John Hancock Life Insurance Company, Boston, MA 02117

Individual Long-Term Care Insurance

Custom Care
California Partnership Sample Policy

If you have any questions, please call
LTC Support Services toll-free at
1-800-543-6415

John Hancock Life Insurance Company
Boston, Massachusetts

An Approved Participant In

COMPREHENSIVE LONG-TERM CARE INSURANCE POLICY

We at John Hancock are pleased to provide **You** with this Policy and the important benefits that it provides.

THIRTY DAY FREE LOOK. If **You** are not completely satisfied with this Policy for any reason, **You** may return it within 30 days from the date it was delivered to **You**. To return the Policy, mail or deliver the Policy to the agent who sold it to **You**, to **Our** LTC Administrative Office, or to the agency office through which it was delivered. **We** will then refund any premium paid, and the Policy will be treated as if it had never been issued.

CAUTION. The issuance of this long-term care insurance Policy is based upon **Your** responses to the questions on **Your** application. A copy of **Your** application is attached. If **Your** answers are not complete, true, and correctly recorded, **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! To contact **Us** at **Our** LTC Administrative Office, write to: John Hancock Life Insurance Company, 333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203 or call **Us** at 1-800-377-7311.

NOTICE TO BUYER. This Policy may not cover all of the costs associated with long-term care **You** incur during the period of coverage. **You** are advised to review all Policy limitations carefully. THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

GUARANTEED RENEWABLE FOR LIFE OR UNTIL THE POLICY LIMIT IS REACHED — LIMITED RIGHT TO INCREASE PREMIUMS. **You** have the right to continue this Policy for as long as **You** live or until the **Policy Limit** is reached. **We** cannot cancel the Policy unless **You** do not make the required premium payments on a timely basis. To continue this Policy, **You** must make sure that **You** pay the premiums when they are due. In the event that **Our** losses are greater than anticipated and exceed the minimum requirements for rating action under California law, **We** reserve the right to increase **Your** premium as of any premium due date. However, any changes in premium rates must be applied to all members of **Your** rate class. **Your** rate class consists of **You** and all other individuals who have purchased this and any other John Hancock California Partnership policy form. All John Hancock California Partnership policies shall be considered a single risk pool for purposes of approving any future premium adjustments. **We** cannot single **You** out for an increase because of any change in **Your** age, health or divorce. In addition, **We** cannot change the provisions of this Policy without **Your** consent.

THE BENEFITS PAYABLE BY THIS POLICY QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. ELIGIBILITY FOR MEDI-CAL IS NOT AUTOMATIC. IF AND WHEN YOU NEED MEDI-CAL, YOU MUST APPLY AND MEET THE ASSET STANDARDS IN EFFECT AT THAT TIME. UPON BECOMING A MEDI-CAL BENEFICIARY, YOU WILL BE ELIGIBLE FOR ALL MEDICALLY NECESSARY BENEFITS MEDI-CAL PROVIDES AT THAT TIME, BUT YOU MAY NEED TO APPLY A PORTION OF YOUR INCOME TOWARD THE COST OF YOUR CARE. MEDI-CAL SERVICES MAY BE DIFFERENT THAN THE SERVICES RECEIVED UNDER THE PRIVATE INSURANCE.

This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits.

This Policy will cover preexisting conditions that are disclosed on the Application.

PLEASE READ THIS POLICY CAREFULLY. This Policy is a legal contract between **You** and **Us**. **We** will provide the benefits stated in this Policy subject to the provisions, exceptions and limitations stated on this and the following pages. **We** have issued this Policy in consideration of the application and payment of the Initial Premium on or before the date this Policy is delivered to **You**.

Signed for the Company at Boston, Massachusetts:

Secretary President

The benefit schedule and the amount of Your First Premium are shown in the Policy Schedule.
Please Read Your Policy Carefully.

INSURED:	[Jane Hancock]	**DATE OF ISSUE:**	[January 1, 2001]
POLICY NUMBER:	[H 9000 000]	**FIRST [ANNUAL] PREMIUM:**	[$XXXXX.XX]
POLICY FORM:	CAP-02	**BASE POLICY PREMIUM:**	[$XXXXX.XX]

POLICY TITLE: Comprehensive Long-Term Care Insurance Policy

POLICY SCHEDULE

This Policy Schedule provides You with specific information about the benefits You selected and how much We will pay.

POLICY LIMIT: * [XXXXXX]
The Policy Limit is calculated by multiplying the Nursing Facility Daily Benefit by the number of days in the Benefit Period as selected in Your application for this Policy.

ELIMINATION PERIOD: [XXX] Days

NURSING FACILITY COVERAGE*
Actual Charges up to the Nursing Facility Daily Benefit: [$XXXX] per day

RESIDENTIAL CARE FACILITY COVERAGE*
Actual Charges up to the Residential Care Facility Daily Benefit: [$XXXX] per day

HOME AND COMMUNITY-BASED CARE COVERAGE*
Actual Charges up to the Home and Community-Based Care Monthly Benefit: [$XXXXX] per month

RESPITE CARE COVERAGE*
Benefit (21 x Nursing Facility Daily Benefit): [$XXX] per calendar year

STAY AT HOME BENEFIT*
Lifetime Benefit (30 x Nursing Facility Daily Benefit): [$XXXX]

INTERNATIONAL COVERAGE BENEFIT AMOUNT*
Actual Charges up to 75% of the Nursing Facility Daily Benefit: [$XXX] per day
Actual Charges up to 75% of the Residential Care Facility Daily Benefit: [$XXXX] per day
Actual Charges up to 75% of the Home and Community-Based Care Monthly Benefit: [$XXXX] per month
Actual Charges up to 75% of the Respite Care Benefit: [$XXXX] per calendar year

* All benefit limits will increase annually due to the inflation coverage provision of the policy.

[COMPOUND, SIMPLE] INFLATION COVERAGE

OPTIONAL BENEFITS SELECTED AND INCLUDED IN THIS POLICY

[SharedCare Benefit]	$ [Annual Premium]
[Survivorship & Waiver of Premium Benefit]	$ [Annual Premium]
[Waiver of the Home and Community-Based Care Elimination Period]	$ [Annual Premium]
[Nonforfeiture Benefit]	$ [Annual Premium]

[POLICY SCHEDULE - (continued)

Base Policy Premium: $ [Annual Premium]

Total Premium Payment Options (includes all optional benefits):

	Annual	Semi-Annual	Quarterly	Monthly
First Year Premium:	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Total Yearly Cost for First Year Premium:	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

If You would like additional information about the costs of our periodic payment, please contact Us at 1-800-377-7311.

Early notification to Our Claims Department will facilitate a timely review of Your claim and avoid any delay in Your qualifying for benefits. Please let Us know immediately or in advance, whenever possible, when You need care or services covered by this Policy. Please call Us at 1-800-377-7311.

***** Important Notice.** You have selected the Ten-Year Premium Payment Option. This means that Your Policy is fully paid-up and no further premiums will be due at the end of Your tenth Policy year. Prior to the end of Your tenth Policy year, You must make sure that You pay the premiums when they are due to continue this Policy. However, in the event that We find that the premium rates for this Policy form are inadequate prior to the end of the tenth Policy year, We reserve the right to increase Your premium as of the next premium due date. ***OR***

***** Important Notice.** You have selected the Paid-Up at Age 65 Payment Option. This means that Your Policy will be paid-up and no further premiums will be due after the Policy anniversary following Your 65th birthday. Prior to this, You must make sure that You pay the premiums when they are due to continue this Policy. However, in the event that We find that the premium rates for this Policy form are inadequate during the premium paying period, We reserve the right to increase Your premium as of the next premium due date.

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PART 1 - WORDS AND PHRASES

This part explains the special meaning given to certain words or phrases as they are used in this Policy. Other terms may be defined in the part in which they are most frequently used.

1.1 Activities of Daily Living means the following activities:

- *Bathing* which means washing **Yourself** by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- *Continence* which means the ability to maintain control of bowel and bladder functions; and when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
- *Dressing* which means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- *Eating* which means feeding **Yourself** by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- *Toileting* which means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- *Transferring* which means moving into or out of a bed, chair or wheelchair.

1.2 Elimination Period means the total number of days that covered**, Formal Long-Term Care Services** must be received after **You** are determined to be a **Chronically Ill Individual** and before the benefits covered by the Policy are payable. The number of days may be accumulated over any period of time after **You** have been determined to be a **Chronically Ill Individual**.

The number of days can be accumulated before the filing of a claim if **You** can establish that **You** were a **Chronically Ill Individual** before filing a claim. The **Elimination Period** need only be met once during a lifetime. Any day when covered services are reimbursed by other insurance or **Medicare** may be counted toward meeting the **Elimination Period**. **Respite Care,** the Stay at Home Benefit and **Care Management Services** are not subject to the **Elimination Period,** nor will any days **You** receive only these services count towards satisfying **Your Elimination Period**.

If **You** receive **Home and Community-Based Care** for one or more days in a **Calendar Week**, **We** will apply seven days toward the satisfaction of **Your Elimination Period**. However, in no event will **Your Elimination Period** be satisfied in less than the number of calendar days in **Your Elimination Period**. (**Calendar Week** means the seven consecutive day period that begins on Sunday at 12:01 a.m.)

1.3 Formal Long-Term Care Services means long-term care services for which the provider is paid.

1.4 Hands-on Assistance means the physical assistance of another person without which **You** would be unable to perform the **Activity of Daily Living.**

1.5 Home means **Your** primary residence. It does not include a **Nursing Facility**, a hospital or rehabilitation facility/hospital, or a facility for the treatment of alcoholism, drug addiction or mental illness.

1.6 **Immediate Family** means **You** or **Your** spouse, or the following relatives of **You** or **Your** spouse: parents, grandparents, siblings, children, stepchildren, grandchildren, and their respective spouses.

1.7 **Informal Long-Term Care Services** means long-term care services for which the provider is not paid.

1.8 **Licensed Health Care Practitioner** means any **Physician** (as defined in section 186(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. The **Licensed Health Care Practitioner** must be independent of **Us** and employed by **a Care Management Provider Agency** or be a Qualified Official Designee of a **Care Management Provider Agency**.

1.9 **Medi-Cal** (and **Medicaid**) means the reimbursement system under Title XIX of the Federal Social Security Act, as amended.

1.10 **Medicare** means the reimbursement system under Title XVIII of the Federal Social Security Act, as amended.

1.11 **Nursing Care** means skilled or intermediate care provided by one or more of the following health care professionals: registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, medical social worker or registered dietitian.

1.12 **Physician** means any person bearing the designation of Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) practicing within the scope of his or her license issued by the jurisdiction in which the services are rendered.

1.13 **Plan of Care** means a written individualized plan of services prescribed by a **Licensed Health Care Practitioner** which specifies the type, frequency, and providers of all **Formal and Informal Long-Term Care Services** required by **You**, and the cost, if any, of any **Formal Long-Term Care Services** prescribed. Changes in the **Plan of Care** must be documented to show that such alterations are required by changes in the client's medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.

1.14 **Policy Limit** means the total dollar amount, as shown on the Policy Schedule, from which **You** will be paid benefits for all covered care and services. All benefits, except for certain **Care Management Services** and the Stay at Home Benefit, will be deducted from the **Policy Limit**. (Please refer to the Care Management Services Benefit section of this Policy. If **You** choose to have the **Care Management Provider Agency** coordinate **Your** care or monitor the services **You** receive, such benefits will be deducted from the **Policy Limit**.) **We** will not pay benefits in excess of the **Policy Limit** as shown in the Policy Schedule.

The **Policy Limit** is calculated by multiplying the Nursing Facility Daily Benefit by the number of days in the Benefit Period as selected in **Your** application for this Policy. The **Policy Limit** will increase annually in accordance with the Inflation Coverage provision of the Policy.

1.15 **Severe Cognitive Impairment** means a loss or deterioration in intellectual capacity that:

- is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and;
- is measured by clinical evidence and standardized tests prescribed or approved by the California Partnership for Long-Term Care.

1.16 **Standby Assistance** means the presence of another person within arm's reach of **You** that is necessary to prevent, by physical intervention, injury to **You** while **You** are performing an **Activity of Daily Living** (such as another person being ready to catch **You** if **You** fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from **Your** throat if **You** choke while eating).

1.17 **Substantial Supervision** means **You** need continual supervision due to **Your Severe Cognitive Impairment** (which may include cueing by verbal prompting, gestures, or other demonstration) by another person that is necessary to protect **You** from threats to **Your** health or safety (such as may result from wandering).

1.18 **Qualified Long-Term Care Services** means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal services which are needed to assist **You** with the disabling conditions that cause **You** to be a **Chronically Ill Individual**.

1.19 **We, Our** and **Us** means the John Hancock Life Insurance Company.

1.20 **You, Your** and **Yourself** means the person listed in the Policy Schedule as the Insured.

PART 2 - YOUR BENEFITS

This part describes when You are eligible for benefits, the benefits available under this Policy and the conditions under which benefits will be paid.

ELIGIBILITY FOR PAYMENT OF BENEFITS

2.1 How to Qualify for Benefits

We will pay for the **Qualified Long Term Care Services** covered by this Policy if:

- **You** are a **Chronically Ill Individual**; and
- The services are prescribed for **You** in a written **Plan of Care**.

You will be considered a **Chronically Ill Individual** when one of the following criteria are met:

- **You** are unable to perform, without **Standby Assistance** or **Hands-on Assistance** from another person, two **Activities of Daily Living** due to a loss of functional capacity and the loss of functional capacity is expected to last for a period of at least 90 days; or
- **You** have a **Severe Cognitive Impairment** requiring **Substantial Supervision** to protect **Yourself** from threats to health and safety.

The certification that **You** are a **Chronically Ill Individual** must be made by a **Licensed Health Care Practitioner**, within the preceding 12 months and must be renewed at least every 12 months. The services to be paid must be prescribed in a written **Plan of Care** prepared by a **Licensed Health Care Practitioner**.

All of the services covered by this policy are **Qualified Long-Term Care Services**.

The definitions for the following terms will help explain how **You** qualify for benefits under this Policy:

- **Activities of Daily Living;**
- **Standby Assistance;**
- **Hands-On Assistance;**
- **Severe Cognitive Impairment;**
- **Substantial Supervision;**
- **Licensed Health Care Practitioner;**
- **Plan of Care;** and
- **Qualified Long-Term Care Services.**

Benefits are payable under this Policy if mental and nervous disorders, Alzheimer's Disease and similar forms of senility and irreversible dementia result in a Severe Cognitive Impairment or inability to perform the Activities of Daily Living.

LIMITATIONS ON OR CONDITIONS FOR ELIGIBILITY FOR BENEFITS

2.2 Conditions

To receive benefits under this Policy:

- **Your Elimination Period** must have been satisfied;
- **You** must receive services while this Policy is in effect;
- **We** have received an Assessment which establishes **Your** eligibility for benefits;
- **You** must receive services covered under this Policy and which are specified in **Your Plan of Care**; and
- a current **Plan of Care** and **Proof of Loss** must be submitted to **Us.**

2.3 Limitations

Home and Community-Based Care received on any day that **You** are also confined in a **Nursing Facility** or a **Residential Care Facility** will be paid under the applicable Nursing Facility Benefit or the Residential Care Facility Benefit, not the Home and Community-Based Care Benefit. In the event that **You** are confined in both a **Nursing Facility** and **Residential Care Facility** on the same day, **We** will pay either the Nursing Facility Benefit or the Residential Care Facility Benefit, whichever is greater.

We will not pay benefits for charges during the **Elimination Period,** except for **Care Management Services**, the Stay at Home Benefit and **Respite Care**. **We** will not pay benefits in excess of the **Policy Limit** as shown in the Policy Schedule. However, benefits for certain **Care Management Services** and the Stay at Home Benefit will not reduce the **Policy Limit.**

HOW YOUR NURSING FACILITY AND RESIDENTIAL CARE FACILITY BENEFITS ARE PAID

2.4 Payment of the Nursing Facility Benefit

We will pay the Nursing Facility Benefit if:

- **You** are a **Chronically Ill Individual**;
- **You** are confined in a **Nursing Facility**;
- confinement in a **Nursing Facility** is included in **Your Plan of Care;**
- **You** have satisfied **Your Elimination Period;** and
- this Policy is in effect when **Your** confinement begins.

We will pay the actual charges incurred while **You** are confined in a **Nursing Facility** up to the Nursing Facility Benefit as shown in the Policy Schedule. Actual charges include: room and board, ancillary services and supplies and **Nursing Care** charged by the **Nursing Facility**, as well as services that are available under the Home and Community-Based Care Benefit. Any unused portion of **Your** Nursing Facility Daily Benefit will remain in **Your Policy Limit**. Any benefits paid under this provision will reduce **Your Policy Limit**.

Eligible Provider -- Nursing Facility

"Nursing Facility" means a facility which:

- is licensed and operated to provide **Nursing Care** for a charge (including room and board), according to the laws of the jurisdiction in which it is located; and
- has services performed by or under the continual, direct and immediate supervision of a registered nurse, licensed practical nurse or licensed vocational nurse, on-site twenty-four (24) hours per day.

A **Nursing Facility** may be a freestanding facility or it may be a distinct part of a facility, including a ward, wing, or swing-bed of a hospital or other facility. In California, a **Nursing Facility** also includes facilities licensed in California as Skilled Nursing Facilities.

Nursing Facility does not mean:

- a hospital or clinic (unless it is licensed by the State of California as a Skilled Nursing Facility);
- a rest home (a home for the aged or a retirement home);
- **Your** primary place of residence, including **Your** living quarters in a continuing care retirement community or similar entity; or
- a facility for the treatment of alcoholism, drug addiction, or mental illness.

What is Not Covered Under the Nursing Facility Benefit

We will not pay for any of the following: **Physician's** charges; hospital and laboratory charges; and items and services furnished at **Your** request for beautification, convenience or entertainment.

2.5 Nursing Facility Bedhold Benefit

If **Your** stay in a **Nursing Facility** is interrupted for any reason and a benefit is payable under this Policy, **We** will continue to pay the actual charges up to the Nursing Facility Daily Benefit, for up to 60 days in any calendar year in order to reserve **Your** bed during **Your** absence. Any benefits paid under this provision will reduce **Your Policy Limit**.

2.6 Payment of the Residential Care Facility Benefit

We will pay the Residential Care Facility Benefit if:

- **You** are a **Chronically Ill Individual**;
- **You** are confined in a **Residential Care Facility**;
- confinement in a **Residential Care Facility** is included in **Your Plan of Care**;
- **You** have satisfied **Your Elimination Period**; and
- this Policy is in effect when **Your** confinement begins.

We will pay the actual charges incurred for **Qualified Long Term Care Services** received while **You** are confined in a **Residential Care Facility** up to the Residential Care Facility Daily Benefit. Actual charges include: care and services provided by the **Residential Care Facility**, all other care and services covered under other benefits of the Policy, and any other care and services that are needed to assist **You** with the disabling conditions that caused **You** to be a **Chronically Ill Individual**. Any unused portion of **Your** Daily Benefit will remain in the **Policy Limit**. Any benefit paid under this provision will reduce **Your Policy Limit**.

Eligible Provider -- Residential Care Facility

"Residential Care Facility" means a facility licensed as a Residential Care Facility for the Elderly or a residential care facility as defined in the California Health and Safety Code.

Outside California, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing on-going care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impairment in cognitive ability and which also:

- provide such care and services on a twenty-four (24) hour a day basis; and
- have a trained and ready-to-respond employee on duty in the facility at all times to provide such care and services; and
- provide three meals a day and accommodates special dietary needs; and
- have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency; and
- have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

What is Not Covered Under the Residential Care Facility Benefit

We will not pay for any of the following: **Physician's** charges; hospital and laboratory charges; and items and services furnished at **Your** request for beautification, convenience or entertainment.

2.7 Residential Care Facility Bedhold Benefit

If **Your** stay in a **Residential Care Facility** is interrupted for any reason and a benefit is payable under this Policy, **We** will continue to pay the actual charges up to the Residential Care Facility Daily Benefit, for up to 60 days in any calendar year in order to reserve **Your** bed during **Your** absence. Any benefits paid under this provision will reduce **Your Policy Limit**.

2.8 Extension of Benefits

If **Your** Policy lapses, while **You** are confined in a **Nursing Facility** or **Residential Care Facility** and **You** are eligible for benefits under this Policy, benefits under the Nursing Facility Benefit or Residential Care Facility Benefit, as the case may be, will be continued until the earlier of the following dates:

- the date **You** are discharged from the **Nursing Facility** or **Residential Care Facility,** as the case may be; or
- the date **Your Policy Limit** is exhausted.

This Extension of the Nursing Facility Benefit or Residential Care Facility Benefit will be subject to all of the provisions of this Policy (including but not limited to the **Elimination Period** and Eligibility for the Payment of Benefits**.**)

HOW YOUR HOME AND COMMUNITY-BASED CARE BENEFITS ARE PAID

This Policy pays for the following types of **Home and Community-Based Care**:

- **Home Health Care**;
- **Adult Day Care**;
- **Personal Care Services**;
- **Homemaker Services**;
- **Hospice Services**; and
- **Respite Care**. (Note - **Respite Care** is paid under the Respite Care Benefit.)

2.9 Payment of the Home and Community-Based Care Benefit

We will pay the Home and Community-Based Care Benefit if:

- **You** are a **Chronically Ill Individual**;
- **You** are receiving **Home and Community-Based Care**;
- **Home and Community-Based Care** is included in **Your Plan of Care**;
- **You** have satisfied **Your Elimination Period**; and
- this Policy is in effect when **You** begin to receive **Home and Community-Based Care**.

We will pay the actual charges incurred during one calendar month for a provider of **Home and Community-Based Care** up to the Home and Community-Based Care Monthly Benefit as shown in the Policy Schedule. The Home and Community-Based Care Monthly Benefit is equal to the Nursing Facility Daily Benefit multiplied by the Home and Community-Based Care Percentage that **You** selected on **Your** application for this Policy, multiplied by 30-days. If **You** are eligible for **Home and Community-Based Care** benefits for only part of a month, **We** will pro-rate benefits based on the percentage of the month for which **You** were eligible for benefits. A partial month can occur when **You** first begin to receive benefits or when **You** stop receiving benefits. Any unused portion of **Your** Monthly Benefit will remain in the **Policy Limit**.

As a reminder, **You** must satisfy **Your Elimination Period** before receiving benefits for all types of **Home and Community-Based Care**, except **Respite Care**. Days that **You** receive **Home and Community-Based Care** will count toward the satisfaction of **Your Elimination Period.** However, days that **You** receive **Respite Care** will not count toward satisfaction of **Your Elimination Period**.

Home and Community-Based Care will be payable while **You** are confined in a **Nursing Facility** or **Residential Care Facility**. However, payment will be made pursuant to the applicable Nursing Facility Benefit or Residential Care Facility Benefit, not the Home and Community-Based Care Benefit.

No payment will be made under the Home and Community-Based Care Benefit if **You** are confined in a **Nursing Facility** or **Residential Care Facility** or receiving **Respite Care**. Any benefit paid under this provision will reduce **Your Policy Limit.**

Types of Home and Community-Based Care Defined and Eligible Home and Community-Based Care Providers

- **Home Health Care** means skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker. **Home Health Care** may be provided by a **Home Health Care Agency**.

  You must satisfy **Your Elimination Period** before receiving benefits for **Home Health Care**. Days that **You** receive **Home Health Care** will count toward the satisfaction of **Your Elimination Period.**

  Home Health Agency means an agency or organization which is primarily engaged in providing **Home Health Care**, and is licensed to provide such services by the jurisdiction in which **You** obtain the services if that jurisdiction requires licensing.

- **Adult Day Care** means a structured, comprehensive program which provides a variety of community-based services including health, social, and related supportive services in a protective setting on a less than 24-hour basis. These community-based services are designed to meet the needs of functionally impaired adults through an individualized service plan, and include the following

  - personal care and supervision as needed;
  - the provision of meals as long as the meals do not meet a full daily nutritional regimen;
  - transportation to and from the service site;
  - and social, health, and recreational activities.

  You must satisfy **Your Elimination Period** before receiving benefits for **Adult Day Care**. Days that **You** receive **Adult Day Care** will count toward the satisfaction of **Your Elimination Period.**

  Adult Day Care Center means a place that is licensed to provide **Adult Day Care** by the jurisdiction in which the services are provided. In California, an **Adult Day Care Center** includes the following facilities as defined by California law: an Adult Day Care Facility, an Adult Day Social Day Care Facility; an Adult Day Health Care Facility and an Alzheimer Day Care Resource Center. If licensing is not required, an **Adult Day Care Center** means a place that provides **Adult Day Care**, has enough full-time staff to maintain no more than an 8 to 1 client-staff ratio, and has established procedures for obtaining appropriate aid in the event of a medical emergency.

- **Personal Care Services** means:

  - *Ambulation assistance*, including help in walking or moving around (i.e. wheelchair) outside or inside the place of residence, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.

- *Bathing and grooming* including cleaning the body, using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.
- *Dressing* including putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
- *Bowel, bladder and menstrual care* including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.
- *Repositioning, transfer skin care, and range of motion exercises*, including moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e. the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.
- *Feeding, hydration assistance*, including reaching for, picking up, grasping utensil and cup; getting food on utensil; bringing food, utensil, cup to mouth, and manipulating food on plate. Cleansing face and hands as necessary following meal.
- *Assistance with self-administration of medications*.
- *Assistance with Instrumental Activities of Daily Living*, which include:
    - domestic or cleaning services;
    - laundry services;
    - reasonable food shopping and errands;
    - meal preparation and cleanup;
    - transportation assistance to and from medical appointments; and,
    - heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt; and,
    - using the telephone.

You must satisfy **Your Elimination Period** before receiving benefits for **Personal Care Services**. Days that **You** receive **Personal Care Services** will count toward the satisfaction of **Your Elimination Period.**

Personal Care Services may be provided by: a **Home Health Agency**; a nurse's aide; a home health aide; or a skilled or unskilled person who is providing **Personal Care Services** as required in a **Plan of Care** which is developed by a **Licensed Health Care Practitioner**. **Personal Care Services** cannot be restricted to licensed providers or Medicare-certified providers.

- **Homemaker Services** means assistance with activities necessary to or consistent with **Your** ability to remain **Your** residence, that is provided by a skilled or unskilled person under a **Plan of Care** developed by a **Licensed Health Care Practitioner**. **Homemaker Services** cannot be restricted to licensed providers or Medicare-certified providers.

You must satisfy **Your Elimination Period** before receiving benefits for **Homemaker Services**. Days that **You** receive **Homemaker Services** will count toward the satisfaction of **Your Elimination Period.**

- **Hospice Services** are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. A skilled or unskilled person may provide care under a **Plan of Care** developed by a **Physician** or a multidisciplinary team under medical direction. "Terminally disease" means that there is no reasonable prospect of cure and **You** have a life expectancy, as estimated by a **Physician**, of 12 months or less. **Hospice Services** also include supportive care to **Your** primary caregiver and **Your** family

  You must satisfy **Your Elimination Period** before receiving benefits for **Hospice Services**. Days that **You** receive **Hospice Services** will count toward the satisfaction of **Your Elimination Period.**

What is Not Covered Under the Home and Community-Based Care Benefit

We will not pay for any of the following: Physician's charges; hospital charges; acute rehabilitation facility and laboratory charges; prescription or non-prescription medication; medical supplies; purchased durable medical equipment; and items and services furnished at **Your** request for beautification, convenience or entertainment.

2.10 Payment of the Respite Care Benefit

We will pay benefits for **Respite Care** if:

- Such care is received while this Policy is in effect.
- A **Licensed Health Care Practitioner** verifies in writing that **You** have met the eligibility requirements of this Policy.
- **Respite Care** is included in **Your Plan of Care** .

You must provide the **Care Management Provider Agency** with written proof that **Your** caregiver is taking a temporary leave of absence. The **Care Management Provider Agency** needs this information in order to develop **Your Plan of Care**.

We will pay the actual charges incurred for **Respite Care** up to the Nursing Facility Daily Benefit as shown in the Policy Schedule, regardless of the site of care.

We will pay up to 21 days per any calendar year for **Respite Care**. **We** will not pay both **Respite Care** and other Policy benefits on the same day. Benefits paid for **Respite Care** will reduce the **Policy Limit**.

You do not need to satisfy **Your Elimination Period** before receiving benefits for **Respite Care**. Days that **You** receive **Respite Care** will not count toward the satisfaction of **Your Elimination Period.**

Respite Care Defined and Eligible Respite Care Providers

Respite Care is the short-term care provided in an institution, in the **Home** or in a community-based program that is designed to provide temporary relief to the primary caregiver from his or her caregiving duties. Such care includes: confinement in a **Nursing Facility** or **Residential Care Facility; Home Health Care, Adult Day Care; Personal Care; Hospice Services;** and **Homemaker Services**.

Eligible providers of **Respite Care** include: a **Nursing Facility**; a **Residential Care Facility**; an **Adult Day Care Center**, persons employed by a **Home Health Agency**; and a person who is qualified by training and experience to provide **Respite Care**. **Respite Care** cannot be restricted to licensed providers or Medicare-certified providers.

What is Not Covered Under the Respite Care Benefit

We will not pay for any of the following: Physician's charges; hospital; acute rehabilitation facility and laboratory charges; prescription or non-prescription medication; medical supplies; purchased durable medical equipment; and items and services furnished at **Your** request for beautification, convenience or entertainment.

HOW YOUR CARE MANAGEMENT SERVICES BENEFITS ARE PAID

2.11 Payment of the Care Management Services Benefit

Before **We** can determine whether **You** are eligible to receive covered benefits under this Policy, **We** require that an approved **Care Management Provider Agency** conduct an assessment of **Your** condition.

All **Care Management Services** that **You** receive must be provided by a **Care Management Provider Agency** that is selected by **Us** and approved by the **California Partnership for Long-Term Care**.

We will arrange for:

- an approved **Care Management Provider Agency** to contact **You** to perform the initial assessment once **You** have notified **Us** that **You** may be eligible for benefits; and
- a **Plan of Care** to be developed if **We** determine that **You** qualify for benefits.

Once **Your** eligibility for benefits is established, the **Care Management Provider Agency** will work with **You** to develop a **Plan of Care**.

We will pay for all initial assessments, reassessments and **Plans of Care**, including a discharge plan and transition plan. These services are not subject to **Your Elimination Period**, nor will any days **You** receive **Care Management Services** count toward satisfying **Your Elimination Period** or apply toward the **Policy Limit**.

You may also choose to have the **Care Management Provider Agency**, that **We** arranged for **You**, coordinate **Your** care or monitor the services **You** receive, if determined necessary by the **Care Management Provider Agency**. If **You** wish to do so, **You** may either contact **Us** or the **Care Management Provider Agency** directly. The actual expense for these services will apply toward the **Policy Limit**, as shown on the Schedule Page, but will not be subject to **Your Elimination Period**, nor will any days **You** receive these services count toward satisfying **Your Elimination Period**.

Care Management Services and Care Management Provider Agency Defined

Care Management Services include, but are not limited to the following:

- the performance of a comprehensive, individualized, face-to-face, initial assessment to determine **Your** eligibility for benefits which is conducted in **Your** place of residence;
- the development of **Your** initial **Plan of Care** when **You** are eligible for benefits;
- the performance of all comprehensive, individualized reassessments which will occur at least every six months while **You** are receiving benefits;
- the development of all subsequent **Plans of Care** as needed per the results of any reassessments, including a discharge plan shortly before **You** no longer require **Care Management Services** or a transition plan if **You** immediately become eligible for **Medi-Cal**; and
- when desired by **You** and determined necessary by the **Care Management Provider Agency**, coordination of appropriate services and ongoing monitoring of the delivery of such services.

Please note that **Your** personal **Physician** will not be able to develop a **Plan of Care** for this Policy unless he/she is also employed by the **Care Management Provider Agency** or is a qualified official designee of the **Care Management Provider Agency**.

Care Management Provider Agency means an agency or other entity that contracts with **Us** to provide **Care Management Services** and is approved by the **California Partnership for Long-Term Care**. A **Care Management Provider Agency** will take an all-inclusive look at **Your** total needs and resources, and link **You** to a full range of appropriate services using all available funding sources.

A BENEFIT TO HELP YOU STAY AT HOME

2.12 Stay at Home Benefit

The Stay at Home Benefit can be used to pay for a variety of **Your** long-term care expenses while **You** are living in **Your Home** that are not otherwise covered under the Policy. **Stay at Home Expenses** include expenses for:

1. **Home Modifications** to **Your Home**;
2. **Emergency Medical Response Systems**;
3. **Durable Medical Equipment**;
4. **Caregiver Training**;
5. **Home Safety Check**; and
6. **Care Check.**

We will pay the Stay at Home Benefit Amount so long as all of the following conditions are met:

- the care or services are provided pursuant to a **Plan of Care** approved by a **Licensed Health Care Practitioner**; and
- **You** are eligible for the payment of benefits under this Policy.

The Stay at Home Benefit Amount is shown on the Policy Schedule. Any unused portion of this benefit amount may be used for future **Stay at Home Expenses**. Benefits paid under the Stay at Home Benefit will not reduce the **Policy Limit**. You do not have to satisfy the **Elimination Period** to receive benefits under the Stay at Home Benefit. The days for which You receive only the Stay at Home Benefit do not count toward the **Elimination Period**. **You** may receive benefits under the Home Health Care Benefit and/or Care Advisory Services Benefit while receiving benefits under the Stay at Home Benefit. **We** will provide information on the Stay at Home Benefit to the **Care Management Provider Agency** so that **Care Management Provider Agency** can help **You** utilize this benefit.

The Stay at Home Benefit Amount is not available for **Your Spouse** to access through operation of the SharedCare Rider, if included in **Your** Policy.

Stay at Home Services Defined:

- **Home Modification** mean modifications to **Your Home** that will improve **Your** ability to perform the Activities of Daily Living and allow **You** to live safely and independently in **Your Home**. Examples of **Home Modifications** include: installation of ramps for wheelchair access, installation of shower bars; widening doorways; and other similar accessibility modifications. **Home Modification** does not include coverage for: hot tubs, swimming pools, home repair; or other modifications that will, other than incidentally, increase the value of **Your Home**.

- **Emergency Medical Response System** means a communication system that is: installed in **Your Home**; and used to call for assistance in the event of a medical emergency. It does not mean a home security system.

- **Durable Medical Equipment** means equipment that **You** rent or purchase which is designed to be used in **Your Home** to either treat a medical condition or assist **You** in performing the **Activities of Daily Living**. Examples of **Durable Medical Equipment** include: walkers; hospital-style beds; crutches; and wheelchairs. **Durable Medical Equipment** does not include: prescription drugs; athletic equipment; equipment placed in **Your** body; or items commonly found in a household.

- **Caregiver Training** means a training program which provides instruction to informal caregivers in basic caregiving techniques which will allow **You** to remain in **Your Home.** The informal caregiver may be a relative or someone chosen by **You**, but in no event will **We** pay for training provided to someone who will be paid to care for **You**.

- **Home Safety Check** means an evaluation of **Your Home,** by the **Care Management Provider Agency**, a **Home Health Agency** or other qualified professional agency or individual acceptable to **Us**, in order to evaluate the safety of **Your Home** environment. Examples of the **Home** settings to be reviewed include: cabinet and appliance height; furniture arrangement; doorway and hallway width; and the need for safety bars in the bathroom.

- **Care Check** means an independent evaluation of **Your** care providers and care **Your** are receiving, in order to evaluate the consistent delivery and quality of care being provided to **You**. This evaluation can be done by the **Care Management Provider Agency**, a **Home Health Agency** or other qualified professional agency or individual acceptable to **Us**.

ADDITIONAL BENEFITS

2.13 Waiver of Premium Benefit

We will waive the payment of premiums under this Policy if:

- **You** are receiving services for which benefits are payable under the Nursing Facility Benefit, the Residential Care Facility Benefit, the Nursing Facility Bedhold Benefit, the Residential Care Facility Bedhold Benefit, or the Home and Community-Based Care Benefit; and
- **You** have satisfied the **Elimination Period**.

The waiver period will start the day after the **Elimination Period** has been satisfied and will end on the date when benefits are no longer payable under this Policy. In the event **You** have already satisfied the **Elimination Period**, the waiver period will start on the next day **You** receive covered services and will end on the date when benefits are no longer payable under this Policy.

If **Your** premium has been paid for a period for which premiums are waived, **We** will refund the premium for such period. In order to keep this Policy in effect after the waiver of premium period ends, payment of premiums must be resumed.

2.14 International Coverage

If You require care or services which would otherwise be covered by this Policy while You are permanently residing outside the fifty (50) United States or the District of Columbia, We will pay the International Coverage Benefit if all the following requirements are met:

- We receive Proof of Loss which is satisfactory to Us that You have met Your Elimination Period and the requirements found in the sections captioned "Eligibility for the Payment of Benefits" and "Conditions".
- All required documentation must be provided to Us in English.
- We reserve the right to require that You provide us with updated documentation and information at reasonable intervals. However, We will not require updates more frequently than monthly.

We also require the following documentation as described in the "Conditions" section of the Policy:

- the required certification from a Licensed Health Care Practitioner:
- a current Plan of Care and any required updates to that Plan of Care; and

- properly completed claim forms and proof, satisfactory to Us, that You are receiving covered care and services.

We will work with the Care Management Provider Agency to obtain these documents.

We will pay actual charges incurred for covered long-term care services (except for Stay at Home Expenses) up to the applicable International Coverage Benefit Amount as shown on the Policy Schedule.

Long-Term Care Services eligible for payment under the International Coverage Benefit include:

- confinement in a Nursing Facility or Residential Care Facility;
- Home and Community-Based Care.

No benefits are payable under the Stay at Home Benefit under the International Coverage Benefit.

In the event You elected the 10-year or lifetime benefit period, no benefit will be paid in excess of an amount equal to a 6-year Benefit Period times the Nursing Facility Daily Benefit.

Any benefit paid under this provision will reduce Your Policy Limit. All terms in the Policy will remain in effect. Any benefits paid will be paid in United States currency.

2.15 Your Right to Increase Benefits

On each Policy anniversary, **You** have the right to increase **Your** Policy benefits in one of the following methods:

- Increasing **Your** Nursing Facility Daily Benefit in $10 increments. The Residential Care Facility Daily Benefit, the Home and Community-Based Care Monthly Benefit and the **Policy Limit** will change accordingly in the same ratio to the Nursing Facility Daily Benefit that **You** had on the policy Date of Issue. Increases are not available at ages that exceed the highest age at which **We** will issue this policy series; or
- Increasing **Your Policy Limit** only. Increases are not available at ages that exceed the highest age at which **We** will issue this policy series.

If **You** elect to increase your coverage, **You** must make this request in writing and send it to us. **You** must meet the approval of **Our** underwriting department. The premium for this additional coverage will be based upon **Your** attained age on the date **You** make this request at the rates then in effect. If **We** approve **Your** request, **You** must pay an additional premium for the increase in coverage. The premium for **Your** underlying coverage will remain unchanged.

2.16 Your Right to Decrease Benefits

After **Your** first Policy anniversary, or in the event of a premium increase, **You** have a right to lower the premiums for this Policy in no fewer than the following ways:

- Reducing the Nursing Facility Daily Benefit (but not less than the minimum amount that was approved by the California Department of Insurance for this policy form). The Residential Care Facility Daily Benefit, the Home and Community-Based Care Monthly Benefit and the **Policy Limit** will decrease accordingly, in the same ratio to the Nursing Facility Daily Benefit that you had on the policy's Date of Issue; or

- Reducing **Your Policy Limit** (but not less than the minimum amount that was approved by the California Department of Insurance for this policy form); or
- Converting this Policy to a Nursing Facility and/or Residential Care Facility Only policy or Home Health Only policy, if **We** are then offering such policies for sale in California.

If **You** elect this option to decrease **Your** coverage by one of the methods described above, a request for the change must be made in writing to **Us** and is not subject to evidence of insurability. **Your** premium will be based on the reduced amount of coverage and **Your** original issue age. If **Your** policy is about to lapse, **We** will advise **You** of options to lower premium by reducing coverage and of the premium, if any, applicable to the reduced coverage.

2.17 Upgrade Privilege

The Upgrade Privilege allows **You** to keep **Your** long-term care coverage current with the latest product innovations. When **We** develop new benefits or benefit eligibility criteria that are not included in **Your** policy or if **We** market a new policy in California, **We** will notify **You** of the availability of the new benefits, benefit eligibility criteria or new policy within 12 months after receiving approval from the California Department of Insurance. This offer will not be available to **You** if **You** are receiving benefits under this Policy or are within an **Elimination Period** at the time of the offer. **You** will have an opportunity to upgrade to the new benefits, benefit eligibility criteria or the new policy in one of the following ways chosen by **Us**:

- **You** may add a rider to this Policy and pay any additional premium for the rider based on **Your** attained age. The premium that **You** paid for the benefits which **You** previously had under this Policy will remain unchanged based on **Your** age at time of issue; or
- **You** may replace this Policy with a subsequent Policy issued by **Us**. Consideration for **Your** past insured status will be recognized by providing a premium credit toward the premiums for the new policy. The premium credit shall be equal to 5% of the annual premium of this ("the prior") Policy for each full year this Policy was inforce. The premium credit shall be applied toward all future premium payments for the replacement policy. The maximum premium credit will not exceed 50%. No premium credit is available if the premium for the replacement policy is less than or equal to the premium for this policy or if any claim was filed under this Policy; or
- **You** may replace this Policy with a subsequent policy issued by **Us** where consideration for **Your** past insured status is recognized by providing a premium for the replacement policy that is based on **Your** issue age as of the original effective date of this Policy.

We will notify **You** of any additional premium amount that would be required to purchase the new benefits, benefit eligibility criteria or the new policy and what **You** must do to obtain the new coverage. If **You** elect to purchase the new coverage, it will be subject to the approval of our underwriting department.

2.18 Duplication of Benefits by Certain Programs

In the event that a non-Medicaid national or state long-term care program created through public funding substantially duplicates benefits covered by **Your** policy, **You** will be entitled to select either a partial refund of premiums paid or an increase in future benefits.

An actuarial method for determining the premium refunds and benefit increases will be mutually agreed upon by the California Department of Insurance and **Us**. The amount of the premium refunds or increases in future benefits to be made will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and claims experience.

PART 3 - EXCEPTIONS

This part describes what care, treatment or services will be excluded under the Policy and when the benefit will not be paid.

3.1 Exceptions

This Policy does not cover care or treatment:

- for intentionally self-inflicted injury.
- for alcoholism or drug abuse (unless the drug abuse was a result of the administration of drugs as part of treatment by a **Physician**.)
- due to war (declared or undeclared) or any act of war, or service in any of the armed forces or auxiliary units.
- due to participation in a felony, riot or insurrection.
- for which no charge is normally made in the absence of insurance.
- provided by a member of **Your Immediate Family**, unless
  - the family member is a regular employee of an organization which is providing the services; and
  - the organization receives the payment for the services; and
  - the family member receives no compensation other than the normal compensation for employees in his or her job category.
- provided outside the fifty United States, the District of Columbia and any country or territory except as provided under International Coverage section of this Policy.
- items and services furnished at **Your** request for beautification, convenience or entertainment.

3.2 Non-Duplication of Benefits

This Policy will only pay covered charges in excess of charges covered under any of the following:

- **Medicare** (including amounts not reimbursable by **Medicare** because of the application of a **Medicare** deductible or coinsurance amounts).
- any other governmental program (except **Medi-Cal** or **Medicaid**).
- any other health insurance or health plan, subscriber contract, HMO plan or prepayment plan or other long-term care insurance policies or certificates.
- any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law.

PART 4 - CLAIMS

This part explains when to file Your claim, the information We need to review, process and pay Your claim, and Your and Our rights and responsibilities.

HOW AND WHEN TO FILE A CLAIM

4.1 How To Provide Us with Notice of Claim

Early notification to **Our** Claims Department will facilitate a timely review of **Your** claim and avoid any delay in **Your** qualifying for benefits. Please let **Us** know immediately or in advance, whenever possible, when **You** need care or services covered by this Policy.

You can notify **Us** by:

- writing to **Us** at **Our** LTC Administrative Office; or
- by calling **Us** at **Our** LTC Administrative Office at 1-800-711-9181.

Your notice must include:

- **Your** name; and
- **Your** Policy number.

If **You** send **Us** written notice, **Your** notice must be mailed to **Us** postmarked within 45 days after a covered loss begins, or as soon as reasonably possible. If **You** notify **Us** by telephone, **You** must call **Us** within 30 days after a covered loss begins or as soon as reasonably possible. **We** will confirm, in writing, **Your** notification within 15 days after **We** receive such notification.

4.2 The Care Management Provider Agency's Role in the Claim Process

When **We** receive **Your** notice of claim, **We** will:

- immediately notify the **Care Management Provider Agency** that has been selected by **Us** and approved by the **California Partnership for Long Term**; and
- initiate **Your** Care Management Services Benefit.

Once **We** receive notice of **Your** claim, **We** will work with the **Care Management Provider Agency** to ensure that **We** understand **Your** condition, any prescribed **Plan of Care** and **Your** care needs.

The **Care Management Provider Agency** will perform a standardized objective assessment, which includes a face-to-face assessment, designed to evaluate **Your** condition and care and service needs.

If **You** qualify for benefits, the **Care Management Provider Agency** will work with **You** to implement a **Plan of Care** for **Your** care and service needs. Please note that **Your** personal **Physician** will not be able to develop a **Plan of Care** for this Policy unless he/she is also employed by the **Care Management Provider Agency** or is a qualified official designee of the **Care Management Provider Agency**. **Your Plan of Care** will specify the type of provider and frequency of care or services provided, regardless of whether the Policy provides reimbursement for such provider, care or services. The **Plan of Care** will also include a list of providers that **You** may consider. (However, **You** are not obligated to use such providers.) The **Plan of Care** will be updated periodically, as appropriate based upon **Your** condition. The **Care Management Provider Agency** will provide both **You** and **Us** with a copy of this **Plan of Care**.

The **Care Management Provider Agency** will perform a reassessment of **Your** individual needs at least every 6-months while **You** are receiving benefits. If **Your** condition so indicates, the **Care Management Provider Agency** may reassess **Your** needs more frequently. **We** may also agree to have the **Care Management Provider Agency** reassess **Your** needs at **Your** request. Such reassessment would determine if changes are needed to **Your Plan of Care** and recommend appropriate changes.

If **You** still need care or services when **Your** coverage under this Policy terminates, the **Care Management Provider Agency** will provide **You** with a care plan. If **You** are immediately eligible for Medi-Cal, the **Care Management Provider Agency** will prepare a transition plan for **You**.

4.3 Claim Forms and Proof of Loss

We will provide the **Care Management Provider Agency** with the appropriate claim forms and instructions for filing **Proof of Loss** once **We** are notified of **Your** claim. **We** are required to provide **You** with claim forms within 15 days after having received **Your** claim notification. If **We** do not provide **You** with the claim forms within 15 days after having received **Your** notification, **You** will be able to satisfy this **Proof of Loss** provision by giving **Us** written letter describing the nature and extent of **Your** loss.

The documentation which makes up **Proof of Loss** includes:

- a completed claim form, or letter as described above,
- **Your** personalized assessment,
- a **Plan of Care;** and
- itemized bills for **Your** care and services.

We or the **Care Management Provider Agency** will work directly with **Your** care or service providers to confirm any licensure or certification requirements as described in the Policy. **We** will also need a copy **Your** Medicare Explanation(s) of Benefits (or similar form) for other plans and programs subject to the Non-Duplication of Benefits provision to determine which expenses (if any are excluded from coverage. In addition, **We** may also request copies of medical records (or **We** may consult with **Your** primary **Physician** and care provider by telephone at **Our** option) or **Your** providers' daily notes of care.

Proof must be given to **Us** within ninety (90) days after the first **You** receive covered services at our **Our** LTC Administrative Office. Failure to give **Us** proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible for **You** to give proof within such time. However, the proof must be given to **Us** as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

In **Your** claim information packet, **We** will also enclose **Our** Advantage List, if such List is available in **Your** state at the time of **Your** claim notification. The Advantage List will include a listing of long-term care providers that offer discounts to **Our** policyholders. **We** will also provide the **Care Management Provider Agency** with information regarding the Advantage List so that the **Care Management Provider Agency** can assist **You** in **Your** decision regarding **Your** care and providers. These discounts can help **You** extend your long-term care benefits. Any unused portion of the applicable Daily or Monthly Benefit will remain in the **Policy Limit**. There is no penalty for using long-term care providers that are not included on this list. Discounts may only relate to certain services or may vary by provider. A provider can be added to, or removed from, this list at such provider's own or **Our** request at any time.

4.4 Our Claims Evaluation Process

Upon receiving **Your** notice of claim, **We** will work with **You**, the **Care Management Provider Agency**, **Your Physician**, **Your** care providers, or anyone acting on **Your** behalf, to obtain information about **Your** health and the care or services **You** are receiving. **We** will then make an objective review of all the information **We** receive to determine whether **You** qualify for benefits as well as the level of benefits for which **You** qualify. As part of **Our** review, **We** reserve the right to do a telephone interview, perform an on-site geriatric nursing assessment or require a physical exam when and as often as **We** may reasonably require while a claim is pending. **We** will pay for any interview, assessment or examination that **We** request.

4.5 Time of Payment of Claims

We will pay benefits for any loss covered by this Policy provided **We** receive **Proof of Loss** as described above. **We** will make these payments on a monthly basis, after services have been rendered.

4.6 Payment of Claims

While **You** are living, all benefits will be paid to **You** unless there is an assignment of benefits. An assignment of benefits is **Your** or **Your** legal representative's request for payments to be sent to someone other than **Yourself**. If **You** have made an assignment of benefits, **We** will send the payments to **Your** care provider or the individual **You** or **Your** legal representative have designated.

Any accrued benefits unpaid at **Your** death will be paid to **Your** estate, or any care provider or individual to whom **You** or **Your** legal representative have assigned benefits. At **Our** option, any benefit of $1,000 or less may be paid to an alternative payee who is deemed by **Us** to be justly entitled to the benefit. **We** will be fully discharged to the extent of any payment made in good faith under this paragraph.

4.7 Misstatement of Age

If **Your** age has been misstated, **Your** Policy benefits will be those that the premium paid would have purchased at **Your** correct age. As a result of such misstatement, **We** may have issued a Policy which would not have been issued to **You** had such misstatement not occurred. In that case, **Our** liability under any such Policy will be limited to refund of the premium paid.

4.8 Appeals

We will notify **You** in writing if **We** do not approve **Your** claim and provide **You** with a written explanation of the reasons for the denial. **You** will then have the right to appeal **Our** claims decision on eligibility, care plans, services, provider and claim payment amounts, and request that **We** make all information directly related to such denial available to **You**. **We** will provide **You** with such requested information within 60 days from the date **We** receive **Your** written request.

You must put this appeal or request for information in writing (no special form is necessary) and send it to:

John Hancock Life Insurance Company
LTC Administrative Office
333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203
Attn: Manager of Claims Administration.

In **Your** appeal, **You** should:

- state why **You** disagree with **Our** determination;
- state what other factors (if any) **We** should take into consideration; and
- identify whom **We** could contact (including names, addresses, and phone numbers) to gather any additional pertinent information regarding **Your** care.

You may authorize someone else to act for **You** in this appeals process. **We** have a Claim Appeals Review Board that will consider **Your** appeal. If the Board needs additional information to objectively evaluate **Your** appeal, they will use at least one of the following resources:

- a Physician Advisor who is a **Physician** living near **You** who will assess **Your** condition and report it to **Us**;
- an on-site geriatric assessment; or
- medical records from **Your Physician**(s) and/or provider(s) of care.

All requests for information will be at **Our** expense.

The Claim Appeals Review Board will then make one of two determinations:

- overturn the initial claim determination and pay any benefits due; or
- uphold the initial claim determination.

4.9 Legal Action

You cannot bring suit against **Us** to recover on this Policy during the 60 days after written **Proof of Loss** has been given to **Us**, as required by this Policy. Also, **You** cannot bring suit against **Us** to recover on this Policy after three years from the date a claim is denied.

PART 5 - PREMIUMS AND REINSTATEMENT

This part explains what happens if You do not pay the premium for this Policy when it is due.

WHEN AND WHERE PREMIUMS ARE PAYABLE

5.1 Payment of Premiums

Payment of the First Premium will keep this Policy in effect for the First Premium payment period. This period starts at 12:01 a.m. on the Date of Issue. It ends at midnight of the day before the next premium due date, subject to the Grace Period provision below. The above times refer to Standard Time at the place where **You** then reside. Each premium, after the first, is due at the end of the period for which the preceding premium was paid. Policy years, months and anniversaries are measured from the Date of Issue.

Premiums must be paid at **Our** LTC Administrative Office or to any of **Our** duly authorized agents. If a premium is paid to an agent, **We** will provide a receipt in exchange for such payment. A receipt will be valid only if signed by **Our** President or Secretary. To be valid, it must also be countersigned by the agent. Payment of a premium will not keep this Policy in effect beyond the period for which it is paid, except as may be otherwise provided in this Policy.

You may elect to pay **Your** premium on an annual, semi-annual, quarterly or monthly basis. **You** may change **Your** mode of premium payment by making a written request to **Us** at **Our** LTC Administrative Office. Please note that the more often you pay, the higher your premium amount will be per year. Additional premium charges are included for semi-annual, quarterly, and monthly premiums. These charges are called “modal fees”. These fees are based upon the following modal factors and are used to determine the premium amount for all payment options. The modal factors are 1.00 for annual, .52 for semi-annual, .27 for quarterly and .09 for monthly. To calculate **Your** approximate total annual premium payment based on **Your** current policy selection:

- multiply the “Base Policy Premium” as shown on the Policy Schedule by the factor associated with **Your** selected mode of payment, and then
- multiply that result by the number of payments required in a year based upon **Your** selected payment mode.

5.2 Grace Period & Termination of This Policy

This Policy has a 65-day Grace Period. If a renewal premium is not paid within 30 days from the date that it is due, **We** will provide written notification of the unpaid premium to **You** and the person or persons **You** designate to receive such notice at the addresses **You** provided to **Us**. **You** have an additional 35-day period to pay the premium after **We** have mailed this notice. During the Grace Period this Policy will stay in effect. If **We** do not receive the premium payment before the end of the Grace Period, this Policy will terminate.

Your application may name the person or persons to receive such notice. **You** may change the designation at any time. **We** will provide **You** with a reminder of the right to change this written designation every year.

REINSTATEMENT AND LAPSE PROTECTION

5.3 Reinstatement

An application and payment of premium is required by **Us** to reinstate the policy. If the application is approved, the Policy will be reinstated as of the termination date. If it is disapproved, **We** will inform **You** in writing within 45 days after the date of the conditional receipt. If **We** fail to inform **You**, the Policy will be reinstated upon such 45th day. Later acceptance of the premium by **Us**, without requiring an application for reinstatement, will reinstate the Policy.

The reinstated Policy will cover only loss due to an injury sustained or physical or mental condition that begins after the date of reinstatement. Except for this and any new provisions added in connection with reinstatement, **Your** rights and **Ours** under this Policy will be the same as they were just before the Policy terminated. A physical or mental condition will be considered to have begun when advice is supplied or treatment is recommended by or received from a **Physician**.

5.4 Added Protection Against Lapse

If **Your** Policy terminates because **You** did not pay the premium due, while **You** would meet the eligibility for the payment of benefits, **You** may request that this Policy be reinstated. Such request for reinstatement must be made within 5 months of the date of termination. In addition **You** must meet the following conditions:

- **You** must furnish **Us** with satisfactory proof that **You** would have qualified for benefits (if not for the **Elimination Period**) on the date of termination; and
- **You** must pay all the unpaid overdue premiums.

REFUND OF UNEARNED PREMIUMS

5.5 Refund of Unearned Premiums at Death

Upon receipt of notice that **You** have died, **We** will refund the premium paid for any period beyond the date of death. Such refund will be made to an alternative payee, if any (see Payment of Claims provision), otherwise to **Your** estate.

PART 6 - GENERAL PROVISIONS

This part explains some of the important provisions that affect Your rights and Our rights under this Policy.

6.1 Entire Contract and Changes

This Policy is a legal binding contract between **You** and **Us**. This entire contract is made up of:

- the Policy;
- the application;
- any riders and endorsements; and
- any attached papers.

No change to this Policy will be valid until approved by **Our** President or Secretary. To be valid, such approval must also be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions. If **We** change **Our** address or **Our** toll-free telephone number, **We** will notify **You**.

Unless **You** request the change in writing or the change is required by law, no change will be made to this Policy after its Date of Issue without **Your** signed acceptance.

6.2 Time Limit on Certain Defenses

If this Policy has been in effect for less than six months, **We** may rescind it or deny an otherwise valid claim if the application contained a misrepresentation that is material to the acceptance of **Your** application.

If this Policy has been in effect for at least six months but less than two years, **We** may rescind it or deny an otherwise valid claim if the application contained a misrepresentation that is both:

- material to the acceptance of **Your** application; and
- pertains to the condition for which the claim is made.

After this Policy has been in effect for two years, it is incontestable except for relevant facts relating to **Your** health that **You** knowingly and intentionally misrepresented.

In the event this Policy is rescinded after **We** have paid benefits, **We** may not recover the payments already made.

6.3 Dividend Participation

Dividends are not paid for this class of policies.

6.4 Assignment

We will not be on notice of any assignment unless it is in writing, nor until a duplicate of the original has been received at **Our** LTC Administrative Office. **We** assume no responsibility for the validity or sufficiency of any assignment.

6.5 Conformity with State Laws

Any part of this Policy which is in conflict with the laws of the state in which **You** reside on the Date of Issue is amended to conform to the minimum requirements of such laws.

6.6 Right to Recovery

If **We** make payments with respect to benefits in a total amount which is, at any time, in excess of the benefits payable under the provisions of this Policy, **We** will have the right to recover such excess from:

- any persons to, or for, or with respect to whom, such payments were made; and
- any organization which should have made such payments.

6.7 Federal Income Tax Treatment of this Policy

Long-term care insurance was granted favorable federal income tax treatment in the Health Insurance Portability and Accountability Act of 1996. Policies meeting certain criteria outlined in this Act are eligible for this treatment. To the best of **Our** knowledge, **We** have designed this Policy to meet the requirements of this law. This Policy is intended to be a qualified long-term care contract under Section 7702B(b) of the Internal Revenue Code and may qualify you for federal and state tax benefits. If, in the future, it is determined that this Policy does not meet these requirements, **We** will make every reasonable effort to amend the Policy if **We** are required to do so in order to gain such favorable federal income tax treatment. **We** will offer **You** an opportunity to receive these amendments.

PART 7 – ASSET PROTECTION

This section explains the California Partnership for Long-Term Care, Medi-Cal Asset Protection and when it begins, the Medi-Cal Property Exemption and how You will be notified of the amount of protected assets which apply toward Your Medi-Cal Property Exemption, and the services that qualify for Medi-Cal Property Exemption.

7.1 California Partnership for Long-Term Care

The State of California has developed a partnership between private insurance companies and Medi-Cal. Individuals who purchase private long term care insurance policies that meet the requirements of the California Partnership for Long-Term Care will not need to impoverish themselves if they later need Medi-Cal assistance. Instead, they will be able to protect one dollar of assets for every one dollar the private insurance policy pays out for state-approved services.

7.2 Medi-Cal Asset Protection

Medi-Cal Asset Protection is a right extended to **You** by California law when **You** use the benefits of this Policy. This right allows **You** to protect one dollar of **Your** assets for every dollar this Policy pays out in benefits, in the event **You** later apply for Medi-Cal benefits or for other qualifying State long term care benefits. The amount of this Asset Protection at any time is equal to the sum of all benefit payments made for **Your** care by this Policy. Should **You** later apply for Medi-Cal benefits or other qualifying public long term care benefits, **You** will not be required to expend **Your** protected assets prior to becoming eligible for these public benefits. **Your** protected assets will also be exempt from any claim the State of California may have against **Your** estate to recover the costs of State-paid long-term care or medical services provided to **You**.

We will send **You** a quarterly statement, while **You** are receiving benefit payments under this Policy, showing the total amount of benefits paid for Services Which Count Toward **Your** Medi-Cal Property Exemption.

7.3 Medi-Cal Property Exemption

The total equity value of real and personal property not otherwise exempt under Medi-Cal regulations equal to the sum of qualifying insurance benefit payments made by Us on **Your** behalf for Services Which Count Toward **Your** Medi-Cal Property Exemption in determining **Your** eligibility for the Medi-Cal program under Title 22, California Code of Regulations.

7.4 Services Which Count Toward Your Medi-Cal Property Exemption

All services that are covered by this Policy and for which **We** have paid any of the following benefits will qualify for the Medi-Cal Property Exemption:

- Nursing Facility Benefits;
- Residential Care Facility Benefits;
- Home and Community-Based Care Benefits;
- Respite Care;
- Stay at Home Benefit; and
- Care Management Services Benefits for coordinating **Your** care and monitoring the services **You** receive.

PART 8 - INFLATION COVERAGE

This part explains how Your Nursing Facility Daily Benefit, Residential Care Facility Daily Benefit, Home and Community-Based Care Monthly Benefit, Stay at Home Lifetime Benefit and Respite Care Benefit will increase each year to provide protection against the increasing cost of long-term care due to inflation.

SIMPLE INFLATION COVERAGE

Annual Increase in the Nursing Facility Daily Benefit, Residential Care Facility Daily Benefit, Home and Community-Based Care Monthly Benefit, Stay at Home Lifetime Benefit and Respite Care Benefit

We will increase the Nursing Facility Daily Benefit, Residential Care Facility Daily Benefit, Home and Community-Based Care Monthly Benefit**,** Stay at Home Lifetime Benefit and Respite Care Benefit shown in the Policy Schedule by five percent (5%) of the original amount on each Policy anniversary. Such increases will continue automatically while this Policy is in effect.

We will determine each applicable Benefit by multiplying the original Daily and Monthly Benefits, as shown in the Policy Schedule, by the applicable factor shown below, and rounding the result to the nearest dollar.

Policy Anniversary	Factor	Policy Anniversary	Factor
1	1.05	12	1.60
2	1.10	13	1.65
3	1.15	14	1.70
4	1.20	15	1.75
5	1.25	16	1.80
6	1.30	17	1.85
7	1.35	18	1.90
8	1.40	19	1.95
9	1.45	20	2.00
10	1.50	etc.	etc.
11	1.55		

When such Benefits are increased, the Policy Limit will be increased by the same percentage as the increase in the Daily and Monthly Benefits and rounded to the nearest dollar.

Annual inflation increases:

- will occur even if **You** are on claim; and
- will not be affected by the payment of claims.

Inflation adjustments will apply to all Policy benefits as well as any optional riders that **You** may elect.

The premium for this inflation coverage is included in Your Policy premium. Your premium will not change, except as described in the Policy.

PART 8 - INFLATION COVERAGE

This part explains how Your Nursing Facility Daily Benefit, Residential Care Facility Daily Benefit, Home and Community-Based Care Monthly Benefit, Stay at Home Lifetime Benefit and Respite Care Benefit will increase each year to provide protection against the increasing cost of long-term care due to inflation.

COMPOUND INFLATION COVERAGE

Annual Increase in the Nursing Facility Daily Benefit, Residential Care Facility Daily Benefit, Home and Community-Based Care Monthly Benefit, Stay at Home Lifetime Benefit and Respite Care Benefit

We will increase the Nursing Facility Daily Benefit, Residential Care Facility Daily Benefit, Home and Community-Based Care Monthly Benefit, Stay at Home Lifetime Benefit and Respite Care Benefit shown in the Policy Schedule on each Policy anniversary, while this Policy is in effect, beginning with the first Policy anniversary. Such increase will be computed at the rate of 5% compounded annually and rounded to the nearest dollar. In other words, each Benefit in effect for the immediately preceding Policy year will be increased by 5% and rounded to the nearest dollar.

When the Daily and Monthly Benefits are increased, the Policy Limit will be increased by the same percentage as the increase in the Benefits and rounded to the nearest dollar.

Annual inflation increases:

- will occur even if **You** are on claim; and
- will not be affected by the payment of claims.

Inflation adjustments will apply to all Policy benefits as well as any optional riders that **You** may elect.

The premium for this inflation coverage is included in Your Policy premium. Your premium will not change, except as described in the Policy.

COPY OF APPLICATION

NOTE: Examine this copy carefully. If You find any error or omission, write or contact Our LTC Administrative Office immediately. Please explain fully the error or omission and give Us Your policy number.

LONG-TERM CARE INSURANCE

Countersigned (When required by law or regulation)

Date _____ _____
Resident Licensed Agent

NOTICE

If You have any questions about this Policy, write Us at Our LTC Administrative Office, 333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203 or call Us toll-free at 1-800-711-9181.

John Hancock Life Insurance Company
Boston, Massachusetts

ENDORSEMENT

NONFORFEITURE BENEFIT

This Endorsement explains how benefits under Your Policy may be continued even after Your Policy lapses.

General

This Endorsement is part of the Policy to which it is attached. It is subject to all the provisions of the Policy unless otherwise provided below. After this Endorsement is added, it cannot be removed.

Nonforfeiture Benefit

After **Your** Policy and this Endorsement have been in effect for three (3) years, **We** cannot terminate **Your** Policy because you failed to pay the required premium within the Grace Period. Instead, this Endorsement modifies the Policy Limit and changes **Your** Policy to paid up status where no further premium is due.

Amount of Nonforfeiture Benefit

The new Policy Limit on the effective date of **Your** paid up status will be equal to the total premium **You** have paid minus any benefits ever paid under **Your** Policy. However, in no event will the new Policy Limit ever be less than:

- thirty (30) times the Nursing Facility Daily Benefit (minus any benefits ever paid under **Your** Policy) after Your Policy has been in effect for three (3) years;

- ninety (90) times the Nursing Facility Daily Benefit (minus any benefits ever paid under **Your** Policy) after Your Policy has been in effect for ten (10) years.

All benefit limits found in the Policy will continue to increase annually due to the inflation coverage provision found in **Your** Policy.

No benefits will be paid in excess of the Policy Limit or any other benefit limit that would have been in effect if **You** had continued to pay premiums as required.

If **Your** Policy has been in effect for <u>less</u> than three (3) years, no Nonforfeiture Benefit is payable and **Your** Policy will terminate.

Effective Date

This Endorsement is effective as of the Effective Date of the Policy, unless a different date is shown below.

Date:

Signed for the Company at Boston, Massachusetts:

Secretary President

John Hancock Life Insurance Company
Boston, Massachusetts

SHAREDCARE BENEFIT RIDER

This Rider allows Your Partner to access the available benefits under Your policy once benefits under Your Partner's policy have been exhausted.

IMPORTANT NOTICE - The SharedCare Rider allows **Your Partner** to access benefits under **Your** Policy. This means that once **Your Partner** exhausts benefits under his/her policy, **Your Partner** could then access and potentially exhaust full benefits under **Your** Policy.

General

This Rider is part of the Policy to which it is attached. It is subject to all the terms of this Policy unless otherwise provided below.

You have designated **Your Partner** as the SharedCare Secondary Insured under **Your** policy. This designation will allow **Your Partner** to access available benefits under **Your** policy if, and only if:

- **Your Partner** has added an identical SharedCare Benefit Rider to his or her policy, naming **You** as the Secondary Insured under that policy; and
- benefits are first exhausted under **Your Partner's** own policy.

IMPORTANT NOTICE REGARDING THE IMPACT OF THE SHAREDCARE RIDER ON ASSET PROTECTION

The amount of assets protected under a policy approved under this Program is equal to the amount of benefits paid under such policy. However, asset protection is only available to the individual actually receiving the benefits. This means that if You receive benefits under this Policy, your assets will be protected, with the specific dollar amount of Your assets to be protected being dependent upon the amount of benefits You, as an individual, receive. If Your Partner is accessing benefits under Your Policy due to the operation of this Rider, You will not receive asset protection for any benefits paid out on Your Partner's behalf. It is Your Partner who is entitled to the asset protection. Asset protection is <u>not</u> transferable between partners. In addition, continued access by Your Partner to Your Policy benefits could lead to the exhaustion of Your Policy Limit. In such an event Your Policy will terminate. Because it is Your Partner who is entitled to the asset protection for benefits paid out on Your Partner's behalf, You may not be able to avail Yourself of the asset protection benefit under the California Long-Term Care Insurance Program.

DEFINITIONS

The following terms have special meaning for use in this Rider:

You, **Your** and **Yourself** means the person listed in the Policy Schedule as the Insured.

Your Partner means the person named as the SharedCare Secondary Insured in the Policy Schedule.

THE SHAREDCARE BENEFIT AND HOW IT WORKS

SharedCare Benefit

If **Your Partner** exhausts the available benefits payable under his or her policy, **We** will automatically continue **Your Partner's** claim subject to the terms and Policy Limit of **Your** Policy.

However,

- **Your Partner** must satisfy the **Elimination Period** under his or her policy; and
- **We** will calculate benefits paid on behalf of **Your Partner** according to the applicable Daily or Monthly Benefit found in **Your Partner's** policy prior to its termination.

You and **Your Partner** may both receive benefits under **Your** Policy at the same time. If that happens, the applicable benefit limits specified in **Your** Policy will continue to apply to **You**. **Your Partner's** claim will be paid as described above. However, in no event will **We** pay benefits that exceed the maximum Policy Limits of both policies combined.

We will provide **You** with written notification when **Your Partner** begins to access benefits under **Your** Policy.

EXHAUSTION OF BENEFITS

What Happens if Benefits Have Been Exhausted Under Your Partner's Policy

In the event **Your Partner** exhausts the benefits under his or her policy, **Your Partner** may maintain access to **Your** Policy if **You** keep this Rider in force. **You** may keep this Rider in force by the timely payment of the Rider premium. Any benefits remaining under **Your** Policy will then be available to both of **You**. When accessing benefits under **Your** Policy:

- **Your Partner** must satisfy the **Elimination Period** under his or her policy; and
- **We** will calculate benefits paid on behalf of **Your Partner** according to the applicable Daily or Monthly Benefit found in **Your Partner's** policy prior to its termination.

In the event that the Policy Limit under both **Your** and **Your Partner's** policies are exhausted, this Rider will terminate.

WHAT HAPPENS IF YOU OR YOUR PARTNER DIE

SharedCare Continued Access

If **You** or **Your Partner** die, **We** will automatically increase the survivor's Policy Limit by the amount of the deceased Partner's remaining Policy Limit, if any. **We** will provide the survivor with written verification of the new Policy Limit and the new Policy premium. The new Policy premium is equal to the survivor's base Policy premium, including the premium for any endorsements/riders (except for SharedCare.)

WHAT HAPPENS IF YOUR PARTNER EXHAUSTS YOUR POLICY BENEFITS

SharedCare Election to Increase Benefits

In the event Your Partner exhausts Your Policy benefits, You may elect to purchase an additional two (2) year Benefit Period. This means Your Policy Limit will be restored to an amount equal to the Nursing Facility Daily Benefit then in effect times 730-days. Any other benefit amounts will also be restored to the same level that were in effect on the date Your Policy Limit was exhausted. Except for SharedCare, all other optional benefit riders and endorsements will also be restored. Your Partner will no longer have access to Your Policy benefits.

This election will not be available to You (and, if requested, will not take effect) if:

- You have been eligible for benefits during the two year period prior to the date Your Policy Limit was exhausted; or
- the date Your Policy Limit is exhausted occurs on or after Your 91st birthday.

We will notify You of the exhaustion of Your Policy Limit and Your right to increase Your Policy Limit. You must notify Us in writing within 60 days of the date of this notice that You elect to increase your Policy Limit as described above. No underwriting will be required. The premium payable for this increase will be based upon the Benefit Amounts then in effect and Your attained age on the date the Policy Limit is increased.

WAIVER OF PREMIUM

Waiver of Premium

We will apply the Waiver of Premium Benefit provision in **Your** Policy if **You** are receiving benefits under **Your** Policy. **We** will not waive premium under **Your** Policy because **Your Partner** is receiving benefits.

WHEN THIS RIDER WILL END

Termination of This Rider

You may continue this Rider until one of the events listed below occurs. **We** cannot cancel this Rider unless one of these events occur.

This Rider will end upon the earliest occurrence of any of the following:

- the date on which the premium for **Your** Policy and/or this Rider is not paid when due, subject to the Grace Period provision of **Your** Policy;
- the date **Your** Policy terminates for any cause;
- the date **We** receive written notice at **Our** LTC Administrative Office that **You** elect to terminate this Rider;
- the date **You** or **Your Partner** dies;
- the date the SharedCare Benefit Rider on **Your Partner's** policy is terminated for any reason other than exhaustion of benefits under that policy;
- the date benefits are exhausted under both **Your** Policy and **Your Partner's** Policy; or
- the date **You** elect to revise **Your** Policy in a manner which the benefit levels or benefit options under **Your** Policy are no longer identical to those of **Your Partner**.

The termination of this Rider will not affect **Your** Policy, except that any benefits paid under it on behalf of **Your Partner** will be deducted from the applicable Policy Limit.

Divorce or dissolution of marriage will not automatically terminate this Rider. Nor will divorce or dissolution of marriage cause the premiums of this Rider to increase.

Effective Date

This Rider will be effective as of the Effective Date, unless another date is noted below:

Date:

Signed for the Company at Boston, Massachusetts:

Secretary President

John Hancock Life Insurance Company
Boston, Massachusetts

An Approved Participant In
CALIFORNIA PARTNERSHIP FOR LONG TERM CARE

Survivorship & Waiver of Premium Benefit Rider

This Rider provides that Your premiums will be waived in the event Your Partner dies or goes on claim after a 10-year claim free period.

General

This Rider is a part of the Policy to which it is attached. It is subject to all the provisions of the Policy unless otherwise provided below.

For purposes of this Rider, "Your Partner" refers to the individual named as **Your Partner** in the application or enrollment form for this Rider.

THE SURVIVORSHIP BENEFIT AND HOW IT WORKS

Survivorship Benefit

If **Your Partner** dies, **Your** Policy will be fully paid up and no further premium payments will be required for **Your** Policy if both of the following conditions have been met:

- on the date of **Your Partner's** death, both **You** and **Your Partner** had individual long-term care insurance policies inforce with **Us** (other than under a Nonforfeiture Benefit, if any) for a period of 10 consecutive full years;
- no benefits (except for Care Advisory Services) were paid to **You** or **Your Partner** under either of such policies during the first10 years these policies were in force; and
- on the date of Your Partner's death, this Rider had been inforce for at least 10-years.

In order for **Us** to provide **You** this benefit, **You** must first notify **Us** in writing at our LTC Administrative Office of the death of **Your Partner**.

Premiums will not be waived for any benefits added after the death of **Your Partner** due to the operation of this Rider.

THE WAIVER OF PREMIUM BENEFIT AND HOW IT WORKS

Waiver of Premium Benefit

We will waive the premium for **Your** Policy if the premium for **Your Partner's** policy is waived by **Us** and all of the following conditions have been met:

- on the date the premium under **Your Partner's** policy is waived, both **You** and **Your Partner** had individual long-term care insurance policies inforce with **Us** (other than under a Nonforfeiture Benefit, if any) for a period of 10 consecutive full years;

- no benefits (except for **Care Advisory Services**) were paid to **You** or **Your Partner** under either of such policies during the first10 yearsthese policies were in force; and

- on the date the premium under Your Partner's policy is waived, this Rider had been inforce for at least 10-years.

Your waiver period will begin on the day after **Your Partner's Elimination Period** has been satisfied. **You** must resume paying premiums on the earlier of the following dates:

- the date the premiums under **Your Partner's** policy is no longer waived; or

- the date **Your Partner's** policy terminates due to exhaustion of benefits.

If **Your** premium has been paid for a period for which premiums are waived under this Rider, **We** will refund the premium for such period. In order to keep this Policy in effect after the waiver of premium period ends, payment of premiums must be resumed.

Premiums will not be waived for any benefits added to **Your** Policy after premiums have been waived due to the operation of this Rider.

WHEN THIS RIDER WILL END

Termination of This Rider

You may continue this Rider until one of the events listed below occurs. **We** cannot cancel this Rider unless one of these events occur. This Rider will end upon the earliest occurrence of any of the following:

- the date **We** receive written notice at **Our** Home Office that **You** elect to terminate this Rider;

- the date on which the premium for **Your** Policy and/or this Rider is not paid when due, subject to the Grace Period provision of **Your** Policy; or

- the date **Your** Policy terminates for any cause.

If **Your Partner** dies and **You** have not met the conditions necessary to qualify for benefits under this Rider, please notify **Us** of the death in writing at our [Home Office], so that **We** can remove this Rider and its associated premium cost.

Divorce or dissolution of marriage will not automatically terminate this Rider. Nor will divorce or dissolution of marriage cause the premiums of this Rider to increase.

Signed for the Company at Boston, Massachusetts:

Secretary President

John Hancock Life Insurance Company
Boston, Massachusetts

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CALIFORNIA PARTNERSHIP FOR LONG TERM CARE

Waiver of the Home and Community-Based Care Elimination Period Benefit

Optional Benefit Rider

This Rider will waive the requirement to satisfy the Elimination Period if You are receiving Home and Community-Based Care.

This Rider is a part of, and should be attached to Your Policy. It is subject to all the provisions of the Policy unless otherwise provided below.

Waiver of the Elimination Period

We will waive the requirement that You satisfy the Elimination Period before receiving benefits if You are:

- eligible for the payment of benefits under the Policy; and
- receiving any of the following care --
  - Home and Community Based Care; or
  - Hospice Care in Your Home, a Nursing Facility or Residential Care Facility.

You still must satisfy Your Elimination Period before benefits are payable under the Nursing Facility or Residential Care Facility Benefits for confinement in a Nursing Facility or an Residential Care Facility. In addition, You must satisfy Your Elimination Period before Your premiums are waived under the Waiver of Premium provision. However, days that You receive Home and Community Based Care may be used to satisfy Your Elimination Period.

The Waiver of the Elimination Period Benefit is only applicable if You are receiving care or services within the fifty (50) United States and the District of Columbia and does not apply to the International Coverage Benefit.

Termination

This Rider will terminate when the Policy terminates, or when the Policy is continued under the provisions of any nonforfeiture benefit.

Signed for the Company at Boston, Massachusetts:

Secretary