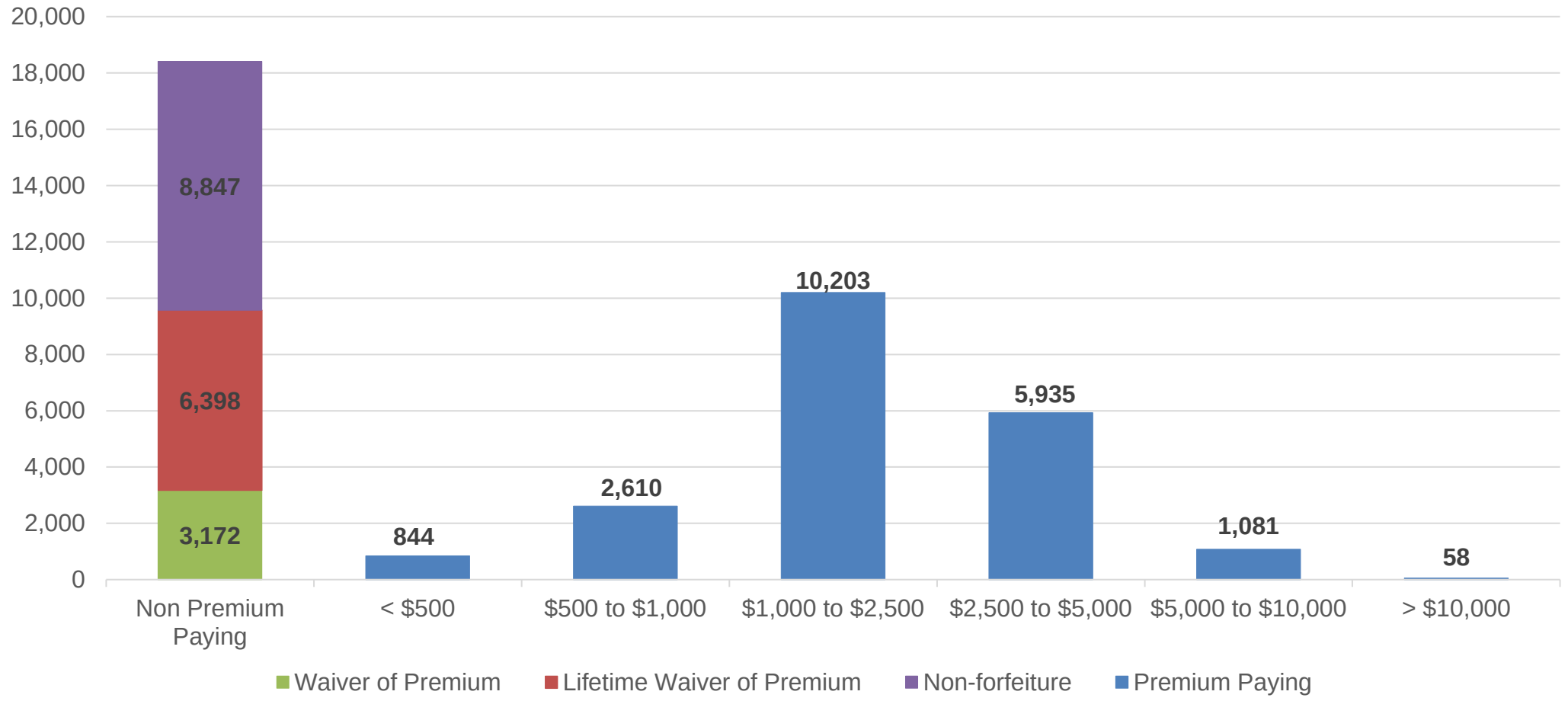
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Claims Paid for In Force Policies



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Policy Annualized Premium



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Premium Paid over Life of Policy For In Force Policies

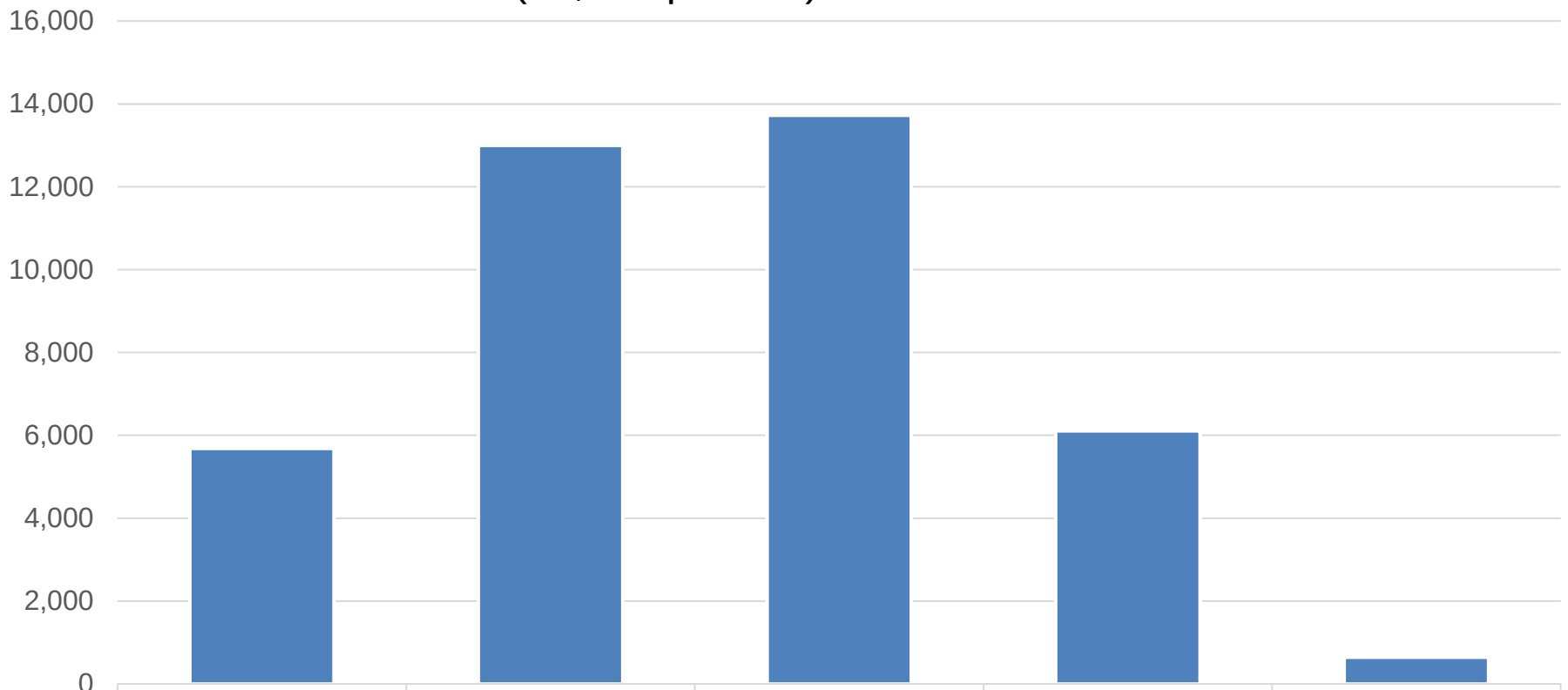
As of Year End 2020

	Percent of In Force Policies	In Force Policy Count	Total Cumulative Premium	Average Cumulative Premium Per Policy
< $10K	15%	5,683	$37M	$6,447
$10K to $25K	33%	12,997	$226M	$17,350
$25K to $50K	35%	13,721	$491M	$35,764
$50K to $100K	15%	6,107	$400M	$65,528
> $100k	2%	640	$80M	$124,272
Total	100%	39,148	$1,233M	$31,485

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SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

Premium Paid over Life of Policy For In Force Policies

As of Year End 2020
(39,148 policies)



	< $10K	$10K to $25K	$25K to $50K	$50K to $100K	> $100k
All In Force Policies	5,683	12,997	13,721	6,107	640
% of In Force Policies	15%	33%	35%	16%	2%

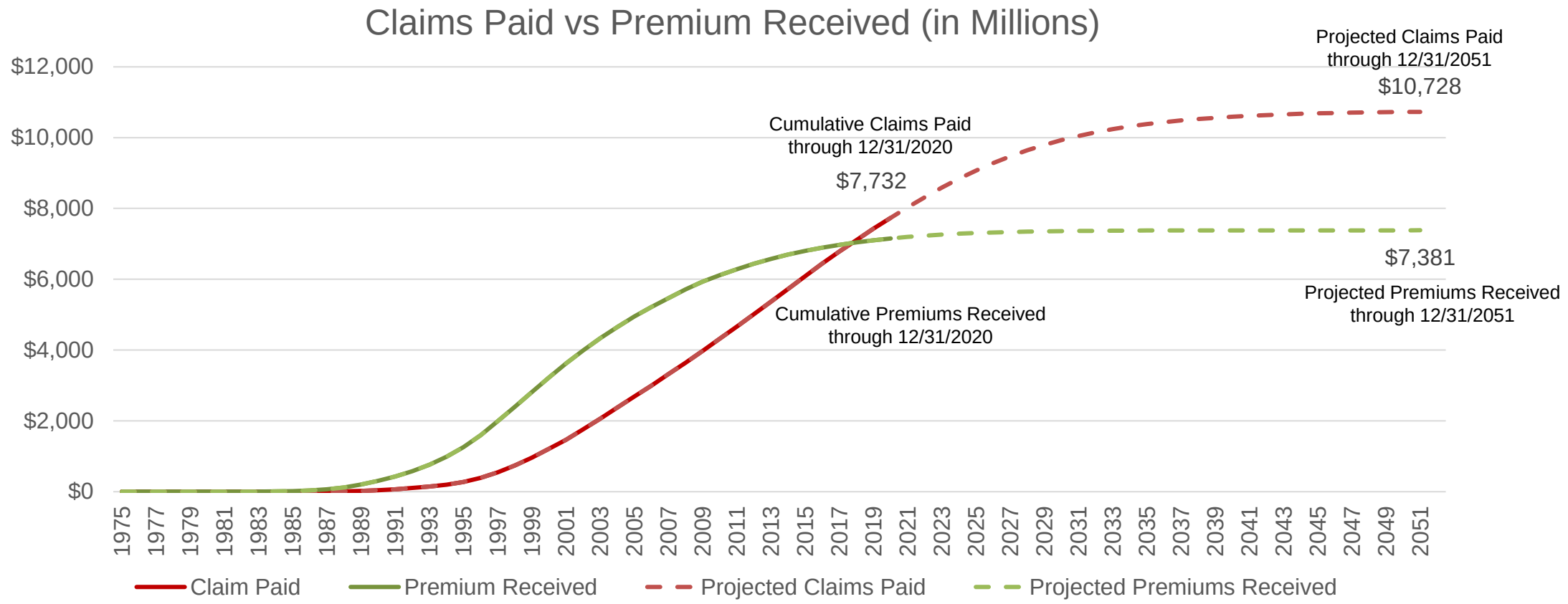
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Claims Paid vs Premium Received

	Number of In Force Policies	Claims Paid	Premium Received	Difference
Claim Payments	8,544 (22%)	$837M (100%)	$313M (25%)	$524M
No Claim Payments	30,604 (78%)	$0M (0%)	$920B (75%)	($1.1B)
Total	**39,148**	**$837M**	**$1.233B**	**($396M)**

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SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

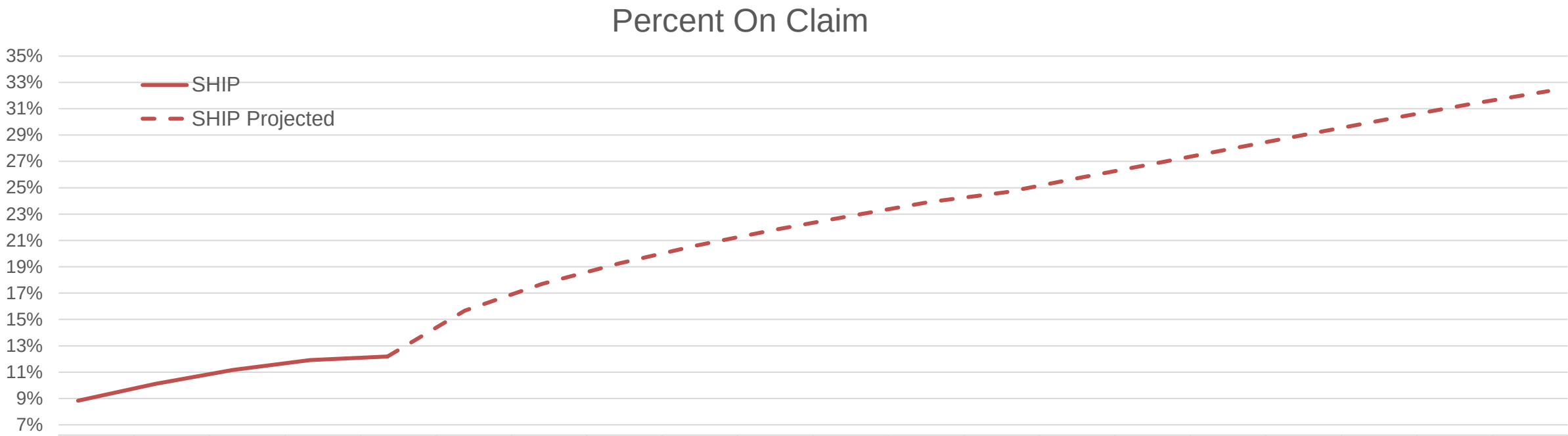
Projection of Claims Paid and Premiums Received



* Historical claims paid includes standard LTC services, but does not include additional benefits, such as ROP. Premiums received includes all collected premium transactions, including those premiums corresponding to the ROP benefit.

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On Claim vs Total In Force Analysis



	2012	2014	2016	2018	2020	2022	2024	2026	2028	2030	2032	2034	2036	2038	2040	2042	2044	2046	2048	2050
SHIP	9%	10%	11%	12%	12%															
SHIP Projected					12%	16%	18%	19%	21%	22%	23%	24%	25%	26%	27%	28%	29%	30%	31%	32%

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

PRODUCT PRICING COMPARISON

1997 Pricing at Issue
Popular SHIP forms and Comparable Industry Policies

4 years of nursing home coverage, a $110 daily benefit, a 5% compounded inflation option, and 50% home care

	Age at Policy Issue			% In Force
	55	65	72	
Senior Health Insurance of Pennsylvania (ATL-LTC-6)	$906	$1,658	$2,554	20%
Senior Health Insurance of Pennsylvania (ATL-FQ-LTC)	$979	$1,925	$3,487	13%
Average annual premium, industry-wide, of policies with similar coverage	$902	$1,626	$3,628	
Range of premium for policies with similar coverage	$558-$1,507	$1,042-$2,695	$2,316-$5,577	

Source: Penn Treaty August 2016 Report, which utilized Consumer Reports (October 1997)
Consumer Reports compared the annual cost of similar policies offered by 25 insurers

*average issue age of all SHIP historical policies is 70

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

1997 Pricing at Issue
Popular SHIP forms and Comparable Industry Policies

4 years of nursing home coverage, a $110 daily benefit, a 5% compounded inflation option, and 50% home care





*average issue age of all SHIP historical policies is 70

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RATE INCREASES

SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
(IN REHABILITATION)

Compound Inflation for Life Round 1

2016-2019

39 States: **48,553 policyholders in force when filings began** **15,849 policyholders in filing population** **8,850 policyholders impacted**
12 state filings: Requested increased approved to implement
13 state filings: Approval received at lower rate than requested
5 state filings: Approval received spanning multiple year implementations
9 state filings: Request rejected, disapproved, withdrawn, or not pursued
~$57M Reserve Impact on Statutory Active Life Reserves due to Downgrade and NFO Elections

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Compound Inflation for Life Round 2

2018-2019

12 States: **38,582 policyholders in force when filings began** **2,702 policyholders in filing population** **320 policyholders impacted**
3 state filings: Requested increased approved to implement
3 state filings: Approval received at lower rate than requested
0 state filings: Approval received spanning multiple year implementations
6 state filings: Request rejected, disapproved, withdrawn, or not pursued
~$2.9M Reserve Impact on Statutory Active Life Reserves due to Downgrade and NFO Elections

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OF PENNSYLVANIA
(IN REHABILITATION)

Zero Day Elimination Period

2018-2020

27 States: **38,582 policyholders in force when filings began** **14,505 policyholders in filing population** **1,965 policyholders impacted**
6 state filings: Requested increased approved to implement
5 state filings: Approval received at lower rate than requested
1 state filings: Approval received spanning multiple year implementations
15 state filings: Request rejected, disapproved, withdrawn, or not pursued
~$1.1M Reserve Impact on Statutory Active Life Reserves due to Downgrade and NFO Elections

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Non-Zero Day Elimination Period

2018-2020

27 States: **38,582 policyholders in force when filings began** **7,312 policyholders in filing population** **1,150 policyholders impacted**
7 state filings: Requested increased approved to implement
4 state filings: Approval received at lower rate than requested
1 state filings: Approval received spanning multiple year implementations
15 state filings: Request rejected, disapproved, withdrawn, or not pursued
~$1.2M Reserve Impact on Statutory Active Life Reserves due to Downgrade and NFO Elections

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(IN REHABILITATION)

Rate Increase Summary

	Compound Inflation for Life Round 1	Compound Inflation for Life Round 2	Zero Day Elimination Period	Non-Zero Day Elimination Period
Years Filed	2016-2019	2018-2019	2018-2020	2018-2020
Number of Policyholders Impacted	8,850	320	1,965	1,150
Percentage of Requested Rate Approved[1]	55%	40%	36%	38%
Reserve Impact by Benefit Reduction or NFO Conversion	$57M	$2.9M	$1.1M	$1.2M
Policyholder Responses by Percentage of Policyholders Impacted:				
Accept Increase	64%	43%	91%	85%
Reduce Benefits	31%	42%	3%	NA
Non-Forfeiture	5%	15%	6%	15%

[1]Approval Percentages factored each state equally, all denied, withdrawn, disapproved states at 0%

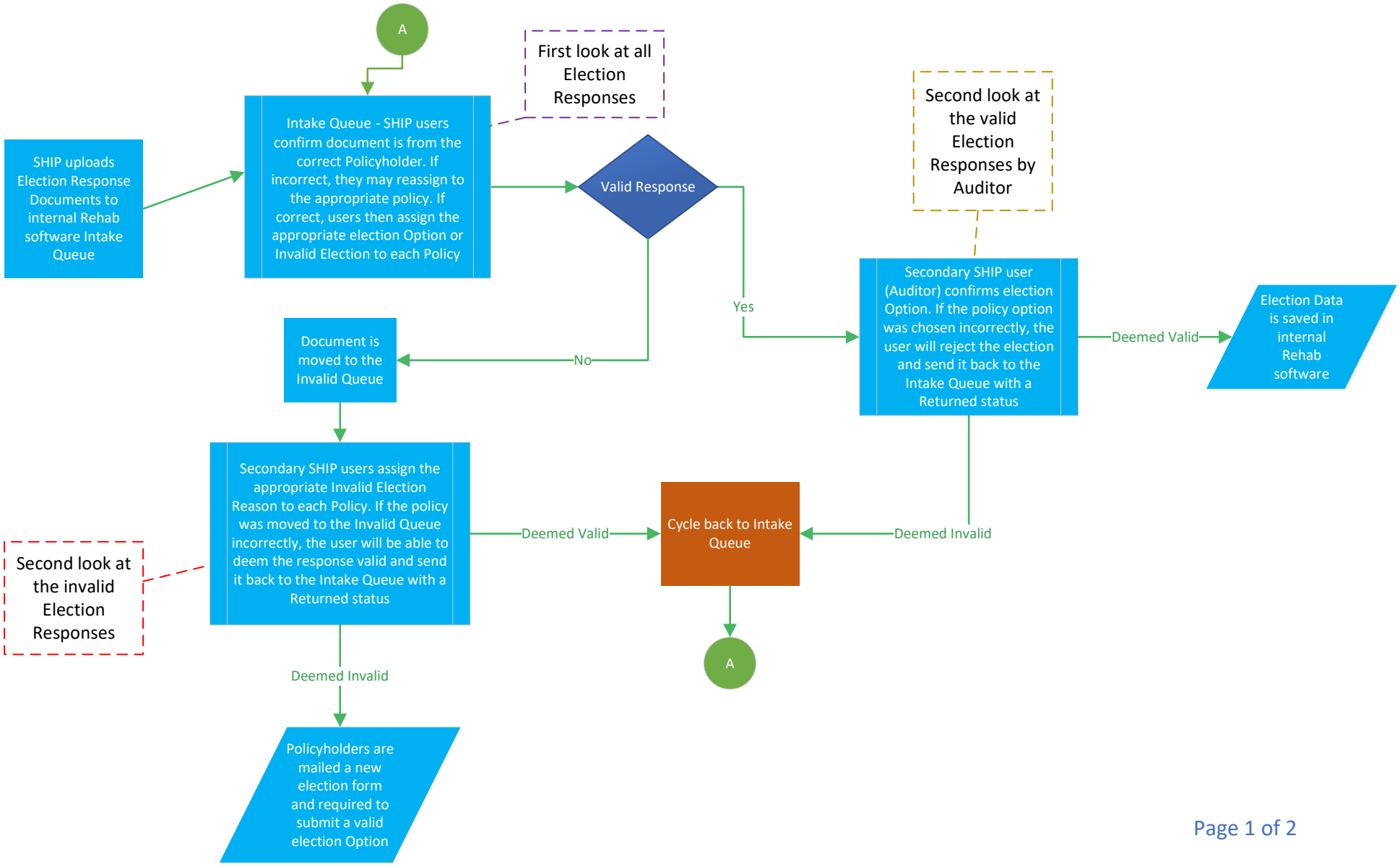
SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)

REHABILITATOR'S PRE-HEARING MEMORANDUM

PROPOSED

EXHIBIT 34

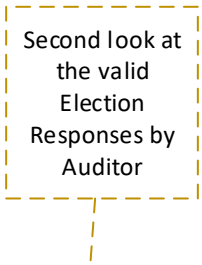
SHIP Rehabilitation Election Response Audit Process



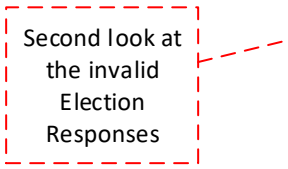
SHIP Rehabilitation Election Response Audit Process



The Intake Queue is the first stop for every election response. The assigned SHIP user reviews the document work item to ensure the following: 1. work item corresponds to the correct policyholder/policy number 2. response is on barcoded election form 3. only one box is checked, and 4. response has a valid signature. The assigned SHIP user either confirms a valid election Option, reassigns work item to correspond with correct policyholder/policy number, or deems the form invalid.



Once the election Option is confirmed the work item is reassigned to the Auditor to be verified. In the event of an error the Auditor rejects the election Option and the work item is returned to the Intake Queue. All verified election Option responses are saved in the database.



If the election response is deemed invalid the work item is assigned to the Invalid Queue. The secondary assigned SHIP user reviews the document work item for the invalid reason. This user either confirms an invalid reason or deems the form valid. A work item deemed valid is returned to the Intake Queue. All policyholders with election responses confirmed invalid are mailed a cover letter with a new election form.

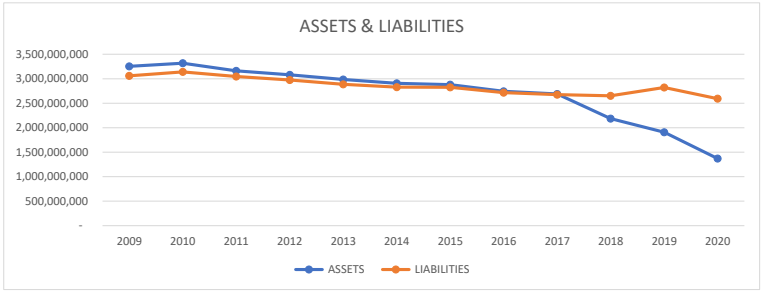
REHABILITATOR'S PRE-HEARING MEMORANDUM

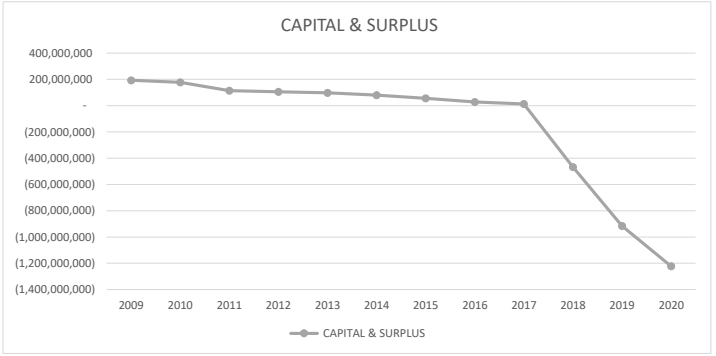
PROPOSED

EXHIBIT 36

SHIP Summary of Balance Sheet Changes

	ASSETS	LIABILITIES	CAPITAL & SURPLUS	CAPITAL AND SURPLUS CHANGES
2009	3,251,994,962	3,058,545,856	193,449,106	(17,161,623)
2010	3,317,023,144	3,139,706,226	177,314,918	(16,134,188)
2011	3,161,093,979	3,046,696,672	114,397,307	(62,917,611)
2012	3,080,745,346	2,975,278,318	105,467,028	(8,930,279)
2013	2,985,938,782	2,887,736,889	98,201,892	(7,265,136)
2014	2,906,965,242	2,826,959,318	80,005,924	(18,195,968)
2015	2,879,794,716	2,824,037,145	55,757,570	(24,248,354)
2016	2,744,535,287	2,716,512,099	28,023,187	(27,734,383)
2017	2,688,468,510	2,675,819,343	12,649,166	(15,374,021)
2018	2,186,058,273	2,652,931,248	(466,872,971)	(479,522,137)
2019	1,907,181,137	2,823,279,366	(916,098,229)	(449,225,258)
2020	1,369,908,000	2,592,415,000	(1,222,507,000)	(306,408,771)





Capital and Surplus Changes:

2010 Investment income and premium exceeded claims paid creating an increase in assets
NFO take rates with rate increases were around 5% reducing premium and liabilties

2011 Liabilities increased more than normal as a result of adverse claims experience primarily on TLI business
NFO take rates with rate increases were around 5% reducing premium and liabilties

2012 ALR methodology was changed with PID approval creating significantly larger drops in liabilities each year thereafter

2013 No significant changes

2014 Beechwood IMA's were entered into; no impact to capital and surplus
Surplus increased more than normal due to a surplus note from Beechwood of $50mm
Management agreement with Fuzion was entered into
CNO LTCi business started to be managed by Fuzion instead of SHIP; the associated block of business was ceded to Beechwood
Certain policy form characteristics were recognized creating an increase in liabilities of $30mm
Adverse claims experience resulted in an increase in liabilities

2015 Through novation, assumed the Teachers Protective block of LTCi creating $6.3mm commission income
Significant realized gains were recognized creating a $50mm increase in surplus but a reduction in future investment yield

2016 Entered into Roebling Re transaction creating a $27mm increase in surplus
Legal fees associated with Beechwood decreased surplus by $1mm
Actuarial fees related to rate increase efforts decreased surplus by $2mm
Investment write downs primarily associated with Beechwood assets resulted in a loss in surplus of $30mm

2017 VA policies of Teachers Protective block went back to Teachers creating a $2mm commission expense
Accrued investment income of $20mm written off due to Beechwood situation reducing net investment income
Recorded a PDR of $15mm due to adverse claims experience
Roebling Re transaction created a $4mm increase in surplus
Legal fees associated with Beechwood decreased surplus by $4mm
Downgrades associated with rate increases caused a larger drop in liabilities than normal
Significant realized gains were recognized creating an increase in surplus but a reduction in future investment yield

2018 PID approved the release of IMR of $192mm resulting in a large increase in net investment income
Recognized significant impairments on the Beechwood assets resulting in a large realized loss on investments
Additional Beechwood assets were non-admitted creating a $19.5mm loss in surplus
Legal fees associated with Beechwood decreased surplus by $4mm
Downgrades associated with rate increases caused a larger drop in liabilities than normal
Recorded a large PDR
- $69mm due to the IMR release
- $290mm due to adverse claims experience, updated rate increase assumptions based on results, lower new money rate

2019 Legal fees associated with Beechwood decreased surplus by $10mm
Increased the PDR $341mm due to adverse claims experience, updated rate increase assumptions, lower new money rate, updates in morbidity improvement assumptions
Recognized additional losses on Beechwood related assets decreasing surplus

2020 Recognized a loss on the Transamerica recapture of $169mm
Legal fees associated with Beechwood were reimbursed by insurance carrier resultin in an increase in surplus of $3mm
Increased the PDR as a result of updating termination assumptions, removing morbidity improvement and a lower new money rate

REHABILITATOR'S PRE-HEARING MEMORANDUM

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EXHIBIT 40

TREASURY BOND HISTORICAL RATES





Received 4/5/2021 11:51:38 PM Commonwealth Court of Pennsylvania

Filed 4/5/2021 11:51:00 PM Commonwealth Court of Pennsylvania
1 SHP 2020

CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that on April 5, 2021, I caused to be served the foregoing Rehabilitator's Pre-Hearing Memorandum and supporting exhibits through the Court's PACFile system and on all parties listed on the Master Service List. In addition, I hereby certify that an electronic copy of the foregoing document will be posted on SHIP's website at https://www.shipltc.com/court-documents.

/s/ Michael J. Broadbent