



Individual Long-Term Care Insurance

New York Partnership Sample Policy

**If you have any questions, please call
LTC Support Services toll-free at
1-800-377-7311**

John Hancock Life & Health Insurance Company, Boston, MA 02117

**John Hancock Life Insurance Company
Boston, Massachusetts**



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 Our LTC Administrative Office. We will then refund any premium paid, and the Policy will be treated as if it had never been issued.

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 First Premium on or before the date this Policy is delivered to You.

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, or if You fail to include all material medical information requested, 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. As long as You pay the required premium, 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. We reserve the right to increase Your premium as of any premium due date; however, any changes in premium rates must apply to all similar policies issued in Your state on this Policy form and be approved by the Superintendent of Insurance of the State of New York. This means We cannot single You out for an increase because of any change in Your age or health. In addition, We cannot change the provisions of this Policy without Your consent unless we are required to do so by federal or state government officials due to this policy's participation in the New York State Partnership for Long Term Care Program.

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. 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.

ALTERNATIVE DISPUTE RESOLUTION. If the Partnership advises You that Your claim may have been denied in error, You may waive Your right to filing a suit and request arbitration of that denial. We will pay all arbitration fees. The arbiter's decision will be binding on both You and Us. Please see the Benefit Authorization Request Denials provision in the Claims section of the Policy.

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.

THIS POLICY HAS BEEN APPROVED BY THE DEPARTMENT OF INSURANCE UNDER THE NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE PROGRAM. FOR MEDICAID PROTECTION AVAILABLE AFTER EXHAUSTION OF THE POLICY BENEFITS, PLEASE REFER TO THE CONSUMER PARTICIPATION (STATE-CONSUMER) AGREEMENT WHICH YOU SIGNED.

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Insured: [Jane Hancock] **Effective Date of Coverage:** [January 1, 2006]
Policy Number: [H 9000 000] **First [Annual] Premium: ***** \$[XXXXXX.XX]
Policy Form: NYP-05
Policy Title: 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.

Coverage Limits:

Elimination Period: [XXX] Dates of Service
Benefit Period: [XX] Years
Policy Limit*: \$[XXXXXX]
Nursing Home Benefit Amount*: \$[XXX] per day
Assisted Living Facility Benefit Amount*: \$[XXX] per day
Home Health Care Benefit Amount*: \$[XXX] per day
Respite Care Benefit Amount*: \$[XXX] per day
In-Hospital Waiting List Benefit Amount*: \$[XXX] per day

[Additional Stay at Home Lifetime Benefit Amount*: \$[XXX]]

* Subject to increases due to inflation coverage, if any.

[Compound Inflation Coverage]

Base Policy Premium: \$[XXX] Annual Premium

Optional Benefits Selected and Included in this Policy:

[Additional Stay at Home Benefit \$[XXX] Annual Premium]
[Waiver of Premium Benefit \$[XXX] Annual Premium]
[Monthly Home Health Care Benefit \$[XXX] Annual Premium]
[Nonforfeiture Benefit \$[XXX] Annual Premium]

Total Policy Annual Premium including Optional Benefits: \$[XXX] Annual Premium

Total Premium Payment Options (includes all optional benefits):

	<u>Annual</u>	<u>Semi-Annual</u>	<u>Quarterly</u>	<u>Monthly</u>
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. 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.

[This Schedule replaces any prior Schedule as of MO/DD/YR.]

POLICY SCHEDULE - (continued)

Minimum Coverage Required Under this Partnership Policy & Asset Protection

*{Insert the following for **Total Asset Plan 3/6/50**:}*

[As a participant in the New York Partnership for Long Term Care Program (“Partnership”), You are eligible to apply for Medicaid without regard to the type or amount of assets You possess so long as You use the benefits of Your policy for the required minimum duration. This means that this Policy must cover You for a minimum of at least: 3 years in a Nursing Home; 6 years for Home Health Care or confinement in an Assisted Living Facility; or combination of the two. In addition, two days of Home Health Care or confinement in an Assisted Living Facility equals one day of Nursing Home confinement. Please always take into consideration how any change You may make to Policy benefits will impact Your eligibility for Medicaid asset protection.

Important Reminder. While Your assets may be protected, You are required to apply Your **income** toward the cost of care in accordance with Medicaid requirements. Please carefully review Your Consumer Participation Agreement for additional information regarding Partnership and Medicaid requirements.]

*{Or insert the following for **Dollar Asset Plan 1.5/3/50**:}*

[As a participant in the New York Partnership for Long Term Care Program (“Partnership”), You are eligible to apply for Medicaid and protect a portion of Your assets equal to the amount of benefits paid under this Policy so long as You use the benefits of Your policy for the required minimum duration. This means that this Policy must cover You for a minimum of at least: 18-months in a Nursing Home; 3 years for Home Health Care or confinement in an Assisted Living Facility; or combination of the two. In addition, two days of Home Health Care or confinement in an Assisted Living Facility equals one day of Nursing Home confinement. Please always take into consideration how any change You may make to Policy benefits will impact Your eligibility for Medicaid asset protection.

Important Reminder. While Your assets may be protected, You are required to apply Your **income** toward the cost of care in accordance with Medicaid requirements. Please carefully review Your Consumer Participation Agreement for additional information regarding Partnership and Medicaid requirements.]

*{Or insert the following for **Dollar for Dollar Asset Plan 2/2/100**:}*

[As a participant in the New York Partnership for Long Term Care Program (“Partnership”), You are eligible to apply for Medicaid and protect a portion of Your assets equal to the amount of benefits paid under this Policy so long as You use the benefits of Your policy for the required minimum benefit duration period. This means that this Policy must cover You for a minimum of at least 24-months in a Nursing Home, Assisted Living Facility or at Home. Please always take into consideration how any change You may make to Policy benefits will impact Your eligibility for Medicaid asset protection.

Important Reminder. While Your assets may be protected, You are required to apply Your **income** toward the cost of care in accordance with Medicaid requirements. Please carefully review Your Consumer Participation Agreement for additional information regarding Partnership and Medicaid requirements.]

{Or insert the following for **Total Asset Plans 4/4/100 & 6/6/100:**}

[As a participant in the New York Partnership for Long Term Care Program (“Partnership”), You are eligible to apply for Medicaid without regard to the type or amount of assets You possess so long as You use the benefits of Your policy for the required minimum benefit duration period. This means that this Policy must cover You for a minimum of at least 48-months in a Nursing Home, Assisted Living Facility or at Home. Please always take into consideration how any change You may make to Policy benefits will impact Your eligibility for Medicaid asset protection.

Important Reminder. While Your assets may be protected, You are required to apply Your **income** toward the cost of care in accordance with Medicaid requirements. Please carefully review Your Consumer Participation Agreement for additional information regarding Partnership and Medicaid requirements.]

***** 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. Any change in premium is subject to the approval by the Superintendent of Insurance of the State of New York.

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. Any change in premium is subject to the approval by the Superintendent of Insurance of the State of New York.]

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. Defined terms are presented with capital letters to help You easily identify them.

We urge You to pay special attention to facility and care provider definitions. The terms used in this Policy are Our way of referencing the collection of information contained in the definition.

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; or 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. Eating does not include preparing a meal.
- *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. Transferring does not include the task of getting into or out of the tub or shower.

Adult Day Care means social and health-related services provided during the day in a community or group setting. The purpose of the program is to support frail or impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center means a place that is licensed to provide Adult Day Care by the jurisdiction in which the services are provided. If licensing is not required, Adult Day Care Center means a place that provides Adult Day Care in a community or group setting of six (6) or more persons, 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. An Adult Day Care Center is a place that provides Adult Day Care for only part of a day.

Assisted Living Facility means:

- If located in New York State –
 - a facility that is licensed as an Adult Home or an Enriched Housing facility (or any term sanctioned by law or regulation) which is approved by the New York State agency with jurisdiction over assisted living facility licensure matters; or
 - a facility legally operating in New York State without licensure and providing assisted living services in a facility as those services are recognized by the laws and regulations of New York State; or
- if located outside of New York State -
 - is licensed to provide Custodial Care according to the laws of the jurisdiction in which it is located; or

- if licensing is not required, meets all of the following --
 - has a 24-hour on-site staff to provide Custodial Care;
 - provides Custodial Care services for a charge, including room and board;
 - has established procedures for obtaining appropriate aid in the event of a medical emergency;
 - provides 3 meals a day and can accommodate special dietary needs;
 - it provides, at a minimum, assistance with Bathing and Dressing; and
 - provides Custodial Care services to 10 or more persons.

Examples of such facilities may include Alzheimer facilities or Assisted Living Facilities that are either free standing facilities or part of a life-care community. They may also be met by some personal care and adult congregate care facilities.

An Assisted Living Facility does not mean:

- a hospital or clinic;
- a rest home (a home for the aged or a retirement home) which does not, as its primary function, provide Custodial Care;
- Your Home; or
- a facility for the treatment of alcoholism, drug addiction, or mental illness.

Care Coordination Organization means an organization, independent of Us, that provides Licensed Health Care Practitioners appropriately trained to:

- conduct assessments and reassessments;
- develop Plans of Care; and
- coordinate and monitor the delivery of long term care services.

Care Coordinator means a Licensed Health Care Practitioner employed by or under contract with Us or a Care Coordination Organization We have selected, to make available to You the following services:

- conduct a face-to-face assessment of Your need for long term care services;
- provide the initial written Certification to Us and thereafter, a written recertification every 12 months that You are a Chronically Ill Individual.
- prepare a written Plan of Care for You; and
- coordinate and monitor the delivery of services as may be appropriate.

A **Chronically Ill Individual** means that You:

- are unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living due to the loss of functional capacity for a period expected to last 90 days; or
- require Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

Cognitive Impairment means a deficiency in a person's short-term or long-term memory; orientation as to person, place, or time; deductive or abstract reasoning; or judgment as it relates to safety awareness. Your Cognitive Impairment must be established and reliably measured by clinical evidence and standardized tests. The need for Substantial Supervision due to the presence of Cognitive Impairment must be established by such clinical evidence and standardized tests.

Custodial Care means non-skilled long term care included in Your Plan of Care and approved by a Licensed Health Care Practitioner: which is necessary due to Your Cognitive Impairment; or to assist You in the Activities of Daily Living.

Date of Service means a day that You are eligible for benefits under this Policy (including Dates of Service during the Elimination Period) on which You:

- are a resident in a Nursing Home or an Assisted Living Facility;
- receive Home Health Care, Adult Day Care, Respite Care or Hospice Care;
- a day which You were confined in a Hospital for purposes of the "In-Hospital Waiting List Benefit"; or
- receive services covered under this Policy that are provided by Medicare (for which benefits are not payable under this Policy).

Elimination Period (waiting period) means the number of Dates of Service that would otherwise be covered by this Policy, for which We will not pay benefits. The Elimination Period is shown in the Policy Schedule. Only one complete Elimination Period needs to be satisfied while Your Policy is in force.

The Elimination Period starts on the first Date of Service. No Date of Service may be counted as more than one day towards the satisfaction of Your Elimination Period. The Dates of Service used to satisfy Your Elimination Period do not need to be consecutive and may be accumulated under separate claims. We will not pay benefits for charges during the Elimination Period.

Home means Your primary residence including Your independent living quarters in a continuing care retirement community or similar entity. It does not include a Nursing Home, an Assisted Living Facility, an Alzheimer's facility, an Adult Day Care Center, a hospital or rehabilitation facility/hospital, or a facility for the treatment of alcoholism, drug addiction or mental illness.

Home Health Care means medical and non-medical professional or personal care services provided in Your Home. These services must be provided by a Home Health Care Provider. Home Health Care includes those services required by the laws and regulations of the jurisdiction in which they are provided.

Home Health Care includes homemaker services. Homemaker services mean non-medical support services provided by a Home Health Agency. These services include meal preparation, shopping, laundry and house cleaning. Home Health Care also includes specialized transportation services where human assistance is required by You to aid in necessary travel, such as to a physician's office.

Home Health Care Provider means either a Home Health Agency or an Independent Home Health Care Provider that provides Home Health Care. A Home Health Care Provider cannot be a member of Your Immediate Family except as provided in the "Exceptions" section of the Policy or an individual who normally resides in Your Home.

- A Home Health Agency must meet one of the following requirements:
 - it is licensed as a Home Health Agency by the jurisdiction in which the Home Health Care is provided; or
 - it possesses one of the following certifications in the jurisdiction in which the Home Health Care is provided - Medicare Certification; Joint Commission of Accreditation of Health Care Organizations (JCAHO) Certification; or Community Health Accreditation Program (CHAP) Certification; or
 - it provides Home Health Care through 2 or more employees of an organization that is in the business of providing Home Health Care according to the laws of the jurisdiction in which it is located.

- An Independent Home Health Care Provider means a care provider not employed by a Home Health Agency who meets one of the following requirements. He or she:
 - is a duly licensed health care provider or certified home health care provider (such as a registered nurse, licensed vocational nurse, licensed practical nurse or licensed social worker;)
 - must be currently qualified as a certified home health aide or certified nurse aide.
- In the case of a home health aide or nurse aide who does not meet one of the standards set forth above, such aide must present written proof of completion of an established training course which must include training in safely assisting persons with the Activities of Daily Living.

Hospice Care means a program for meeting Your care needs if You are Terminally Ill. Terminally Ill means there is no reasonable prospect of cure and You have a life expectancy, as estimated by a Licensed Health Care Practitioner, of 12 months or less. Hospice Care must be provided by an organization that is licensed to provide such care according to the laws of the jurisdiction in which it is located. Hospice Care is limited to those services received by You. You must satisfy Your Elimination Period before receiving benefits for Hospice Services. Hospice Care may be provided in Your Home, a Nursing Home, an Assisted Living Facility, and Adult Day Care Center or in a Hospice Care facility.

Hospital means an institution that meets any of the following standards:

- it is accredited as a hospital by the Joint Commission for Accreditation of Healthcare Organizations;
- it is certified as a hospital under Medicare; or
- it is licensed as a hospital by the appropriate agency in the jurisdiction in which it operates.

Hospital also means an ambulatory surgical center that is operated pursuant to law.

Hospital does not include:

- a Nursing Home;
- an Assisted Living Facility;
- a rest home (a home for the aged or a retirement home; or
- a facility for the treatment of alcoholism, drug addiction, or mental illness.

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

Licensed Health Care Practitioner means a Physician, a registered nurse (R.N.), a licensed social worker, or any other individual who meets the requirements as may be prescribed by the Secretary of the Treasury or as required by state law or regulation as appropriate. A Licensed Health Practitioner may not be a member of Your Immediate Family.

Long Term Care Services means the following covered care or services:

- confinement in a Nursing Home or Assisted Living Facility for room, board and care services (such care services being Nursing Care, Custodial Care and Hospice Care);
- Home Health Care, Hospice Care, Respite Care;
- attendance at an Adult Day Care Center providing Adult Day Care; or
- confinement in a hospital for purposes of the "In-Hospital Waiting List Benefit".

Medicaid means the reimbursement system under Title XIX of the Federal Social Security Act, as amended.

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

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 registered dietitian or person licensed or certified to provide such care.

Nursing Home 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. If licensing or certification is not required by the jurisdiction in which the Nursing Home is located, a Nursing Home means a facility which 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.

Services provided in a Nursing Home are covered to the extent required by the laws and regulations of the jurisdiction where the policy is delivered.

A Nursing Home may be a freestanding facility or it may be a distinct part of a facility, including a ward or a wing of a hospital or other facility.

Nursing Home does not mean:

- a hospital or clinic;
- a rest home (a home for the aged or a retirement home) which does not, as its primary function, provide Custodial Care;
- Your Home; or
- a facility for the treatment of alcoholism, drug addiction, or mental illness.

Partner means the unmarried person who is not related to You with whom You have lived in a committed relationship for at least 3-years prior to the date You applied for this Policy. This person is the individual You named in Your application or other subsequent document as Your Partner in order to obtain the Partner premium discount under this Policy.

Physician means any person licensed as a 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. In New York State, a Physician includes a practitioner of the healing arts.

Plan of Care means a written plan for long term care services designed especially for You. This Plan of Care must specify the:

- type and frequency of services You need;
- providers of all the services You require;
- expected duration of the need for such services.

Services must be in accordance with accepted relevant standards of practice and appropriate to meet the needs identified in the assessment of Your functional and cognitive needs.

Your Plan of Care must be updated as Your condition and needs change. We must be provided with a revised Plan of Care each time it is updated. We reserve the right to request periodic updates regarding Your Plan of Care, but not more frequently than once every 30 days. No more than one Plan of Care may be in effect at a time.

Policy means this policy form including any associated riders, endorsements, amendments and Your application for this Policy.

Policy Limit means the total amount, as shown on the Policy Schedule, from which You will be paid benefits for all covered care and services. All benefits will be deducted from the Policy Limit. However, services provided by a Care Coordinator will not count against Your 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 Home Benefit Amount times the number of days in the Benefit Period as shown in the Policy Schedule.

Respite Care is the short-term care designed to provide temporary relief to Your primary uncompensated caregiver from his or her caregiving duties and provided in: a Nursing Home; an Assisted Living Facility; an Adult Day Care Center; Your Home; or a community-based program. Respite Care includes: confinement in a Nursing Home or Assisted Living Facility; Home Health Care; Adult Day Care; and Hospice Services.

Substantial Assistance means You need hands-on or standby assistance while You are performing an Activity of Daily Living.

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

Substantial Supervision means You need continual supervision due to Your 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).

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

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

PART 2 - YOUR LONG TERM CARE 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.

This Policy provides coverage for Long Term Care Services which are needed due to mental illness, Alzheimer's Disease and forms of senility and irreversible dementia that result in a Cognitive Impairment subject to the provisions, exclusions and limitations found in this Policy.

ELIGIBILITY FOR PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits

You are eligible for benefits under this Policy if You are a Chronically Ill Individual. A Chronically Ill Individual means that You:

- are unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living due to the loss of functional capacity for a period expected to last 90 days; or
- require Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

LIMITATIONS ON OR CONDITIONS FOR ELIGIBILITY FOR BENEFITS

Conditions

To receive benefits under this Policy:

- Your Elimination Period must have been satisfied unless otherwise provided in this Policy;
- You must receive covered care or services while this Policy is in effect or continued under the Extension of Benefits provision;
- You must receive care or services that are consistent with Your care needs and are covered under this Policy, and specified in the Plan of Care; and
- We must receive a current Plan of Care and written Proof of Loss, both of which are acceptable to Us.

Because this Policy is intended to be tax-qualified under federal law, You must ALSO provide Us with a written Certification from a Licensed Health Care Practitioner that You are a Chronically Ill Individual. This written document will be referred to as the Certification throughout this Policy. The Certification must be renewed and submitted to Us every 12 months.

Limitations

We will pay only one Benefit Amount on any given day. Benefits will be paid for the covered service(s) that will provide You with the largest Benefit Amount. We will not pay benefits, in excess of the Policy Limit as shown in the Policy Schedule. We will not pay benefits for charges during the Elimination Period.

Charges Not Covered

We will not pay for any of the following: Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; medical supplies; durable medical equipment (unless the Additional Stay at Home Benefit is included in this Policy); transportation (except for transportation as described in the definition of Home Health Care); items and services furnished at Your request for beautification, comfort, convenience or entertainment; and charges for care or services which are not included in and/or are inconsistent with Your Plan of Care.

CARE COORDINATION

Care Coordination provides You with an important and valuable resource. The Care Coordination Benefit provides You and Your family members with access to the services of a Care Coordinator who is also a Licensed Health Care Practitioner. The Care Coordinator will assess Your needs for long term care, develop a written Plan of Care designed to meet those needs, and help You and Your family to navigate through the long term care delivery system; and may assist in the coordination and the monitoring of long term care services as appropriate. In addition, using the Care Coordination Benefit will help You minimize the paperwork by streamlining the claim process.

Please Contact Us as Soon as You Believe You May Need Care or Services. You, Your family members or representatives should contact Us as soon as the need for long term care arises. Please call Us at 1-800-377-7311. The sooner You call, the sooner We can arrange to have Your Care Coordinator begin Your needs assessment and care planning.

The entire cost of the services provided by the Care Coordinator is paid by Us and will ***not*** count against Your Policy Limit. In addition, the Elimination Period does ***not*** have to be met in order for You to receive Care Coordination services.

When You choose to access the Care Coordination Benefit, the Care Coordinator may provide You with the following services:

- ***Assessment and Certification.*** The Care Coordinator will conduct an assessment to determine Your status and needs. The assessment encompasses a wide range of factors that make Your situation unique, such as Your functional, cognitive, behavioral, and emotional well-being, as well as family support and the safety of Your environment. This assessment of Your needs will form the basis of the Care Coordinator's Certification that You are a Chronically Ill Individual and Your Plan of Care.
- ***Development of Your Plan of Care.*** The Care Coordinator will work with You, Your Physician, Your family or Your representative, to develop a Plan of Care. This is a collaborative process. The Plan of Care will describe the type and frequency of services that will meet Your needs as identified in the assessment. Please note that the Plan of Care may also include services that are not covered by this Policy.
- ***Coordinating Service Delivery.*** The Care Coordinator may assist You in securing the services recommended in Your Plan of Care as necessary. The Care Coordinator will provide You with information on provider resources local to You, community programs, and health information resources.

- **Monitoring.** After You begin to receive services through Your Plan of Care, We will periodically check with You, Your family and Your providers to: re-assess Your current condition; monitor and assess the care You are receiving; determine whether Your Plan of Care continues to be appropriate; and recommend any necessary changes. This re-assessment will occur at least once a year (or more frequently as We determine appropriate) in order to provide You with the required annual Certification and to update Your Plan of Care as needed.

If You choose not to access the Care Coordination Benefit, You must arrange for Your Physician or another Licensed Health Care Practitioner to certify that You are a Chronically Ill Individual and prepare a Plan of Care for You at Your own expense. In such event, We will pay the actual charges incurred by such Licensed Health Care Practitioner up to the Additional Care Coordination Benefit Amount for a new assessment, Certification and Plan of Care. The Additional Care Coordination Benefit Amount is equal to 2-times the Nursing Home Daily Benefit Amount per calendar year. Only benefits paid under the Additional Care Coordination Benefit will reduce the Policy Limit. Any unused portion of Your Additional Care Coordination Benefit Amount will remain in the Policy Limit. You must submit all Certifications and Plans of Care to Us. Please see the Claims section for more details.

HOW YOUR LONG TERM CARE BENEFITS ARE PAID

Nursing Home Benefit

We will pay the actual charges incurred for Your confinement in a Nursing Home up to the Nursing Home Benefit Amount as shown in the Policy Schedule, if:

- You are a resident in a Nursing Home;
- You are receiving Nursing Care, Custodial Care or Hospice Care; and
- You are eligible for the payment of benefits under this Policy.

Actual charges include: room and board, Nursing Care, Custodial Care and Hospice Care. Any unused portion of Your Nursing Home Benefit Amount will remain in the Policy Limit. Any benefit paid under this provision will reduce Your Policy Limit.

Nursing Home Bedhold Benefit

If Your stay in a Nursing Home is interrupted because You are hospitalized and a benefit is payable under this Policy, We will continue to pay the actual charges up to the Nursing Home Benefit Amount, for up to 20 days per calendar year in order to assure a place will be available when You return to the same or a different Nursing Home. Any benefits paid under this provision will reduce Your Policy Limit.

Assisted Living Facility Benefit

We will pay the actual charges incurred for Your confinement in an Assisted Living Facility up to the Assisted Living Facility Benefit Amount as shown in the Policy Schedule, if:

- You are a resident in an Assisted Living Facility;
- You are receiving Nursing Care, Custodial Care or Hospice Care; and
- We determine You are eligible for the payment of benefits under this Policy.

Actual charges include: room and board, Nursing Care, Custodial Care and Hospice Care. Any unused portion of Your Assisted Living Facility Benefit Amount will remain in the Policy Limit. Any benefit paid under this provision will reduce Your Policy Limit.

Assisted Living Facility Bed Hold Benefit

Important Notice – the Assisted Living Facility Bed Hold Benefit is not available to You if You elected the 1.5 or 3-year Benefit Period. The Benefit Period You elected is shown in the Policy Schedule.

If Your stay in a Assisted Living Facility is interrupted because You are hospitalized and a benefit is payable under this Policy, We will continue to pay the actual charges up to the Assisted Living Facility Benefit Amount, for up to 20 days per calendar year, in order to assure a place will be available when You return to the same or a different Assisted Living Facility. Any benefits paid under this provision will reduce Your Policy Limit.

Home Health Care Benefit

We will pay the actual charges incurred for a provider of Home Health Care up to the Home Health Care Benefit Amount as shown in the Policy Schedule, if:

- You are receiving Home Health Care or Hospice Care in Your home, a rest home or in an Adult Day Care Center; and
- You are eligible for the payment of benefits under this Policy.

Any unused portion of Your Home Health Care Benefit Amount will remain in the Policy Limit. Any benefit paid under this provision will reduce Your Policy Limit.

Respite Care Benefit

We will pay the actual charges incurred for a provider of Respite Care up to the Respite Care Benefit Amount as shown in the Policy Schedule, if:

- You are receiving Respite Care in a Nursing Home, Assisted Living Facility or in an Adult Day Care Center, or from a Home Health Care Provider; and
- You are eligible for the payment of benefits under this Policy.

The Respite Care Benefit is limited to a total of fourteen (14) days during a calendar year. Any unused portion of Your Respite Care Benefit Amount will remain in the Policy Limit.

In-Hospital Waiting List Benefit

We will pay the actual charges incurred for Your confinement in a Hospital up to the In-Hospital Waiting List Benefit Amount as shown in the Policy Schedule, if:

- You are resident in a Hospital and awaiting Home Health Care or a bed in a Nursing Home or Assisted Living Facility; and
- You are eligible for the payment of benefits under this Policy.

Any unused portion of Your In-Hospital Waiting List Benefit Amount will remain in the Policy Limit. Any benefit paid under this provision will reduce Your Policy Limit.

Extension of Benefits

If eligibility for benefits under this Policy or Total Disability began while this Policy was in effect and continues without interruption after this Policy terminates (lapses), benefits for confinement in a Nursing Home or an Assisted Living Facility, or for Home Health Care or Respite Care or for any benefits added to the Policy by endorsement or rider will continue to be paid. However, such extension of benefits after this Policy has terminated (lapsed) will be subject to all of the provisions of this policy (including but not limited to the Policy Limit and the Elimination Period).

“Total Disability” means:

- You need Substantial Assistance to perform at least two of the Activities of Daily Living; or
- You require substantial supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

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Please note that in the event this Policy is continued under this provision:

- all required premiums must still be paid when due; and
- We will automatically deduct all required premiums from any benefits paid under this Policy unless You have elected the Waiver of Premium Benefit and it is included in this Policy.

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.

Exceptions

This Policy does not cover care, treatment or charges:

- for intentionally self-inflicted injury.
- required as a result of alcoholism or drug addiction (unless drug addiction 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.
- normally not made in the absence of insurance.
- provided by a member of Your Immediate Family, unless
 - the family member is one of the following professionals -- a duly licensed registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, licensed social worker, or registered dietitian; and
 - the family member is a regular employee of a Nursing Home, Assisted Living Facility, Adult Day Center or Home Health Care Agency which is providing the services;
 - 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 United States and its possessions.

Non-Duplication of Benefits

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

- Medicare (amounts that are reimbursed by Medicare or would have been reimbursed but for the application of a Medicare deductible or coinsurance amounts).
- any other governmental program (except Medicaid).
- any state or federal workers' compensation, employer's liability or occupational disease law, or any mandatory motor vehicle no-fault law.

PART 4 - CLAIMS

Early notification to Our Claims Department will facilitate a timely review of Your claim. 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.

HOW AND WHEN TO FILE A CLAIM

Notice of Claim

Please Contact Us as Soon as You Believe You May Need Care or Services – You, Your family member or representative should notify Us as soon as You believe that You may need care or services, as described in the Care Coordination section of this Policy. When you contact Us to arrange the visit with a Care Coordinator, We will consider that as Notice of Claim. The best way to notify Us is by calling Us at 1-800-377-7311. If you prefer, You can write to Us at Our LTC Administrative Office.

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

Claim Forms

When We receive Your notice of claim, We will provide You with instructions and the necessary forms for filing Proof of Loss. You must file Your Proof of Loss with Our LTC Administrative Office. When You use a Care Coordinator, he or she will assist You in the completion and submittal of these forms

If We do not provide You with the claim forms within 15 days after having received Your notification, You may give Us written proof of the nature and extent of Your loss in place of the claim forms.

Proof of Loss

Proof of Loss means detailed written documentation acceptable to Us which describes and confirms: Your inability to perform any of the Activities of Daily Living or Your Severe Cognitive Impairment; Your confinement in a Nursing Home or Assisted Living Facility; or the Home Health Care, Respite Care or Hospice Care You are receiving.

This documentation includes:

- a completed claim form;
- confirmation of provider licensure as required by the jurisdiction in which it is located;
- the Certification described in Part 2 of this Policy;
- itemized bills for Your care and services; and
- Your Plan of Care.

In addition, We may also request copies of medical records (or We may consult with Your primary Physician and provider by telephone at Our option) or Your providers' daily notes of care.

Proof of Loss for which this Policy provides any periodic payment contingent upon continuing loss must be provided within ninety (90) days after the end of the period for which We are liable and in the case for any other loss, Proof of Loss must be given to Us within ninety (90) days after the first Date of Service. If it is not reasonably possible to give such proof in the time required, Your claim will not be affected if the proof is sent as soon as reasonably possible. Unless you are legally incapacitated, proof must be provided to Us no later than one year after the time specified.

At time of claim, We will make available to You Our Advantage Provider Program, if such Program is available in Your state at the time of Your claim notification. This Program will include long term care providers that offer discounts to Our policyholders. These discounts can help You extend your long term care benefits. Any unused portion of Your benefits will remain in the Policy Limit. There is no penalty for using long term care providers that are not included on this list.

Our Claims Evaluation Process

We will work with You, the Care Coordinator, 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 nursing or functional/cognitive assessment or require a physical exam when and as often as We may reasonably require while a claim is pending or any time during the claim. We will pay for any interview, assessment or examination that we request.

Time of Payment of Claims

Benefits under this Policy are payable on a monthly basis, after services have been rendered and charges have been incurred for such services.

Payment of Claims

While You are living, all benefits will be paid to You unless You request and We accept 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.

You may cancel or change an assignment of benefits at any time. We will not be on notice of any assignment unless it is in writing and 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.

Any accrued benefits unpaid at Your death will be paid to your estate. At our option, a benefit of up to \$1,000 may be paid to someone related to You by blood or marriage, who We believe is equitably entitled to the benefit. We will be fully discharged to the extent of any payment made in good faith under this paragraph.

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 and request that We make 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 required) and send it to:

John Hancock Life Insurance Company
P.O. Box 111
Boston, MA 02117
Attn: Director of RLTC 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 may use one or more of the following resources at Our expense:

- a Physician who will assess Your condition and report it to Us;
- an on-site geriatric assessment;
- medical records from Your Physician(s) and/or provider(s) of care; or
- other information that is determined to be relevant to address the appeal.

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

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

The Claim Appeals Review Board will make and notify You of the determination within 60-days.

Benefit Authorization Request Denials

If We deny Your Benefit Authorization Request (BAR), the Partnership Office will automatically review the denial if You are confined to a Nursing Home located in New York.

If We deny Your BAR while You are receiving care at home inside or outside of New York, or You are confined to a Nursing Home outside of New York, You may request an independent assessment review if You believe Your BAR was denied incorrectly. You can obtain information regarding the independent assessment review by contacting the Partnership Office. The Partnership Office will review the independent assessment and information provided by Us.

In the event We deny Your BAR, the Partnership Office will notify You of Your option to elect arbitration in lieu of the pursuing litigation and provide You with the New York State Partnership for Long Term Care Rules of Arbitration. If You elect to use arbitration in contesting a denied BAR, the judgment of the arbiter shall be binding on both You and Us. We will pay all arbitration fees as specified in the Rules of Arbitration.

This process is more fully described in the "Consumer Participation Agreement" You signed when You applied for this Policy.

Misstatement of Age

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

Legal Action

You may not bring suit against Us to recover benefits under this Policy until at least 60 days has expired after written Proof of Loss has been given to Us. Also, You cannot bring suit against Us to recover benefits under this Policy after four 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

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., Eastern Standard Time on the Effective Date of Coverage. It ends at midnight of the day before the next premium due date, subject to the Grace Period provision below. 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 Effective Date of Coverage.

Your first premium must be paid at Our LTC Administrative Office or to any of Our duly authorized agents. Any subsequent premium payment must be paid to Our LTC Administrative Office. If a premium is paid to an agent, We will provide a receipt in exchange for such payment. To be valid, it must also be countersigned by the agent shown on the receipt. 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, .2625 for quarterly and .0875 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.

Grace Period

This Policy has a 65-day Grace Period. If a premium other than the initial premium is not paid within 30 days from the date that it is due, We will provide written notification of the nonpayment of the 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.

You may designate a person or persons to receive such notice on Your application. You may change the designation or make a new designation at any time while this Policy is in effect, but it must be in writing and sent to Our LTC Administrative Office. Please note that You are responsible for notifying Us of any change in address of Your designee. We will provide You with a reminder of the right to change this written designation every two years.

REINSTATEMENT AND LAPSE PROTECTION

Reinstatement

An application and payment of premium is required to reinstate the policy. We will issue a conditional receipt for the premium paid. If the application is approved and payment received, the Policy will be reinstated as of the last premium due date. If it is disapproved, We will inform You in writing within 45 days of such disapproval and any premium paid will be returned to You promptly. 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.

Added Protection Against Lapse

If Your Policy terminates because You did not pay the premium due, You may obtain reinstatement of this Policy, if You so request, within 5 months after the date of termination, and You meet the following conditions:

- You furnish Us with satisfactory proof that You were unable to perform at least two of the Activities of Daily Living; or had a Cognitive Impairment on the date of termination; and
- You pay all the unpaid overdue premiums.

REFUND OF UNEARNED PREMIUMS

Refund of Unearned Premiums at Death

Upon receipt of proof that You have died, We will refund the portion of premium paid between the date of death and the next premium due date. Such refund will be made to Your beneficiary, if any, otherwise to Your estate.

