SUM-100

SUMMONS
(CITACION JUDICIAL)

NOTICE TO DEFENDANT:
(AVISO AL DEMANDADO):
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, and Does 1 through 100, inclusive.

YOU ARE BEING SUED BY PLAINTIFF:
(LO ESTÁ DEMANDANDO EL DEMANDANTE):
WILLIAM HALL, on behalf of himself and others similarly situated.

FOR COURT USE ONLY
(SOLO PARA USO DE LA CORTE)
FILED
SUPERIOR COURT
COUNTY OF SAN BERNARDINO
RANCHO CUCAMONGA DISTRICT
FEB 07 2012
Cesar R Lepe

NOTICE! You have been sued. The court may decide against you without your being heard unless you respond within 30 days. Read the information below.

You have 30 CALENDAR DAYS after this summons and legal papers are served on you to file a written response at this court and have a copy served on the plaintiff. A letter or phone call will not protect you. Your written response must be in proper legal form if you want the court to hear your case. There may be a court form that you can use for your response. You can find these court forms and more information at the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), your county law library, or the courthouse nearest you. If you cannot pay the filing fee, ask the court clerk for a fee waiver form. If you do not file your response on time, you may lose the case by default, and your wages, money, and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may want to call an attorney referral service. If you cannot afford an attorney, you may be eligible for free legal services from a nonprofit legal services program. You can locate these nonprofit groups at the California Legal Services Web site (*www.lawhelpcalifornia.org*), the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), or by contacting your local court or county bar association. **NOTE:** The court has a statutory lien for waived fees and costs on any settlement or arbitration award of $10,000 or more in a civil case. The court's lien must be paid before the court will dismiss the case.

¡AVISO! Lo han demandado. Si no responde dentro de 30 días, la corte puede decidir en su contra sin escuchar su versión. Lea la información a continuación.

Tiene 30 DÍAS DE CALENDARIO después de que le entreguen esta citación y papeles legales para presentar una respuesta por escrito en esta corte y hacer que se entregue una copia al demandante. Una carta o una llamada telefónica no lo protegen. Su respuesta por escrito tiene que estar en formato legal correcto si desea que procesen su caso en la corte. Es posible que haya un formulario que usted pueda usar para su respuesta. Puede encontrar estos formularios de la corte y más información en el Centro de Ayuda de las Cortes de California (www.sucorte.ca.gov), en la biblioteca de leyes de su condado o en la corte que le quede más cerca. Si no puede pagar la cuota de presentación, pida al secretario de la corte que le dé un formulario de exención de pago de cuotas. Si no presenta su respuesta a tiempo, puede perder el caso por incumplimiento y la corte le podrá quitar su sueldo, dinero y bienes sin más advertencia.

Hay otros requisitos legales. Es recomendable que llame a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de remisión a abogados. Si no puede pagar a un abogado, es posible que cumpla con los requisitos para obtener servicios legales gratuitos de un programa de servicios legales sin fines de lucro. Puede encontrar estos grupos sin fines de lucro en el sitio web de California Legal Services, (www.lawhelpcalifornia.org), en el Centro de Ayuda de las Cortes de California, (www.sucorte.ca.gov) o poniéndose en contacto con la corte o el colegio de abogados locales. AVISO: Por ley, la corte tiene derecho a reclamar las cuotas y los costos exentos por imponer un gravamen sobre cualquier recuperación de $10,000 ó más de valor recibida mediante un acuerdo o una concesión de arbitraje en un caso de derecho civil. Tiene que pagar el gravamen de la corte antes de que la corte pueda desechar el caso.

The name and address of the court is:
(El nombre y dirección de la corte es):
San Bernardino Superior Court
8303 Haven Avenuet
Rancho Cucamonga, California 91730

CASE NUMBER:
(Número del Caso): CIVRS 1200996

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:
(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):
Samuel L. Bruchey, Esq. #271995 909-621-4935
SHERNOFF BIDART ECHEVERRIA BENTLEY LLP
600 S. Indian Hill Boulevard Claremont, California 91711

DATE: FEB 07 2012 (*Fecha*)
Clerk, by Cesar R. Lepe (*Secretario*), Deputy (*Adjunto*)

(For proof of service of this summons, use Proof of Service of Summons *(form POS-010).)*
(Para prueba de entrega de esta citatión use el formulario Proof of Service of Summons, *(POS-010)).*

[SEAL]

NOTICE TO THE PERSON SERVED: You are served
1. ☐ as an individual defendant.
2. ☐ as the person sued under the fictitious name of *(specify):*
3. ☐ on behalf of *(specify):*
   under: ☐ CCP 416.10 (corporation) ☐ CCP 416.60 (minor)
   ☐ CCP 416.20 (defunct corporation) ☐ CCP 416.70 (conservatee)
   ☐ CCP 416.40 (association or partnership) ☐ CCP 416.90 (authorized person)
   ☐ other *(specify):*
4. ☐ by personal delivery on *(date):*

Form Adopted for Mandatory Use
Judicial Council of California
SUM-100 [Rev. July 1, 2009]

SUMMONS

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SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF SAN BERNARDINO

CIVRS 1200996

WILLIAM HALL, on behalf of himself and others similarly situated,

Plaintiff,

vs.

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, and Does 1 through 100, inclusive,

Defendants.

Case No.:

CLASS ACTION COMPLAINT AND DEMAND FOR JURY TRIAL

(1) BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING

(2) BREACH OF CONTRACT

(3) VIOLATION OF WELFARE AND INSTITUTIONS CODE § 15610.30 et seq.

(4) VIOLATIONS OF UNFAIR COMPETITION LAW, BUS. & PROF. CODE § 17200 et seq.

(5) DECLARATORY RELIEF

Plaintiff, by his attorneys, brings this action on behalf of himself and all other similarly situated persons, against Senior Health Insurance Company of Pennsylvania ("SHIP") and Does 1-100. Plaintiff alleges the following on information and belief, except as to those allegations which individually pertain to Plaintiff.

I. INTRODUCTION

1. This case arises from an unfair and unlawful scheme perpetrated by SHIP to delay and deny valid claims for coverage submitted by California long-term care policyholders.

2. At the center of the scheme is SHIP's abusive claims process – a protocol designed to frustrate and confuse policyholders with needless demands for irrelevant information in violation of SHIP's own policy and California law.

3. The victims of this scheme are among society's most vulnerable. Long-term care policyholders are often elderly and infirm. Their reliance on long-term care is itself evidence of their vulnerability, as these products purport to defray the cost of caregivers when such care becomes an unfortunate necessity.

4. SHIP represents that it protects the interests of its policyholders. Indeed, SHIP recently sent a letter assuring its California policyholders that it operates "without profit and solely for the benefit of policyholders," a message the carrier also displays on its website. Its long-term care product similarly assures that "benefits payable under this Policy will be paid as soon as we receive proper written proof of loss."

5. These assurances could not be farther from the truth. In fact, SHIP deliberately places demands upon policyholders that are so steeped in obfuscation that SHIP's purpose could only be to cook up grounds to deny claims. SHIP routinely requires insureds to submit forms and documents that are not referenced, described, or required by their policies, and that were never otherwise disclosed or provided to insureds.

6. SHIP requires that policyholders undergo unnecessary, and even biased, examinations conducted by medical professionals selected by SHIP to initially determine whether an insured qualifies for benefits, when the policies allow for any medical professional to perform the initial benefit eligibility assessment.

7. SHIP requires that caregivers have certification and/or licensure as a prerequisite to approving claims for Home Care in violation of the policies and California law.

8. Even if insureds diligently comply with SHIP's improper requirements, SHIP still withholds benefits by taking an unreasonably long time to process claims, ignoring claims altogether, sending letters to insureds notifying them of claims denials with either ambiguously worded explanations or without any reason whatsoever, and denying claims for lack of information or documentation that an insured has already provided to the company.

9. Plaintiff Dr. William Hall is a victim of this scheme. Dr. Hall is an 87-year old resident of Upland, California. As a young man, he served as a physician in the Army, where he rose to the rank of Colonel, and earned a Purple Heart during the Korean War. Afterward, he practiced medicine for two decades at Kaiser Permanente in Fontana, California. At the time of his retirement in 1988, Dr. Hall held the position of Chief of Medicine.

10. In 1994, Dr. Hall purchased long-term care insurance from Transport Life Insurance Company, which later became SHIP. Last year, he submitted a claim for personal care benefits.

11. SHIP delayed payment on this claim for eight months. Eventually, it approved the claim, but only paid a fraction of the benefits promised by the policy.

12. SHIP's unlawful conduct has forced Dr. Hall to spend thousands of dollars paying for personal care services. It has also caused him to suffer immeasurable frustration, anxiety, distress, anger, worry, and depression.

13. Plaintiff, in his individual capacity, brings claims seeking damages for breach of the implied covenant of good faith and fair dealing, breach of contract, and for remedies for financial elder abuse under Welfare and Institutions Code sections 15610.30 et seq. and 15657.5 et seq.

14. Plaintiff brings additional claims on behalf of himself and on behalf of a class of similarly situated California residents insured by SHIP. These class claims alleged by Plaintiff seek injunctive relief under the Unfair Competition Law, Business & Professions Code section 17200 et seq. ("UCL") and declaratory relief under Code of Civil Procedure, section 1060.

II. THE PARTIES

15. Plaintiff Dr. William Hall is, and at all relevant times was, a resident of Upland, California, which is located in the county of San Bernardino. Plaintiff is insured by SHIP under a long-term care insurance policy.

16. Defendant Senior Health Insurance Company of Pennsylvania, formerly known as Conseco Senior Health Insurance Company, is a corporation duly organized under the laws of the State of Pennsylvania with its principal place of business in Carmel, Indiana. At all relevant times, SHIP was duly authorized to transact, and does transact, the business of life and disability insurance, including the business of long-term care insurance, in the State of California.

17. The true names or capacities, whether individual, corporate, associate, or otherwise, of Does 1 through 100, inclusive, are unknown to the Plaintiff, who therefore sues said defendants by such fictitious names. Plaintiff is informed and believes and thereon alleges that each of the defendants sued herein as a Doe is legally responsible in some manner for the events and happenings referred to herein, and will ask leave of this court to amend his Complaint to insert their true names and capacities in place and instead of the fictional names when the same becomes known to Plaintiff.

18. At all relevant times, defendants, and each of them, were the agents and employees of each of the remaining defendants, and were at all times acting within the purpose and scope of said agency and employment, and each defendant has ratified and approved said agency and employment, and each defendant has ratified and approved the acts of its agent.

III. JURISDICTION

19. The amount of damages sought by Plaintiff exceeds the minimum jurisdictional limit of this Court.

IV. FACTUAL BACKGROUND

The Policy

20. In 1994, Dr. Hall purchased a Comprehensive Long Term Care Insurance Policy (Policy No. ET 20948) ("the Policy") from Transport Life Insurance Company. Attached as Exhibit "A" is a true and correct copy of the Policy.

21. Transport Life Insurance Company merged into American Travelers Life Insurance Company in 1997, which was later renamed Conseco Senior Health Insurance Company in 1998, and again renamed Senior Health Insurance Company of Pennsylvania in 2008. The Policy is, and at all relevant times was, administered by SHIP.

22. Dr. Hall pays $247.52 in monthly premiums to keep his policy in force.

23. The Policy provides Home Care Benefits. Home Care Benefits covered under the policy include payment for "Personal Care Services."

24. Personal Care Services are defined under the policy as "services whose primary function is to provide assistance with Activities of Daily Living ['ADLs'] and Instrumental Activities of Daily Living ['IADLs']." (Exhibit A) ADLs are defined as "bathing, dressing, eating, toileting, transferring, continence and ambulating." (Exhibit A) and IADLs" are defined as "using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, doing laundry, and doing light housekeeping." (*Id.* at 7.)

25. The Policy specifically states that Personal Care Services may be provided in a home "by skilled or unskilled persons who do not require prior certification or licensure by state law to perform these services." (Exhibit A)

26. In order to qualify for Home Care Benefits, policyholders must either require direct human assistance or continual supervision with two or more ADLs, or have a cognitive impairment. In addition, before policyholders receive Home Care Benefits in the form of reimbursement for Personal Care Services, policyholders must submit a "written Plan of Care that is developed by a Doctor or multidisciplinary team under medical direction" and "satisfy the Waiting Period" indicated by the Policy. (Exhibit A)

27. The policy includes a section entitled QUALIFICATIONS FOR BENEFITS. This section states:

> To qualify for any CONFINED CARE BENEFITS, HOME CARE BENEFITS or RESPITE CARE BENEFIT under this Policy, you must satisfy the requirements of Paragraphs A or B below. Additionally, you must satisfy the requirements of Paragraphs C and D. Benefits for any confinement or service require that you have a statement from a Doctor, who is not a member of your Immediate Family that:

A. For two or more Activities of Daily Living you need direct human assistance or continual supervision every time you perform the activity. Direct human assistance or continual supervision means you alone cannot perform the entire activity with the supports and mechanical aides that are normally available to you;

OR

B. You have a Cognitive impairment.

AND

C. You must submit a written Plan of Care that is developed by a Doctor or multidisciplinary team under medical direction. The Plan of Care must be submitted with the initial claim or within 30 calendar days of the date services begin. Plan of Care means a written individualized assessment which evaluates the degree to which you are disabled and specifies the duration, frequency, type and scope of services necessary for your care. The Plan of Care must be developed by someone who is not a member of your Immediate Family and who does not stand to benefit financially if you receive CONFINED CARE BENEFITS or HOME CARE BENEFITS. The Plan of Care must be reviewed by a Doctor or multidisciplinary team and submitted by the Doctor or multidisciplinary team to us in writing every 60 days if such care is continuing at that time. A Plan of Care is not required to be eligible for the RESPITE CARE BENEFIT.

D. Before you receive CONFINED CARE BENEFITS or HOME CARE BENEFITS, you must satisfy the Waiting Period show in the Schedule.

For HOME CARE BENEFITS, the Waiting Period is the initial number of days for which we will not pay benefits which qualify under this Policy for any of the following types of care or services:

- ...Personal Care Services

(Exhibit A)

28. The Policy's "Schedule" page states that a waiting period of 100 days will be applied before any benefits are paid. It indicates that the maximum benefit period is three years. It also states that "Home Care Daily Benefits" cover "80% of Actual Charges, up to $60.00." (See Exhibit A)

29. The policy contains a BENEFIT PROVISIONS section, containing, *inter alia*, the following language:

B. HOME CARE BENEFITS: Provided you have qualified for benefits as stated in the QUALIFICATIONS FOR BENEFITS provision, we will pay

80% of actual charges for Home Care for any given day up to the Home Care Daily Benefit Amount. Benefits are not payable for room and board, rent, drugs, equipment and supplies. The itemized billing statements from each provider of services must separately identify such charges from charges which are eligible for payment under the terms of this Policy. Home Care includes:

2) PERSONAL CARE SERVICES: Personal Care Services are services whose primary function is to provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Instrumental Activities of Daily Living are the following activities: using the telephone, managing medications, moving about outside, shipping for essentials, preparing meals, doing laundry, and doing light housekeeping.

Personal Care Services may be provided in a Home by skilled or unskilled persons who do not require prior certification or licensure by state law to perform these services.

(Exhibit A)

30. Dr. Hall has paid all premiums due on the policy. At all relevant times, he has performed all obligations under the policy. He has paid more than $20,000 in premiums since entering into the policy in 1994.

Dr. Hall's Declining Health

31. In approximately 2004, Dr. Hall's health declined. He began experiencing back and leg pain, dizziness, and signs of dementia. He underwent two urology surgeries. Before the second surgery, he required Flomax. Despite the two surgeries, he remained incontinent and requires an in-dwelling catheter.

32. In October 2004, Dr. Hall's wife of more than 20 years, Carol Jean Hall, died of colon cancer. Her death devastated Dr. Hall, who experienced profound feelings of grief, loneliness and isolation. These emotions were exacerbated by Dr. Hall's fears about what he clearly recognized to be the early stages of his own dementia.

33. Carol also had a long-term care insurance policy with SHIP. A short time after Carol's death, Dr. Hall submitted a claim for benefits to reimburse two home health aides who had cared for Carol during the two days prior to her death. The claim totaled $152. SHIP, then

Conseco, waited eight months before paying the claim. In a letter to Conseco, Dr. Hall described the ordeal and the effect it had on him as follows:

> My wife had colon cancer and was cared for at home under hospice. I and my daughter-in-law cared for her. I had her physicians medical summary and all forms that were requested by the company sent in as foundation for expected claims. Only two were made, each for Home health Aides for 4 hours each on October 18th and October 19th of 2004. My wife died on October 20th. I made claim soon after and a long series of phone calls and letters followed. No case manager was assigned and there seemed to be no organized file of the extensive correspondence. Each contact was with someone new and there was seemingly no record of the prior calls or letters. I was repeatedly asked for forms or records that had previously been provided. Even when they were sent certified with return receipt they were not acknowledged. This went on for months and began to have the appearance of a culture of stonewalling. The claim, for only $152 was finally paid in June 2005, after 8 months. It has been very difficult for me without my wife and this tedious process was very frustrating.

34. In 2005, Dr. Hall fell inside his home and lay unconscious and unattended for hours. Afterward, his son, Eric, and other family members determined that Dr. Hall should no longer be permitted to live alone.

35. In early 2007, Dr. Hall underwent back surgery. Afterward, he was prescribed antibiotics and morphine. The medication caused severe intestinal problems.

36. In January 2007, while reviewing records in preparation for taxes, Dr. Hall was reminded of the aggravation Conseco caused after Carol's passing. Impulsively, he terminated coverage. Soon after, however, he realized the decision was foolish, and took the proper steps to have his coverage reinstated. As of August 2007, Dr. Hall's coverage was back in place. He has paid all premiums, and the policy has remained in force without interruption ever since.

37. In February 2009, Dr. Hall and his son, Eric, hired caregivers Ashley Lane and Christine Mendez to perform personal care services at Dr. Hall's home. Mmes. Lane and Mendez assist Dr. Hall on a daily basis with bathing, dressing, continence, toileting, transferring and walking/mobility/ambulating. Each is paid approximately $12.50 per hour before taxes are withheld. They are available on site during the night for care as needed.

38. In early 2010, Dr. Hall fell and broke his left hip. A few months later, he broke the left hip again. He also began suffering from hypotension, or abnormally low blood pressure,

and hyponatremia, a condition in which water accumulates in the body at a higher rate than can be excreted. Although his health would eventually improve, Dr. Hall's treating physicians predicted that these conditions would result in his imminent death.

SHIP's Unfair Handling of Claims

39. In June 2010, Dr. Hall and his son, Eric, assisted Mmes. Lane and Mendez with obtaining Home Health Aide certification from the California Department of Public Health.[1] They did so because they believed that SHIP required all caregivers to be licensed as a prerequisite to approval of benefits under its long-term care policy. This belief was reasonable as SHIP's claim form expressly states that all caregivers must be licensed regardless of the level of care they administer.

40. In fact, Dr. Hall did not bother to submit claims for benefits for the services Mmes. Lane and Mendez provided prior to becoming certified because SHIP's claim forms led him to believe any such claims would be denied.

41. In August 2010, Dr. Hall submitted a claim to SHIP for benefits under his long-term care policy. On his claim form, he indicated that the condition causing the loss was "spinal stenosis, osteoporosis and osteoarthritis." He also has coronary artery disease and had coronary bypass surgery in 1993. He indicated that the first treatment for these conditions took place on December 18, 2007. His request sought benefits beginning in July 2010.

42. In support of his claim, Dr. Hall completed the following materials: a claim form, two provider claim forms, a physician's claim form, and a health benefit claim sheet. He also provided copies of the licenses Mmes. Lane and Mendez had obtained, and quarterly wage and withholding reports for both caregivers for 2009 through June 30, 2010.

43. On August 16, 2010, SHIP wrote Dr. Hall to inform him that it had received his long-term care claim forms. Accompanying the letter were several additional forms for Dr. Hall to fill out and submit, and a lengthy insert warning policyholders of the consequences of

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[1] "Home Health Aide" is defined by Health and Safety Code § 1727(d) as "an aide who has successfully completed a state-approved training program, is employed by a home health agency or hospice program, and provides Personal Care Services in the patient's home."

insurance fraud. The forms Dr. Hall received included an authorization to allow SHIP to obtain medical records, a revocable assignment/acceptance form, copies of blank home health care daily progress notes, home health care provider forms, and an instruction sheet, and a multi-page fraud warning. Attached as Exhibit "B" is a true and correct copy of the instruction sheet.

44. The instruction sheet states:

> If you do wish to submit a claim at this time, please complete and return the claim form recently provided to you. Upon receipt of the completed claim form, we may need additional information to process your claim. For example, it may be necessary for us to request documentation from one or more of your past or current care providers:
>
> - **For all claim types:**
> A copy of the state-issued license for each caregiver, agency or long term care facility and itemized billing statements

(See Exhibit B.)

45. The instruction sheet also states:

> Our goal is to provide you with prompt service. You can expect your benefit request to be completed within 30 days of receipt of all the information needed.

(*Id.*)

46. Dr. Hall completed all forms and provided SHIP with the materials on August 31, 2011.

47. On September 8, 2010, SHIP wrote Dr. Hall informing him that it was not able to process his request for benefits until it received all "Daily Visit Notes" for both Ms. Lane and Ms. Mendez.

48. On September 22, 2010, SHIP wrote Dr. Hall a letter stating that it was not able to process his request for benefits until a nurse was able to visit him at his residence and assess the "level of care that you are presently requiring."

49. On September 25, 2011, Dr. Hall wrote a letter to SHIP explaining that he was unable to provide SHIP with the Daily Visit Notes it required for each of his caregivers because of the nature of the services they provided him. His letter explains:

> This is in response to your letter of 9-8-2010 requesting specifics of the services provided to me by my two caregivers, Ashley Lane and Christine Mendez. I have two caregivers that care for me on a schedule of days. Each works for me on a schedule of 8 am to 8 am while on duty. (24 hr shifts) Ashley Lane cares for me on Tuesday, Wednesday, Saturdays, and Sundays. Christine on the other days which are Mondays, Thursdays, and Fridays. I am entirely confined to bed so the caregivers provide very comprehensive care. They provide all errands and daily household maintenance, tasks such as maintaining cleanliness and orderliness. There are regular daily tasks including planning, preparation, and serving of meals. They provide baths and they do laundry. They provide transportation to doctors appointments, including laboratory, x-ray, consultations, and all needed medical support services. They also provide transportation for all other out of the house services such as hair cuts. I depend on them for all errands both within the house and outside. Their services are uninterrupted and cannot be summarized in diary form. They do not maintain daily visit notes, since their services are continuous and more than can be accounted for by a daily task list.

50. On September 27, 2010, SHIP wrote Dr. Hall a letter stating that it remained unable to complete processing of his benefits request as it had not received "All Daily Visit Notes for Ashley Lane and Christine Mendez."

51. On October 5, 2010, SHIP responded in writing to Dr. Hall's September 25, 2010 letter. SHIP's letter states that Dr. Hall's request "is currently being researched" and that it would send him a written response in "no later than 15 business days."

52. Three days later, on October 8, 2010, SHIP sent Dr. Hall another letter reiterating that it was unable to complete processing of his request for benefits until he provided "All Daily Visit Notes for Ashley Lane and Christine Mendez."

53. On October 8, 2010, SHIP sent Dr. Hall a second letter stating that it was unable to accept his letter summarizing the care provided to him by his two caregivers. "We require Daily Visit Notes be taken in real time by your caregivers," the letter states.

54. On March 21, 2011, Dr. Hall wrote SHIP a letter and enclosed additional documents in support of his claim. The letter states:

> We have provided more than reasonable due diligence and good faith compliance with providing all documentation necessary to prove the validity of my claim(s). The sole purpose for purchasing a long-term care health care policy is to defray long-term health care costs through the payment of claims. Instead we have received nothing from SHIP but

> delays and evasive requests for superfluous documentation. It is beyond time for SHIP to honor their clear contractual obligations and pay these claims that have been submitted in good faith and in a state of completeness within any reasonable requirement or expectation.

55. On April 8, 2011, SHIP wrote Dr. Hall to advise him that "your claim for benefits is still under consideration. We have received the information requested and a claims adjuster will be reviewing your claim. We will contact you as soon as a decision is reached."

56. On April 14, 2011, SHIP wrote Dr. Hall to confirm receipt of his recent claim for Ashley Lane and Christine Mendez for dates of service July 5, 2010 to March 13, 2011.

57. On April 20, 2011, SHIP wrote Dr. Hall informing him that his request for benefits had been approved through April 19, 2012 provided that he continued to qualify for benefits.

58. Enclosed with this letter was a "Plan of Care Summary." The Plan of Care Summary stated that Dr. Hall's dependency level was determined to be "dependent" for activities including bathing, dressing, continence, toileting, transferring, but "independent" for eating. The summary defined "dependent" as "regular assistance is required."

59. In this same mailing, SHIP also provided Dr. Hall with a "Summary of Covered Services." This summary explained that the approved benefits period was October 28, 2010 to April 19, 2012. It offered no explanation why services dating back to July 2010 had not been approved. It stated that care provided by Mmes. Lane and Mendez at a rate of $12.50/hour had been approved. It stated that the "Approved Frequency of Service" was 24 hours per day, 7 days per week. It stated that benefits could not exceed the "Approved Frequency of Service" or the "maximum benefit amount" under the policy. It stated that Dr. Hall was not eligible for benefits during any applicable elimination period, or the number of days that an insured must wait before receiving benefits, and for benefits exceeding the Approved Frequency of Service.

60. The mailing also contained an "Explanation of Benefits" ("EOB") for the period of July 10, 2010 to March 12, 2011. The EOB identified service days, the amount billed, the portion of that amount covered under the plan, and a "remarks" column purporting to explain the amount paid under the policy.

61. The EOB shows that SHIP paid no benefits whatsoever from July 10, 2010 to February 12, 2011. On many of these days, the EOB indicates cryptically that the amount billed was "Not a Covered Service." On other days, benefits are denied because amounts billed supposedly fell within the policy's elimination period.

62. The EOB does indicate that benefits were approved on certain days. Discerning the basis for any particular approved amount, however, is virtually impossible.

63. The mailing also provided Dr. Hall with a check in the amount of $3,943.41 representing the entirety of his benefits.

64. In the months since, Dr. Hall and his son, Eric, have continued to submit claims for benefits under this policy. SHIP has refused to make any additional payments.

65. SHIP's delay and denial of Dr. Hall's claims, have caused him considerable worry, anxiety, stress, fear, anger, and frustration. SHIP's refusal to pay benefits has forced Dr. Hall to deplete savings and burn through his fixed income. This too has caused considerable emotional distress.

CLASS ALLEGATIONS

66. The fourth and fifth causes of action alleged below are brought on behalf of the Plaintiff individually and on behalf of all others similarly situated pursuant to Code of Civil Procedure section 382. Plaintiff seeks to represent the following class ("the Class" or "Class members"):

> All persons insured by SHIP, or who were insured by SHIP or Conseco Senior Health Insurance Company, under a long-term care or home care insurance policy that was purchased from Conseco Senior Health Insurance Company, American Travelers Life Insurance Company, Transport Life Insurance Company, United General Life Insurance Company, or Continental Life Insurance Company, who submitted to SHIP or Conseco Senior Health Insurance Company a claim for Home Care Benefits within four years prior to the date of the filing of this action.

67. The proposed Class is composed of thousands of persons dispersed throughout the State of California and joinder is impracticable. The precise number and identity of Class members is unknown to Plaintiff but can be obtained from defendants' records.

68. There are questions of law and fact common to the members of the Class, which predominate over questions affecting only individual Class members.

69. Plaintiff is a member of the Class and Plaintiff's claims are typical of the claims of the Class.

70. Plaintiff is willing and prepared to serve the Court and the proposed Class in a representative capacity. Plaintiff will fairly and adequately protect the interests of the Class and has no interests adverse to or which conflict with the interests of the other members of the Class.

71. The self-interest of Plaintiff is co-extensive with and not antagonistic to those of absent Class members. Plaintiff will undertake to represent and protect the interests of absent Class members.

72. Plaintiff has engaged the services of counsel indicated below who are experienced in complex class litigation, will adequately prosecute this action, and will assert and protect the rights of and otherwise represent the Plaintiff and absent Class members.

73. The prosecution of separate actions by individual members of the Class would create a risk of inconsistency and varying adjudications, establishing incompatible standards of conduct for defendants.

74. Defendants have acted on grounds generally applicable to the Class, thereby making relief with respect to the members of the Class as a whole appropriate.

75. A class action is superior to other available means for the fair and efficient adjudication of this controversy. Prosecution of the complaint as a class action will provide redress for individual claims too small to support the expense of complex litigation and reduce the possibility of repetitious litigation.

76. Plaintiff anticipates no unusual management problems with the pursuit of this Complaint as a class action.

FIRST CAUSE OF ACTION: BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING

(Brought by Plaintiff in his Individual Capacity)

77. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

78. Defendants, and each of them, have breached the duty of good faith and fair dealing owed to Plaintiff in the following respects:

a. Unreasonably and in bad faith placing its financial interests ahead of its policyholders in violation of California's statutory, regulatory and common law;

b. Unreasonably and in bad faith failing and refusing to give at least as much consideration to the interests of its policyholders as it gave to its own interests;

c. Unreasonably and in bad faith delaying and denying benefits for long-term care under the terms of the Policy, by employing the following tactics:

i. Requiring that Plaintiff's caregivers satisfy certification/licensure requirements in violation of both its own policy and California law;

ii. Failing to provide adequate explanations of coverage decisions as required under California law;

iii. Requiring as a prerequisite to benefits that policyholders submit daily activity notes by caregivers;

d. Failing to consider the insured's interests at least as much as its own in handling plaintiff's claims;

e. Failing to diligently search for reasons to support providing benefits for Plaintiff's personal care benefit claims, and instead creating tenuous reasons for denying coverage;

f. Unreasonably and in bad faith compelling Plaintiff to litigate to recover benefits due to him.

79. Plaintiff is informed and believes and thereon alleges that defendants, and each of them, have breached their duty of good faith and fair dealing owed to Plaintiff by other acts or omissions of which Plaintiff is presently unaware and which will be shown according to proof at the time of trial.

80. Defendants furthermore have committed institutional bad faith. Defendants' institutional bad faith amounts to reprehensible conduct because the conduct is part of a repeated pattern of unfair practices and not an isolated occurrence. The pattern of unfair practices

constitutes a conscious course of wrongful conduct that is firmly grounded in the established company policy of defendants. Plaintiff is informed and believes and thereon alleges that defendants have engaged in similar wrongful conduct as to other individuals and that defendants have substantially increased their profits as a result of causing similar harm to others.

81. As a proximate result of the aforementioned unreasonable and bad faith conduct of defendants, Plaintiff has suffered, and will continue to suffer in the future, damages, plus interest, and other economic and consequential damages including emotional distress damages, in an amount to be proven at trial.

82. As a further proximate result of the unreasonable and bad faith conduct of defendants, Plaintiff was compelled to retain legal counsel and to institute litigation to obtain the benefits due under the contract. Therefore, defendants are liable for those attorney's fees, witness fees and litigation costs reasonably incurred in order to obtain Plaintiff's benefits owed.

83. Defendants' conduct described herein was intended by the defendants to cause injury to Plaintiff and/or was despicable conduct carried on by the defendants with a willful and conscious disregard of the rights of Plaintiff, subjected Plaintiff to cruel and unjust hardship in conscious disregard of his rights, and was an intentional misrepresentation, deceit, or concealment of material facts known to the defendants with the intention to deprive Plaintiff of property, legal rights, or to otherwise cause injury, such as to constitute malice, oppression or fraud under California Civil Code section 3294, thereby entitling Plaintiff to punitive damages in an amount appropriate to punish or set an example of defendants.

84. Defendants' conduct described herein was undertaken by defendants' officers or managing agents who were responsible for claims supervision and operations decisions. The previously described conduct of said managing agents and individuals was therefore undertaken on behalf of the corporate defendant. Furthermore, said corporate defendant had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents whose precise identities are unknown to plaintiff at this time and are therefore identified and designated herein as Does 1 through 100.

SECOND CAUSE OF ACTION: BREACH OF CONTRACT
(Brought by Plaintiff in his individual capacity)

85. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

86. In 1994, Plaintiff entered into a written contract with Transport Life Insurance Company, currently known as SHIP.

87. In accordance with the terms of this insurance contract, Plaintiff paid all monthly premiums and performed all terms and conditions required under the Policy.

88. By delaying and denying benefits under the contract, defendants have breached the terms and provisions of the insurance contract.

89. As a direct and proximate result of defendants' breach of contractual obligations, Plaintiff has suffered damages under the insurance contract in an amount to be determined according to proof at the time of trial.

THIRD CAUSE OF ACTION: FINANCIAL ELDER ABUSE UNDER WELFARE AND INSTITUTIONS CODE SECTION 15610.30
(Brought by Plaintiff in his Individual Capacity)

90. Plaintiff incorporates by reference each of the preceding paragraphs as though fully set forth herein.

91. Plaintiff is, and at all relevant times was, an "elder" under California law. An elder is defined as "any person residing in this state, 65 years of age or older." (Welf. & Inst. Code § 15610.27.)

92. Plaintiff is informed and believes and thereon alleges that defendants' system of delaying and denying valid claims, which is designed to avoid payment of benefits to ailing senior citizens entitled to long-term care under their insurance contracts, constitutes financial elder abuse which, in relevant part, "occurs when a person or entity ... (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both" and "(2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both." (Welf. & Inst. Code § 15610.30(a).)

93. Defendants made various misrepresentations to Plaintiff as to what documents he was required to submit to begin receiving benefits, including, but not limited to, copies of caregivers' licenses and "Daily Visit Notes." Defendants made various misrepresentations and omissions as to the reasons for denying valid claims, through their correspondence with Plaintiff and in the EOB sent to Plaintiff for the period of July 10, 2010 to March 12, 2011, which shows defendants paid no claims whatsoever from July 10, 2010 to February 12, 2011. Defendants also delayed payment of claims by misrepresenting the terms and conditions of the Policy to Plaintiff. As a direct result of defendants' conduct, Plaintiff depleted his savings to cover the cost of his care, despite having paid SHIP over $20,000 in premiums.

94. In engaging in such conduct, defendants have taken, secreted, appropriated, and retained the property of Plaintiff, an elder, for a wrongful use and with the intent to defraud Plaintiff within the meaning of Welfare and Institutions Code section 15610.30 et seq. Defendants engaged in such conduct either directly, or assisted others in such conduct.

95. At all relevant times, the conduct of defendants was knowing, reckless, oppressive, fraudulent and malicious within the meaning of Welfare and Institutions Code section 15657.5 et seq.

96. As a direct and proximate cause of defendants' wrongful conduct, Plaintiff has sustained damages in an amount to be proven at trial.

97. Defendants' conduct constituted oppression, fraud, and malice in the commission of the financial abuse and Plaintiff is entitled to recover damages for the sake of example and by way of punishing defendants for financial abuse pursuant to Civil Code section 3294.

98. Plaintiff is entitled to recover treble damages pursuant to Civil Code section 3345.

99. In addition to all other remedies provided by law, Plaintiff is entitled to recover reasonable attorneys fees and costs for financial abuse pursuant to Welfare and Institutions Code section 15657.5 et seq.

FOURTH CAUSE OF ACTION: VIOLATION OF BUSINESS AND PROFESSIONS CODE SECTION 17200 et seq.

(Brought by Plaintiff in his Individual and Representative Capacity)

100. Plaintiff incorporates by reference all preceding paragraphs as though fully set forth herein.

101. Plaintiff suffered substantial injury in fact resulting in lost money or property by virtue of defendants' conduct.

102. The Unfair Competition Law ("UCL"), Business and Professions Code section 17200 et seq., prohibits acts of "unfair competition" which is defined by Business and Professions Code section 17200 as including "any unlawful, unfair or fraudulent business act or practice..."

103. Defendants' conduct as set forth herein, constitutes unlawful business acts and practices by, *inter alia*:

a. Violating Insurance Code section 10234.8, subd. (a), which provides that, "with regard to long-term care insurance, all insurers ... and others engaged in the business of insurance owe a policyholder ... a duty of honesty, and a duty of good faith and fair dealing." Defendants are engaged in the business of long-term care insurance, and breached the duties of honesty, good faith, and fair dealing owed to Plaintiff and Class members by:

i. Failing to make reasonable efforts to inform consumers of their legal rights when in the process of denying a claim;

ii. Denying claims in breach of the implied covenant of good faith and fair dealing;

iii. Denying claims without giving sufficient consideration to the interests of the insured;

iv. Denying claims without first thoroughly investigating the basis of the denial;

v. Denying claims without first thoroughly investigating the basis of the denial;

vi. Denying claims by considering only those facts believed to justify denial of the claim, and by unreasonably ignoring evidence supporting the consumer's position.

b. Violating Welfare and Institutions Code section 15610.30 et seq. by accepting premium payments and then refusing benefits due to Plaintiff and the Class through a system designed to retain Plaintiff and Class members' money. Defendants made misrepresentations to Plaintiff and Class members as to policy terms and coverage, thereby depriving them of payments owed for reimbursement of care services. In obtaining the property of Plaintiff and Class members, defendants took, secreted, appropriated, and retained the property of an elder for a wrongful use and with the intent to defraud. Defendants engaged in such conduct either directly, or assisted others in such conduct.

c. Violating Insurance Code section Insurance Code section 10232.9, et seq., which prohibits long-term care insurers from "limiting or excluding Home Care Benefits by ... [l]imiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law." Defendants have unlawfully limited and excluded Home Care Benefits in violation of Insurance Code section 10232.9 by:

i. Requiring insureds to submit proof of Home Care provider certification before paying benefits for "personal care" as defined by Insurance Code section 10232.9(b)(3),[2] where California law prohibits any such requirement;

ii. Denying valid claims for Home Care Benefits on the grounds that a personal care provider is not certified, where California law prohibits any such certification.

[2] "Personal care" is defined as "assistance with the activities of daily living, including the instrumental activities of daily living, provided by a *skilled or unskilled* person under a plan of care developed by a multidisciplinary team under medical direction." (Ins. Code § 10232.9, subd. (b)(3), italics added.)

104. Defendants have further violated the UCL by engaging in one or more of the following unfair business acts and practices:

a. Violating the established public policy of the State of California, which, among other things, seeks to protect the reasonable expectations of consumers concerning the nature, extent and quality of their care coverage;

b. Requiring elderly and infirm policyholders to produce unreasonable documentation as a prerequisite to approval of claims;

c. Delaying and denying payment of claims without providing adequate explanation in support of its claims decisions;

d. Assigning multiple or no adjusters to handle claims under one policy, without adequate coordination;

e. Requiring policyholders to send duplicate submissions of forms or claims;

f. Requiring that policyholders undergo unnecessary, and even biased, examinations conducted by medical professionals selected by SHIP to initially determine whether an insured qualifies for benefits, when the policies allow for any medical professional to perform the initial benefit eligibility assessment.

105. Defendants' unfair conduct does not benefit consumers or competition. Indeed the injury to consumers and competition is substantial.

106. Plaintiff and Class members could not have reasonably avoided the injury each of them suffered.

107. The gravity of the consequences of defendants' conduct as described above outweighs any justification, motive or reason therefore and is immoral, unethical, oppressive, unscrupulous, offends established public policy or is substantially injurious to Plaintiff and other members of the Class.

108. Defendants, and each of them, have further violated the UCL by engaging in one or more of the following fraudulent business acts and practices:

a. Selling largely illusory insurance coverage to consumers by means of misrepresentations and the concealment of material information;

b. Misrepresenting to policyholders the qualifications for eligibility to begin receive benefits by demanding information/documentation/forms not required by the policy before processing claims;

c. Concealing from customers that its abusive claims process requires an inordinate amount of largely superfluous materials as a prerequisite to approval of claims;

d. Fraudulently leading consumers to believe that it processes claims expeditiously.

109. Pursuant to Business and Professions Code section 17203, Plaintiff and Class members seek an order requiring defendants to immediately cease such unlawful, unfair and fraudulent business practices. Defendants' acts of unfair competition present a continuing threat to the public's health, safety and welfare, and Plaintiff and Class members have no adequate remedy at law. Accordingly, unless defendants are permanently enjoined and restrained by order of this court, they will continue to commit acts of unfair competition and will continue to cause irreparable harm and injury to the public's health, safety and welfare.

FIFTH CAUSE OF ACTION: DECLARATORY RELIEF UNDER CODE CIV. PROC. § 1060

(Brought by Plaintiff in His Individual and Representative Capacity)

110. Plaintiff incorporates by reference all preceding paragraphs as though fully set forth herein.

111. California Code of Civil Procedure section 1060 provides that any person "interested under ... a contract ... may, in cases of actual controversy relating to the legal rights and duties of respective parties" bring an action in Superior Court for a declaration of his or her rights and the "the court may make a binding declaration of these rights or duties, whether or not further relief is or could be claimed at the time."

112. An actual controversy has arisen between Plaintiff and the members of the Class he represents, on the one hand, and defendants on the other hand, regarding defendants' obligations under long-term care and home care insurance contracts between the parties.

113. Defendants contend that the initial benefit eligibility assessment must be performed by a medical professional of defendants' choice as a predicate to paying claims. Plaintiff and Class members contend that the policies allow for any medical professional to

perform the initial assessment, and that the policies only allow for defendants to select the medical examiner for subsequent eligibility assessments.

114. Defendants require Plaintiff and Class members to submit copies of caregivers' certification before they will process a claim. Plaintiff and Class members contend that defendants are prohibited from denying Home Care Benefits for personal care for lack of caregiver certification or licensure by the policies, which allow for personal care provided by skilled or unskilled caretakers, and by Insurance Code section 10232.9, et seq.

115. Plaintiff and Class members contend that defendants must process and pay claims pursuant to the terms of the insurance contracts, and that defendants may not deny claims for lack of documents or forms never mentioned in the insurance contract and never provided to policyholders. Defendants contend that they may require such documents.

116. Plaintiff and Class members seek a declaration as to the respective rights and obligations of the parties.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, prays for judgment as follows:

1. For Plaintiff in his individual capacity: damages, according to proof, including damages for benefits under the contract, pain and suffering, mental and emotional distress plus prejudgment interest;

2. For Plaintiff in his individual capacity: damages pursuant to Welfare and Institutions Code sections 15610.30 and 15657.5 for financial elder abuse, in a sum to be determined at the time of trial;

3. For Plaintiff in his individual capacity: punitive and exemplary damages in an amount to be determined at trial;

4. For Plaintiff in his individual capacity: treble damages pursuant to Civil Code section 3345;

5. As to the fourth and fifth causes of action, certification of the proposed Class pursuant to Code of Civil Procedure section 382 and Civil Code section 1780 et seq. and

appointing Plaintiff to represent the proposed Class and designating their counsel as Class Counsel;

6. For Plaintiff in his individual capacity and on behalf of the Class, injunctive relief pursuant to Business and Professions Code et seq. ordering that defendants be enjoined from engaging in the unlawful, unfair and fraudulent business acts and practices described herein;

7. For attorney fees and costs of suit incurred herein; and

8. For such other and further relief as the court deems just and proper.

DATED: February 6, 2012

SHERNOFF BIDART
ECHEVERRIA BENTLEY LLP

By: _____
WILLIAM M. SHERNOFF
SAMUEL BRUCHEY
Attorneys for Plaintiff

HARVEY ROSENFIELD
PAMELA PRESSLEY
LAURA ANTONINI
Consumer Watchdog

SHERNOFF BIDART ECHEVERRIA BENTLEY LLP
LAWYERS FOR INSURANCE POLICYHOLDERS

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a jury trial on all causes of action that are triable to a jury.

DATED: February 6, 2012

SHERNOFF BIDART
ECHEVERRIA BENTLEY LLP

By: _____
WILLIAM M. SHERNOFF
SAMUEL BRUCHEY
Attorneys for Plaintiff

HARVEY ROSENFIELD
PAMELA PRESSLEY
LAURA ANTONINI
Consumer Watchdog

SHERNOFF BIDART ECHEVERRIA BENTLEY LLP
LAWYERS FOR INSURANCE POLICYHOLDERS

EXHIBIT A

WILLIAM H HALL

ET20948

THIS IS YOUR POLICY WITH

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

IF YOU HAVE A CLAIM OR QUESTIONS CALL OUR

CUSTOMER SERVICE DEPARTMENT TOLL FREE AT

1-877-451-5824

WE ARE PROUD TO HAVE YOU AS A POLICYHOLDER AND LOOK FORWARD TO PROVIDING YOU WITH THE BEST POSSIBLE SERVICE!

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

BENSALEM, PENNSYLVANIA

Administrative Office: 1289 City Center Dr.
Carmel, Indiana 46032
1-877-450-5824

COMPANY NAME CHANGE ENDORSEMENT

The name of the insurance company that issued your policy or certificate is changed from Conseco Senior Health Insurance Company to Senior Health Insurance Company of Pennsylvania. It is the same as if it had been issued originally under the name of Senior Health Insurance Company of Pennsylvania.

All other terms of your policy or certificate remain unchanged.

This endorsement becomes a part of your policy or certificate and should be attached thereto.

IMPORTANT

All inquiries should be directed to Senior Health Insurance Company of Pennsylvania; 1289 City Center Dr., Carmel, Indiana 46032

Executive Vice President/
Chief Operating Officer

SHIP-7000

SCHEDULE

This Schedule contains important benefit periods, benefit amounts you have selected and the premiums for your Policy

		PREMIUM
WAITING PERIOD	100 DAYS	
BENEFIT PERIOD	3 YEARS	
MAXIMUM DAYS	1095 DAYS	
CONFINED CARE DAILY BENEFIT	$60 00	
HOME CARE DAILY BENEFIT 80% of Actual Charges, up to	$60 00	
RESPITE CARE Daily Benefit for Respite Confined Care Actual Charges, up to	$60 00	
Daily Benefit for Respite Home Care 80% of Actual Charges, up to	$60.00	
	BASE POLICY PREMIUM:	$777.60
INFLATION PROTECTION RIDER		$260.64
	TOTAL ANNUAL PREMIUM:	$1,038.24

Your Policy is effective on the POLICY DATE. AUGUST 4, 1994

INSURED

WILLIAM H HALL

2407 LINDA LANE

UPLAND CA 91784

POLICY NUMBER ET 20948

INITIAL PREMIUM $86.52

MODE MONTHLY

11001-A-CA(93)

TRANSPORT LIFE INSURANCE COMPANY
(We, Us, Our)
714 Main Street
Fort Worth, Texas 76102

COMPREHENSIVE LONG TERM CARE INSURANCE POLICY

NOTICE TO BUYER: This Policy may not cover all of the costs you incur associated with long term care during the period of coverage. *You are advised to review all Policy limitations carefully.*

RENEWAL CONDITIONS - GUARANTEED RENEWABLE FOR LIFE

This Policy is guaranteed renewable for life if you pay the premium when due or within the Grace Period. If you pay the premium on time; we cannot cancel the Policy or place any restrictions on it. We may change the premium rates for this Policy. If we do change such premiums, we will do so only if we change the premiums for all policies which have the same form number as this Policy and which are in the same premium class and in the same state as this Policy. Premium class means the set of characteristics that determine the premium such as your issue age and the Benefit Period, Waiting Period, benefit amounts, and any optional riders you have selected.

IMPORTANT NOTICE! PLEASE READ!

This Policy was issued based on your responses to the questions on your Application. A copy of your Application is attached and is a part of this Policy. Please read it and check to see that the information is correct and complete. If any requested medical history has been left out, or if there is an error, please notify us immediately. If your answers are misstated or untrue, we have the right to deny benefits or rescind your Policy, subject to the Time Limit on Certain Defenses provision. The best time to clear up any questions is now, before a claim arises!

30-DAY RIGHT TO EXAMINE POLICY

If you are not satisfied for any reason, return the Policy to us or our agent within 30 days after you receive it. We will refund your premium within 30 days, and the Policy will be void.

This Policy is signed for Transport Life Insurance Company by its President and Secretary.

President Secretary

EXCEPT AS PROVIDED IN THE "TERMINATION OF COVERAGE" AND "TERMINATION FOR NONPAYMENT OF PREMIUM" PROVISIONS, WE WILL PROVIDE BENEFITS FOR EXPENSES INCURRED ONLY WHILE THIS POLICY IS IN FORCE.

INDEX

INSURING PROVISION

Ve agree to pay you the benefits provided by this Policy, subject to the definitions, provisions, t ons and exclusions..

CONSIDERATION

/e have issued this Policy in consideration of the Application and payment of the first premium on or efore the Policy Date.

overage begins on the Policy Date at 12 noon, standard time, at your residence. The Policy will main in force for any period for which the premium is paid when due or during the grace period.

DEFINITIONS

his section provides the meaning of special terms used in this Policy.

ctivities of Daily Living are:

Bathing (washing yourself, including a sponge bath);

Dressing (putting on and taking off clothing);

Eating (consuming food that has already been prepared and made available. "Eating" does not mean to prepare and cook food.);

Toileting (doing both of the following: getting on and off the toilet; and maintaining a reasonable level of personal hygiene);

Transferring (moving from one sitting or lying position to another sitting or lying position);

Continence (the ability to voluntarily control bowel and bladder functions or to otherwise maintain a reasonable level of personal hygiene); and

Ambulating (walking or moving about inside the home. Ambulation does not include movement solely for the purpose of exercise.).

gnitive Impairment means the need for direct human assistance or continual supervision to protect rself and others because you suffer from deterioration or loss in your intellectual capacity, as ssured and confirmed by clinical evidence and standardized tests which reliably measure impairment he following areas:

Your short-term or long-term memory;

Your orientation as to person (such as who you are), place (such as your location), and time (such as day, date, and year); and

Your deductive or abstract reasoning.

Cognitive Impairment may result from Alzheimer's disease and similar forms of senility or irreversible dementia.

A Doctor is a person, other than a Nurse, who is legally qualified and licensed to practice medicine and is operating within the scope of that license.

Home means your home, a private home, assisted living facility, residential facility or any facility where you reside, but not a hospital, Hospice Facility, or Nursing Facility.

A Home Health Care Agency is an agency or organization which is (1) appropriately licensed (if such licensing is required in the state where such agency operates) or is state or federally certified to provide home health care; and (2) which maintains a complete medical record of each patient.

A Hospice Facility is a place which provides a formal program of care which is: (1) for terminally ill patients whose life expectancy is one year or less; and (2) provided on an inpatient basis. The program of care must be directed by a Doctor. Such facility must be licensed, certified or registered in accordance with state law.

Immediate Family means you, your spouse, your brothers, your sisters, your step-brothers, your step-sisters, your children, your step-children and your grandchildren.

Instrumental Activities of Daily Living: Using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, doing laundry, and doing light housekeeping.

A Nurse is a person who is licensed as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.), and is operating within the scope of that license.

A Nursing Facility is a place which: (1) Is licensed by the state to provide nursing care; (2) Provides skilled, intermediate, or custodial care on an inpatient basis; (3) Provides 24-hour nursing service by or under the supervision of a Nurse; (4) Has a staff of at least one Doctor to evaluate administrative and patient care policies and procedures; and (5) Maintains a daily medical record of each patient which is available for review by the Company.

QUALIFICATIONS FOR BENEFITS

To qualify for any CONFINED CARE BENEFITS, HOME CARE BENEFITS or RESPITE CARE BENEFIT under this Policy, you must satisfy the requirements of Paragraphs A or B below. Additionally, you must satisfy the requirements of Paragraphs C and D. Benefits for any confinement or service require that you have a statement from a Doctor, who is not a member of your Immediate Family, that:

A. For two or more Activities of Daily Living you need direct human assistance or continual supervision every time you perform the activity. Direct human assistance or continual supervision means you alone cannot perform the entire activity with the supports and mechanical aides that are normally available to you;

OR

B. You have a Cognitive Impairment.

AND

You must submit a written Plan of Care that is developed by a Doctor or multidisciplinary team under medical direction. The Plan of Care must be submitted with the initial claim or within 30 calendar days of the date services begin. Plan of Care means a written individualized assessment which evaluates the degree to which you are disabled and specifies the duration, frequency, type and scope of services necessary for your care. The Plan of Care must be developed by someone who is not a member of your Immediate Family and who does not stand to benefit financially if you receive CONFINED CARE BENEFITS or HOME CARE BENEFITS. The Plan of Care must be reviewed by a Doctor or multidisciplinary team and submitted by the Doctor or multidisciplinary team to us in writing every 60 days if such care is continuing at that time. A Plan of Care is not required to be eligible for the RESPITE CARE BENEFIT.

). Before you receive CONFINED CARE BENEFITS or HOME CARE BENEFITS, you must satisfy the Waiting Period shown in the Schedule.

For CONFINED CARE BENEFITS, the Waiting Period is the initial number of days of your confinement for which we will not pay benefits which qualify under this Policy for Nursing Facility or Hospice Facility confinement.

For HOME CARE BENEFITS, the Waiting Period is the initial number of days for which we will not pay benefits which qualify under this Policy for any of the following types of care or services:

- Confinement to a Nursing Facility or Hospice Facility; or
- Home Health Care; or
- Personal Care Services; or
- Homemaker Services; or
- Adult Day Care; or
- Hospice Services; or
- Any combination of the above.

If you qualify for the BENEFIT REBUILDER, you must again satisfy the Waiting Period before benefits become payable. You need not satisfy the Waiting Period to receive the RESPITE CARE BENEFIT.

BENEFIT PROVISIONS

/e will pay the amounts described in the Benefit sections below for days of care received, not to xceed the Maximum Days shown in the Schedule. Each day for which benefits are payable will count ›ward the Maximum Days, except days for which benefits are payable for RESPITE CARE BENEFITS. he Maximum Days are shown in the Schedule.

/e will pay for either CONFINED CARE BENEFITS, HOME CARE BENEFITS or RESPITE CARE ENEFITS for any given day.

A. CONFINED CARE BENEFITS: Provided you have qualified for benefits, as stated in the QUALIFICATIONS FOR BENEFITS provision, we will pay the Nursing Facility Benefit or the Hospice Facility Benefit as follows:

1) NURSING FACILITY BENEFIT: For each day you are confined to a Nursing Facility, we will pay the Confined Care Daily Benefit shown in the Schedule.

A Nursing Facility is a place which: (1) is licensed by the state to provide nursing care; (2) Provides skilled, intermediate, or custodial care on an inpatient basis; (3) Provides 24-hour nursing service by or under the supervision of a Nurse; (4) Has a staff of at least one Doctor to evaluate administrative and patient care policies and procedures; and (5) Maintains a daily medical record of each patient which is available for review by the Company.

"Nursing Facility" does not mean a hospital or clinic, boarding home, home for the aged or mentally ill, rest home, community living center, an assisted living facility, a residential facility, an adult congregate living facility, a domiciliary facility, a sheltered living facility, a place or section of a facility that provides domiciliary, residential, or retirement care, a place which operates primarily for the treatment of alcoholics or drug addicts, a hospice, or a rehabilitation facility.

We will not pay the Nursing Facility Benefit if you are confined in a Nursing Facility and the Doctor prescribing your care and treatment is the owner of or has an ownership interest in the Nursing Facility where you are confined.

2) HOSPICE FACILITY BENEFIT: For each day you are confined to a Hospice Facility, we will pay the Confined Care Daily Benefit shown in the Schedule.

A Hospice Facility is a place which provides a formal program of care which is: (1) for terminally ill patients whose life expectancy is one year or less; and (2) provided on an inpatient basis. The program of care must be directed by a Doctor. Such facility must be licensed, certified or registered in accordance with state law.

We will not pay the Hospice Facility Benefit if you are confined in a Hospice Facility and the Doctor prescribing your care and treatment is the owner of or has an ownership interest in the Hospice Facility where you are confined.

3) WAIVER OF PREMIUM: When benefits have been payable for 90 consecutive days of confinement to a Nursing Facility or Hospice Facility, you do not have to pay premium for this Policy while you continue to be confined. If you paid premium for a quarterly, semi-annual or annual period, your premium period will be changed to monthly during the time you do not pay premium. We will refund prepaid premium for every month that we determine you are eligible for this benefit.

HOME CARE BENEFITS: Provided you have qualified for benefits as stated in the QUALIFICATIONS FOR BENEFITS provision, we will pay 80% of actual charges for Home Care for any given day up to the Home Care Daily Benefit Amount. Benefits are not payable for room and board, rent, drugs, equipment and supplies. The itemized billing statements from each provider of services must separately identify such charges from charges which are eligible for payment under the terms of this Policy. Home Care includes:

1) HOME HEALTH CARE: Services performed by a Home Health Care Agency. Benefits are payable for skilled nursing or other professional services in a Home.

A Home Health Care Agency is an agency or organization which is (1) appropriately licensed (if such licensing is required in the state where such agency operates) or is state or federally certified to provide home health care; and (2) which maintains a complete medical record of each patient.

2) PERSONAL CARE SERVICES: Personal Care Services are services whose primary function is to provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Instrumental Activities of Daily Living are the following activities: using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, doing laundry, and doing light housekeeping.

Personal Care Services may be provided in a Home by skilled or unskilled persons who do not require prior certification or licensure by state law to perform these services.

3) HOMEMAKER SERVICES: Homemaker services are services for assistance with activities necessary to or consistent with your ability to remain in your residence, that are provided by a skilled or unskilled person.

4) ADULT DAY CARE: Medical or nonmedical care on a less than 24-hour basis, provided in a state licensed facility outside the Home, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including Activities of Daily Living and taking medicine.

5) HOSPICE SERVICES: Hospice Services are outpatient services (excluding drugs and other supplies) not paid by Medicare, that are designed to: provide palliative care; alleviate the physical, emotional, social, and spiritual discomforts of an individual whose life expectancy is one year or less due to the existence of a terminal disease, and to provide supportive care to the primary caregiver and the family. Care may be provided by a skilled or unskilled person in a Home.

RESPITE CARE BENEFIT: Respite Care is short-term, temporary care that is for the relief of an unpaid person who is providing you with care in the Home. It may be provided in a facility, Home, community-based program, or adult day care program, provided you have a statement from a Doctor who is not a member of your Immediate Family that, for two or more Activities of Daily Living, you need direct human assistance or continual supervision every time you perform the activity or that you have a Cognitive Impairment. Respite Care benefits are payable, as follows:

For each day Respite Care is provided while you are confined to a Nursing Facility or Hospice Facility, we will pay the actual charge made by the facility, up to the amount shown in the Schedule for Respite Confined Care.

For each day Respite Care is provided in a Home or a community-based program, we will pay 80% of the actual charges, up to the amount shown in the Schedule for Respite Home Care. Benefits are not payable for room and board, rent, drugs, equipment and supplies.

We will pay for 14 days of Respite Care each Policy Year. A Policy Year begins on the Policy Date and ends on the anniversary of the Policy Date. Unused days cannot be carried over into the next Policy Year. A day of Respite Care is limited to a 24-hour consecutive period during which you receive Respite Care. Respite Care which extends beyond the 24-hour period will be considered another day.

You do not have to meet a Waiting Period to receive Respite Care benefits. This benefit does not count toward the Maximum Days and is not eligible for the BENEFIT REBUILDER.

D. BENEFIT REBUILDER: After we have paid you benefits and you have used some or all of your Maximum Days, your benefits will be restored to the Maximum Days shown in the Schedule if you are free from care for 180 consecutive days. "Free from care" means that for 180 consecutive days you:

- Are not confined to a Nursing Facility or a Hospice Facility;
- Do not receive any Home Health Care, Personal Care Services, Homemaker Services, Adult Day Care, or Hospice Services;
- Are able to perform all the Activities of Daily Living and all Instrumental Activities of Daily Living without assistance or supervision; and
- Do not have a Cognitive Impairment.

After meeting the eligibility requirements for this benefit, you must again satisfy the Waiting Period before benefits become payable.

Eligibility for benefits to be restored in accordance with this section are subject to the PHYSICAL EXAMINATION AND EVALUATION provision.

EXCLUSIONS

We will not pay benefits for any of the following:

1. Alcoholism or chemical dependency. However, we will pay for chemical dependency that results from drugs administered on the advice of and in such doses as prescribed by a Doctor;
2. Neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind without demonstrable organic origin (Alzheimer's disease, Parkinson's disease, and senile dementia are not excluded);
3. Confinement in a Nursing Facility or Hospice Facility if the Doctor prescribing your care and treatment is the owner of or has an ownership interest in the Nursing Facility or Hospice Facility where you are confined;
4. Services or care provided by a member of your Immediate Family;
5. Services for which no charge is normally made in the absence of insurance;

6. Services rendered according to a Plan of Care developed by someone who stands to benefit financially if you receive CONFINED CARE BENEFITS or HOME CARE BENEFITS;

7. Services received during the Waiting Period or after the expiration of the Maximum Days shown in the Schedule;

8. Self-inflicted injury or sickness, whether sane or insane;

9. Confinement or care received outside of the United States;

10. Confinement or care received after termination of your coverage, except as provided in the section entitled, "TERMINATION FOR NONPAYMENT OF PREMIUM" provision; or

11. Confinement or care received while this Policy is not in force.

PREMIUMS

PAYMENT OF PREMIUM: All premium due dates are determined from the Policy Date. The first premium was due before we delivered the Policy. All other premiums are due in advance of the period they are to cover. Premiums after the first one are to be payable to us. The premiums for this Policy may change, as stated in the Renewal Premiums provision.

REFUND OF PREPAID PREMIUMS: If we are notified of your death, we will refund any prepaid premium for any period beyond the end of the month in which your death occurred.

RENEWAL PREMIUMS: We may change the premium rates for this Policy. If we do change such premiums, we will do so only if:

1. We change the premium rates for all policies in the same premium class and in the same state as this Policy; and

2. We have notified you in writing at your last known address at least thirty-one (31) days before the change becomes effective.

ALTERNATE PREMIUM PAYOR: If you have given us notice of an alternate premium payor, as shown in the Application, we will send the alternate premium payor a copy of any late premium notice and a copy of any lapse notice. You may change the alternate premium payor by giving us written notice.

TERMINATION OF COVERAGE

TERMINATION FOR NONPAYMENT OF PREMIUM: Your coverage will end if the required premium is not paid when due or within the 31-day Grace Period. This will not affect a claim for expenses incurred before the coverage ended.

GRACE PERIOD: This Policy has a 31-day grace period. This means that if a premium is not paid on or before the date it is due, it may be paid during the 31 days following the due date. During the grace period, this Policy will stay in force.

REINSTATEMENT: If the renewal premium is not paid before the Grace Period ends, the Policy will lapse. Our later acceptance of the premium without requiring an application for reinstatement will reinstate this Policy.

If we require an application, you will be given a conditional receipt for the premium. If the application is approved, the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the 30th day after the date of the conditional receipt unless we have previously written you of our disapproval.

If the Policy is reinstated, we will cover only loss that begins after the date of reinstatement. In all other respects your rights and our rights will remain the same, subject to any provisions imposed by us.

Premium must be paid from the date of the last premium payment at the rate that would have been in effect had the Policy been in force. Payment must be made to us within 15 days from the date it is requested by us.

EXTENDED REINSTATEMENT: Within 120 days after the Policy lapses for nonpayment of premium, you or any person authorized to act on your behalf, may request reinstatement of the Policy if you were diagnosed as having a Cognitive Impairment at the time the Policy lapsed.

We may request that a Doctor who is not a member of your Immediate Family provide written certification that diagnosis of Cognitive Impairment was established at the time the Policy lapsed. Upon our receipt of such certification, the Policy will be reinstated without evidence of insurability.

The reinstated Policy will cover loss which occurred from the date the Policy lapsed. Coverage will be provided at the same level provided prior to reinstatement.

Premium must be paid from the date of the last premium payment at the rate that would have been in effect had the Policy been in force. Payment must be made to us within 15 days from the date it is requested by us.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to us within 180 days after a covered loss starts or as soon as reasonably possible. The notice must be given to us at our Home Office. Notice should include your name and Policy number.

CLAIM FORMS: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days after we receive your notice, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. We must receive this statement within the time limit stated in the PROOF OF LOSS section.

PROOF OF LOSS: Written proof of loss must be furnished to us within 90 days after we receive notice of claim. The Plan of Care must be submitted with initial claim or within 30 calendar days of the date services begin. We will not deny or reduce any benefit because we are not furnished proof in the time required if it is not possible for you to do so. However, proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than 18 months from the time proof is required.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this Policy will be paid as soon as we receive proper written proof of loss.

PAYMENT OF CLAIMS: We will pay all benefits to you. If any accrued benefits are unpaid at your death, we may pay them to your spouse, if living, otherwise to your estate. We may pay benefits up to $1,000 to anyone related to you by blood or by connection of marriage whom we consider to be entitled to the benefits if the benefits are payable: to your estate; or to a person who is a minor or otherwise not competent to give a valid release. Any payment made by us in a good faith under this provision will fully discharge us to its extent.

CLAIM APPEAL PROCESS: Our procedure is to treat each claim submission fairly, based on the facts we are provided. You may have additional information that could change a claim decision. To provide a full and fair review, we have established an appeal process in the event you want to appeal or review a claim decision. You will be notified of your right to appeal and the appeal process at the time an initial claim decision is made.

PHYSICAL EXAMINATION AND EVALUATION: At our expense, we have the right to have you examined as often as reasonably necessary while a claim is pending or to determine your eligibility for the BENEFIT REBUILDER. We reserve the right to periodically review the extent to which you need assistance with Activities of Daily Living, Instrumental Activities of Daily Living or in association with your Cognitive Impairment or to have a third party professional organization do so on our behalf. Any such review will be at our expense. It will be solely for the purpose of determining whether your treatment qualifies for benefits under the terms of this Policy.

LEGAL ACTION: No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No action may be brought after three years from the time written proof of loss is required to be given.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the Application and any attachments and Riders, is the entire contract between you and us. No change in this Policy will be valid until approved, in writing, by an officer of the Company and the approval has been forwarded to you for attachment to your Policy. No other person has the authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After six months from the Policy Date, no misstatements, except fraudulent misstatements, made in the Application may be used to void the Policy or to deny a claim for loss incurred after the expiration of the six-month period.

MISSTATEMENT OF AGE: If your age has been misstated, we will pay only such amount as the premium paid would have purchased at the correct age.

ASSIGNMENT: Any assignment of your interest under this Policy must be in writing. It must be filed in our Home Office, prior to payment of any benefit. We assume no responsibility for the validity of any assignment.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on the Policy Date, is in conflict with the laws of the state in which you live on that date is amended to conform to the minimum requirements of such laws.

TRANSPORT LIFE INSURANCE COMPANY
714 Main Street, Fort Worth, Texas 76102

ENDORSEMENT

NOTICE. This Endorsement is made a part of the Policy to which it is attached. It is effective on the Policy Date shown in the Schedule. This Endorsement is subject to all of the Policy definitions, provisions, exceptions and limitations which are not inconsistent with the provisions of this Endorsement.

GUARANTEED INSURABILITY FOR INFLATION PROTECTION (INCREASE OF 5% COMPOUNDED ANNUALLY): On each policy anniversary, you may elect to purchase an increase of 5% (compounded annually) of all the dollar amounts for this Policy and any optional Rider benefits shown in the Policy Schedule. You are eligible to make this election even if benefits are being paid. Upon election, an additional premium will be required for the increased dollar amounts. The premium payable for each such increase will be based on the rates then in effect for your attained age.

At least 30 days prior to each policy anniversary, you may elect an increase of benefits by giving us written notice of such election. If you decline an increase at any time on or after the third policy anniversary, no future elections to increase benefits can be made.

TRANSPORT LIFE INSURANCE COMPANY

President

Secretary

11001-GI-CA

EXHIBIT B

If you do wish to submit a claim at this time, please complete and return the claim form recently provided to you. Upon receipt of the completed claim form, we may need additional information to process your claim. For example, it may be necessary for us to request documentation from one or more of your past or current care providers:

- **For all claim types:**
  A copy of the state-issued license for each caregiver, agency or long term care facility and itemized billing statements

- **For Nursing Home care:**
  The initial Minimum Data Set (MDS) or admission assessment and any subsequent updated Minimum Data Set's or ongoing assessments that reflect your care needs.

- **For Assisted Living care:**
  A copy of the initial admission assessment and/or Service Plan (care plan) and any updates to those documents.

- **For Home Health Care:**
  A copy of the initial in-home assessment or agency assessment, any updates, as well as visit notes documenting the cares provided to you on a daily basis.

Once we receive the documentation we have requested, our care management team will review the information to determine your and your provider's benefit eligibility and will notify you of the results.

Upon completion of the eligibility decision, all billing statements and invoices are forwarded to the claims examination team for processing and payment.

Our goal is to provide you with prompt service. You can expect your benefit request to be completed within 30 days of receipt of all the information needed.

We have found that your active participation in the process outlined helps us process your claim more quickly. Please consider contacting your provider and asking them to send the information we need. Doing so may help to expedite the processing of your claim.

As a reminder, it is important that you return a fully completed claim form only if you are requesting benefits. If you are requesting benefits, we will be unable to initiate the claim review process if we do not have all the information outlined on the claim form and all the documentation noted above. If you are not requesting benefits, then no action is required from you at this time.

If you have any questions about filing a claim, please call our Customer Service Representatives at 877-451-5824

Long Term Care Claims