



Custom Care III

Individual Long-Term Care Insurance

NEW YORK 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, Massachusetts**



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.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE OR UNTIL THE POLICY LIMIT IS REACHED - LIMITED RIGHT TO INCREASE PREMIUMS. PREMIUMS ARE NOT GUARANTEED TO REMAIN UNCHANGED. 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 cannot change the provisions of this Policy without Your consent. **However, We do reserve the right to increase Your premium as of any premium due date in the future. Any changes in premium rates must apply to all similar policies issued in Your state to policyholders in the same class 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 Your advancing age, declining health, claim status or for any other reason related solely to you.**

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/Misrepresentation 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 & Health Insurance Company, 1 John Hancock Way, Suite 1700, Boston MA 02217-1700 or call 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.**

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.

Signed for the Company at Boston, Massachusetts:

Secretary

President

LONG-TERM CARE INSURANCE POLICY

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

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	Any Riders, Endorsement, Notices and other papers	Attached

Policy Number:	[H 9000 000]	Policy Form:	LTC-11 NY
Insured:	[John Hancock]	Policy Title:	Long-Term Care Insurance Policy
Premium Class:	[Standard]	Effective Date of Coverage:	[January 1, 2011]
		First [Annual] Premium: [***]	[\$XXXXX.XX]

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]
Long Term Care Benefit Amount*^:	\$ [XXX] per month/per day
Care Advisory Services Benefit Amount:*	\$ [XXX] per calendar year
Additional Stay At Home Lifetime Benefit Amount:*	\$ [XXX]
<i>(The Additional Stay at Home Benefit includes benefits for home modifications, emergency medical response systems, durable medical equipment, caregiver training, home safety check and provider care check.)</i>	
[Double Coverage Accident Benefit Amount:*	\$ [XXX] per month/per day]
[Additional Cash Benefit Amount:*	\$ [XXX] per month]

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

^ Subject to the Limited Benefit for Independent Home Health Care Providers described in the policy section entitled "Long Term Care Benefit".

[5% Compound Inflation Coverage]

Base Policy Premium: \$ [XXX] Annual Premium

Optional Benefits Selected and Included in this Policy:

[SharedCare Benefit	\$ [XXX] Annual Premium]
[Survivorship & Waiver of Premium Benefit	\$ [XXX] Annual Premium]
[Waiver of the Home Care Elimination Period	\$ [XXX] Annual Premium]
[Additional Cash 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]

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

POLICY SCHEDULE - (continued)

[* Important Notice.** You have selected the **Twenty-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 twentieth Policy year. Prior to the end of Your twentieth 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 twentieth 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.]

[* Important Notice.** You have selected the **Paid-Up at Age 75 Payment Option**. This means that Your Policy will be paid-up and no further premiums will be due after the Policy anniversary following Your 75th 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.]

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SAMPLE

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.

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 or mobility outside the place where you reside.

Medication management is not an Activity of Daily Living.

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 to 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 while You are residing in Your Home.

Assisted Living Facility means a facility or a distinctly separate part of a facility, that is engaged primarily in providing 24-hour Custodial Care and:

- is licensed to provide primarily 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;
 - 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.

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 the Home of one of Your Immediate Family Members; or
- a facility for the treatment of alcoholism, alcohol abuse, drug addiction, or mental illness.

Care Advisory Services means assessment and care planning by a Home Health Agency, a Care Management Organization or an Independent Care Manager. Care Advisory Services do not determine eligibility for benefits under this Policy. Care Advisory Services include:

- assessing Your need for long-term care services;
- developing a recommendation for long-term care services that is consistent with Your care needs based upon their assessment;
- coordinating delivery of long-term care and services; and
- monitoring the long-term care and services delivered.

Care Management Organization means an organization which is licensed, if required, and operated to provide Care Advisory Services according to the laws, if any, of the jurisdiction in which it is located. If licensing is not required, a Care Management Organization means an organization that provides Care Advisory Services and meets all the following requirements:

- has a full-time administrator;
- maintains records of services provided to each client; and
- has a staff including at least one full-time registered nurse, one full-time licensed social worker, one full-time individual who holds the designation of a 'Care Manager' from the National Association of Professional Care Managers, or a full-time person with a Masters in Gerontology from an accredited school of Gerontology.

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 at least 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:

- incurring costs for covered services while You are a resident in a Nursing Home or an Assisted Living Facility;
- incurring costs for Home Health Care, Adult Day Care or Hospice Care; or
- receiving services covered under this Policy that are Medicare eligible (for which benefits are not payable under this Policy).

For purposes of crediting Home Health Care Dates of Service to the satisfaction of the Elimination Period, a Date of Service will only count toward Your Elimination Period if You have received at least 2-hours of covered care on that date and such care is not primarily Incidental Homemaker Services.

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.

The Elimination Period starts on the first Date of Service. A Date of Service will only count toward Your Elimination Period if You have been certified by a Licensed Health Care Practitioner as a Chronically Ill Individual. For purposes of Home Health Care only, a Date of Service will only count toward Your Elimination Period if You have received at least 2-hours of covered care on that date and such care is not primarily Incidental Homemaker Services. 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 except for the Additional Stay at Home Benefit and Care Advisory Services.

Home means the primary residence, including an independent living quarters in a continuing care retirement community, a rest home 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, alcohol abuse, drug addiction or mental illness.

Home Health Care means the following medical and non-medical professional or personal care services provided to You in Your Home that are included in a Plan of Care:

- skilled nursing or social work services;
- therapist services consisting of physical, occupational, respiratory, speech or dietary services;
- Substantial Assistance in the Activities of Daily Living; or
- Substantial Supervision needed because of Your Cognitive Impairment.

Home Health Care includes those services required by the laws and regulations of the jurisdiction in which they are provided.

Home Health Care also includes Homemaker Services. Homemaker Services means non-medical support services , which are included in a Plan of Care and which provide one of more of the following non-medical support services necessary for You to remain in Your home: meal preparation; laundry; light housekeeping; and supervising self-administration of medication. Homemaker Services must be provided during the same visit and by the same individual providing Substantial Assistance in the Activities of Daily Living or Substantial Supervision needed because of a Cognitive Impairment.

Home Health Care must be provided by a Home Health Agency. However, if a Home Health Agency is not available within a 40-mile radius of Your Home, Home Health Care may be provided by an Independent Home Health Care Provider, and the Limited Benefit for Independent Home Health Care Provider will apply as described in the Long-Term Care Benefit provision of the Policy.

Home Health Care cannot be provided by: a member of Your Immediate Family except as provided in the "Exceptions" section of the Policy; an individual who normally resides in Your Home; Your legal representative; an individual who has been authorized as Your Power of Attorney; or Your insurance agent/producer.

A **Home Health Agency** is an agency or organization that meets one of the following requirements:

1. it is licensed as a Home Health Agency or similar entity by the jurisdiction in which the Home Health Care is provided; or
2. 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
3. it provides Home Health Care through 7 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 the care is provided.;
or
4. it is state licensed or a Medicare certified provider for Hospice Care.

Hospice means a facility, unit of a facility, public or private agency or unit of a public or private agency that meets Federal certification requirements as a Hospice or is licensed, certified or registered to provide Hospice Care under the law of the jurisdiction in which it is located.

Hospice Care means a program for meeting Your palliative 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 Physician, of 6 months or less. Hospice Care must be provided by or supervised by a Hospice. You must be enrolled in a federal or state approved Hospice program in order to be eligible to receive benefits for Hospice Care under this Policy. Hospice Care is limited to those services received by You. Hospice Care may be provided in Your Home or in a Hospice facility. Hospice Care is subject to all requirements under this Policy including satisfaction of the Elimination Period.

Immediate Family means Your spouse or Partner, or the following relatives (and their respective spouses or Partners) of You, Your spouse or Partner: parents; stepparents; grandparents; siblings; children; stepchildren grandchildren; aunts/uncles; or nieces/nephews.

For purposes of this definition, a person is a "Partner" of an individual if such person is unmarried, not related to the individual by blood or marriage, and has lived with the individual in a committed relationship for at least 3-years.

Independent Care Manager means:

- a registered nurse;
- a licensed social worker;
- an individual who holds the designation of a 'Care Manager' from the National Association of Professional Care Managers; or
- a person with a Masters degree in Gerontology (or equivalent) from an accredited school of Gerontology.

Independent Home Health Care Provider means an individual not employed by a Home Health Agency or similar entity, who meets the following requirements. He or she is currently:

- a licensed registered nurse, licensed vocational nurse, licensed practical nurse, registered physical therapist, registered occupational therapist, registered speech therapist, registered respiratory therapist, licensed social worker, or registered dietitian; or
- licensed as or is a certified home health aide or licensed or certified nurse aide

In the case of a home health aide or nurse aide who is not licensed, certified or registered, such aide must present written proof of either:

- employment verification (for each employer) certifying employment within the past 5 years as a nurse aide at a hospital, skilled rehabilitation, nursing home, assisted living facility or home care agency with a minimum of 12 months employment; or
- completion of an established training course within the past 5 years which includes the following components with a minimum of 75 hours of in-class training and 16 hours of clinical training: bathing, dressing, safe transferring and lifting techniques; personal hygiene; basic nutrition; infection protection and control; managing incontinence; psychosocial and emotional support; and safety monitoring for the cognitively impaired.

In addition, the Independent Home Health Care Provider must be 18 years of age or older and must submit a valid government-issued form of identification. The Independent Home Health Care Provider cannot be a member of Your Immediate Family; an individual who normally resides in Your Home; Your legal representative; an individual who has been authorized as Your Power of Attorney; or Your insurance agent/producer. The Independent Home Health Care Provider must maintain and provide written notes of care for each Date of Service. We may require that the care be monitored at least every 30-days by a Licensed Health Care Practitioner at our cost.

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.

Long-Term Care Services means the following covered care or services provided for in a Plan of Care:

- 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 or Hospice Care; or
- attendance at an Adult Day Care Center providing Adult Day Care.

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; ; or
- 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;
- an Assisted Living Facility;
- a rehabilitation hospital;
- Your Home; or
- a facility for the treatment of alcoholism, alcohol abuse, drug addiction, or mental illness.

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 is any legally qualified practitioner of the health arts acting within the scope of his/her NYS license as appropriate to a tax-qualified policy.

Plan of Care means a written plan for long-term care services developed by a Licensed Health Care Practitioner especially for You. This Plan of Care must specify the type, cost, frequency, and expected duration of care, hours of care per day, and type of providers of all the services You require. Services must be in accordance with accepted relevant standards of practice and appropriate to meet the care requirements identified in the assessment of Your functional and cognitive abilities.

The Plan of Care is subject to change as Your condition and service requirements change. We reserve the right to request an assessment or 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 or other papers issued by Us to be made part of Your 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. We will not pay benefits in excess of the Policy Limit as shown in the Policy Schedule, except for the Additional Stay at Home Benefit and Care Advisory Services.

A **Policy Year** starts at 12:01 a.m., Eastern Time on a Policy anniversary (the Effective Date of Coverage for the first Policy Year) and ends at midnight of the day before Your next Policy anniversary.

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 & Health 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.

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. You are a Chronically Ill Individual if 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 at least 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;
- You must receive covered care or services while this Policy is in effect or You qualify for Extension of Benefits;
- You must receive care or services that are consistent with and specified in Your Plan of Care; and
- We must receive a current Plan of Care and written Proof of Loss that are acceptable to Us.

Because this Policy is intended to be tax-qualified under federal law, a written Certification from a Licensed Health Care Practitioner that You are a Chronically Ill Individual is required. 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 not pay benefits in excess of the Policy Limit except for the Additional Stay at Home Benefit and Care Advisory Services. We will not pay benefits for charges during the Elimination Period except for the Additional Stay at Home Benefit and Care Advisory Services. We will only pay benefits for services specified in the Plan of Care. We will determine services under the Plan of Care for which benefits are payable, and the amount of such benefits, which shall not exceed charges normally made for similar care, services or other items in the locality where they are received.

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 (except as described in the Additional Stay at Home Benefit) and shipping charges for such equipment; any transportation or mileage charge; items and services furnished at Your request for beautification, comfort, convenience or entertainment; room and board charges for independent living quarters in a continuing care retirement community or similar entity; any type of residential upkeep, construction, renovation, or home maintenance (such as painting or plumbing); lawn/yard care; snow removal; or vehicle or equipment upkeep; and charges for care or services which are not included in and/or are inconsistent with Your Plan of Care.

CORE BENEFITS AND ALTERNATIVE BENEFITS

What are Core Benefits and Alternative Benefits?

Core Benefits are those benefits required to be provided in a Long-Term Care Insurance Policy by New York Regulation 62. Those benefits are care in a Nursing Home and Home Health Care.

Alternative Benefits are those that are provided in this policy in addition to the Core Benefits. They are: care in an Assisted Living Facility; Hospice Care; Adult Day Care, Care Advisory Services and Stay at Home Benefits.

What Happens to the Policy Limit if You Use Core Benefits and/or Alternative Benefits?

The Policy Limit applies to both the Core Benefits and the Alternative Benefits. If You use the Alternative Benefits, it will decrease the amount remaining for Core Benefits. You do not have to use the Alternative Benefits if You want to keep the Policy Limits for the Core Benefits only. You have the right to choose whether or not to use the Policy Limit to pay for the Alternative Benefits. If You do not want to use the Policy Limit to pay for the Alternative Benefits, do not file a claim for them.

HOW YOUR LONG-TERM CARE BENEFITS ARE PAID

Long-Term Care Benefit

We will pay the actual charges incurred by You for Long-Term Care Services consistent with our review of Your Plan of Care up to the Long-Term Care Benefit Amount as shown in the Policy Schedule if You are eligible for the payment of benefits under this Policy.

Long-Term Care Services mean the following covered care or services:

- Your confinement in a Nursing Home or Assisted Living Facility for Your room, board, Nursing Care, and Custodial Care);
- Home Health Care;
- Hospice Care; or
- attendance at an Adult Day Care Center providing Adult Day Care.

Please note the following:

- Limited Benefit for Independent Home Health Care Providers - In the event a Home Health Agency is not available within a 40-mile radius of Your Home, We will pay the actual charges incurred by You for Home Health Care in Your Home provided by an Independent Home Health Care Provider up to 75% of the Long-Term Care Benefit Amount.

- Bedhold Benefit - If Your stay in a Nursing Home or Assisted Living Facility is interrupted for any reason and a benefit is payable under this Policy, We will continue to pay the actual charges for up to 60-days in any calendar year in order to reserve Your bed during Your absence.

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

Notwithstanding any provisions to the contrary, payment for benefits will conform to Section 52.12 of Regulation 62.

Additional Stay at Home Benefit

The Additional 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. Additional Stay at Home Services consist of:

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

We will pay actual charges incurred while this Policy is in effect for Additional Stay at Home Services up to the Additional Stay At Home Lifetime Benefit Amount so long as all of the following conditions are met:

- You are a Chronically Ill Individual; and
- the care or services are consistent with Your care needs and are provided pursuant to a Plan of Care.; and
- We have determined that the charges do not exceed charges normally made for similar care, services or other items in the locality where they are received

The Additional Stay At Home Lifetime Benefit Amount is shown on the Policy Schedule. Any unused portion of this benefit amount may be used for future Additional Stay at Home Services. Benefits paid under the Additional Stay at Home Benefit will not reduce the Policy Limit. You do not have to satisfy the Elimination Period to receive benefits under the Additional Stay at Home Benefit. The days for which You receive only the Additional Stay at Home Benefit do not count toward the Elimination Period. You may receive benefits under the Long Term Care Benefit and/or Care Advisory Services Benefit while receiving benefits under the Additional Stay at Home Benefit.

The Additional Stay at Home Benefit will no longer be available to You on the earliest of the following dates: the date You terminate Your Policy; the date You exhaust Your Policy Limit; the date You exhaust Your Additional Stay at Home Lifetime Benefit Amount; or the date Your Policy goes on nonforfeiture status.

Additional Stay at Home Services Defined:

- *Home Modifications* mean modifications to Your Home that are primarily being made to 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: hot tubs, swimming pools, home repair or maintenance; or other modifications that may, other than incidentally, increase the value of Your Home. Nor does Home Modification include the costs of any building permits or inspections.
- *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 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 uncompensated informal caregivers in basic caregiving techniques which will allow You to remain in Your Home. Such training is to help Your caregiver tend to Your specific long term care needs. 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 a written evaluation of Your Home, by 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 items in the Home that may be evaluated include: cabinet and appliance height; furniture arrangement; doorway and hallway width; and the need for safety bars in the bathroom.
- *Provider Care Check* means an independent written evaluation of Your care providers and the care You are receiving, in order to confirm consistent delivery of care being provided to You as defined in Your Plan of Care. This evaluation must be performed by a Home Health Agency or other qualified professional agency or individual acceptable to Us.

Care Advisory Services Benefit

We will pay the Care Advisory Services Benefit if:

- You are receiving Care Advisory Services;
- the provider of Care Advisory Services submits a written record to Us, detailing their recommendations;
- the provider of Care Advisory Services submits their written assessment and an itemized bill; and
- You are eligible for the payment of benefits under this Policy.

We will pay the actual charges for Care Advisory Services up to the Care Advisory Services Benefit Amount as shown in the Policy Schedule. You do not have to satisfy the Elimination Period. The days for which You receive only the Care Advisory Services Benefit do not count toward the Elimination Period. Benefits paid under the Care Advisory Services Benefit will not reduce the Policy Limit.

Alternate Services Benefit

The Alternate Services Benefit may cover long-term care services not expressly covered by the Policy so long as all the requirements of this provision are met.

We will consider paying actual charges for alternate services under the Alternate Services Benefit only if We determine You are eligible for benefits under this Policy, and the alternate services are:

- a less expensive alternative to Long-Term Care Services that would otherwise be covered under this Policy; and
- medical or non-medical professional or personal care services to assist You in the Activities of Daily Living or to provide supervision needed because of Your Cognitive Impairment; and
- necessary, suitable and appropriate for You based upon Your medical status and current and expected future care plans; and
- included in Your Plan of Care; and
- agreed upon by You and Us.

If We determine that You are eligible for the Alternate Services Benefit, the alternate services will be described in an alternate services agreement that is mutually agreed to in writing by You and Us and may be subject to periodic review by Us. Such agreement will specify the maximum amount that We will reimburse for such services. We will only pay for alternate services received on or after the effective date of the alternate services agreement. In addition, Your Policy must be in effect when the charges for alternate services are incurred.

Any benefits paid under this provision will reduce Your Policy Limit. Days for which You receive alternate services on or after the effective date of the alternate services agreement will count toward the Elimination Period. We will not pay this benefit until Your Elimination Period has been satisfied.

The Alternate Services Benefit may not be used to pay for any charges for services described in the Charges Not Covered or Exceptions provisions of the Policy. In addition, the Alternate Services Benefit may not be used to supplement existing coverage limits under this Policy.

You may choose to discontinue the use of Alternate Services Benefits at any time.

Payment of the Alternate Services Benefit does not waive any of Your or Our rights under the Policy.

Waiver of Premium Benefit

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

- You are receiving care or services for which benefits are payable under the Long-Term 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. In the event You have already satisfied the Elimination Period, the waiver period will start on the next Date of Service and will end on the date when benefits are no longer payable under this Policy.

Your premium will not be waived if You:

- are only receiving benefits under the Additional Stay at Home Benefit, the Care Advisory Services Benefit or the Alternate Services Benefit; or
- have exhausted the International Coverage Benefit, unless and until You receive care or services for which benefits are payable under the Long-Term Care Benefit within the United States and its possessions.

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.

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, Home Health Care, or other covered services or care (including any services and care referenced by a rider attached to this Policy) 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 are a Chronically Ill Individual.

This Extension of Benefits will be subject to all of the provisions of this Policy.

International Coverage Benefit

Important Notice - Notwithstanding any provisions to the contrary, payment for benefits under the International Coverage Benefit will conform to Section 52.13 of Regulation 62 and not to Section 52.12 of Regulation 62.

If You are a Chronically Ill Individual and require care or services while You are outside the outside the United States and its possessions, You will be eligible to receive the International Coverage Benefit for certain Long Term Care Services 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 "Limitations On Or Conditions For Eligibility for Benefits".
- You provide Us (at Your own expense) with the documentation as described in the "Proof of Loss" section of the Policy, and any updates to such information as We may request. We will not require updates more frequently than monthly.
- All required documentation must be provided to Us in English.

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

- confinement in a Nursing Home or Assisted Living Facility; or
- Home Health Care, Adult Day Care or Hospice Care.

No benefits under the International Coverage Benefit are payable for: the Additional Stay at Home Benefit, the Double Coverage for Accident Benefit (if included in Your Policy); Care Advisory Services; or the Limited Benefit for Independent Home Health Care Providers.

The amount payable under the International Coverage Benefit is actual charges for covered services up to the Long Term Care Benefit Amount, and subject to the following limit:

- 365-times the Long Term Care Benefit Amount if You elected the daily Benefit Amount option; or
- 12-times the Long Term Care Benefit if You elected the monthly Benefit Amount option.

This Policy will continue in force after the International Coverage Benefit is exhausted so that any remaining benefits are available to pay for care and services received in the United States and its possessions.

In the event that the International Coverage Benefit is exhausted, premiums will no longer be waived pursuant to the Waiver of Premium provision.

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.

Return of Premium upon Death Benefit

Important Notice - The Return of Premium Benefit is not applicable to You if You are age 65 or older

If You die before Your 65th birthday, We will pay to Your beneficiary a Return of Premium upon Death Benefit if Your Policy is in force on the date of Your death. (That is, Your insurance is not being continued under the provisions of any nonforfeiture benefit.)

The Return of Premium upon Death Benefit will be calculated by subtracting the sum of all benefits paid under Your Policy for charges incurred prior to the date of Your death from the sum of all premiums paid for Your Policy (accumulated without interest). In the event the amount of benefits paid exceed the sum of premiums paid for Your Policy, no Return of Premium upon Death Benefit will be payable to Your beneficiary.

If We receive a claim for benefits for Long-Term Care Covered Charges after the Return of Premium upon Death Benefit has been paid, benefits for those services will be reduced by the amount of the Return of Premium upon Death Benefit that has been paid.

Your beneficiary for the Return of Premium upon Death Benefit is the individual that You designated as beneficiary in Your application for this Policy. You may change the beneficiary for this benefit at any time. However, such request for a change in beneficiary must be in writing and sent to Our LTC Administrative Office.

Important Notice Regarding Federal Income Tax Law – Please note that the payment of the Return of Premium Benefit may have Federal Income Tax implications for Your estate or beneficiary. You are advised to review this benefit with a qualified tax professional or attorney to determine any such tax impact.

PART 3 - EXCEPTIONS

This part describes care, treatment or services that will be excluded under the Policy and situations under which 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, alcohol abuse 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 provided or 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, Home Health Agency, Adult Day Care Center 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 United States and its possessions except as described in the International Coverage Benefit section of this Policy.

Non-Duplication of Benefits

This Policy will only pay covered charges in excess of charges covered 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). This means that this Policy does not pay for Your Medicare deductibles or coinsurance.
- any other governmental program (except Medicaid).
- any workers' compensation law, employer's liability or occupational disease law, or any mandatory 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

Notice of Claim

You, Your family member or representative should notify Us as soon as You become a Chronically Ill Individual. The best way to notify Us is by calling Us at 1-800-233-1449. If you prefer, You can write to Us at Our LTC Administrative Office.

Your notice must include:

- Your name;
- Your Policy number; and
- the type of care You are receiving or plan to receive

If You notify Us by telephone, You must call Us within 45 days after any Long-Term Care Services or Care Advisory Services begin 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 or Care Advisory 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.

We will send You 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 may give Us written proof of the nature and extent of Your loss in place of the claim forms, provided that the Proof of Loss requirement is met.

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 Cognitive Impairment; and Your confinement in a Nursing Home or Assisted Living Facility, or the Home Health Care, Adult Day Care, Hospice Care, Care Advisory Services or Alternative Services You are receiving.

This documentation includes:

- a completed claim form;
- confirmation of Nursing Home, Assisted Living Facility, Adult Day Care Center, Home Health Agency and/or Independent Home Health Care Provider licensure/certification as required by the jurisdiction in which it is located or care is rendered;

- the Certification described in Part 2 of this Policy;
- itemized bills for charges You incurred for care and services; and
- Your Plan of Care (including the functional and cognitive assessment on which the Plan of Care is based.)

In addition, We may also require copies of medical records (or We may consult with Your primary Physician and provider by telephone at Our option), facility residency agreements, service plans, Your providers' daily notes of care and copies of cancelled checks or other proof of payment. No additional requirements are placed on agencies licensed by the jurisdiction they are located within.

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 one hundred twenty days (120) 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. You are considered legally incapacitated if You have a Cognitive Impairment.

At time of claim, We will make available to You Our provider discount 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. Discounts may only relate to certain services or may vary by provider. A provider may be added to, or removed from, this list at such provider's own or Our request at any time and the discount may be discontinued. We reserve the right to enhance, modify or terminate this Program at any time. Please note that the discounted fees charged by a provider who participates in the provider discount program may not be the least expensive fees available and not all providers may qualify for reimbursement under Your Policy. You should review cost of care and services as well as the providers in Your area. In addition, We do not endorse, sponsor or guarantee the quality of a provider who participates in the provider discount program, or the care or services provided by such provider. It is Your responsibility to choose a provider who will best meet Your long-term care and service needs.

Our Claims Evaluation Process

We will work with You, 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 after services have been rendered and charges have been incurred for such services.

We will send claim payment no later than 30 days after We receive notice of claim and Proof of Loss, provided that all Policy requirements have been satisfied. If We take more than 30 days to send the claim payment, We will pay interest on the amount of the claim that should have been paid, beginning 31 days after receiving all required information, until payment is made. Interest will be at the rate of 1% per month (or a higher rate if required by state law or regulation).

As a reminder, in order for Us to process Your Claim, We will need Your assistance. You have a responsibility to comply with all applicable Policy provisions, provide Us with requested information and comply with Our requests in a timely manner. If You refuse to provide requested information or undergo any requested assessment, interview or exam, We will be unable to process Your claim and therefore, We will not be liable for the payment of benefits.

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, 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.

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 has assigned benefits. At Our option, any benefit of \$1,000 or less may be paid to an alternative payee who We believe to be 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 necessary) and send it to:

John Hancock Life & Health Insurance Company
Attn: R-02-B Long-Term Care
P.O. Box 55231
Boston, MA 02205-5231
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
- submit any additional pertinent information regarding Your care that You wish to be considered.

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. The Claim Appeals Review Board may request additional information or an assessment to objectively evaluate Your 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.

Independent Third Party Review

You have the right to request an Independent Third Party Review if the Claim Appeals Review Board upholds a denial of Your claim based upon a determination that You are not a Chronically Ill Individual.

We will provide You with written instructions on Your right to request an Independent Third Party Review when we notify you of the Claim Appeals Review Board's decision. You must make a request for an Independent Third Party Review in writing no later than 120-days after the date of Our notice informing You of the Claim Appeals Review Board's decision. The role of the Independent Third Party is to review relevant material related to the denial of Your claim that We provide. You will not undergo an exam. We will be happy to review any new or additional information that You wish to provide Us throughout this process.

The Independent Third Party will provide You, the State Insurance Department (if required) and Us with written notice of its final decision within 30-calendar days from its receipt of Your request for an Independent Third Party Review. If the Independent Third Party overturns the denial of Your claim, the Independent Third Party shall:

- establish the precise date within the specific period of time under review that You were a Chronically Ill Individual;
- specify the specific period for which We declined eligibility, but the Independent Third Party determined that You were a Chronically Ill Individual; and
- provide a certification from a Licensed Health Care Practitioner that You are a Chronically Ill Individual.

The decision of the Independent Third Party is final and binding on Us. We will pay the costs associated with an Independent Third Party Review.

The Independent Third Party must be either:

- state approved or certified to conduct such reviews if the state requires such approvals or certifications; or
- if state approval is not required, mutually agreed to by You and Us.

In addition, an Independent Third Party must:

- be, or have on staff or contract with a qualified and licensed health care professional in an appropriate field for determining an individual's ability to perform the Activities of Daily Living or an individual's Cognitive Impairment, whichever applies to Your claim;

- not be affiliated with nor in any manner related to an entity or individual that previously provided care or services to You;
- not employ a licensed health care professional who is associated with Us or related to You in any manner; and
- not be compensated in any manner that is dependent upon the outcome of the review.

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 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, .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.

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 reinstatement 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.

Your rights and Our rights under this Policy will be the same as they were just before the Policy terminated, subject to the following exceptions:

- The reinstated Policy will cover only loss due to an injury sustained or physical or mental condition that begins after the date of reinstatement. A physical or mental condition will be considered to have begun when advice or diagnosis is supplied or treatment is recommended by or received from a Physician for such condition.
- If the reinstatement application contains a misrepresentation, Your Policy shall be deemed to be in effect beginning on the date We received Your reinstatement application solely for purposes of the Time Limit on Certain Defenses/Misrepresentation provision.
- Any provision added to this Policy in connection with reinstatement shall apply.

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 for the time period between the date of death and the next premium due date. Such refund will be made to Your surviving spouse, if any, 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.

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; and
- any riders, amendments, endorsements or other papers issued by Us to be made part of Your Policy.

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.

Time Limit on Certain Defenses/Misrepresentation

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:

- was 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.

If You request an increase in coverage under the Changes in Your Coverage section and the information provided in support of Your request contains a misrepresentation, We may rescind the increase or deny increased benefits on an otherwise valid claim in accordance with the above provisions, provided that the time limits shall be adjusted to reflect the time period that the increase in coverage (rather than the Policy) has been in effect, and the reference to application shall mean the information provided in support of Your request to increase coverage.

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

Changes in Your Coverage

Please contact Us if You would like to make any changes in Your coverage.

On each Policy anniversary, You have the right to request an increase to Your Long-Term Care Benefit Amount in \$10 increments if You elected the daily option, or \$100 increments if You elected the monthly option. Your Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will increase by the same percentage. You must make the request in writing, and You must meet the approval of Our underwriting department. If We approve Your request, You must pay an additional premium for the increase in coverage. The premium for the additional coverage will be based upon Your attained age and rating class on the date You make this request, at the rates then in effect. The premium for Your underlying coverage will remain unchanged.

At any time, You may request a decrease to Your Long-Term Care Benefit Amount in \$10 increments if You elected the daily option, or \$100 increments if You elected the monthly option. The decrease will take effect on Your next premium due date. Your Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will decrease by the same percentage. You must make the request in writing, and any election to decrease coverage is not subject to approval of Our underwriting department. The premium reduction for any decreased coverage will be based on your age at the time the coverage to be reduced was issued.

The amount of a benefit increase or decrease is subject to available Policy options at the time of Your request. At the time You make a request to change Your coverage, We will also provide You with information on any additional increase or decreases options that are currently available to You.

Clerical Error

Clerical error shall not prejudice the rights of John Hancock, except as otherwise provided in the Policy. In the event of such clerical error, the Policy will be administered in accordance with Policy provisions as if there had been no such error.

Conformity with State Laws

Any part of this Policy which, as of the Effective Date of Coverage, is in conflict with the laws of the state in which this Policy was issued, is amended to conform to the minimum requirements of such laws.

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.

We reserve the right to deduct any such overpayments from any benefits under this Policy that are payable.

Suspended Coverage During Military Service

If You are a member of a reserve component of the armed forces of the United States, including the National Guard, You may request in writing a suspension of this Policy during a period of active duty. This does not apply to active duty for training that lasts 90 days or less.

This Policy will not be in force while it is suspended, and You will not be required to pay premiums. We will refund that part of any premium paid for the suspended period.

Upon termination of military service of no longer than five years, You may renew coverage on the same basis as before suspension of coverage took effect.

Renewal will take effect on the date military service terminates, subject to written application and payment of the required premium within sixty days after such date. No proof that You are insurable is needed. Premiums will be at the same rate as if this Policy was never suspended. The restored Policy will not cover any condition that arose during the period of active duty and that condition has been determined by the Secretary of Veterans' Affairs to be incurred in the line of duty.

Policy Termination

This Policy will terminate at 12:01 a.m. Eastern Time on the earliest occurrence of one of the following events:

- You have exhausted Your Policy Limit;
- You do not pay Your premium when due (see the provision captioned "Grace Period");
- You cancel Your Policy; or
- The date of Your death.

SAMPLE

COPY OF APPLICATION AND OTHER ATTACHED PAPERS

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

SAMPLE

NOTICE

If You have any questions about this Policy, write Us at Our LTC Administrative Office, 1 John Hancock Way, Suite 1700, Boston MA 02217-1700 or call Us toll-free at 1-800-377-7311.



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY
ENDORSEMENT

CPI COMPOUND INFLATION COVERAGE AND GUARANTEED INCREASE OPTION

This Endorsement explains how Your Long-Term Care Benefit Amount increases to provide protection against the increasing cost of long term care due to inflation.

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

Annual Automatic CPI Increase in Long-Term Care Benefit Amount

We will increase the current Long-Term Care Benefit Amount on each Policy anniversary, while this Policy is in effect, beginning with the first Policy anniversary. The Long-Term Care Benefit Amount will be increased by the percentage change in the CPI three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest dollar. In the event the CPI decreases, We will not reduce the Long-Term Care Benefit Amount by such CPI decrease on the Policy anniversary. However, We will offset any such CPI decreases when calculating future CPI increases to the Long-Term Care Benefit Amount. When the Long-Term Care Benefit Amount is increased, the remaining Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

CPI means the non-seasonally adjusted Consumer Price Index, Urban, All Items, Base Years 1982 – 1984, published by the Bureau of Labor Statistics of the United States Department of Labor (CPI). If the CPI is discontinued, if there is a delay in the announcement of the CPI, or if its method of computation is changed, We may use another nationally published index. "CPI" will then mean the chosen index. This new index must be approved by the Superintendent of Insurance of the State of New York prior to its use.

No inflation adjustment will be made while this Policy is in effect under the provisions of any nonforfeiture benefit.

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

Guaranteed Increase Option

Important Notice – The Guaranteed Increase Option is *not* applicable to You if You are paying Your premium via the Twenty-Year Premium Payment Option or the Paid up at Age 75 Payment Option or if You purchased the Survivorship and Waiver of Premium Benefit.

Option Dates

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long-Term Care Benefit Amount by purchasing an additional amount of coverage equal to 5% of the current Long-Term Care Benefit Amount that was in effect immediately prior to that Option Date. No additional underwriting will be required.

We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

When the Long-Term Care Benefit Amount is increased under the Guaranteed Increase Option, the remaining Policy Limit (as well as any remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

At the time of each offer, We will provide You with information regarding:

- Your current Long-Term Care Benefit Amount;
- the amount of increase available to You under this Guaranteed Increase Option;
- the additional premium amount for the increase under this Guaranteed Increase Option; and
- instructions on how You may elect this increase. We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

IMPORTANT NOTICE - If You do not elect an increase when offered, that increase will not be available on any future date. You will, however, still have the opportunity to accept future offers unless You decline the offer two times. After You decline the offer of an optional increase on any two Option Dates, no future offers will be available to You. However, You may request to resume such offers by making the request to Us in writing and provide evidence of insurability satisfactory to Us. Any resumed offers will be subject to all conditions of this Endorsement.

The premium for any increase under the Guaranteed Increase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect.

The increase on any Option Date will not be available to You (and, if requested, will not take effect) if:

- You were a Chronically Ill Individual at any time during the two year period prior to the Option Date; or
- the Option Date occurs on or after Your 76th birthday.

No Guaranteed Increase Option offer or adjustment will be made while this Policy is in effect under any nonforfeiture benefit.

Termination

Nothing in this Endorsement will extend termination of the Policy or create a new Policy Limit after the then applicable Policy Limit is exhausted. This Endorsement 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

SAMPLE



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

ENDORSEMENT

CPI COMPOUND INFLATION COVERAGE THROUGH AGE 75 AND GUARANTEED INCREASE
OPTION

This Endorsement explains how Your Long Term Care Benefit Amount increases to provide protection against the increasing cost of long term care due to inflation.

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

Annual Automatic CPI Increase in Long Term Care Benefit Amount

We will increase the current Long Term Care Benefit Amount on each Policy anniversary, while this Policy is in effect, beginning with the first Policy anniversary through age 75. The Long Term Care Benefit Amount will be increased by the percentage change in the CPI three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest dollar. In the event the CPI decreases, We will not reduce the Long Term Care Benefit Amount by such CPI decrease on the Policy anniversary. However, We will offset any such CPI decreases when calculating future CPI increases to the Long Term Care Benefit Amount. When the Long Term Care Benefit Amount is increased, the remaining Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long Term Care Benefit Amount and rounded to the nearest dollar.

CPI means the non-seasonally adjusted Consumer Price Index, Urban, All Items, Base Years 1982 – 1984, published by the Bureau of Labor Statistics of the United States Department of Labor (CPI). If the CPI is discontinued, if there is a delay in the announcement of the CPI, or if its method of computation is changed, We may use another nationally published index. "CPI" will then mean the chosen index. This new index must be approved by the Superintendent of Insurance of the State of New York prior to its use.

When Will Annual Inflation Increases Stop

There will be no further increases under this Endorsement on or after Your 76th birthday. After such date has been reached all annual benefit increases under this provision will stop

No inflation adjustment will be made while this Policy is in effect under the provisions of any nonforfeiture benefit.

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

Guaranteed Increase Option

Important Notice – The Guaranteed Increase Option is *not* applicable to You if You are paying Your premium via the Twenty-Year Premium Payment Option or the Paid up at Age 75 Payment Option or if You purchased the Survivorship and Waiver of Premium Benefit.

Option Dates

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long-Term Care Benefit Amount by purchasing an additional amount of coverage equal to 5% of Your current Long-Term Care Benefit Amount that was in effect immediately prior to that Option Date. No additional underwriting will be required.

We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

When the Long-Term Care Benefit Amount is increased under the Guaranteed Increase Option, the remaining Policy Limit (as well as any remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

At the time of each offer, We will provide You with information regarding:

- Your current Long-Term Care Benefit Amount;
- the amount of increase available to You under this Guaranteed Increase Option;
- the additional premium amount for the increase under this Guaranteed Increase Option; and
- instructions on how You may elect this increase. We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

IMPORTANT NOTICE - If You do not elect an increase when offered, that increase will not be available on any future date. You will, however, still have the opportunity to accept future offers unless You decline the offer two times. After You decline the offer of an optional increase on any two Option Dates, no future offers will be available to You. However, You may request to resume such offers by making the request to Us in writing and provide evidence of insurability satisfactory to Us. Any resumed offers will be subject to all conditions of this Endorsement.

The premium for any increase under the Guaranteed Increase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect.

The increase on any Option Date will not be available to You (and, if requested, will not take effect) if:

- You were a Chronically Ill Individual at any time during the two year period prior to the Option Date; or
- the Option Date occurs on or after Your 76th birthday.

No Guaranteed Increase Option offer or adjustment will be made while this Policy is in effect under any nonforfeiture benefit.

Termination

Nothing in this Endorsement will extend termination of the Policy or create a new Policy Limit after the then applicable Policy Limit is exhausted. This Endorsement 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:

SAMPLE
Secretary



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

ENDORSEMENT

5% COMPOUND INFLATION COVERAGE

This Endorsement explains how Your Long-Term Care Benefit Amount increases each year to provide protection against the increasing cost of long-term care due to inflation.

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

5% Annual Increase in Long-Term Care Benefit Amount

We will increase the Long-Term Care Benefit Amount 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, the Long-Term Care Benefit Amount in effect for the immediately preceding Policy year will be increased by 5% and rounded to the nearest dollar.

When the Long-Term Care Benefit Amount is increased, the remaining Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

No inflation adjustment will be made while this Policy is in effect under the provisions of any nonforfeiture benefit.

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

Nothing in this Endorsement will extend termination of the Policy or create a new Policy Limit after the then applicable Policy Limit is exhausted.

Termination

This Endorsement 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



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

ENDORSEMENT

GUARANTEED PURCHASE OPTION

This Endorsement explains how Your Long-term Benefit Amount increases on each Option Date to provide protection against the increasing cost of long-term care due to inflation.

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.

Important Notice – The Guaranteed Purchase Option is *not* applicable to You if You are paying Your premium via the Twenty-Year Premium Payment Option or the Paid up at Age 75 Payment Option or if You purchased the Survivorship and Waiver of Premium Benefit..

Option Dates

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long-Term Care Benefit Amount by purchasing an additional amount of coverage equal to 10% of the current Long-Term Care Benefit Amount that was in effect immediately prior to that Option Date. No additional underwriting will be required.

We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

When the Long-Term Care Benefit Amount is increased under the Guaranteed Purchase Option, the remaining Policy Limit (as well as any remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

At the time of each offer, We will provide You with information regarding:

- Your current Long-Term Care Benefit Amount;
- the amount of increase available to You under this Guaranteed Purchase Option;
- the additional premium amount for the increase under this Guaranteed Purchase Option; and
- instructions on how You may elect this increase. We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

IMPORTANT NOTICE - If You do not elect an increase when offered, that increase will not be available on any future date. You will, however, still have the opportunity to accept future offers unless You decline the offer two times. After You decline the offer of an optional increase on any two Option Dates, no future offers will be available to You. However, You may request to resume such offers by making the request to Us in writing and provide evidence of insurability satisfactory to Us. Any resumed offers will be subject to all conditions of this Endorsement.

The premium for any increase under the Guaranteed Purchase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect.

The increase on any Option Date will not be available to You (and, if requested, will not take effect) if:

- You were a Chronically Ill Individual at any time during the two year period prior to the Option Date; or
- the Option Date occurs on or after Your 76th birthday.

No Guaranteed Purchase Option offer or adjustment will be made while this Policy is in effect under any nonforfeiture benefit.

Nothing in this Endorsement will extend termination of the Policy or create a new Policy Limit after the then applicable Policy Limit is exhausted.

One-Time Offer to Switch to CPI Compound Inflation Coverage On Your 65th Birthday

This provision applies to individuals under age 65.

CPI means the non-seasonally adjusted Consumer Price Index, Urban, All Items, published by the Bureau of Labor Statistics of the United States Department of Labor (CPI).

We will make You a one-time written offer on Your Policy anniversary which falls on or after Your 65th birthday to switch Your Guaranteed Purchase Option to CPI Compound Inflation Coverage. This offer will be available to You for a period of 60-days. Your election must be in writing on the form that We provide You. You must then send this form back to Our LTC Administrative Office. We will provide You notice of the new increased premium. The increase in Your premium will be equal to the difference between the premium for CPI Compound Inflation Coverage and Your Guarantee Purchase Option coverage at Your attained age for Your then current benefits.

If You are eligible for a Guaranteed Purchase offer immediately prior to You being eligible to switch to CPI Compound Inflation Coverage, You may elect such offer and then switch to CPI Compound Inflation Coverage.

The offer to switch Your Guaranteed Purchase Option to CPI Compound Inflation will not be available to You (and, if requested, will not take effect) if You were a Chronically Ill Individual at any time during the two year period prior to the date this offer is made to You.

If You elect to switch to CPI Compound Inflation Coverage, You will not receive any future Guaranteed Purchase Option offers.

Termination

This Endorsement 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:

SAMPLE

Secretary



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

SHARED CARE BENEFIT

OPTIONAL BENEFIT RIDER

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

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.

General

You have designated Your Partner as the SharedCare Covered Person 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 John Hancock policy, naming You as the SharedCare Covered Person under that policy; and
- The Policy Limit of Your Partner's own John Hancock policy has been exhausted.

DEFINITIONS

The following term has special meaning for use in this Rider:

- "Your Partner" means the person named as Your Partner in the application or enrollment form for this Rider.

THE SHARED CARE BENEFIT AND HOW IT WORKS

SharedCare Benefit

If Your Partner exhausts the Policy Limit under his or her John Hancock policy, We will automatically continue Your Partner's claim subject to the terms and Policy Limit of Your Policy as long as 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 John Hancock policy; and
- We will calculate benefits paid on behalf of Your Partner according to the applicable Long-Term Care Benefit Amount 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.

Important Notice:

- Your Partner only has access to Your Policy Limit less the following dollar amount – the sum of 365-days or 12-months, as the case may be, multiplied by your Long-Term Care Benefit Amount. This means that this amount remains available for Your exclusive use while Your Policy is in force.
- Notwithstanding any provisions to the contrary, payment for benefits under the SharedCare Rider will conform to Section 52.13 of Regulation 62 and not to Section 52.12 of Regulation 62

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

Please note that Your Stay at Home Lifetime Benefit Amount and the Additional Cash Benefit (if included in Your Policy) is not available for Your Partner to access through operation of this Rider.

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

Upon receipt of proof of the death of You or Your Partner, We will 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 (minus the premium 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 Long-Term Care Benefit Amount then in effect times the applicable 730-days or 24-months, as the case may be. 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 were a Chronically Ill individual at any time 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 Long-Term Care Benefit Amount then in effect and Your attained age on the date the Policy Limit is increased.

WAIVER OF PREMIUM

Waiver of Premium

We will only 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

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.

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

In addition, this Rider will terminate on any of the following dates:

- 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 that 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. This does not include increases in benefits due to the operation of any Guaranteed Increase or Guaranteed Purchase Option, if included in Your Policy.

Signed for the Company at Boston, Massachusetts:

Secretary



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

WAIVER OF THE HOME HEALTH CARE ELIMINATION PERIOD BENEFIT

OPTIONAL BENEFIT RIDER

This Rider will waive the requirement to satisfy the Elimination Period if You are receiving Home Health Care, Hospice Care or Adult Day 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 Health Care in Your Home;
 - Hospice; or
 - Adult Day Care in an Adult Day Care Center.

You still must satisfy Your Elimination Period before benefits are payable under the Long-Term Care Benefit for confinement in a Nursing Home or an Assisted Living 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 Health Care, Hospice Care or Adult Day 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



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

SURVIVORSHIP & WAIVER OF PREMIUM BENEFIT

OPTIONAL 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.

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.

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 all of the following conditions have been met:

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

In order for Us to provide You this benefit, You must provide Us proof 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:

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

Your Partner 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 are no longer waived; or
- the date Your Partner's policy terminates.

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 You may purchase in the future due to the operation of this Rider.

WHEN THIS RIDER WILL END

Termination of This Rider

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

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, so that We can remove this Rider and its associated premium cost from future premium notices.

Signed for the Company at Boston, Massachusetts:

Secretary



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

ADDITIONAL CASH BENEFIT

OPTIONAL BENEFIT RIDER

This Rider will provide You with access to additional funds in order to allow You to remain in Your Home.

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.

Additional Cash Benefit

The Additional Cash Benefit can be used to pay for a variety of Your long-term care expenses while You are receiving services in Your Home.

Each month, We will pay You the Additional Cash Benefit Amount if:

- You are a Chronically Ill Individual;
- You have satisfied Your Elimination Period;
- You have received Home Health Care at least one day during the calendar month; and
- You have not been confined in a Nursing Home or Assisted Living Facility at any time during the calendar month.

The Additional Cash Benefit Amount is shown on the Policy Schedule. The Additional Cash Benefit Amount is equal to 15% of the Long Term Care Benefit Amount if You elected a monthly benefit or 4.5 times the Long Term Care Benefit Amount if You elected a daily benefit. A benefit paid under the Additional Cash Benefit will not reduce the Policy Limit. You may receive Policy benefits such as the Long-Term Care Benefit, the Additional Stay at Home Benefit and/or Care Advisory Services while receiving benefits under the Additional Cash Benefit. Payment of the Additional Cash Benefit Amount will begin only after You have satisfied Your Elimination Period. Any inflation adjustment (or benefit level increase as a result of Your acceptance of an offer under any Guaranteed Increase or Guaranteed Purchase Option Endorsement if included in Your Policy) will apply equally to the Additional Cash Benefit Amount.

Payment of the Additional Cash Benefit will end on the earlier of the following dates:

- the date that You are no longer eligible for benefits under the Policy; or
- the date the Policy Limit has been exhausted.

The Additional Cash Benefit is only applicable if You are receiving care or services within the fifty (50) United States and the District of Columbia and is not subject to the International Coverage Benefit.

Important Notice Regarding Federal Income Tax Law

Benefits paid under the Additional Cash Benefit are subject to certain aggregation rules under the Internal Revenue Code Section 7702B for purposes of Federal Income Tax calculation. This means that Monthly Cash Benefits will be aggregated with other benefits paid for You under the Policy. In the event that total payments exceed the "Per Diem Limitation" for that period, any benefits paid in excess of such limitation are includable in gross income. You are advised to review this benefit with a qualified tax professional or attorney to determine any such tax impact.

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



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

ENDORSEMENT

NONFORFEITURE BENEFIT

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

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

Nonforfeiture Benefit

After Your Policy and this Endorsement have been in effect for three (3) years (one (1) year if Your Policy Schedule shows You have selected a limited payment option), 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. However, in no event will the new Policy Limit ever be less than:

- thirty (30) times the Long-Term Care Benefit Amount at the time of lapse if You elected the daily Long-Term Care Benefit Amount; or
- one (1) times the Long-Term Care Benefit Amount at the time of lapse if You elected the monthly Long-Term Care Benefit Amount.

No benefits will be paid in excess of the new Policy Limit. Benefits will be paid subject to the Long-Term Care Benefit Amount level in effect at the time You lapsed Your Policy.

Also, no benefits will be paid in excess of the Policy Limit that would have been in effect if You had continued to pay premiums as required.

If Your Policy has been in effect for less than three (3) years (one (1) year if Your Policy Schedule shows You have selected a limited payment option), no Nonforfeiture Benefit is payable and Your Policy will terminate for non-payment of premium.

All optional benefit riders will automatically terminate when Your Policy changes to paid-up status under the provisions of the Nonforfeiture Benefit. In addition, no inflation adjustment will be made while the Policy is in effect under the Nonforfeiture Benefit.

Signed for the Company at Boston, Massachusetts:

SAMPLE Secretary



JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY

ENDORSEMENT

DOUBLE COVERAGE FOR ACCIDENT BENEFIT

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

Double Coverage for Accident Benefit

Important Note – This benefit is not available to You if You are age 65 or older at the time of an Accidental Injury.

We will pay the actual charges incurred by You for Long-Term Care Services up to the Double Coverage for Accident Benefit Amount as shown in the Policy Schedule if all of the following requirements are satisfied:

You become a Chronically Ill Individual due solely to an Accidental Injury;

- Your Accidental Injury occurs after the effective date of Your Policy and prior to Your 65th birthday;
- You were not a Chronically Ill Individual immediately before the Accidental Injury; and
- A Licensed Health Care Practitioner certifies within 90 days of the date of the Accidental Injury that because of such Accidental Injury You are a Chronically Ill Individual.

For purposes of this benefit, the term "Accidental Injury" means a sudden, unexpected and unintentional physical event that causes you to become a Chronically Ill Individual.

The Double Coverage for Accident Benefit Amount is equal to 2-times the Long-Term Care Benefit Amount. Benefits paid in excess of the Long-Term Care Benefit Amount will ***not*** be deducted from the Policy Limit. We will never pay more than the actual charges You incur for care and services covered by this Policy. Payment of the Double Coverage for Accident Benefit will begin only after You have satisfied Your Elimination Period.

Benefits payable under the Double Coverage for Accident Benefit will terminate when You are no longer a Chronically Ill Individual.

If You suffer an additional loss or condition after You recover from an Accidental Injury, but that loss or condition does not result primarily from an Accidental Injury, You will not qualify for payment of the Double Coverage for Accident Benefit for that loss or injury.

Termination

This Endorsement 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:

SAMPLE

Secretary