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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

PRAECIPE TO SUBSTITUTE APPROVED PLAN OF REHABILITATION

On September 24, 2021, Jessica K. Altman, Insurance Commissioner of Pennsylvania, in her capacity as Statutory Rehabilitator ("Rehabilitator") of Senior Health Insurance Company of Pennsylvania ("SHIP"), filed a Notice of Filing of Approved Rehabilitation Plan ("Notice of Approved Plan"). The Notice of Approved Plan included as Exhibit A thereto the Approved Rehabilitation Plan for SHIP ("Approved Plan") for which notice of filing was being provided.

After filing the Notice of Approved Plan, the Rehabilitator identified extraneous text in and functional issues with the Approved Plan, and the Rehabilitator wishes to correct these inadvertent errors, which do not impact the substance of the Approved Plan. Accordingly, the Rehabilitator hereby requests that the Court replace Exhibit A to the Notice of Approved Plan with the attached Exhibit A, a corrected Approved Plan. (A redline comparing the previously filed Approved Plan and the corrected Approved Plan is attached hereto as Exhibit B-2.)

Dated: September 30, 2021

Respectfully submitted,

/s/ Michael J. Broadbent

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EXHIBIT A

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

SEPTEMBER 30, 2021

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SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, *IN REHABILITATION*
APPROVED 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 APPROVED BY THE COMMONWEALTH COURT OF PENNSYLVANIA ON AUGUST 25, 2021, FOR SHIP'S REHABILITATION (THE "PLAN"). 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.

This version dated September 30, 2021, corrects an omission on page 19 of the September 24 version regarding disposition of the agent's commissions issue left open in the Court's August 25, 2021, Memorandum Opinion approving the Plan.

IMPORTANT NOTICE

THE PLAN DESCRIBED BELOW, AS 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 ENVISIONS 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 UNDERPRICED OR NON-SELF-SUSTAINING 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 ADEQUATELY 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, INCREASES IN THE PREMIUM RATES THAT MUST BE PAID TO MAINTAIN SUCH POLICIES IN FORCE, OR A COMBINATION OF PERMANENT BENEFIT REDUCTIONS AND PREMIUM RATE INCREASES. THIS PLAN DOCUMENT DESCRIBES THE METHODOLOGY FOR SUCH MODIFICATIONS IN DETAIL BUT DOES NOT CONTAIN SPECIFIC INFORMATION ABOUT HOW THEY WILL AFFECT ANY PARTICULAR POLICYHOLDER. THE SPECIFIC MANNER IN WHICH THE PLAN WILL IMPACT A PARTICULAR POLICY CAN ONLY BE DETERMINED AFTER CALCULATIONS THAT WILL BE MADE AS THE PLAN IS IMPLEMENTED. 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 APPROVED REHABILITATION PLAN. NONETHELESS, IT IS POSSIBLE THAT ISSUES WILL ARISE THAT HAVE NOT BEEN ENVISIONED IN THIS PLAN DOCUMENT, AND THAT CHANGES AND EVENTS OCCURRING AFTER THIS PLAN WAS APPROVED BY THE COURT WILL REQUIRE ADDITIONAL ADJUSTMENTS TO THE PLAN. THE REHABILITATOR ANTICIPATES OBTAINING 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 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 which is the rehabilitation court (the ***Commonwealth Court***). 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, on October 21, 2020, the Rehabilitator filed the ***Amended Rehabilitation Plan,*** among other things, addressing many of the issues raised in those comments. Additional comments have been received following the filing of the Amended Rehabilitation Plan and work continued to improve the plan. The ***Second Amended Rehabilitation Plan*** was filed with the Court on May 3, 2021, in contemplation of the hearing held by the Court beginning on May 17, 2021. Following the conclusion of that hearing and the submission of briefs, the Court approved the Proposed Rehabilitation Plan in a Memorandum Opinion and Order filed on August 25, 2021.

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

The details of the actual choices for, and projected impact upon, each policyholder will not be known until after the Plan provisions are calculated by the Company's systems. Those calculations may 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 are not justified given that the results will may not be sufficiently accurate to be meaningful. However, beginning at page 68 there are 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 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 under the Plan. Much more detail about the Plan and related matters is provided in the sections that follow.

1. GOAL AND PHASES OF THE PLAN

Recognizing that SHIP faces a substantial Funding Gap (described on page 87), 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 39,000 policies in force as of the filing of this Second Amended Rehabilitation 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 recognized 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 to cover reasonable long-term care expenses. That is expected to help narrow the Funding Gap and potentially reduce their own premium, or at least avoid part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. ***Phase One***, commencing now, 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 long-term care insurance ("LTCI") policies, more fully explained at page 27. Policyholders with Current Premium (see page 122) 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. It is expected that modifications in Phase Two will largely be based on ***Self-sustaining Premiums*** as explained at page 27. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies that meet the following conditions may be modified in Phase Two:

a. Their premiums are not already Self-sustaining,

b. They are not ***Fully Covered*** (*i.e.*, they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 123), and

c. The policyholders have not selected ***Option Two (a or b)*** or ***Option Three*** (described below) in Phase One.

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 apart from policy liabilities (addressed in Phase One and Two).

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 24. In Phase One every policyholder whose Current Premium (including the premium they would be paying but for a premium waiver) is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium (including the premium they would be paying but for a premium waiver) 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 or to maintain the premium waiver if one is in effect, but if Current or waived Premium is less than the If Knew Premium, have benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis 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 (sometimes greater than the benefits provided by Option One) at a lower premium than Option Four. This option, of which an enhanced alternative 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 choose to make no changes (i.e., 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 31. 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.7, page 29. 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 (including the premium they would be paying but for a premium waiver) 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 off 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 67). In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements - see Section III.A.2.d, page 48) 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 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 in Phase One.

5. CHANGES IN POLICYHOLDER ELECTIONS

Policyholders will not have the opportunity to change their elections after the applicable ***Policyholder Election Date*** (the deadline for policyholder option elections under the Plan). Before the Policyholder Election Date, policyholders may change their elections by submitting new

Policyholder Election Forms if they are received before the applicable Policyholder Election Date. A new valid Policyholder Election Form received before the Policyholder Election Date will replace and invalidate a valid or invalid Policyholder Election Form 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 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 (including the enhanced alternative) 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.

7. EFFECT OF ELECTIONS

Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits (see Section VI.J, page 92) will apply will be those as modified as a result of the Policyholder Elections. The elections are not intended to, and will not, eliminate the Unfunded Benefit Liability described in the discussion of policy restructuring (Section VI.H, page 91).

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 have been 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% compound Inflation Protection, one that provides 2% simple 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 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 policies 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. The enhanced version of Option Two provides more generous benefits in the form of a longer benefit period and some inflation protection. 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 material rate increases, Option Four might be attractive in that it would enable them to retain the most generous benefits, even at high premium rates. Many of these policyholders would face very large rate increases when selecting Option Four. This is because, in many cases, the premiums being paid 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 (including the enhanced alterative) 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 array 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 the Second Amended Plan, at least 140 million people had been infected worldwide, resulting in at least 3 million deaths. In the U.S., the first cases were reported in January 2020, with total estimates by then exceeding 32 million and fatalities exceeding 570,000. 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 the time the Second Amended Rehabilitation Plan was filed, more than one quarter of the U.S. population had been fully vaccinated, more than 40% having received at least one of two vaccines. The emphasis on vaccinating the older population first had resulted in nearly three quarters of those over 65 having received at least one dose, more than 60% having been fully vaccinated. As a result, COVID-19 mortality in nursing home and assisting living facilities has plummeted, approaching pre-pandemic levels after having peaked in December 2020. All told, more than 1.1 million residents and staff had by then been infected with the virus, and more than 133,000 succumbed to it.

The full impact of the COVID-19 pandemic on the U.S. insurance industry remains to be determined. The life insurance industry makes the following observations. Between March 2020 and February 2021, the number of actual deaths was 120% higher than the number of expected deaths.[1] This led to a 14% increase in mortality rates among group life claimants in the first quarter of 2020.[2] Excess deaths were concentrated "among those in the preferred underwriting class, particularly those ages 60 and older."[3] However, this has not increased life insurance premiums or decreased policy offerings.[4]

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[1] Susan Rupe, What Record Mortality Rates Mean for the Life Insurance Industry, INSURANCE NEWS NET (Apr. 14, 5:00 PM), https://insurancenewsnet.com/conference-post/what-record-mortality-rates-mean-for-the-life-insurance-industry.

[2] Id.

[3] Id.

[4] Andrew Keshner, Has COVID-19 Made Life Insurance More Expensive? MARKET WATCH, (Apr. 12, 12:00 PM), https://www.marketwatch.com/story/has-covid-19-made-life-insurance-more-expensive-these-researchers-say-they-have-the-answer-2020-12-07.

The impact on health insurers differs somewhat. Due to unemployment caused by COVID-19, between 3.1 and 27 million Americans lost employer-sponsored health insurance in 2020.[5] Health spending also dropped considerably, because of the cancellation of elective surgeries.[6] This loss was concentrated in the first half of 2020 but persisted enough to cause a 2.7% drop in non-prescription medical spending from 2019 to 2020.[7] This drop in spending could result in higher-than-average premium rebates for insureds.[8] Overall, health insurers fared well, with average gross margins at the end of the third quarter of 2020 for individual market and fully-insured group market plans almost 25% higher than in 2019.[9] Medicaid Advantage plans saw a 35% average gross margin increase over the same time period.[10] As a result, 2021 health insurance premiums are expected to remain largely unchanged.[11]

For long-term care insurance, the effects of the pandemic have been mixed. COVID-19 seemed to reduce long-term care insurance costs by (1) shortening the amount of time some insureds used benefits either because they died or because they left long-term care facilities, or (2) preventing some insureds from starting to use long-term care services.[12] A Fitch Ratings report indicates that the long-term care insurance industry gained roughly $2.5 billion in net operating profits from 2019 to 2020.[13] Actuaries are unsure about what effect COVID-19 will have on long-term care insurance over the long run, as COVID-19 could have "accelerated the deaths of people who were likely to die

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[5] Lola Butcher, How Health Insurance is Faring Under COVID, THE WEEK (Apr. 14, 2:00 PM), https://theweek.com/articles/975895/how-health-insurance-faring-under-covid.

[6] Cynthia Cox, Krutika Amin, and Rabah Kamal, How Have Health Spending and Utilization Changed During the Coronavirus Pandemic, PETERSON-KFF HEALTH SYSTEM TRACKER (Apr. 12, 1:00 PM), https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start.

[7] Id.

[8] Id.

[9] Daniel McDermott, et al., Health Insurer Financial Performance Through September 2020, KFF (Apr. 14, 4:00 PM), https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/.

[10] Id.

[11] Cox, *supra* note 12.

[12] Long-Term Care Insurance Dashboard: 2020, FITCH RATINGS, (Apr. 14, 4:00 PM), https://www.fitchratings.com/research/insurance/long-term-care-insurance-dashboard-2020-improved-results-view-of-reserve-adequacy-unchanged-06-04-2021.

[13] Id.

soon . . . and spared healthier older people."[14] This would mean that the surviving elderly population could spend more time using long-term care services.[15]

However, this seems to vary from insurer to insurer. A Milliman survey covering April to September 2020 found that the overall use of long-term care benefits remained unchanged.[16] While active life mortality increased for most responding insurers, 40% of responding insurers saw a decrease or no change.[17] The death rate for insureds already receiving benefits decreased by 5% or more for two-thirds of responding insurers.[18] An American Academy of Actuaries issue brief suggests that the bulk of COVID-19 deaths in long-term care facilities "may be associated with Medicaid funded-homes, which might not house a meaningful number of insureds."[19]

The implications of COVID-19 for SHIP and the Plan fall in three major areas.

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.

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 they are not expected to be material.

SUSPENSION OF PREMIUM PAYMENTS: Many SHIP policyholders had delayed making their required premium payment. While SHIP had delayed lapsing or cancelling policies for non-payment of premiums because of the exceptional circumstances, protracted delays in making these payments

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[14] Keshner, *supra* note 5.

[15] Id.

[16] Allison Bell, Long-Term Care Insurers Reveal Early COVID-19 Effects, THINK ADVISOR (Apr. 14, 3:30 PM), https://www.thinkadvisor.com/2021/03/18/long-term-care-insurers-reveal-early-covid-19-effects/ (of the 4 insurers that responded, one saw a 5-10% increase in benefit use, two saw a less than 5% decrease in benefit use, and one saw no change).

[17] Id.

[18] Id.

[19] Impact of COVID-19 on Long-Term Care Insurance, AMERICAN ACADEMY OF ACTUARIES (Apr. 15, 10:15 AM), https://www.actuary.org/node/14151

could have aggravated substantially SHIP's financial difficulties. Some regulatory agencies had requested or required that insurers (including SHIP) accommodate some premium deferrals, but many or most of these deferrals are also expiring or will soon expire. The net effect of the delays, therefore are also not expected to be material. 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.

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 provided for policyholders and other interested parties to comment on the Plan through September 15, 2020. Over 100 people have submitted comments, some formal but most informal, and a few parties have also been admitted as intervenors. The Approved Rehabilitation Plan reflects the analysis of those comments and continuing work by the rehabilitation team.

At page 35 is a 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, a hearing on the Plan was held beginning on May 17, 2021. On August 25, 2021, The Court filed a Memorandum Opinion and Order approving the Second Amended Rehabilitation Plan with the exception of Section VI.N. relating to the suspension of agents' commissions, which was addressed in a separate hearing on September 8, 2021, and approved on September 13, 2021, along with a settlement between certain intervening agents and the Rehabilitator. Implementation of the Plan commenced following the entry of the Court's Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year. The details of options available to some policyholders and these dates may differ because of changes in their circumstances (see Subsection II.L.3, page 37) or decisions made by the senior insurance regulator of the states in which their policies were issued (see Section VI.V, page 108). It is also possible that changes in circumstances generally may result in changes in these dates. This matter is complex and delays in this timetable remain 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 and 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, especially at adequate premium rates, 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. It is important to note that Plan premium rate increases are not based on state of issue or state of residence. They are based exclusively on the characteristics of each individual policy, including the difference between Current Premium and If Knew Premium (in Phase One) or Self-sustaining Premiums (in Phase Two).

5. In every case, policyholders will have at least one option (Option Two) calibrated to provide outcomes no less favorable than liquidation, including applicable Guaranty Association benefits.

6. 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.

7. 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. 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 the Plan 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 $650 million, 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 of the other options vs. Option Four.

G. ORDER OF DISBURSEMENTS

Apart from the amounts owed to policyholders for benefits under long-term care insurance policies for which it is directly responsible, SHIP has a variety of other debts. For purposes of the Plan all of SHIP's debts are classified as falling into one of five categories, described in more detail below. These categories are consistent with the order of distribution promulgated in 40 P.S. § 221.44, governing distributions in liquidation. While SHIP is not in liquidation, the rehabilitation plan is designed to provide creditor distribution priorities that respect the order therein promulgated and to avoid unintended advantages and disadvantages in the payment of SHIP's debts. Payments will not be made to debts in a particular category until all debts owed to a higher category have been paid in full or reasonable provision has been made for their full payment. Creditors who are not paid in full retain the right to assert claims for unpaid amounts owed to them. Creditors in each category will receive pro-rata distributions of the amounts owed to them as assets become available for the payment of debts in that category.

1. ADMINISTRATIVE EXPENSES

This category, corresponding to that established in 40 P.S. § 221.44(a), includes the costs of conducting SHIP's business, including development and implementation of the Plan. Payments to

vendors for goods or services procured by the Rehabilitator are within this category. That includes employee salaries and benefits, consultant and counsel fees, office and equipment leases, utilities, bills for operating supplies, and other debts incurred in the course of operating SHIP's business.

2. POLICYHOLDER LIABILITIES

This category, corresponding to that established in 40 P.S. § 221.44(b), includes all claims for benefits arising under long-term care insurance policies issued directly by SHIP or its predecessors: American Travelers Life Insurance Company, Conseco Senior Health Insurance Company, and Teachers Protective Mutual Insurance Company. It does not include policies reinsured by SHIP but not issued by SHIP or its predecessors. See Section VI.M.7, page 98. It also does not include claims arising under SHIP's 46,000 non-long-term care insurance policies, for which Conseco Life Insurance Company is responsible. See Section VI.M.5, page 98.

3. CERTAIN FEDERAL PRIORITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(c), includes all claims of the federal government other than those owed to it as a policyholder, which would fall in Category 2, above. However, the Rehabilitator does not believe that SHIP has any insurance policy obligations to the federal government.

4. GENERAL CREDITOR CLAIMS

This category, corresponding to those established in 40 P.S. § 221.44(d-h) includes all other debts owed by SHIP except those described in Category 5, below. It encompasses, among other debts:

a. all employee benefits accrued pre-rehabilitation for employees separated from the Company (including retiree claims - see Section VI.O, page 100),
b. claims of state and local governments,
c. agent and broker commissions (see Section VI.N, page 100),
d. claims of ceding insurers under reinsurance treaties (see Section VI.M.7, page 98),
e. surplus note contribution claims, and
f. other claims not specifically enumerated in this Section.

The Rehabilitator does not contemplate establishing a new claim filing procedure and instead creditors may continue submitting bills and invoices in the ordinary course of business.

5. EQUITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(1). Includes the claims of shareholders and owners. As to SHIP, this would only be the claims of Conseco and the Senior Health Care Oversight Trust.

II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION

This Section of the Plan Document provides detailed and technical explanations of 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 designed 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 the premiums of which 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 (see definition at page 126), 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 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 - not premium paying (further segregated between lifetime or dual Premium Waiver);
    (3) Disabled - premium paying; and
    (4) Disabled - not premium paying.

2. There may be some policyholders who do not fit neatly into the Plan's defined policyholder categories in each Phase, though none have yet been identified. If so, those will be addressed on an *ad hoc* basis.

C. POLICYHOLDER OPTIONS

1. In each category, policyholders whose Current Premiums are below the If Knew Premium rate for their policies will have four choices (one with two variants), 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 43. 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 48) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. The Basic Policy Endorsements convert 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 48, 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 50); 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*** (see page 127) 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 122) was 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. NOTE THAT A POLICYHOLDER WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM MAY NONETHELESS HAVE A NON-SELF-SUSTAINING POLICY (SEE PAGE 126) AND THEREFORE BE REQUIRED TO MAKE AN ELECTION IN PHASE TWO. SUCH A POLICYHOLDER WILL NOT HAVE TO MAKE A PHASE TWO ELECTION IF HE OR SHE HAS SELECTED OPTION TWO OR OPTION THREE IN PHASE ONE OR IF HIS OR HER POLICY IS FULLY COVERED (SEE PAGE 123).

6. Subject to the orders of the Commonwealth 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.

7. 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 48.

8. 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.

9. It is important to note, and policyholders will be advised before making such elections, that policies for which Option 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.

10. 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 48), 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.6) 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.

11. The approximately 8,000 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.

12. 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 42. 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, under the Plan 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 42.

4. Self-sustaining Premium is the premium calculated after evaluating the results of Phase One by determining the amount of premium required to eliminate a policy's ***Shortfall Amount*** in Phase Two.

    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 28. 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. Although this Plan Document assumes that in Phase Two determinations will be based on Self-sustaining Premiums, it is possible that, depending on the outcome of Phase One and other relevant considerations, in Phase Two the Plan will utilize an alternative premium

structure. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.

7. 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**

8. For a policy's Shortfall Amount to be eliminated completely, 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*** (see page 128) 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, if the Plan were not implemented, the approved premium rate increase would not take effect until after the Plan Effective Date.

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 policyholders on Claim Waiver make an election under the Plan that increases their premiums (Option Two or Option Four, see page 24), 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 (waived) 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 Spousal 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.

(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). Of course, if the If Knew Differential Premium for that policyholder is zero, he or she need not pay any additional 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. The Rehabilitation team believes that 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 "traditional" 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 8,000 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 federal 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. 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.	October 21, 2020 - Filing of Amended Proposed Rehabilitation Plan
7.	October 30, 2020 - Deadline for authorized interveners to file description of intended testimony and exhibits
8.	February 25, 2021 Scheduling Order
9.	May 3, 2021 Deadline for filing of Final Plan Amendments
10.	May 17, 2021 Hearing on Rehabilitation Plan
11.	July 31, 2021 Determination Date
12.	August 25, 2021 Memorandum Opinion and Order approving the Plan
13.	[TBD] Final Approval Date (assuming approval)
14.	Plan Preparation Period

15.	Begin Policyholder Transition Period
16.	[TBD] Policyholder Election Package
17.	[TBD] Policyholder Election Deadline
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 has been 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 held a hearing on the Plan beginning on May 17, 2021. Following the hearing, participating parties submitted post-hearing briefs to the Court. On August 25, 2021, the Court filed her Memorandum Opinion and Order approving the Plan with one exception relating to agents' commissions. [**AGENTS UPDATE**] The date upon which such approval becomes final (including exhaustion of appeals, if any) will be the ***Final Approval Date***. The ***Plan Preparation Period***, commenced with the Court's approval and 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 91. 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 the July 31, 2021, ***Determination Date*** which may vary for some policyholders 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 37, 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 Subsection II.L.3.c and Section VI.V, page 108, 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 125 and 126.

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 applicable Plan Determination 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 24), or Option Four (retain current benefits at Phase One

Premium - see Section II.C.1.d, page 24), 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 28.

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 applicable Plan 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 Care 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. 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. The MPV for current (pre-election) benefits will be used to determine the floor for the Basic Policy Endorsements. A policy's MPV will be newly determined after giving effect to modifications resulting from policyholder elections and the resulting MPV will be used to determine whether the policy is subject to change in Phase Two.

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 Policyholder 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 ***Downgrade Target Premium*** (see page 123) 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 Premium equals or exceeds the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the Downgrade 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 Premium is 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	$3,000	$3,200
and 2. THE IF KNEW PREMIUM FOR THE CURRENT BENEFITS IS	$2,800	$5,000
THEN:		
IN CASE 1, SINCE THE IF KNEW PREMIUM IS LOWER THAN THE CURRENT PREMIUM, THERE WILL BE NO BENEFIT REDUCTIONS.	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 45 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 of $600;

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

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

(5) In order to achieve the Downgrade Target Premium (which is equal to 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 49. 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.12, page 85. 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. Benefit Reduction Six (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. Active-paying 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) 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 an MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that it is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

3. OPTION THREE - NFO.

a. Active-paying 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. Generally, 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. Active-paying policyholders can elect to keep their current benefits and their premiums will increase to the corresponding Phase One Premium. See Section I.A.1.a.(1)(a)i)a)69), page 127, 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 42) 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, the policyholder need not make any election, there will be no default 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 43, above).

(3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, above.

(4) The benefit reductions will be calibrated to the Current Premium as explained in Section III.A.1.b, page 42.

(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 (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

(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 policy provides benefits (has an MPV) 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 50. If the current policy has an MPV below the applicable GA limits, the benefits of the endorsed policy will be adjusted so that the resulting MPV is at least equal to the current MPV.

c. OPTION THREE - NFO (see Section III.A.3, page 50).

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 (waived) 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 policyholder need not make an election and the policy will not be downgraded by default. 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 43 subject to the following provisions.

      (2) The same possible benefit reductions will apply, as described in Section III.A.1.f, page 45. 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 42). 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 48). 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 (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

(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 50. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that the resulting MPV is 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.7.b, page 29). 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 (waived) Premium is equal to or greater than the If Knew Premium, the policyholder will not be required to make an election or 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 42), 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 election will be necessary and no default downgrade would apply because they are already paying the Downgrade 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 43, and III.A.1.f, page 45, 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 42).

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 48, at If Knew Premium.

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

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

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

d. 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 Policyholder 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 43, and the benefit reductions described in Section III.A.1.f, page 45, 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 42). However, because of the waiver, the policyholder will not be required to pay any premium.

   d. If the policyholder is required to resume 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 42).

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 48, above.

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement"at higher If Knew Premiums. See Section III.A.2.f, page 49.

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 benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. 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 make an election or pay a Differential Premium.

   a. Policyholders on claim with Premium Waiver (whose waived premium is below the If Knew Premium) 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.7.b, page 29).

   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. THE DETAILS OF PHASE TWO CALCULATIONS ARE SUBJECT TO CHANGE AND REFINEMENT DEPENDING ON THE RESULTS OF PHASE ONE AND INTERVENING EVENTS. POLICYHOLDERS WHO WERE REQUIRED TO PAY MODERATELY HIGHER PREMIUMS FOR OPTION FOUR IN PHASE ONE MAY BE REQUIRED TO PAY MATERIALLY HIGHER PREMIUMS TO PRESERVE THEIR COVERAGE IN PHASE TWO.

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.

6. While policy modifications in Phase Two will largely be based on Self-sustaining Premiums rather than If Knew Premium, it is possible that, depending on the outcome of Phase One and other relevant considerations, an alternative premium structure will be used in Phase Two. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.

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

Policyholders who, as of the Phase Two Policyholder 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 43) 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. Active-paying 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 48.

   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 will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

   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 benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. 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 Amount 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 Allocated Assets (the PCA). See Section II.E.4, page 27, above.

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

Policyholders who, as of the Phase Two Policyholder 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 59) 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 43, above).

      (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, 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 50. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. 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 will also be offered an "Enhanced Basic Policy Endorsement". See Section III.A.2.f, page 49 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 50).

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 43 subject to the following provisions.

(2) The Benefit Reductions will apply, as described in Section III.A.1.f, page 45. 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 48). 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 50. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

(3) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

(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 62).

(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 59) 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 43. The Benefit Reductions described in Section III.A.1.f, page 45 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 48, 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 MPVs that are currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce MPVs at least equal to the applicable GA limits. For those policies with MPVs below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

    d. This will be the default for these policyholders.

    e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

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 Policyholder 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 43. The Benefit Reductions described in Section III.A.1.f, page 45, 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 49.

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 48.

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

e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

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 62). 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

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

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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	$2,614	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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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	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.	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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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	$6,336	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.

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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. # 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	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	$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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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 policyholders, agents, 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 91. 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. The UBL payments to policyholders will actually take the form of extended Maximum Benefit Periods.

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 92.

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 90) so it could continue running off its long-term care insurance ("LTCI") business independently. At the time, SHIP had 152,000 LTC policies in force. As of year-end 2019 that number was down to close to 45,000 and as of this filing it is at around 35,000. 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. After SHIP was placed in rehabilitation, the Rehabilitator has retained some and replaced others of these service providers.

Table 7 summarizes the Company's corporate history.

TABLE 7 - CORPORATE HISTORY

B. LONG-TERM CARE INSURANCE

At the time this Approved Rehabilitation Plan is filed, the insurance business of SHIP consists entirely of long-term care insurance (LTCI), much of it issued many decades ago, and none issued any later than 2003, when the Company ceased writing new business. Of approximately 646,000 LTCI policies sold by SHIP and its predecessors since the late 1970s, fewer than 36,000 remain in force. More precisely,

1. As of year-end 2018, SHIP had 51,635 LTC 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 96. 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 LTCI business was down to 45,518 policies, with 5,776 on claim. Its assumed business was down to 2,267 policies, 376 on claim. At the end of that 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 LTC 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. As noted, by the time of this filing, direct LTC policies number around 39,000.

4. 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.

5. 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).

6. The Company's business is comprised of LTCI and health policies written by the Company and assumed reinsurance. The non-LTC health policies written by SHIP and its predecessors were assumed by reinsurance by Conseco when SHIP was spun off in 2008. SHIP, therefore, is not administering those policies, which, as of the time SHIP was placed in rehabilitation numbered around 45,500. For the LTCI policies written by the Company and its predecessors, average policyholder age is 86 and the average claimant is 89 years old. SHIP's policies are approximately 13% Home Health Care coverage, 17% Facility Care coverage (nursing home and/or assisted living facility), and 70% 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.

7. 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.

8. "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.

9. 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.

10. 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 and can be envisioned to continue increasing to over $1,000, far in excess of the cost of care. The Company's average Maximum Daily Benefit for in-force policyholders is $173.

11. 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 benefit may be limited to 20 years, or until a policyholder attains the 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.

12. 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.

13. 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 28% of policyholders have lifetime policies.

14. 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.

15. 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 eligible for the Waiver of Premium benefit.

16. Restoration of Benefits - The Restoration of Benefits ("ROB") provision restores the policy's Benefit Period 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. 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.

17. 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)
2020	1,369,908,000	2,592,415,000	(1,222,507,000)

More complete financial information as of December 31, 2019, is included at Appendix B, along with summary updated information through December 31, 2020. It is estimated that SHIP's Funding Gap is more than $1.2 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 $1.2 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 typically 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 of, or contributing cause to, 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 levels 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; back down to 3.25% on April 10, 2020, and staying at that level since.

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 90) 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 86, 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 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, an Amended Rehabilitation Plan was filed on October 21, 2020, the Second Amended Rehabilitation Plan was filed on May 3. 2021, and this version was prepared following the Court's August 25, 2021, Memorandum Opinion and Order approving the rehabilitation plan. This Approved Rehabilitation Plan reflects updates made necessary by the Court's approval, including those affecting the payment of agent's commissions addressed in Section VI.N, page 100.

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 the Company 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 and other vendors 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. Now that the Plan has been approved, the Rehabilitator expects to file an application with the Court for approval of the Restructuring Statement within the next few weeks. The Rehabilitator will request that the Court deem SHIP's liabilities for Impaired Policies to have been restructured as of a specified 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 gross premium reserve - 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 28, 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. It is important to note that the Policyholder Elections are not intended to, and will not, eliminate the Unfunded Benefit Liability. To the extent that it cannot be paid, that liability is expected to be discharged in due course by the Commonwealth Court upon the Rehabilitator's application.

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. If made, those payments will take the form of extensions of the benefit periods in the affected policies. 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. As noted, a complete Restructuring Statement will soon be filed with the Court for approval.

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 should 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 the policyholders of a licensed insurance company 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 other countries 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. Thus, since many SHIP policyholders have more than one SHIP LTC policy, this limit will apply to all of them combined. If one policy is expected to receive benefits up to 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), typically 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 premium rates using a methodology similar to the Plan's If Knew Premium. Thus, the resulting premium rate increases can be expected to resemble those contemplated by the Plan. 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 expected 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 LTC policies would exceed the statutory limits of guaranty association coverage as described in the preceding Section. While the Rehabilitator believed 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. This issue has so far prevented the liquidator of Penn Treaty Network America Insurance Company and American Network Insurance Company from making such payments. The matter is the subject of litigation pending in the Commonwealth Court. In that proceeding the Court has ruled that policyholders are not entitled to benefits in excess of guaranty association limits. The litigation continues and it is possible that this decision will be reversed on appeal. However, for now at least, that is the law in Pennsylvania, which would also govern a liquidation of SHIP. These two insurers are also Pennsylvania-domiciled long-term care insurers and if that decision remains in place, the Rehabilitator, who is also the Liquidator in those cases, believes 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" the contractual benefits for which policyholders have been paying premiums to the limits of guaranty association coverage.

L. JURISDICTION OF COMMONWEALTH COURT

In composing this Plan, the Rehabilitator makes the assumption that the Commonwealth Court has exclusive *in rem* jurisdiction over SHIP and all of its assets. The Rehabilitator believes that this principle is both established law and indispensable to the success of a rehabilitation plan of this breadth and complexity. That means that 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. The governing Pennsylvania statute, 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, the Rehabilitator believes 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 not surprising 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 premium rate increases they can authorize for long-term care insurance policies. Regulations have the same effect in other jurisdictions. 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. Nonetheless, the Rehabilitator has added Section VI.V (page 108) as a means of addressing these concerns. That Section strives to reconcile the desire of certain states to make their own rate increases determinations with the fundamental goals of 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 is required, and appears, to be adequately funded. The business they manage consists of:

1. 5,781 Traditional Life,
2. 175 Universal Life,
3. 71 Deferred Annuities,
4. 273 Medicare Supplement,
5. 37,682 Specified Disease,
6. 689 Accident Only,
7. 603 Hospital Indemnity,
8. 435 Long term disability, and
9. 38 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 LTC 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. In turn, the ceding companies retain contractual rights against SHIP. However, under the Plan, payments owed by SHIP to the ceding companies on account of these rights are subordinated to amounts owed by SHIP to policyholders under SHIP policies. 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 changed that provision of the preliminary plan of rehabilitation. The Plan now treats 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.

Consistent with this change in the Plan, on October 1, 2020, 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 Commonwealth Court on December 29, 2020.

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' LTC 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's 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). The Rehabilitator believes that the payment of commissions should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44. Certain Agents and Brokers formally objected to this Section VI.N, but per settlement with the Rehabilitator, withdrew their objections as moot.

O. CERTAIN RETIREE BENEFITS

Transport Life Insurance Company, SHIP's predecessor, had entered into employment agreements with several of its former executives that provided for the post-retirement payment of health care benefits for them and their spouses. Through the series of transactions as a result of which Transport Life became SHIP (see page 97), SHIP became responsible for these payments and has continued to make them without interruption. The Rehabilitator believes that these payments are pre-rehabilitation contractual obligations to general creditors. Like agent commissions, they should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44. As part of the Plan, these payments will be suspended until all policyholder obligations have been satisfied or reasonable provision has been made for them.

P. 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 would satisfy an opt-out requirement if one were found to be applicable. 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 34. 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.

Q. 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, as the Plan is implemented, she should pursue recovery of those deposits so that the funds can be used to support the Plan.

R. 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 liability. 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.

S. 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.

T. 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 have made 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.

U. ALTERNATIVES TO THE PLAN

Before determining that the 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 Approved 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 Approved 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 95.

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 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 Approved 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 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 Rehabilitator has considered the alternatives described in the following three Sections 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 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 proposed this approach and it is now part of the Approved Rehabilitation Plan. Section VI.V, below at page 108, describes the basic elements of the 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 concluded that the best approach is the Plan as approved by the Court, with the component as described in alternative seven, above. Accordingly, the Approved Plan now includes the additional following section.

V. ISSUE-STATE RATE APPROVALS

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 Approved 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.

IT SHOULD ALSO BE NOTED THAT THE DECISIONS OF OPT-OUT STATES WILL AFFECT POLICYHOLDERS RESIDING IN OTHER STATES WHOSE POLICIES HAD BEEN ISSUED IN THE OPT-OUT STATE. CONVERSELY, THOSE DECISIONS WILL NOT AFFECT POLICIES HELD BY RESIDENTS OF THE OPT-OUT STATES BUT ISSUED IN OTHER STATES.

2. OPT-OUT ELECTIONS

a. In the next few weeks, the Rehabilitator will provide every state in which SHIP policies in force (and not in NFO status) 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 they receive the opt-out election notice. The Rehabilitator will be pleased to answer any question that may assist a state in evaluating this matter. States have not been required to take any action under this Section before the Plan was 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. Accordingly, I 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 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 (including those in NFO status). 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 (including those on premium waiver) issued in that state the Current Premium (whether or not waived) 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 by 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 unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group.

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 43). The Downgrade Process for Option A has fewer steps than the Plan downgrade mechanism for Opt-in policies in that Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. 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 II.E.6, page 28.

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 unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group. 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-out 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.

W. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented 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 references in the Plan to the Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make (and hereby disclaim) 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, defenses, 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 28.

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 48, 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"** 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 equivalent to the Downgrade Target Premium for the Downgrade Process. See Section III.A.1.c, page 43.

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 July 31, 2021, the date as of which all the determinations and calculations required to construct the options available to each policyholder will be made by the Rehabilitator, which may vary among policyholders. For Phase One it will be before the applicable Policyholder Election Date to be selected by the Rehabilitator pursuant to the Plan. Different Determination Dates will be used for Phase One and Phase Two calculations. The Phase Two Determination Date will not be established until the components of Phase Two are finalized.

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 43.

28) **"Downgrade Target Premium"** means the premium paid by, or waived for, a long-term care policy before the applicable Effective Date under the Plan. This is also equivalent to the Current Premium. See Section III.A.1.b, page 42.

29) **"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.

30) **"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 have undergone Transitional Events (see definition at page 131) during the Policyholder Transition Period as described in Section II.L.3.c, page 38, the Effective Date will be the Supplemental Plan Effective Date. Other Effective Dates may apply to policies issued in Opt-out States.

31) **"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.

32) **"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.

33) **"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.

34) **"Fully Covered"** means that the Maximum Policy Value projected for a particular policy 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.

35) **"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.

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

37) **"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.

38) **"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.

39) **"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.

40) **"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.

41) **"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.

42) **"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.

43) **"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, the Plan assumes a 60% target loss ratio. Thus, the If Knew Premium rate is the rate that, if charged from policy issue, would produce a 60% lifetime loss ratio. It is sometimes described as the premium the insurer would have charged from inception had it known then what it knows now.

44) **"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.

45) **"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.

46) **"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.

47) **"Initial Plan Effective Date"** is the Effective Date for most policyholders. 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 125 and 126. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date.

48) **"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 Transitional Events during the Policyholder Transition Period as described in Section II.L.3.c, page 38 and whose policies were not issued in Opt-out States.

49) **"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).

50) **"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.

51) **"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.

52) **"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.

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

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

55) **"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.

56) **"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.

57) **"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.

58) **"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.

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

60) **"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.

61) **"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 33.

62) **"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.

63) **"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.

64) **"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. Policies containing such provisions were formerly called "traditional" Long-term Care Insurance policies. 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.**

65) **"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.

66) **"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.

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

68) **"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.

69) **"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.

70) **"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.

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

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

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

74) **"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 43, 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.

75) **"Plan Option"** means any of the options available to policyholders under the Plan, which are described on page 24.

76) **"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.

77) **"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.

78) **"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.

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

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

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

82) **"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.

83) **"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.

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

85) **"Policyholder Transition Period"** means the period between the Plan Determination 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.

86) **"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 45.

87) **"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.

88) **"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.

89) **" 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.

90) **"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.

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

92) **"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.

93) **"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).

94) **"Restructured Policy"** means a policy that has been restructured as described in Section VI.H, page 91, to allocate the liabilities arising under the policy between its IFRPV and its UBL.

95) **"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).

96) **"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.

97) **"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.

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

99) **"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.

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

101) **"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.

102) **"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.

103) **"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.

104) **"Supplemental Plan Effective Date"** is the Effective Date for policyholders who undergo Transitional Events during the Policyholder Transition Period as described in Section II.L.3.c, page 38. It will occur on the policy's Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.

105) **"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. See the discussion in Section VI.B.7, page 83. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

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

107) **"Transitional Events"** means the events described on page 38 as a result of which a policyholder must make an election after the Initial Policyholder Election Date and before the Supplemental Plan Effective Date.

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

109) **"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.

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

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

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).

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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.

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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:

a. Current Year	Insured	Commercial 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	Insured	Commercial All Other	Total
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:

a. Current Year	Insured	Commercial 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

a. Current Year	Insured	Commercial 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	-	-	-

(7) Allowance for Credit Losses:	Current Year	Prior Year
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 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 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.'

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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

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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)

Senior Health Insurance Company in Rehabilitation
Income Statement
($ in thousands)

	Quarter Ended 09/30/2020	Year Ended 12/31/2019
Premiums	$ 52,217	$ 80,672
Investment Income	51,509	77,412
Investment Expense	(794)	(10,695)
Total Income	102,932	147,389
Benefits Paid	261,760	369,626
Change in Claim Reserves	(47,675)	(26,160)
Change in ALR	(91,744)	(74,651)
Change in PDR Reserves	96,122	262,914
Total Benefits	218,463	531,729
Commissions	3,651	5,654
General Insurance Expenses	24,153	29,396
Insurance Taxes, Licenses and Fees	722	3,890
Total Benefits and Expenses	246,989	570,669
Federal Income Taxes	(217)	205
Net Loss before Realized Losses	(143,840)	(423,485)
Realized Losses	(6,281)	(38,549)
Net Loss	$ (150,121)	$ (462,034)
Cash from Operations	$ (169,210)	$ (251,711)

Senior Health Insurance Company in Rehabilitation

Balance Sheet

($ in thousands)

	Quarter Ended 09/30/2020	Year Ended 12/31/2019
Assets		
Bonds	$ 1,548,916	$ 1,721,888
Preferred stock	79,903	86,271
Common stock	4,264	3,578
Mortgage loans	11,967	12,682
Cash and short term investments	47,736	46,682
Other invested assets	9,263	15,701
Receivable for securities	-	136
Total invested assets	1,702,049	1,886,938
Investment income due and accrued	10,852	12,082
Uncollected premiums	879	928
Federal income tax recoverable	2,581	2,364
Guaranty funds receivable	1,220	1,209
Reimbursement from insurance carrier	1,497	3,588
Other	127	72
Total Assets	$ 1,719,205	$ 1,907,181
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	$ 1,141,574	$ 1,234,831
Premium deficiency reserves	732,659	636,537
Claim reserves	885,098	932,811
Premiums paid in advance	1,214	1,462
Interest maintenance reserve	5,849	4,746
Accounts payable and other liabilites	23,188	12,892
Total Liabilities	$ 2,789,582	$ 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	(1,127,877)	(973,598)
Total Capital and Surplus	$ (1,070,377)	$ (916,098)
Total Liabilities and Capital and Surplus	$ 1,719,205	$ 1,907,181

Senior Health Insurance Company in Rehabilitation
Investment Summary

Core Portfolio

	9/30/2020	12/31/2019	Incr(Decr)
Bonds and Short Term Investments	$ 1,585,652,266	$ 1,757,570,714	$ (171,918,448)
Sutton Capital Trust	72,143,500	72,143,500	-
Preferred and Common Stock Unaffiliated	7,759,540	14,641,092	(6,881,552)
Common Stock - Fuzion Analytics	4,263,838	2,975,269	1,288,569
Mortgage Loans	11,966,574	12,681,751	(715,177)
Other Invested Assets	1,612,467	1,645,981	(33,514)
	$ 1,683,398,184	$ 1,861,658,307	$ (178,260,123)

Non-Core Portfolio

	9/30/2020	12/31/2019	Incr(Decr)
AB Private Credit	$ 16,373,979	$ 19,435,088	$ (3,061,109)
Phonex	-	89,817	(89,817)
Sun Trust COOF	262,862	271,266	(8,404)
Equipment Finance V	11,000,000	11,000,000	-
PPCO	-	3,335,380	(3,335,380)
Kingdom	930,000	930,000	-
Rent Path	-	-	-
PPCA	-	-	-
	$ 28,566,841	$ 35,061,551	$ (6,494,710)

Senior Health Insurance Company in Rehabilitation
Income Statement
($ in thousands)

	Year Ended 12/31/2020	Year Ended 12/31/2019
Premiums	$ 66,982	$ 80,672
Investment Income	70,421	77,412
Investment Expense	(1,053)	(10,695)
Gain/Loss Transferred to IMR	(16,210)	(3,679)
Transamerica Service Fees	144	-
Total Income	120,284	143,710
Benefits Paid	333,201	369,626
Change in Claim Reserves	(143,406)	(26,160)
Change in ALR	(128,983)	(74,651)
Change in PDR Reserves	170,775	262,914
Loss from Transamerica Recpature	168,507	-
Total Benefits	400,094	531,729
Commissions	4,622	5,654
General Insurance Expenses	31,306	29,396
Insurance Taxes, Licenses and Fees	1,132	3,890
Total Benefits and Expenses	437,154	570,669
Federal and State Income Taxes	(505)	205
Net Loss before Realized Gains/ Losses	(316,365)	(427,164)
Realized Gains/Losses	10,518	(34,870)
Net Loss	$ (305,847)	$ (462,034)
Cash from Operations	$ (208,461)	$ (251,711)

Senior Health Insurance Company in Rehabilitation
Balance Sheet
($ in thousands)

	Year Ended 12/31/2020	Year Ended 12/31/2019
Assets		
Bonds	$ 1,201,083	$ 1,721,888
Preferred stock	77,608	86,271
Common stock	4,735	3,578
Mortgage loans	11,717	12,682
Cash and short term investments	46,100	46,682
Other invested assets	9,862	15,701
Receivable for securities	-	136
Total invested assets	1,351,105	1,886,938
Investment income due and accrued	9,362	12,082
Uncollected premiums	961	928
Federal income tax recoverable	1,380	2,364
Guaranty funds receivable	1,135	1,209
Reimbursement from insurance carrier	421	3,588
Transamerica receivable	5,408	-
Other	136	72
Total Assets	$ 1,369,908	$ 1,907,181
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	$ 1,047,771	$ 1,234,831
Premium deficiency reserves	762,600	636,537
Claim reserves	732,814	932,811
Premiums paid in advance	972	1,462
Interest maintenance reserve	18,457	4,746
Transamerica liability	21,073	-
Accounts payable and other liabilites	8,728	12,892
Total Liabilities	$ 2,592,415	$ 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	(1,280,007)	(973,598)
Total Capital and Surplus	$ (1,222,507)	$ (916,098)
Total Liabilities and Capital and Surplus	$ 1,369,908	$ 1,907,181

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1 SHP 2020

EXHIBIT B-2

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

SEPTEMBER ~~24~~30, 2021

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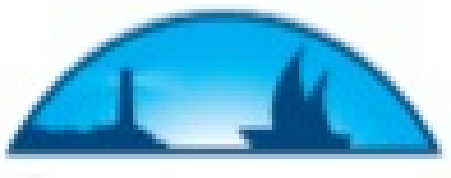

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, *IN REHABILITATION*
APPROVED REHABILITATION PLAN

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

==========

HOW TO PROVIDE COMMENTS AND OBJECTIONS

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

Formal 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 APPROVED BY THE COMMONWEALTH COURT OF PENNSYLVANIA ON AUGUST 25, 2021, FOR SHIP'S REHABILITATION (THE "PLAN"). 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.

This version dated September 30, 2021, corrects an omission on page 19 of the September 24 version regarding disposition of the agent's commissions issue left open in the Court's August 25, 2021, Memorandum Opinion approving the Plan.

IMPORTANT NOTICE

THE PLAN DESCRIBED BELOW, AS 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 ENVISIONS 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 UNDERPRICED OR NON-SELF-SUSTAINING 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 ADEQUATELY 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, INCREASES IN THE PREMIUM RATES THAT MUST BE PAID TO MAINTAIN SUCH POLICIES IN FORCE, OR A COMBINATION OF PERMANENT BENEFIT REDUCTIONS AND PREMIUM RATE INCREASES. THIS PLAN DOCUMENT DESCRIBES THE METHODOLOGY FOR SUCH MODIFICATIONS IN DETAIL BUT DOES NOT CONTAIN SPECIFIC INFORMATION ABOUT HOW THEY WILL AFFECT ANY PARTICULAR POLICYHOLDER. THE SPECIFIC MANNER IN WHICH THE PLAN WILL IMPACT A PARTICULAR POLICY CAN ONLY BE DETERMINED AFTER CALCULATIONS THAT WILL BE MADE AS THE PLAN IS IMPLEMENTED. 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 APPROVED REHABILITATION PLAN. NONETHELESS, IT IS POSSIBLE THAT ISSUES WILL ARISE THAT HAVE NOT BEEN ENVISIONED IN THIS PLAN DOCUMENT, AND THAT CHANGES AND EVENTS OCCURRING AFTER THIS PLAN WAS APPROVED BY THE COURT WILL REQUIRE ADDITIONAL ADJUSTMENTS TO THE PLAN. THE REHABILITATOR ANTICIPATES OBTAINING 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 THE PLAN. THE FINAL PLAN AS IMPLEMENTED MAY THEREFORE VARY IN SOME MEASURE FROM THE DESCRIPTION IN THIS PLAN DOCUMENT.

==========

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 which is the rehabilitation court (the ***Commonwealth Court***). 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, on October 21, 2020, the Rehabilitator filed the ***Amended Rehabilitation Plan,*** among other things, addressing many of the issues raised in those comments. Additional comments have been received following the filing of the Amended Rehabilitation Plan and work continued to improve the plan. The ***Second Amended Rehabilitation Plan*** was filed with the Court on May 3, 2021, in contemplation of the hearing held by the Court beginning on May 17, 2021. Following the conclusion of that hearing and the submission of briefs, the Court approved the Proposed Rehabilitation Plan in a Memorandum Opinion and Order filed on August 25, 2021.

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

The details of the actual choices for, and projected impact upon, each policyholder will not be known until after the Plan provisions are calculated by the Company's systems. Those calculations may 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 are not justified given that the results will may not be sufficiently accurate to be meaningful. However, beginning at page 68 there are 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 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 under the Plan. Much more detail about the Plan and related matters is provided in the sections that follow.

1. GOAL AND PHASES OF THE PLAN

Recognizing that SHIP faces a substantial Funding Gap (described on page 87), 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 39,000 policies in force as of the filing of this Second Amended Rehabilitation 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 recognized 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 to cover reasonable long-term care expenses. That is expected to help narrow the Funding Gap and potentially reduce their own premium, or at least avoid part or all of a necessary premium rate increase.

The Plan is designed to operate in three phases. ***Phase One***, commencing now, 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 long-term care insurance ("LTCI") policies, more fully explained at page 27. Policyholders with Current Premium (see page 122) 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. It is expected that modifications in Phase Two will largely be based on ***Self-sustaining Premiums*** as explained at page 27. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. Only policies that meet the following conditions may be modified in Phase Two:

a. Their premiums are not already Self-sustaining,

b. They are not ***Fully Covered*** (*i.e.*, they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 123), and

c. The policyholders have not selected ***Option Two (a or b)*** or ***Option Three*** (described below) in Phase One.

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 apart from policy liabilities (addressed in Phase One and Two).

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 24. In Phase One every policyholder whose Current Premium (including the premium they would be paying but for a premium waiver) is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium (including the premium they would be paying but for a premium waiver) 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 or to maintain the premium waiver if one is in effect, but if Current or waived Premium is less than the If Knew Premium, have benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis 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 (sometimes greater than the benefits provided by Option One) at a lower premium than Option Four. This option, of which an enhanced alternative 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 choose to make no changes (i.e., 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 31. 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.7, page 29. 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 (including the premium they would be paying but for a premium waiver) 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 off 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 67). In general, the Default Option will be Option One (the downgrade) for policyholders on Premium Waiver. However, if the Non-forfeiture Option (NFO) would provide these policyholders better benefits than the downgrade, the NFO will be the Default Option. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements - see Section III.A.2.d, page 48) 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 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 in Phase One.

5. CHANGES IN POLICYHOLDER ELECTIONS

Policyholders will not have the opportunity to change their elections after the applicable ***Policyholder Election Date*** (the deadline for policyholder option elections under the Plan). Before the Policyholder Election Date, policyholders may change their elections by submitting new

Policyholder Election Forms if they are received before the applicable Policyholder Election Date. A new valid Policyholder Election Form received before the Policyholder Election Date will replace and invalidate a valid or invalid Policyholder Election Form 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 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 (including the enhanced alternative) 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.

7. EFFECT OF ELECTIONS

Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits (see Section VI.J, page 92) will apply will be those as modified as a result of the Policyholder Elections. The elections are not intended to, and will not, eliminate the Unfunded Benefit Liability described in the discussion of policy restructuring (Section VI.H, page 91).

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 have been 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% compound Inflation Protection, one that provides 2% simple 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 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 policies 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. The enhanced version of Option Two provides more generous benefits in the form of a longer benefit period and some inflation protection. 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 material rate increases, Option Four might be attractive in that it would enable them to retain the most generous benefits, even at high premium rates. Many of these policyholders would face very large rate increases when selecting Option Four. This is because, in many cases, the premiums being paid 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 (including the enhanced alterative) 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 array 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 the Second Amended Plan, at least 140 million people had been infected worldwide, resulting in at least 3 million deaths. In the U.S., the first cases were reported in January 2020, with total estimates by then exceeding 32 million and fatalities exceeding 570,000. 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 the time the Second Amended Rehabilitation Plan was filed, more than one quarter of the U.S. population had been fully vaccinated, more than 40% having received at least one of two vaccines. The emphasis on vaccinating the older population first had resulted in nearly three quarters of those over 65 having received at least one dose, more than 60% having been fully vaccinated. As a result, COVID-19 mortality in nursing home and assisting living facilities has plummeted, approaching pre-pandemic levels after having peaked in December 2020. All told, more than 1.1 million residents and staff had by then been infected with the virus, and more than 133,000 succumbed to it.

The full impact of the COVID-19 pandemic on the U.S. insurance industry remains to be determined. The life insurance industry makes the following observations. Between March 2020 and February 2021, the number of actual deaths was 120% higher than the number of expected deaths.[1] This led to a 14% increase in mortality rates among group life claimants in the first quarter of 2020.[2] Excess deaths were concentrated "among those in the preferred underwriting class, particularly those ages 60 and older."[3] However, this has not increased life insurance premiums or decreased policy offerings.[4]

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[1] Susan Rupe, What Record Mortality Rates Mean for the Life Insurance Industry, INSURANCE NEWS NET (Apr. 14, 5:00 PM), https://insurancenewsnet.com/conference-post/what-record-mortality-rates-mean-for-the-life-insurance-industry.

[2] Id.

[3] Id.

[4] Andrew Keshner, Has COVID-19 Made Life Insurance More Expensive? MARKET WATCH, (Apr. 12, 12:00 PM), https://www.marketwatch.com/story/has-covid-19-made-life-insurance-more-expensive-these-researchers-say-they-have-the-answer-2020-12-07.

The impact on health insurers differs somewhat. Due to unemployment caused by COVID-19, between 3.1 and 27 million Americans lost employer-sponsored health insurance in 2020.[5] Health spending also dropped considerably, because of the cancellation of elective surgeries.[6] This loss was concentrated in the first half of 2020 but persisted enough to cause a 2.7% drop in non-prescription medical spending from 2019 to 2020.[7] This drop in spending could result in higher-than-average premium rebates for insureds.[8] Overall, health insurers fared well, with average gross margins at the end of the third quarter of 2020 for individual market and fully-insured group market plans almost 25% higher than in 2019.[9] Medicaid Advantage plans saw a 35% average gross margin increase over the same time period.[10] As a result, 2021 health insurance premiums are expected to remain largely unchanged.[11]

For long-term care insurance, the effects of the pandemic have been mixed. COVID-19 seemed to reduce long-term care insurance costs by (1) shortening the amount of time some insureds used benefits either because they died or because they left long-term care facilities, or (2) preventing some insureds from starting to use long-term care services.[12] A Fitch Ratings report indicates that the long-term care insurance industry gained roughly $2.5 billion in net operating profits from 2019 to 2020.[13] Actuaries are unsure about what effect COVID-19 will have on long-term care insurance over the long run, as COVID-19 could have "accelerated the deaths of people who were likely to die

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[5] Lola Butcher, How Health Insurance is Faring Under COVID, THE WEEK (Apr. 14, 2:00 PM), https://theweek.com/articles/975895/how-health-insurance-faring-under-covid.

[6] Cynthia Cox, Krutika Amin, and Rabah Kamal, How Have Health Spending and Utilization Changed During the Coronavirus Pandemic, PETERSON-KFF HEALTH SYSTEM TRACKER (Apr. 12, 1:00 PM), https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start.

[7] Id.

[8] Id.

[9] Daniel McDermott, et al., Health Insurer Financial Performance Through September 2020, KFF (Apr. 14, 4:00 PM), https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/.

[10] Id.

[11] Cox, *supra* note 12.

[12] Long-Term Care Insurance Dashboard: 2020, FITCH RATINGS, (Apr. 14, 4:00 PM), https://www.fitchratings.com/research/insurance/long-term-care-insurance-dashboard-2020-improved-results-view-of-reserve-adequacy-unchanged-06-04-2021.

[13] Id.

soon . . . and spared healthier older people."[14] This would mean that the surviving elderly population could spend more time using long-term care services.[15]

However, this seems to vary from insurer to insurer. A Milliman survey covering April to September 2020 found that the overall use of long-term care benefits remained unchanged.[16] While active life mortality increased for most responding insurers, 40% of responding insurers saw a decrease or no change.[17] The death rate for insureds already receiving benefits decreased by 5% or more for two-thirds of responding insurers.[18] An American Academy of Actuaries issue brief suggests that the bulk of COVID-19 deaths in long-term care facilities "may be associated with Medicaid funded-homes, which might not house a meaningful number of insureds."[19]

The implications of COVID-19 for SHIP and the Plan fall in three major areas.

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.

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 they are not expected to be material.

SUSPENSION OF PREMIUM PAYMENTS: Many SHIP policyholders had delayed making their required premium payment. While SHIP had delayed lapsing or cancelling policies for non-payment of premiums because of the exceptional circumstances, protracted delays in making these payments

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[14] Keshner, *supra* note 5.

[15] Id.

[16] Allison Bell, Long-Term Care Insurers Reveal Early COVID-19 Effects, THINK ADVISOR (Apr. 14, 3:30 PM), https://www.thinkadvisor.com/2021/03/18/long-term-care-insurers-reveal-early-covid-19-effects/ (of the 4 insurers that responded, one saw a 5-10% increase in benefit use, two saw a less than 5% decrease in benefit use, and one saw no change).

[17] Id.

[18] Id.

[19] Impact of COVID-19 on Long-Term Care Insurance, AMERICAN ACADEMY OF ACTUARIES (Apr. 15, 10:15 AM), https://www.actuary.org/node/14151

could have aggravated substantially SHIP's financial difficulties. Some regulatory agencies had requested or required that insurers (including SHIP) accommodate some premium deferrals, but many or most of these deferrals are also expiring or will soon expire. The net effect of the delays, therefore are also not expected to be material. 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.

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 provided for policyholders and other interested parties to comment on the Plan through September 15, 2020. Over 100 people have submitted comments, some formal but most informal, and a few parties have also been admitted as intervenors. The Approved Rehabilitation Plan reflects the analysis of those comments and continuing work by the rehabilitation team.

At page 35 is a 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, a hearing on the Plan was held beginning on May 17, 2021. On August 25, 2021, The Court filed a Memorandum Opinion and Order approving the Second Amended Rehabilitation Plan with the exception of Section VI.N. relating to the suspension of agents' commissions~~. That matter~~, which was addressed in a separate hearing on September 8, 2021, and approved on September 13, 2021, along with a settlement between certain intervening agents and the Rehabilitator. ~~**[INSERT OUTCOME]**~~ Implementation of the Plan commenced following the entry of the Court's Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year. The details of options available to some policyholders and these dates may differ because of changes in their circumstances (see Subsection II.L.3, page 37) or decisions made by the senior insurance regulator of the states in which their policies were issued (see Section VI.V, page 108). It is also possible that changes in circumstances generally may result in changes in these dates. This matter is complex and delays in this timetable remain 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 and 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, especially at adequate premium rates, 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. It is important to note that Plan premium rate increases are not based on state of issue or state of residence. They are based exclusively on the characteristics of each individual policy, including the difference between Current Premium and If Knew Premium (in Phase One) or Self-sustaining Premiums (in Phase Two).

5. In every case, policyholders will have at least one option (Option Two) calibrated to provide outcomes no less favorable than liquidation, including applicable Guaranty Association benefits.

6. 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.

7. 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. 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 the Plan 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 $650 million, 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 of the other options vs. Option Four.

G. ORDER OF DISBURSEMENTS

Apart from the amounts owed to policyholders for benefits under long-term care insurance policies for which it is directly responsible, SHIP has a variety of other debts. For purposes of the Plan all of SHIP's debts are classified as falling into one of five categories, described in more detail below. These categories are consistent with the order of distribution promulgated in 40 P.S. § 221.44, governing distributions in liquidation. While SHIP is not in liquidation, the rehabilitation plan is designed to provide creditor distribution priorities that respect the order therein promulgated and to avoid unintended advantages and disadvantages in the payment of SHIP's debts. Payments will not be made to debts in a particular category until all debts owed to a higher category have been paid in full or reasonable provision has been made for their full payment. Creditors who are not paid in full retain the right to assert claims for unpaid amounts owed to them. Creditors in each category will receive pro-rata distributions of the amounts owed to them as assets become available for the payment of debts in that category.

1. ADMINISTRATIVE EXPENSES

This category, corresponding to that established in 40 P.S. § 221.44(a), includes the costs of conducting SHIP's business, including development and implementation of the Plan. Payments to vendors for goods or services procured by the Rehabilitator are within this category. That includes employee salaries and benefits, consultant and counsel fees, office and equipment leases, utilities, bills for operating supplies, and other debts incurred in the course of operating SHIP's business.

2. POLICYHOLDER LIABILITIES

This category, corresponding to that established in 40 P.S. § 221.44(b), includes all claims for benefits arising under long-term care insurance policies issued directly by SHIP or its predecessors: American Travelers Life Insurance Company, Conseco Senior Health Insurance Company, and Teachers Protective Mutual Insurance Company. It does not include policies reinsured by SHIP but not issued by SHIP or its predecessors. See Section VI.M.7, page 98. It also does not include claims arising under SHIP's 46,000 non-long-term care insurance policies, for which Conseco Life Insurance Company is responsible. See Section VI.M.5, page 98.

3. CERTAIN FEDERAL PRIORITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(c), includes all claims of the federal government other than those owed to it as a policyholder, which would fall in Category 2, above. However, the Rehabilitator does not believe that SHIP has any insurance policy obligations to the federal government.

4. GENERAL CREDITOR CLAIMS

This category, corresponding to those established in 40 P.S. § 221.44(d-h) includes all other debts owed by SHIP except those described in Category 5, below. It encompasses, among other debts:

a. all employee benefits accrued pre-rehabilitation for employees separated from the Company (including retiree claims - see Section VI.O, page 100),
b. claims of state and local governments,
c. agent and broker commissions (see Section VI.N, page 100),
d. claims of ceding insurers under reinsurance treaties (see Section VI.M.7, page 98),
e. surplus note contribution claims, and
f. other claims not specifically enumerated in this Section.

The Rehabilitator does not contemplate establishing a new claim filing procedure and instead creditors may continue submitting bills and invoices in the ordinary course of business.

5. EQUITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(1). Includes the claims of shareholders and owners. As to SHIP, this would only be the claims of Conseco and the Senior Health Care Oversight Trust.

II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION

This Section of the Plan Document provides detailed and technical explanations of 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 designed 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 the premiums of which 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 (see definition at page 126), 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 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 - not premium paying (further segregated between lifetime or dual Premium Waiver);
    (3) Disabled - premium paying; and

(4) Disabled - not premium paying.

2. There may be some policyholders who do not fit neatly into the Plan's defined policyholder categories in each Phase, though none have yet been identified. If so, those will be addressed on an *ad hoc* basis.

C. POLICYHOLDER OPTIONS

1. In each category, policyholders whose Current Premiums are below the If Knew Premium rate for their policies will have four choices (one with two variants), 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 43. 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 48) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. The Basic Policy Endorsements convert 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 48, 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 50); 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*** (see page 127) 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 122) was 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. NOTE THAT A POLICYHOLDER WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM MAY NONETHELESS HAVE A NON-SELF-SUSTAINING POLICY (SEE PAGE 126) AND THEREFORE BE REQUIRED TO MAKE AN ELECTION IN PHASE TWO. SUCH A POLICYHOLDER WILL NOT HAVE TO MAKE A PHASE TWO ELECTION IF HE OR SHE HAS SELECTED OPTION TWO OR OPTION THREE IN PHASE ONE OR IF HIS OR HER POLICY IS FULLY COVERED (SEE PAGE 123).

6. Subject to the orders of the Commonwealth 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.

7. 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 48.

8. 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.

9. It is important to note, and policyholders will be advised before making such elections, that policies for which Option 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.

10. 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 48), 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.6) 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.

11. The approximately 8,000 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.

12. 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 42. 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, under the Plan 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 42.

4. Self-sustaining Premium is the premium calculated after evaluating the results of Phase One by determining the amount of premium required to eliminate a policy's ***Shortfall Amount*** in Phase Two.

    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 28. 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. Although this Plan Document assumes that in Phase Two determinations will be based on Self-sustaining Premiums, it is possible that, depending on the outcome of Phase One and other relevant considerations, in Phase Two the Plan will utilize an alternative premium structure. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.

7. 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**

8. For a policy's Shortfall Amount to be eliminated completely, 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*** (see page 128) 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, if the Plan were not implemented, the approved premium rate increase would not take effect until after the Plan Effective Date.

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 policyholders on Claim Waiver make an election under the Plan that increases their premiums (Option Two or Option Four, see page 24), 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 (waived) 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 Spousal 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.

(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). Of course, if the If Knew Differential Premium for that policyholder is zero, he or she need not pay any additional 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. The Rehabilitation team believes that 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 "traditional" 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 8,000 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 federal 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. 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.	October 21, 2020 - Filing of Amended Proposed Rehabilitation Plan
7.	October 30, 2020 - Deadline for authorized interveners to file description of intended testimony and exhibits
8.	February 25, 2021 Scheduling Order
9.	May 3, 2021 Deadline for filing of Final Plan Amendments
10.	May 17, 2021 Hearing on Rehabilitation Plan
11.	July 31, 2021 Determination Date
12.	August 25, 2021 Memorandum Opinion and Order approving the Plan

13.	[TBD] Final Approval Date (assuming approval)
14.	Plan Preparation Period
15.	Begin Policyholder Transition Period
16.	[TBD] Policyholder Election Package
17.	[TBD] Policyholder Election Deadline
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 has been 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 held a hearing on the Plan beginning on May 17, 2021. Following the hearing, participating parties submitted post-hearing briefs to the Court. On August 25, 2021, the Court filed her Memorandum Opinion and Order approving the Plan with one exception relating to agents' commissions. [**AGENTS UPDATE**] The date upon which such approval becomes final (including exhaustion of appeals, if any) will be

the ***Final Approval Date***. The ***Plan Preparation Period***, commenced with the Court's approval and 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 91. 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 the July 31, 2021, ***Determination Date*** which may vary for some policyholders 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 37, 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 Subsection II.L.3.c and Section VI.V, page 108, 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 125 and 126.

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 applicable Plan Determination 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 24), or Option Four (retain current benefits at Phase One Premium - see Section II.C.1.d, page 24), 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 28.

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 applicable Plan 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 Care 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. 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. The MPV for current (pre-election) benefits will be used to determine the floor for the Basic Policy Endorsements. A policy's MPV will be newly determined after giving effect to modifications resulting from policyholder elections and the resulting MPV will be used to determine whether the policy is subject to change in Phase Two.

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 Policyholder 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 ***Downgrade Target Premium*** (see page 123) 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 Premium equals or exceeds the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the Downgrade 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 Premium is 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	$3,000	$3,200
and 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 45 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 of $600;

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

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

(5) In order to achieve the Downgrade Target Premium (which is equal to 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 49. 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.12, page 85. 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. Benefit Reduction Six (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. Active-paying 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) 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 an MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that it is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

3. OPTION THREE - NFO.

a. Active-paying 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. Generally, 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. Active-paying policyholders can elect to keep their current benefits and their premiums will increase to the corresponding Phase One Premium. See Section I.A.1.a.(1)(a)i)a)69), page 127, 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 42) 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, the policyholder need not make any election, there will be no default 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 43, above).

(3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, above.

(4) The benefit reductions will be calibrated to the Current Premium as explained in Section III.A.1.b, page 42.

(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 (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

(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 policy provides benefits (has an MPV) 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 50. If the current policy has an MPV below the applicable GA limits, the benefits of the endorsed policy will be adjusted so that the resulting MPV is at least equal to the current MPV.

c. OPTION THREE - NFO (see Section III.A.3, page 50).

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 (waived) 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 policyholder need not make an election and the policy will not be downgraded by default. 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 43 subject to the following provisions.

      (2) The same possible benefit reductions will apply, as described in Section III.A.1.f, page 45. 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 42). 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 48). 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 (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.

(2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

(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 50. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that the resulting MPV is 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.7.b, page 29). 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 (waived) Premium is equal to or greater than the If Knew Premium, the policyholder will not be required to make an election or 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 42), 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 election will be necessary and no default downgrade would apply because they are already paying the Downgrade 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 43, and III.A.1.f, page 45, 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 42).

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 48, at If Knew Premium.

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

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

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

d. 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 Policyholder 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 43, and the benefit reductions described in Section III.A.1.f, page 45, 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 42). However, because of the waiver, the policyholder will not be required to pay any premium.

d. If the policyholder is required to resume 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 42).

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 48, above.

b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement"at higher If Knew Premiums. See Section III.A.2.f, page 49.

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 benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. 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 make an election or pay a Differential Premium.

   a. Policyholders on claim with Premium Waiver (whose waived premium is below the If Knew Premium) 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.7.b, page 29).

   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. THE DETAILS OF PHASE TWO CALCULATIONS ARE SUBJECT TO CHANGE AND REFINEMENT DEPENDING ON THE RESULTS OF PHASE ONE AND INTERVENING EVENTS. POLICYHOLDERS WHO WERE REQUIRED TO PAY MODERATELY HIGHER PREMIUMS FOR OPTION FOUR IN PHASE ONE MAY BE REQUIRED TO PAY MATERIALLY HIGHER PREMIUMS TO PRESERVE THEIR COVERAGE IN PHASE TWO.

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.

6. While policy modifications in Phase Two will largely be based on Self-sustaining Premiums rather than If Knew Premium, it is possible that, depending on the outcome of Phase One and other relevant considerations, an alternative premium structure will be used in Phase Two. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.

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

Policyholders who, as of the Phase Two Policyholder 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 43) 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. Active-paying 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 48.

   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 will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

   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 benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. 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 Amount 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 Allocated Assets (the PCA). See Section II.E.4, page 27, above.

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

Policyholders who, as of the Phase Two Policyholder 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 59) 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 43, above).

      (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, 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 50. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. 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 will also be offered an "Enhanced Basic Policy Endorsement". See Section III.A.2.f, page 49 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 50).

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 43 subject to the following provisions.

(2) The Benefit Reductions will apply, as described in Section III.A.1.f, page 45. 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 48). 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 50. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

(3) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

(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 62).

(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 59) 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 43. The Benefit Reductions described in Section III.A.1.f, page 45 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 48, 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 MPVs that are currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce MPVs at least equal to the applicable GA limits. For those policies with MPVs below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

    d. This will be the default for these policyholders.

    e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

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 Policyholder 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 43. The Benefit Reductions described in Section III.A.1.f, page 45, 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 49.

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 48.

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

e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.

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 62). 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.

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 policyholders, agents, 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 91. 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. The UBL payments to policyholders will actually take the form of extended Maximum Benefit Periods.

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 92.

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 90) so it could continue running off its long-term care insurance ("LTCI") business independently. At the time, SHIP had 152,000 LTC policies in force. As of year-end 2019 that number was down to close to 45,000 and as of this filing it is at around 35,000. 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. After SHIP was placed in rehabilitation, the Rehabilitator has retained some and replaced others of these service providers.

Table 7 summarizes the Company's corporate history.

TABLE 7 - CORPORATE HISTORY

B. LONG-TERM CARE INSURANCE

At the time this Approved Rehabilitation Plan is filed, the insurance business of SHIP consists entirely of long-term care insurance (LTCI), much of it issued many decades ago, and none issued any later than 2003, when the Company ceased writing new business. Of approximately 646,000 LTCI policies sold by SHIP and its predecessors since the late 1970s, fewer than 36,000 remain in force. More precisely,

1. As of year-end 2018, SHIP had 51,635 LTC 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 96. 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 LTCI business was down to 45,518 policies, with 5,776 on claim. Its assumed business was down to 2,267 policies, 376 on claim. At the end of that 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 LTC 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. As noted, by the time of this filing, direct LTC policies number around 39,000.

4. 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.

5. 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).

6. The Company's business is comprised of LTCI and health policies written by the Company and assumed reinsurance. The non-LTC health policies written by SHIP and its predecessors were assumed by reinsurance by Conseco when SHIP was spun off in 2008. SHIP, therefore, is not administering those policies, which, as of the time SHIP was placed in rehabilitation numbered around 45,500. For the LTCI policies written by the Company and its predecessors, average policyholder age is 86 and the average claimant is 89 years old. SHIP's policies are approximately 13% Home Health Care coverage, 17% Facility Care coverage (nursing home and/or assisted living facility), and 70% 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.

7. 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.

8. "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.

9. 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.

10. 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 and can be envisioned to continue increasing to over $1,000, far in excess of the cost of care. The Company's average Maximum Daily Benefit for in-force policyholders is $173.

11. 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 benefit may be limited to 20 years, or until a policyholder attains the 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.

12. 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.

13. 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 28% of policyholders have lifetime policies.

14. 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.

15. 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 eligible for the Waiver of Premium benefit.

16. Restoration of Benefits - The Restoration of Benefits ("ROB") provision restores the policy's Benefit Period 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. 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.

17. 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)
2020	1,369,908,000	2,592,415,000	(1,222,507,000)

More complete financial information as of December 31, 2019, is included at Appendix B, along with summary updated information through December 31, 2020. It is estimated that SHIP's Funding Gap is more than $1.2 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 $1.2 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 typically 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 of, or contributing cause to, 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 levels 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; back down to 3.25% on April 10, 2020, and staying at that level since.

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 90) 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 86, 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 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, an Amended Rehabilitation Plan was filed on October 21, 2020, the Second Amended Rehabilitation Plan was filed on May 3. 2021, and this version was prepared following the Court's August 25, 2021, Memorandum Opinion and Order approving the rehabilitation plan. This Approved Rehabilitation Plan reflects updates made necessary by the Court's approval, including those affecting the payment of agent's commissions addressed in Section VI.N, page 100.

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 the Company 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 and other vendors 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. Now that the Plan has been approved, the Rehabilitator expects to file an application with the Court for approval of the Restructuring Statement within the next few weeks. The Rehabilitator will request that the Court deem SHIP's liabilities for Impaired Policies to have been restructured as of a specified 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 gross premium reserve - 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 28, 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. It is important to note that the Policyholder Elections are not intended to, and will not, eliminate the Unfunded Benefit Liability. To the extent that it cannot be paid, that liability is expected to be discharged in due course by the Commonwealth Court upon the Rehabilitator's application.

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. If made, those payments will take the form of extensions of the benefit periods in the affected policies. 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. As noted, a complete Restructuring Statement will soon be filed with the Court for approval.

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 should 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 the policyholders of a licensed insurance company 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 other countries 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. Thus, since many SHIP policyholders have more than one SHIP LTC policy, this limit will apply to all of them combined. If one policy is expected to receive benefits up to 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), typically 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 premium rates using a methodology similar to the Plan's If Knew Premium. Thus, the resulting premium rate increases can be expected to resemble those contemplated by the Plan. 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 expected 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 LTC policies would exceed the statutory limits of guaranty association coverage as described in the preceding Section. While the Rehabilitator believed 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. This issue has so far prevented the liquidator of Penn Treaty Network America Insurance Company and American Network Insurance Company from making such payments. The matter is the subject of litigation pending in the Commonwealth Court. In that proceeding the Court has ruled that policyholders are not entitled to benefits in excess of guaranty association limits. The litigation continues and it is possible that this decision will be reversed on appeal. However, for now at least, that is the law in Pennsylvania, which would also govern a liquidation of SHIP. These two insurers are also Pennsylvania-domiciled long-term care insurers and if that decision remains in place, the Rehabilitator, who is also the Liquidator in those cases, believes 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" the contractual benefits for which policyholders have been paying premiums to the limits of guaranty association coverage.

L. JURISDICTION OF COMMONWEALTH COURT

In composing this Plan, the Rehabilitator makes the assumption that the Commonwealth Court has exclusive *in rem* jurisdiction over SHIP and all of its assets. The Rehabilitator believes that this principle is both established law and indispensable to the success of a rehabilitation plan of this breadth and complexity. That means that 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. The governing Pennsylvania statute, 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, the Rehabilitator believes 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 not surprising 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 premium rate increases they can authorize for long-term care insurance policies. Regulations have the same effect in other jurisdictions. 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. Nonetheless, the Rehabilitator has added Section VI.V (page 108) as a means of addressing these concerns. That Section strives to reconcile the desire of certain states to make their own rate increases determinations with the fundamental goals of 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 is required, and appears, to be adequately funded. The business they manage consists of:

1. 5,781 Traditional Life,
2. 175 Universal Life,
3. 71 Deferred Annuities,
4. 273 Medicare Supplement,
5. 37,682 Specified Disease,
6. 689 Accident Only,
7. 603 Hospital Indemnity,
8. 435 Long term disability, and
9. 38 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 LTC 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. In turn, the ceding companies retain contractual rights against SHIP. However, under the Plan, payments owed by SHIP to the ceding companies on account of these rights are subordinated to amounts owed by SHIP to policyholders under SHIP policies. 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 changed that provision of the preliminary plan of rehabilitation. The Plan now treats 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.

Consistent with this change in the Plan, on October 1, 2020, 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 Commonwealth Court on December 29, 2020.

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' LTC 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's 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). The Rehabilitator believes that the payment of commissions should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44. Certain Agents and Brokers formally objected to this Section VI.N, but per settlement with the Rehabilitator, withdrew their objections as moot.

O. CERTAIN RETIREE BENEFITS

Transport Life Insurance Company, SHIP's predecessor, had entered into employment agreements with several of its former executives that provided for the post-retirement payment of health care benefits for them and their spouses. Through the series of transactions as a result of which Transport Life became SHIP (see page 97), SHIP became responsible for these payments and has continued to make them without interruption. The Rehabilitator believes that these payments are pre-rehabilitation contractual obligations to general creditors. Like agent commissions, they should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44. As part of the Plan, these payments will be suspended until all policyholder obligations have been satisfied or reasonable provision has been made for them.

P. 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 would satisfy an opt-out requirement if one were found to be applicable. 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 34. 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.

Q. 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, as the Plan is implemented, she should pursue recovery of those deposits so that the funds can be used to support the Plan.

R. 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 liability. 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.

S. 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.

T. 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 have made 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.

U. ALTERNATIVES TO THE PLAN

Before determining that the 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 Approved 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 Approved 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 95.

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 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 Approved 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 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 Rehabilitator has considered the alternatives described in the following three Sections 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 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 proposed this approach and it is now part of the Approved Rehabilitation Plan. Section VI.V, below at page 108, describes the basic elements of the 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 concluded that the best approach is the Plan as approved by the Court, with the component as described in alternative seven, above. Accordingly, the Approved Plan now includes the additional following section.

V. ISSUE-STATE RATE APPROVALS

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 Approved 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.

IT SHOULD ALSO BE NOTED THAT THE DECISIONS OF OPT-OUT STATES WILL AFFECT POLICYHOLDERS RESIDING IN OTHER STATES WHOSE POLICIES HAD BEEN ISSUED IN THE OPT-OUT STATE. CONVERSELY, THOSE DECISIONS WILL NOT AFFECT POLICIES HELD BY RESIDENTS OF THE OPT-OUT STATES BUT ISSUED IN OTHER STATES.

2. OPT-OUT ELECTIONS

a. In the next few weeks, the Rehabilitator will provide every state in which SHIP policies in force (and not in NFO status) 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 they receive the opt-out election notice. The Rehabilitator will be pleased to answer any question that may assist a state in evaluating this matter. States have not been required to take any action under this Section before the Plan was 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. Accordingly, I 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 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 (including those in NFO status). 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 (including those on premium waiver) issued in that state the Current Premium (whether or not waived) 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 by 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 unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group.

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 43). The Downgrade Process for Option A has fewer steps than the Plan downgrade mechanism for Opt-in policies in that Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. 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 II.E.6, page 28.

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 unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group. 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-out 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.

W. DISCLAIMERS AND SOURCES OF INFORMATION

The discussion of the Rehabilitation Plan in this document describes how it is proposed to be implemented 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 references in the Plan to the Rehabilitator should be interpreted as including the SDR unless specified otherwise. The Rehabilitator and SHIP do not make (and hereby disclaim) 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, defenses, 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 28.

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 48, 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"** 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 equivalent to the Downgrade Target Premium for the Downgrade Process. See Section III.A.1.c, page 43.

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 July 31, 2021, the date as of which all the determinations and calculations required to construct the options available to each policyholder will be made by the Rehabilitator, which may vary among policyholders. For Phase One it will be before the applicable Policyholder Election Date to be selected by the Rehabilitator pursuant to the Plan. Different Determination Dates will be used for Phase One and Phase Two calculations. The Phase Two Determination Date will not be established until the components of Phase Two are finalized.

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 43.

28) **"Downgrade Target Premium"** means the premium paid by, or waived for, a long-term care policy before the applicable Effective Date under the Plan. This is also equivalent to the Current Premium. See Section III.A.1.b, page 42.

29) **"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.

30) **"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 have undergone Transitional Events (see definition at page 131) during the Policyholder Transition Period as described in Section II.L.3.c, page 38, the Effective Date will be the Supplemental Plan Effective Date. Other Effective Dates may apply to policies issued in Opt-out States.

31) **"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.

32) **"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.

33) **"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.

34) **"Fully Covered"** means that the Maximum Policy Value projected for a particular policy 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.

35) **"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.

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

37) **"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.

38) **"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.

39) **"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.

40) **"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.

41) **"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.

42) **"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.

43) **"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, the Plan assumes a 60% target loss ratio. Thus, the If Knew Premium rate is the rate that, if charged from policy issue, would produce a 60% lifetime loss ratio. It is sometimes described as the premium the insurer would have charged from inception had it known then what it knows now.

44) **"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.

45) **"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.

46) **"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.

47) **"Initial Plan Effective Date"** is the Effective Date for most policyholders. 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 125 and 126. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date.

48) **"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 Transitional Events during the Policyholder Transition Period as described in Section II.L.3.c, page 38 and whose policies were not issued in Opt-out States.

49) **"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).

50) **"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.

51) **"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.

52) **"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.

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

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

55) **"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.

56) **"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.

57) **"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.

58) **"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.

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

60) **"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.

61) **"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 33.

62) **"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.

63) **"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.

64) **"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. Policies containing such provisions were formerly called "traditional" Long-term Care Insurance policies. 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.**

65) **"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.

66) **"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.

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

68) **"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.

69) **"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.

70) **"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.

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

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

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

74) **"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 43, 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.

75) **"Plan Option"** means any of the options available to policyholders under the Plan, which are described on page 24.

76) **"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.

77) **"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.

78) **"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.

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

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

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

82) **"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.

83) **"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.

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

85) **"Policyholder Transition Period"** means the period between the Plan Determination 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.

86) **"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 45.

87) **"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.

88) **"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.

89) **" 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.

90) **"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.

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

92) **"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.

93) **"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).

94) **"Restructured Policy"** means a policy that has been restructured as described in Section VI.H, page 91, to allocate the liabilities arising under the policy between its IFRPV and its UBL.

95) **"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).

96) **"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.

97) **"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.

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

99) **"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.

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

101) **"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.

102) **"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.

103) **"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.

104) **"Supplemental Plan Effective Date"** is the Effective Date for policyholders who undergo Transitional Events during the Policyholder Transition Period as described in Section II.L.3.c, page 38. It will occur on the policy's Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.

105) **"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. See the discussion in Section VI.B.7, page 83. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

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

107) **"Transitional Events"** means the events described on page 38 as a result of which a policyholder must make an election after the Initial Policyholder Election Date and before the Supplemental Plan Effective Date.

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

109) **"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.

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

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

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.

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CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that on September 30, 2021, I served the foregoing PRAECIPE TO SUBSTITUTE APPROVED PLAN OF REHABILITATION 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