FLTCIP 1.0

The Federal Long Term Care Insurance Program
Benefit Booklet

The **Federal** Long Term Care Insurance Program™

BENEFIT BOOKLET
FLTCIP 1.0

FEDERAL LONG TERM CARE INSURANCE PROGRAM
P.O. Box 797
Greenland, New Hampshire 03840-0797
1-800-LTC-FEDS (1-800-582-3337)
TTY 1-800-843-3557

Group Policyholder: United States Office of Personnel Management ("OPM")
Insurer: John Hancock Life & Health Insurance Company ("John Hancock")
Federal Program Administrator: Long Term Care Partners, LLC

Group Policy Number: 900-003

NOTICES: PLEASE READ CAREFULLY!

Important: Our decision to issue coverage was based upon your responses to the questions on your Application, a copy of which has been or will be sent to you. We may deny benefits or rescind your insurance coverage if your answers are incorrect or untrue. If any information you provided to us about your health or eligibility status changed before the Original Effective Date shown on your Schedule, you must notify us immediately. The best time to clear up any questions is now, before a claim arises! If for any reason, any of your answers is incorrect, please contact: Federal Long Term Care Insurance Program, P.O. Box 797, Greenland, New Hampshire 03840-0797. You may also call 1-800-LTC-FEDS (1-800-582-3337), TTY 1-800-843-3557.

The Group Policy, including this Benefit Booklet, is designed to be a qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Subject to specified dollar limits that vary depending on your age, you may be able to include your premium in your itemized deductions on your Federal income tax return, if your total medical expenses, including the allowable portion of your premium, exceed 7½% of adjusted gross income. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly. We have designed the Group Policy so that benefits you receive under the Federal Program should be tax-free. Please remember that tax laws can change and to consult your tax advisor if you have any questions or need further details.

The Federal Program may not cover all of your long term care costs. Please review all coverage limitations and exclusions described in this Benefit Booklet and your Schedule of Benefits.

Please refer to the Definitions section for a definition of New Enrollee and Existing Enrollee.

New Enrollees Under the Federal Program. If you are a New Enrollee, within 30 days after you receive this Benefit Booklet, you may cancel your coverage if you are not satisfied with it and receive a refund of any premium you paid. If you wish to do this, you must notify us within 30 days of receiving this Benefit Booklet. Then we will refund all of your premium paid for coverage under this Benefit Booklet within 30 days. You may cancel your coverage at any other time; however, we will only refund premium that covers a period after the effective date of your cancellation.

Existing Enrollees Under the Federal Program. If you are an Existing Enrollee, coverage under your prior Benefit Booklet terminates as of the Effective Date of the Schedule of Benefits that accompanied this Benefit Booklet. If you are not satisfied with this Benefit Booklet and wish to cancel it, you must notify us within 30 days of receiving this Benefit Booklet. Then, we will cancel your coverage as of the Effective Date of the Schedule of Benefits that accompanied this Benefit Booklet, and refund any premium you paid for coverage after that date. Your cancellation of this Benefit Booklet will also cancel the prior Benefit Booklet on the same date. Please refer to the Benefit Changes section for information on cancelling an increase or decrease to your coverage.

YOUR COVERAGE IS GUARANTEED RENEWABLE. This means we will not cancel your coverage as long as you pay your premium on time. However, this does not mean that your premiums are guaranteed to remain unchanged. Please see the When We May Increase Your Premium section below and the Premiums section for information on when we may change your premium. Please see the Statements Made by You Relating to Insurability subsection of the General Provisions section for information on when we may Void your coverage. We and OPM will determine whether to renew the Group Policy. Your consent or the consent of any other person who may have a beneficial interest under the Group Policy is not required. You will be notified in the event the Group Policy is ended. You may continue your coverage, even if the Group Policy ends, subject to the terms and conditions of the Continuation of Coverage section.

WHEN WE MAY INCREASE YOUR PREMIUM. We reserve the right to increase your premium in the future. However, it is important to note that we cannot single you out and raise your premium because of your advancing age, declining health, claim status or for any other reason related solely to you. We may only increase your premium if you are among a group of enrollees whose premium is determined to be inadequate. While the Group Policy is in effect, OPM must approve the increase in premium. As a reminder, your premium may also increase if you voluntarily elect to increase your benefits. Please see the subsection How Benefit Changes Affect Your Premium.

This Benefit Booklet together with your Schedule of Benefits is your evidence of coverage.

TABLE OF CONTENTS

SECTION PAGE

NOTICES: PLEASE READ CAREFULLY! 4
New Enrollees Under the Federal Program 4
Existing Enrollees Under the Federal Program 5

YOUR COVERAGE IS GUARANTEED RENEWABLE 5

WHEN WE MAY INCREASE YOUR PREMIUM 5

TABLE OF CONTENTS 6

INTRODUCTION 10
Defined Terms 10

EFFECTIVE DATE OF COVERAGE — NEW ENROLLEES 10
If You Lost Your Eligibility Status Before Your Original Effective Date 11
If Your Eligibility Status Changed Before Your Original Effective Date 11
Actively at Work Requirement for Employees and
Members of the Uniformed Services 11

EFFECTIVE DATE OF COVERAGE — EXISTING ENROLLEES 12

CONDITIONS FOR PAYMENT OF BENEFITS 12

ELIGIBILITY FOR BENEFITS 13
How to Ask Us to Determine Whether You Are Eligible for Benefits 13
Continuing Assessment of Your Eligibility for Benefits 13
Notice and Review of Benefit Eligibility Decision 13

WAITING PERIOD 14

COVERED SERVICES 14
Facilities-Only Option 14
Nursing Home and Assisted Living Facility 15
Hospice Facility 15
Comprehensive Option 15
Services Provided by a Formal Caregiver at Home 15
Services Provided by an Informal Caregiver 15
Hospice Care at Home 16
Services Provided at an Adult Day Care Center 16
Additional Covered Services and Benefits 16
Bed Reservations 16
Caregiver Training 16
Respite Services 17
Alternate Plan of Care 17
International Benefits 18

MAXIMUM BENEFIT WE WILL PAY 19
For the Facilities-Only Option 19
For the Comprehensive Option 19
Exception for Caregiver Training 20

SECTION PAGE
CARE COORDINATION SERVICES 20
EXCLUSIONS 21
Your Coverage Does Not Have a War Exclusion 21
COORDINATION OF BENEFITS 21
Government Programs 23
CLAIMS 23
Notice and Review of Claim Determination 23
APPEALS 24
Appeals Committee 24
Independent Third Party 24
Exhaustion of the Appeals Process 25
PAYMENT OF BENEFITS 25
BENEFIT CHANGES 25
Automatic Compound Inflation Option 25
Future Purchase Option 26
Other Benefit Changes (Upgrades and Downgrades) 27
PREMIUMS 27
How Benefit Changes Affect Your Premium 28
Contingent Benefit Upon Lapse 28
GRACE PERIOD 29
Protection Against Unintended Lapse (“PAUL”) 29
WAIVER OF PREMIUM 29
WHEN YOUR COVERAGE WILL END 29
PORTABILITY 30
CONTINUATION OF COVERAGE 30
EXTENSION OF BENEFITS 30
REINSTATEMENT OF COVERAGE 31
GENERAL PROVISIONS 31
Statements Made by You Relating to Insurability 31
Age 32
No Cash Surrender Value 32
Insurer 32
Right to Change Contract Provisions 32
Interpretation of Terms, Conditions and Provisions 33
Limits on Legal Actions 33
Refund of Premiums 33
Payments on Your Death 33

TABLE OF CONTENTS *(continued)*

SECTION PAGE

DEFINITIONS 34
Act 34
Actively at Work or Active Work 34
Activities of Daily Living 34
Adult Day Care Center 35
Annuitant 35
Application 35
Assisted Living Facility 35
Bed Reservations 36
Benefit Amount 36
Benefit Booklet 36
Benefit Period 36
Caregiver Training 36
Comprehensive Option 36
Covered Services 37
Daily Benefit Amount 37
Employee 37
Existing Enrollee 37
Facilities-Only Option 37
Family Member 37
Federal Program 37
Formal Caregiver 37
Group Policy 37
Home 38
Home Care Agency 38
Home Health Aide 38
Homemaker 38
Hospice 38
Hospice Care 38
Hospital 38
Informal Caregiver 39
Licensed Health Care Practitioner 39
Maintenance or Personal Care 39
Material To Your Insurability 39
Maximum Lifetime Benefit 39
Medicare 39
Member of the Uniformed Services 39
Misrepresentation 39
New Enrollee 39
Nurse 39
Nursing Care 40
Nursing Home 40
OPM 40

SECTION PAGE

Original Effective Date 40
Physician 40
Plan of Care 40
Qualified Long Term Care Services 41
Qualified Relative 41
Respite Services 41
Retired Member of the Uniformed Services 41
Schedule of Benefits 41
Severe Cognitive Impairment 41
Signed 41
Social Worker 41
Substantial Assistance 41
Substantial Supervision 41
Terminal Illness or Terminally Ill 42
Therapist 42
Therapy Services 42
United States 42
Void 42
Week 42
Weekly Benefit Amount 42
Workforce 42
Written or Writing 42

INTRODUCTION

Thank you for selecting the Federal Long Term Care Insurance Program (Federal Program) to help meet your long term care insurance needs.

When you applied for coverage under the Federal Program, you selected one of two coverage options – the Facilities-Only Option or the Comprehensive Option. (If you applied during the Early Enrollment Period, you have the Comprehensive Option). The Facilities-Only Option includes as Covered Services those you receive while in a Nursing Home, Assisted Living Facility, or Hospice facility. The Comprehensive Option includes all of the Covered Services under the Facilities-Only Option plus Covered Services you receive at Home or an Adult Day Care Center. This Benefit Booklet describes both options. Your Schedule of Benefits provided with this Benefit Booklet shows your coverage option and the amounts of coverage that you have.

Long Term Care Partners, LLC, is the Federal Program administrator. You may contact Long Term Care Partners at 1-800-LTC-FEDS (1-800-582-3337), TTY 1-800-843-3557. In consultation with OPM, we may change the Federal Program administrator at any time without notice.

Defined Terms

Throughout this Benefit Booklet, “you” and “your” mean the person that is named as the enrollee in the Schedule of Benefits and “we”, “us” and “our” mean John Hancock Life & Health Insurance Company. All other words that have special definitions in this Benefit Booklet begin with capital letters and are defined in the Definitions section.

EFFECTIVE DATE OF COVERAGE — NEW ENROLLEES

If you do not pay your first premium when due, your coverage will not take effect.

Your coverage is scheduled to take effect on the Original Effective Date shown on your Schedule of Benefits. However, your coverage will not go into effect, or your Original Effective Date changes, in the situations described below.

If You Lost Your Eligibility Status Before Your Original Effective Date

Except as described below, if you lost your status as a Workforce member or a Qualified Relative before your Original Effective Date, coverage does not go into effect for you under the Federal Program.

Your coverage goes into effect on your Original Effective Date if you are an Employee or Member of the Uniformed Services who was involuntarily sepa-rated, for reasons other than your misconduct, after your Application date but

before your Original Effective Date. If you were involuntarily separated because of your misconduct, coverage for you and your Qualified Relatives does not go into effect.

Your coverage goes into effect on your Original Effective Date if you lost your status as a Qualified Relative after your Application date but before your Original Effective Date due to:

- the death of the Workforce member who was the basis of your status as a Qualified Relative; or
- the involuntary separation (for reasons other than misconduct) of the Employee or Member of the Uniformed Services who was the basis of your status as a Qualified Relative.

Note: If you were planning to pay your premium through the Workforce member's payroll deduction, you will have to make other arrangements for payment of your premium.

If Your Eligibility Status Changed Before Your Original Effective Date

If your eligibility status changed between your Application date and your Original Effective Date, coverage does not go into effect for you under the Federal Program, unless you have already passed the same or additional underwriting requirements that apply to your new status. If your status change requires additional underwriting, you must submit a new application that we must approve in order for you to receive coverage under the Federal Program. If your status change does not require additional underwriting, no action by you is required. Two examples follow. If you were an Employee or a Member of the Uniformed Services who submitted an abbreviated underwriting Application, and retire before your Original Effective Date, you must submit a new application with the additional underwriting required for an Annuitant or a Retired Member of the Uniformed Services. If you apply as an Annuitant, and become an Employee before your Original Effective Date, your coverage will go into effect as scheduled.

Actively at Work Requirement for Employees and Members of the Uniformed Services

If you are an Employee or a Member of the Uniformed Services who submitted an abbreviated underwriting application, you must be Actively at Work at least one day during the calendar week immediately prior to the week which contains the Original Effective Date shown on your Schedule of Benefits. From time to time, OPM may implement revised Actively at Work requirements for specified periods under the Federal Program.

You must inform us if you do not meet this requirement. In the event you do not meet this requirement, we will issue you a revised Original Effective Date, which will be the 1st day of the next month. You also must meet the Actively at

Work requirement for any revised Original Effective Date for coverage to become effective, or you will be issued another revised Original Effective Date in the same manner. You must notify us if you do not meet Actively at Work requirements for your new Original Effective Date. In this case, your coverage will not go into effect until you are Actively at Work as required above.
Your Original Effective Date does not change under this Actively at Work requirement if you were involuntarily separated from Federal civilian services (for reasons other than your misconduct) or from the uniformed services (except for a dishonorable discharge) after your Application date but before your Original Effective Date.

EFFECTIVE DATE OF COVERAGE — EXISTING ENROLLEES

As of May 27, 2005, the Effective Date of Coverage requirements above apply to Existing Enrollees before their coverage under the Federal Program first became effective as specified in the Federal Program regulations (5 CFR Part 875), as amended. Before May 27, 2005, the requirements for Existing Enrollees were the same as those described above, except the day the Employees or Members of the Uniformed Services were required to be Actively at Work was the Original Effective Date shown on the Schedule of Benefits or, if that fell on a weekend or holiday, the last work day before the Original Effective Date.

CONDITIONS FOR PAYMENT OF BENEFITS

We will pay benefits for long term care services if:

- you receive them after your coverage becomes effective (please see the Original Effective Date shown on your Schedule of Benefits and the Effective Date of Coverage section); and
- you are eligible for benefits (please see the Eligibility for Benefits section); and
- you receive them after satisfying any required waiting period (please see the Waiting Period section); and
- they are Covered Services (please see the Covered Services section); and
- you have not exhausted your Maximum Lifetime Benefit (please see the When Your Coverage Will End section).

Payment of benefits is also subject to the maximums and limitations shown on your Schedule of Benefits and the exclusions and limitations contained in the following sections: Maximum Benefit We Will Pay, Exclusions, Coordination of Benefits and When Your Coverage Will End.

ELIGIBILITY FOR BENEFITS

You are eligible for benefits if, after your coverage becomes effective:

- a Licensed Health Care Practitioner has certified within the last 12 months that:
  - you are unable to perform, without Substantial Assistance from another person, at least 2 Activities of Daily Living for an expected period of at least 90 days due to a loss of functional capacity; or
  - you require Substantial Supervision due to your Severe Cognitive Impairment; and
- we agree with that certification; and
- we approve a Written Plan of Care established for you by a Licensed Health Care Practitioner or our care coordinator.

How to Ask Us to Determine Whether You Are Eligible for Benefits

If you believe you may be eligible for benefits, you or your representative must call 1-800-LTC-FEDS (1-800-582-3337), TTY 1-800-843-3557.

If we need more information to make our determination:

- we may contact you, your Physician or other persons familiar with your condition; and/or
- we may access your medical records to get information about your condition (we cannot determine that you are eligible for benefits if we are not given access to your medical records); and/or
- we may request, at our expense, to have you examined by a licensed health care professional and/or to conduct an on-site assessment.

Continuing Assessment of Your Eligibility for Benefits

We will reassess whether you continue to be eligible for benefits at least once every 12 months, but no more frequently than every 30 days.

Notice and Review of Benefit Eligibility Decision

We will send you Written notice of our decision on whether you are eligible for benefits no later than 10 business days after we have received all the information we need. If we determine that you are eligible for benefits, the notice will state the date as of which you are eligible for benefits and will include claim forms.

If we determine that you are not eligible for benefits, the notice will provide the reason(s) for the denial. You or your representative may request a review of a denial by sending a Written request to us no later than 60 days after the date of the denial. No later than 60 days after the date we receive your request, we will send you Written notice of our decision. If, on review, we determine that you

are eligible for benefits, the notice will state the date as of which you are eligible for benefits and will include claim forms. If, on review, we uphold the initial denial, you may request an appeal. Please see the Appeals section.

WAITING PERIOD

The waiting period is the number of days during which you must be eligible for benefits and receiving Covered Services before we will pay benefits. The waiting period applies to payment of benefits for all Covered Services unless otherwise stated. You only have to satisfy the waiting period once in your lifetime. For Existing Enrollees, any days applied toward the waiting period under a prior Benefit Booklet will count toward the waiting period under this Benefit Booklet. Days applied toward satisfying the waiting period need not be consecutive, nor associated with the same episode of care. The length of your waiting period is shown on your Schedule of Benefits. We do not pay benefits for services you receive during your waiting period, unless otherwise stated.

The waiting period does not apply to Hospice Care, Respite Services and Caregiver Training. Because we do not apply the waiting period to Hospice Care, Respite Services and Caregiver Training, these Covered Services do not count toward meeting your waiting period.

COVERED SERVICES

Your Schedule of Benefits shows whether you selected the Facilities-Only Option or the Comprehensive Option. If your Schedule of Benefits shows that you selected the Facilities-Only Option, the provisions of the Comprehensive Option do not apply to you.

The Federal Program provides reimbursement for actual charges you incur up to the Benefit Amount shown in your Schedule of Benefits for the following Covered Services if you are eligible for benefits (see the Eligibility for Benefits section) and you have satisfied the applicable waiting period. Please see the Exclusions section for information on those services and supplies that are not covered under the Federal Program.

Facilities-Only Option

The following are Covered Services under the Facilities-Only Option.

Nursing Home and Assisted Living Facility

On any day you are in a Nursing Home or Assisted Living Facility, including those specializing in the care of persons with Alzheimer's disease, we will pay for:

- room and board accommodations; and
- Nursing Care, Maintenance or Personal Care, and Therapy Services provided to you by a Formal Caregiver; and
- drugs, incontinence supplies, dietary supplements, personal medical equipment and laundry services.

Hospice Facility

On any day you are in a Hospice facility, we will pay for:

- room and board accommodations; and
- Hospice Care; and
- drugs, incontinence supplies, dietary supplements, personal medical equipment and laundry services.

The waiting period does not apply to care in a Hospice facility. Care in a Hospice facility does not count toward meeting your waiting period.

Please see the Additional Covered Services and Benefits subsection for information on additional Covered Services and benefits that apply to the Facilities-Only Option.

Comprehensive Option

The Comprehensive Option includes all Covered Services under the Facilities-Only Option and also includes the following as Covered Services.

Services Provided by a Formal Caregiver at Home

We will pay for the following services provided to you by a Formal Caregiver at Home: Nursing Care, Maintenance or Personal Care and Therapy Services.

Services Provided by an Informal Caregiver

We will pay for services provided by an Informal Caregiver if the services are:

- provided to you at Home or at a location other than a Nursing Home, Hospice facility or Assisted Living Facility (such as the home of a friend or relative); and
- approved by our care coordinator as part of your Written Plan of Care; and
- provided by a person who did not normally live in your Home at the time you became eligible for benefits. (Note: we will pay for Informal Caregiver services provided by a person who began living in your Home after you became eligible for benefits.)

Benefits for Informal Caregivers who are Family Members are limited to 365 days in your lifetime and will be reduced by any days you received Informal Caregiver services from a Family Member under any prior Federal Program Benefit Booklet.

Hospice Care at Home

We will pay for Hospice Care provided to you at Home.

The waiting period does not apply to Hospice Care at Home. Hospice Care at Home does not count toward meeting your waiting period.

Services Provided at an Adult Day Care Center

We will pay for services provided to you under an adult day care program at an Adult Day Care Center.

Please see the Additional Covered Services and Benefits subsection for information on additional Covered Services and benefits that apply to the Comprehensive Option.

Additional Covered Services and Benefits

(Applies to both the Facilities-Only Option and the Comprehensive Option)

Bed Reservations

We will pay for actual charges you incur for Bed Reservations. We will not pay more than the benefit that we would pay if you had been in the Nursing Home, Assisted Living Facility or Hospice facility on those days. Benefits for Bed Reservations are limited to 30 days per calendar year and will be reduced by any days you received Bed Reservation Benefits under any prior Federal Program Benefit Booklet.

Caregiver Training

We will pay for Caregiver Training. Benefits for Caregiver Training are limited to an amount equal to 7 times your Daily Benefit Amount in your lifetime and will be reduced by any Benefits you received for Caregiver Training under any prior Federal Program Benefit Booklet.

The waiting period does not apply to Caregiver Training. Caregiver Training does not count toward meeting your waiting period.

Respite Services

For the Facilities-Only Option, if you are eligible for benefits but are being cared for at Home (rather than in a facility), we will pay for Respite Services provided in a Nursing Home, Assisted Living Facility or Hospice facility.

For the Comprehensive Option, we will pay for Respite Services:

- provided in a Nursing Home, Assisted Living Facility or Hospice facility; or
- provided by a Formal or Informal Caregiver at Home; or
- provided at an Adult Day Care Center.

Benefits for Respite Services are limited to an amount equal to 30 times your Daily Benefit Amount per calendar year and will be reduced by any Benefits you received for Respite Services under any prior Federal Program Benefit Booklet.

The waiting period does not apply to Respite Services. Respite Services do not count toward meeting your waiting period.

Alternate Plan of Care

Under the circumstances described below, our care coordinator can authorize benefits for services for your care that are not specifically defined as Covered Services. For example, under an alternate plan of care, we will consider a facility that is not otherwise covered under the Federal Program (such as a residential care facility licensed in California). If you selected the Comprehensive Option, our care coordinator can also authorize benefits for supplemental items that enable you to remain at Home, such as modification to your Home to make it wheelchair-accessible, durable medical equipment, and emergency response systems.

Services for your care and supplemental items for which benefits are authorized by us under this section are called an alternate plan of care and, as such, will be considered Covered Services. Benefits under an alternate plan of care will only be authorized if we determine, in our sole discretion, that the alternate plan of care meets the following criteria:

- it is part of your Written Plan of Care approved by us; and
- it effectively meets your long term care service needs; and
- it does not include services provided by a person who normally lived in your Home at the time you became eligible for benefits; and
- it is cost-effective for the Federal Program; and
- for the Facilities-Only Option, it does not include services that are provided outside a facility.

Your receipt of services for your care under an alternate plan of care will be subject to the Waiting Period section. The benefits we will pay for such services will be subject to the Maximum Benefit We Will Pay section.

Supplemental items you pay for under an alternate plan of care will not count toward satisfying your waiting period. However, after you satisfy your waiting period and if you remain eligible for benefits, we will reimburse you retroactively for any expenses you incurred for approved supplemental items you received during your waiting period. Our care coordinator will determine whether reimbursement for supplemental items is subject to the Maximum Benefit We Will Pay section.

International Benefits

We will pay benefits for Covered Services you receive outside the United States (see the Definitions section for the definition of United States). When you receive such services, we will pay benefits up to 80% of the Benefit Amounts shown on your Schedule of Benefits.

If your Schedule of Benefits shows that you have a 3 or 5 year Benefit Period, 80% of your Maximum Lifetime Benefit can be used for Covered Services you receive outside the United States; the remaining 20% will be available for Covered Services you receive in the United States.

If your Schedule of Benefits shows that you have an unlimited Benefit Period, your Benefit Period will be limited to 10 years for Covered Services you receive outside the United States. For such services, your Maximum Lifetime Benefit will be equal to 3,650 days (10 years) x 80% of your Daily Benefit Amount. Your Maximum Lifetime Benefit for Covered Services you receive in the United States will remain unlimited.

Example 1: Let's assume that you selected the Comprehensive Option with a Daily Benefit Amount of $150 and that you have a 5 year Benefit Period. For purposes of determining international benefits, your Daily Benefit Amount is $120 ($150 x 80%) instead of $150. We would pay up to $120 per day for services provided to you in a Nursing Home. We would pay up to $90 ($120 x 75%) per day for services provided to you by a Formal or Informal Caregiver at Home. Out of your Maximum Lifetime Benefit of $273,750, you could use up to 80% ($219,000) for all Covered Services you receive outside the United States. If you return to the United States and receive Covered Services, the remaining 20% ($54,750) of your Maximum Lifetime Benefit will be available for those services.

Example 2: Let's assume that you selected the Comprehensive Option with a Daily Benefit Amount of $150 and that you have an unlimited Benefit Period. Let's also assume that you chose to have that amount reimbursed as a Weekly Benefit Amount equal to $1,050 ($150 x 7). For purposes of determining international benefits, your Daily Benefit Amount is $120 ($150 x 80%) and your Weekly Benefit Amount is $840 ($120 x 7). We would pay up to $840 per Week for services provided to you in a Nursing Home. We would pay up to $630 per Week ($840 x 75%) for services provided to you by a Formal or Informal Caregiver at Home. Your Maximum Lifetime Benefit for Covered Services you

receive outside the United States would be limited to $438,000 (3,650 x $120). If you return to the United States and receive Covered Services, your Maximum Lifetime Benefit would remain unlimited for those services.

The Coordination of Benefits section does not apply to international benefits.

MAXIMUM BENEFIT WE WILL PAY

All benefit payments are limited by your Maximum Lifetime Benefit, unless your Schedule of Benefits shows that it is unlimited, and the following provisions.

For Existing Enrollees, your Maximum Lifetime Benefit will be reduced by any benefit payments made under any prior Benefit Booklet issued to you under the Federal Program.

For the Facilities-Only Option

If you receive more than one Covered Service on the same day, the most we will pay for all of those services is the Daily Benefit Amount shown on your Schedule of Benefits.

For the Comprehensive Option

If you receive more than one Covered Service on the same day, the most we will pay for all of those services is the highest Benefit Amount shown on your Schedule of Benefits for one of those services.

If you selected the Weekly Benefit Amount and receive more than one Covered Service during the same Week, the most we will pay for all of those services is the highest Benefit Amount shown on your Schedule of Benefits for one of those services.

Example 1: Let’s assume that you selected a Daily Benefit Amount of $100 and you incur charges of $75 for Hospice Care at Home and charges of $50 for Informal Caregiver services on the same day. The Benefit Amount for Hospice Care is $100 (100% of your Daily Benefit Amount) and the Benefit Amount for Informal Caregiver services is $75 (75% of your Daily Benefit Amount). The most we would pay for the services received on that day is the Benefit Amount for Hospice Care ($100) since Hospice Care has a higher Benefit Amount than Informal Caregiver services. The total amount of benefits we would pay for that day would be $100.

Example 2: Let’s assume that you selected a Daily Benefit Amount of $100 and the Weekly Benefit Amount. Your Weekly Benefit Amount is $700 ($100 x 7). Let’s also assume that you incur charges of $300 for Hospice Care at Home and $300 for Informal Caregiver services during the same Week. The Benefit Amount for Hospice Care is $700 (100% of your Weekly Benefit Amount) and

the Benefit Amount for Informal Caregiver Services is $525 (75% of your Weekly Benefit Amount). The most we would pay for the services received during that Week is the Benefit Amount for the Hospice Care ($700) since Hospice Care has a higher Benefit Amount than Informal Caregiver services. The total amount of benefits we would pay for that Week would be $600.

Exception for Caregiver Training

We will pay up to the Benefit Amount shown on your Schedule of Benefits for Caregiver Training without considering benefits we pay for other Covered Services you receive on the same day, or if applicable, during the same Week. In addition, we will not consider Caregiver Training when determining the maximum we will pay for other Covered Services you receive on the same day, or if applicable, during the same Week.

Example 1: If you incur charges for Nursing Home services and Caregiver Training on the same day, we will pay up to 100% of your Daily Benefit Amount for each service.

Example 2: If you selected the Comprehensive Option with the Weekly Benefit Amount and you incur charges for services provided by an Informal Caregiver and Caregiver Training during the same Week, we will pay up to 75% of your Weekly Benefit Amount for the Informal Caregiver services and up to 100% of your Weekly Benefit Amount for Caregiver Training.

CARE COORDINATION SERVICES

Our care coordinators are Licensed Health Care Practitioners who provide the following services at no additional charge to you:

1. provide general information about long term care services; and
2. assess and approve your need for long term care services; and
3. develop a plan for long term care services; and
4. monitor and reassess from time to time the long term care services that you receive; and
5. provide access to discounts for services, when available.

Our care coordinators will provide the services described above for your Qualified Relatives. These services will be provided regardless of whether your Qualified Relatives are enrolled in the Federal Program, as long as you are enrolled.

You do not have to be eligible for benefits or satisfy the waiting period in order to receive care coordination services.

EXCLUSIONS

This section describes those services and supplies that are not covered under the Federal Program.

The Federal Program does not pay benefits for any of the following:

1. illness, treatment or medical condition arising out of:
   - your participation in a felony, riot or insurrection; or
   - your attempted suicide, while sane or insane; or
   - injuries you intentionally inflict on yourself; or
2. care or treatment for alcoholism or drug addiction; or
3. care or treatment provided in a government facility, including a Department of Defense or Department of Veterans Affairs facility, unless otherwise required by law; or
4. care you receive while in a Hospital, except in a unit specifically designated as a Nursing Home or Hospice facility; or
5. any service or supply to the extent the expense for it is reimbursable under Medicare, or would be so reimbursable except for the application of a deductible, coinsurance or copayment amount. (This exclusion will not apply in those instances where Medicare is determined to be the secondary payor under applicable law.); or
6. services or supplies for which you are not obligated to pay in the absence of insurance; or
7. services provided by any person who normally lived in your Home at the time you became eligible for benefits.

Your Coverage Does Not Have a War Exclusion

Your coverage does not have a war exclusion. As a result, benefits may be payable under the Federal Program for conditions due to war or acts of war, declared or undeclared, or service in the armed forces or auxiliary units.

COORDINATION OF BENEFITS

Some enrollees may be eligible for benefits for long term care services under another plan or through other programs that are not listed in the Exclusions section. For this reason, the Federal Program includes this Coordination of Benefits (COB) provision. This COB provision follows the guidelines set by the National Association of Insurance Commissioners (NAIC).

In determining the amount of benefits we will pay, this COB provision allows us to look at other plans that might pay benefits for long term care services that you receive. The other plans we look at include government programs (other than Medicaid), group medical benefits, and other employer-sponsored long

term care insurance. We do not look at Medicaid, individual insurance policies or association group insurance policies. This COB provision does not apply to international benefits, except that we will not pay international benefits that duplicate international benefits paid under any prior Benefit Booklet issued to you under the Federal Program.

If the Federal Program is primary (this means it pays first), we will pay benefits without coordinating with other plans. That means that we will pay benefits to the maximum extent permitted by your coverage.

If another plan or program is primary, then it will pay first. In this case, we will require you to submit the explanation of benefits you received from that other plan or program showing that you submitted a claim to it and how that claim was decided. We may also request a copy of the other plan or program booklet or terms of coverage. We will pay no more than the difference between the amount payable by your other coverage(s) and your actual expenses.

In those instances where this COB provision applies, the rules for determining which plan or program is primary (pays first) are as follows. These rules are subject to the special rules for government programs explained below.

1. The plan or program that covers you as a member, an employee, or a Workforce member is considered primary over that covering you as a dependent or a Qualified Relative.

2. The plan or program covering you as a member, an employee, or a Member of the Uniformed Services is considered primary over that covering you as a laid-off or retired employee, an Annuitant, or a Retired Member of the Uniformed Services.

3. The plan or program covering you as a dependent or a Qualified Relative of: a member, an employee, or a Member of the Uniformed Services, is considered primary over that covering you as a dependent or a Qualified Relative of: a laid-off or retired employee, an Annuitant or a Retired Member of the Uniformed Services.

If none of these rules determine the order, then the plan or program that has covered you for the longest period of time will be primary.

In no event will we pay benefits that duplicate benefits paid under any prior Benefit Booklet issued to you under the Federal Program.

Government Programs

Unless otherwise required by law, any benefits for long term care services that you receive under other plans or programs established by the Federal or a state government are primary (pay first) to the Federal Program. Please see the Exclusions section, which excludes payment of benefits for care provided in a government facility.

CLAIMS

You or your representative must submit Written proof of your claim to us within 12 months after the date you incurred charges for Covered Services, or by April 1 of the year following the year you incurred charges for Covered Services, whichever is later. If you or your representative do not submit proof of claim within this time limit, we may deny benefits unless you can show that it was not reasonably possible for you to submit proof of claim within the time limit, and you or your representative submitted proof of claim as soon as reasonably possible.

We must receive adequate Written proof (such as bills for services) that you have incurred charges for Covered Services. To assist us in determining whether you have incurred charges for Covered Services:

- we may contact you, your Physician or other persons familiar with the services provided to you; and/or
- we may access your medical records to get information about your condition or the services provided to you (we cannot approve a claim if we are not given access to your medical records); and/or
- we may request to have you examined, at our expense, by a health care provider and to conduct an on-site assessment; and/or
- we may require you to submit Medicare explanations of benefits or documentation from any other source from whom you may have received or are eligible to receive reimbursement for the Covered Service for which you have submitted a claim.

Notice and Review of Claim Determination

We will send you Written notice of our claim determination as soon as possible after we receive all the information we need. In general, that means within 10 business days.

If we deny your claim, in whole or in part, the notice will provide the reason(s) for the denial. You or your representative may request a review of a denial by sending a Written request to us no later than 60 days after the date of the denial. No later than 60 days after the date we receive your request, we will send you Written notice of our decision. If the initial denial is upheld on review, you may request an appeal. Please see the Appeals section.

APPEALS

As stated in the Notice and Review of Benefit Eligibility Decision subsection of the Eligibility for Benefits section, and the Notice and Review of Claim Determination subsection of the Claims section, the Federal Program includes an appeals process. This section explains your right to appeal in the event we initially deny your eligibility for benefits or your claim and then, on review, we uphold our denial.

Appeals Committee

If you choose to appeal our eligibility for benefits or claim decision, you must send a Written request to us, with any additional information that you wish to have us consider, no later than 60 days after the date of our review decision. Your appeal will be reviewed by an appeals committee composed of: one or more representatives of John Hancock and other person(s) if mutually agreed upon by OPM and us.

The appeals committee will provide you with Written notice of its final decision no later than 60 days after the date we receive your Written request for appeal. If the appeals committee upholds the denial and that denial is eligible for appeal to an independent third party (as explained below), our Written notice will let you know how to request such an appeal.

Independent Third Party

If the appeals committee upholds a denial of your eligibility for benefits or your claim due to its evaluation of your medical condition/functional capacity (such as your ability to perform Activities of Daily Living or your cognitive status), you may request to appeal that decision to an independent third party mutually agreed to by OPM and us. You must make this request in Writing no later than 60 days after the date of our notice informing you of the appeals committee's decision.

The independent third party will provide you with Written notice of its final decision no later than 60 days after we receive your request for appeal to the independent third party. The decision of the independent third party is final and binding on us.

The following is an example of when a denial by the appeals committee <u>will</u> be eligible for appeal to an independent third party: the appeals committee upholds a denial of your eligibility for benefits because its review indicates that you can perform 5 out of 6 Activities of Daily Living.

The following is an example of when a denial by the appeals committee <u>will not</u> be eligible for appeal to an independent third party: the appeals committee upholds a denial of your claim for benefits for Nursing Home services because you exhausted your Maximum Lifetime Benefit.

Exhaustion of the Appeals Process

Once you have exhausted this appeals process, you may seek judicial review of a final denial of eligibility for benefits or a claim. Please see the Limits on Legal Actions subsection of the General Provisions section for more information.

PAYMENT OF BENEFITS

All benefits will be paid in United States currency. All benefits will be paid directly to you unless you have completed an assignment of benefits. You may not assign benefits to any provider of Covered Services outside the United States. For the Comprehensive Option, we will determine, in our sole discretion, whether to honor assignments to Informal Caregivers. You may not assign benefits prior to a claim.

If you have any unpaid premiums that are due, we will deduct these premiums from any benefits that are payable.

If we determine that the benefits paid to you or on your behalf for a claim were more than the benefits owed, we have the right to recover the excess amount from you or the person or entity we paid, provided we seek recovery within two years from the date on which the claim in question was paid.

However, we may not recover any benefit payments paid to you or on your behalf in the event that we Void your coverage.

BENEFIT CHANGES

Anytime your Daily Benefit Amount changes under this section, all those benefit amounts that are determined based on your Daily Benefit Amount will change accordingly.

Automatic Compound Inflation Option

(Applies only if your Schedule of Benefits indicates "Yes" for this option)

On each anniversary of your Original Effective Date (or of the date you switch to this option), your Daily Benefit Amount and the remaining portion of your Maximum Lifetime Benefit will automatically increase at the Automatic Compound Inflation rate shown on your Schedule of Benefits, compounded annually. In addition, the remaining portions of: (1) your lifetime maximum for Caregiver Training; and (2) your calendar year maximum for Respite Services, will increase at the same rate as your Daily Benefit Amount. Increases under this option are made even if you are eligible for benefits, without regard to your age, claim status, claim history or the length of time your coverage has been in effect, and will not cause your premium to increase. However, your premiums may still increase under the conditions described in the Premiums section and the When We May Increase Your Premium section

If we determine in the future that the cumulative actual rate of inflation in the cost of long term care services since the last increase under this provision is significantly higher than the Automatic Compound Inflation rate shown on your Schedule of Benefits, compounded annually, OPM and we will agree upon a method to allow you, at your option, to adjust your Daily Benefit Amount. This method will account for the higher rate of inflation for an additional premium if you are not then eligible for benefits.

Future Purchase Option
(Applies only if your Schedule of Benefits indicates "Yes" for this option)

Every two years we will increase your Daily Benefit Amount and the remaining portion of your Maximum Lifetime Benefit, except as described below. We will send notice in the fall of 2011 for the increase that will apply on January 1, 2012. Increases will occur every two years on January 1st thereafter. Your coverage must be in effect for at least 12 months in order for you to receive your first increase under this provision. The increase will be based on the change in the Department of Labor's Consumer Price Index for Medical Care or another index mutually agreed upon by OPM and us. We will include the amount of the increase in the notice. Please see the Premiums section, How Benefit Changes Affect Your Premium subsection, for information on how increases under this option affect your premium. Please note that your premiums may also increase under the conditions described in the Premiums section and the When We May Increase Your Premium section.

An increase under this provision will also increase the remaining portions of: (1) your lifetime maximum for Caregiver Training; and (2) your calendar year maximum for Respite Services, at the same rate as your Daily Benefit Amount.

If you do not want the increase, we must receive your rejection before the date specified in the increase notice. If you want the increase, you do not have to take any action other than paying the additional premium. The increase will automatically take effect. Increases under this option will be made regardless of your age, but we will not increase your benefits under this option if you satisfy the requirements of Eligibility for Benefits section or if you declined a total of 3 prior increases, including those increases made under any prior Benefit Booklet issued to you under the Federal Program. However, if you are insured for less than 24 months, whether under this or any prior Benefit Booklet, and you reject the first increase under this option, it will not count as a declined increase for purposes of determining your eligibility to receive increases in the future.

Increases under this option do not require you to provide evidence of your good health, except as noted below. Each time we send you notice of an increase under this option, we will also offer you the opportunity to receive future benefit increases under the automatic compound inflation option instead of this option. If you elect to switch to the automatic compound inflation option:

- you must send us Your Written election by the date specified in the increase notice;
- you will not receive the current increase under the future purchase option; and
- the effective date of all future automatic compound inflation benefit increases will be January 1st beginning with the January 1st that next occurs after we receive your Written election to switch to the automatic compound inflation option.

(Please note that you may request to switch from the future purchase option to the automatic compound inflation option apart from the above described procedure; but should you make such a request:

- you will be required to provide, at your expense, evidence of your good health that is satisfactory to us; and
- the effective date of all future automatic compound inflation benefit increases will be the anniversary of the first day of the month that next follows the date of our approval of your request.)

If you declined a total of 3 increases under this option and you later wish to resume receiving increases, you must provide, at your expense, evidence of your good health that is satisfactory to us.

Other Benefit Changes (Upgrades and Downgrades)

At any time, you may request an increase (upgrade) or decrease (downgrade) in your coverage by Writing to us or calling us at 1-800-LTC-FEDS (1-800-582-3337), TTY 1-800-843-3557. If you make a request that we determine is for an increase in coverage, you must provide, at your expense, evidence of your good health that is satisfactory to us. You do not have to provide evidence of your good health for a decrease. The amount of an increase or decrease is subject to Federal Program options available at the time of your request.

Within 30 days after you receive approval of a request for an increase or a decrease in your coverage, you may cancel the increase or decrease in your coverage, and it will be as if the increase or decrease in your coverage was never issued. We will refund any premium that is due you within 30 days.

PREMIUMS

Your premium is payable when due. Please be sure to review your Application for premium payment options and requirements. If you elected to pay your premium via automatic bank withdrawal, we reserve the right to collect any past due premium by withdrawing up to 2 months of premiums from your account each month until current. In addition, if you pay your premium via payroll or annuity deduction, you will be directly billed for any required premium that we are unable to collect via such deduction.

The amount of your premium when coverage first goes into effect is based upon your Original Issue Age as shown on your Schedule of Benefits. Your premium will not change because you get older, your health declines, or for any other reason related solely to you. We may only increase your premium if you are among a group of enrollees whose premium is determined to be inadequate. While the Group Policy is in effect, OPM must approve the premium increase. Please see the When We May Increase Your Premium section.

How Benefit Changes Affect Your Premium

If you selected the automatic compound inflation option, your premium is designed to include all future inflation increases you will receive each year while you are insured. Your premium will not increase with each inflation increase under this option. However, your premiums may still increase under the conditions described in the above paragraph and the When We May Increase Your Premium section at the beginning of this Benefit Booklet.

If you selected the future purchase option, your premium will increase for each inflation increase under this option; the additional premium for each increase will be based on your age and the premium rates in effect at the time the increase takes effect. If you accept an offer to switch from the future purchase option to the automatic compound inflation option, your premium will increase based on your age and the premium rates in effect at the time that switch goes into effect. This increase in premium is intended to pay for future inflation increases under the automatic compound inflation option. Once you have switched, your premium will not increase with each inflation increase. However, your premiums may still increase under the conditions described in the above Premiums section and the When We May Increase Your Premium section at the beginning of this Benefit Booklet.

If you request and we approve any coverage increase other than an inflation increase, your premium for the additional coverage will be based on your age and the premium rates in effect at the time the increase takes effect. If you request a decrease in coverage consistent with available Federal Program options, your premium will decrease. The amount of the decrease in premium associated with the decrease in coverage will be computed assuming that the levels of benefits purchased last are discontinued first.

Please see the Benefit Changes section for information on these benefit change provisions.

Contingent Benefit Upon Lapse

We will provide a contingent benefit upon lapse as provided in the Group Policy.

GRACE PERIOD

There is a 30-day grace period for payment of your premium. This means that we must receive your premium payment by the 30th day after the date it is due. If we do not receive your premium by the end of this grace period, we will send you Written notice of termination of your coverage by first class United States mail. You will have 35 days from the date of the termination letter to pay your premium, otherwise your coverage will end. (Please see the When Your Coverage Will End section for more information.)

Protection Against Unintended Lapse ("PAUL")

To help protect you from unintended lapse of your coverage, you should name a person (if you have not already done so) to whom we will also send any notice of termination that we send to you. The person that you name will not be responsible for your premium payment. You must notify us of any change in the person that you name.

WAIVER OF PREMIUM

You will not have to pay your premium if you are eligible for benefits and have satisfied the waiting period. We will also waive your premium if you are eligible for benefits and receiving Hospice Care. If you satisfy the requirements for waiver of premium on the first day of a month, the waiver will take effect on that date. Otherwise, the waiver will take effect on the first day of the following month.

If, at a later date, you are no longer eligible for benefits (*e.g.*, you recover) and wish to maintain your coverage, you may do so provided you have not exhausted your Maximum Lifetime Benefit. To maintain your coverage, you will have to resume paying your premium on the first day of the month following the month in which you are no longer eligible for benefits.

WHEN YOUR COVERAGE WILL END

Your coverage will end on the earliest of the following:

- the date you specify to us that you wish your coverage to end; or
- the date of your death; or
- the end of the period covered by your last premium payment if you do not pay the required premium when due; or
- the date the Group Policy ends, subject to the Continuation of Coverage section below; or
- the date that you have exhausted your Maximum Lifetime Benefit. (In this event, care coordination services will continue.)

PORTABILITY

Your long term care insurance coverage under the Federal Program is portable. This means that you can keep your coverage if you are no longer a Workforce member or Qualified Relative provided you continue to pay your premium and have not exhausted your Maximum Lifetime Benefit.

CONTINUATION OF COVERAGE

If the Group Policy ends, OPM has stated that it intends to continue your insurance coverage by replacing the Group Policy with another one that will:

- be effective on the day after the Group Policy ends; and
- provide coverage that is substantially the same as that provided by the Group Policy; and
- calculate your premium based on the same issue age(s) as under the Group Policy.

In the unlikely event that the Group Policy ends and there is no replacement policy as described above, we will continue your coverage.

EXTENSION OF BENEFITS

The purpose of this extension of benefits provision is to continue your coverage in the event that it ends while you are confined in a Nursing Home, Assisted Living Facility or Hospice facility.

If, as of the date your coverage ends, you are eligible for benefits and are in a Nursing Home, Assisted Living Facility or Hospice facility, we will extend payment of benefits under the Federal Program for Covered Services you receive while you are in any of these facilities. Payment of benefits will be subject to all other requirements stated in this Benefit Booklet.

This extension of benefits will end on the earliest of the following:

- the date you are no longer eligible for benefits; or
- the date your confinement ends; or
- the date you exhaust your Maximum Lifetime Benefit.

REINSTATEMENT OF COVERAGE

If your coverage ends because you did not pay your premium when due, your coverage will be reinstated as of the date it ended if, within 6 months of the date your coverage ended, you or your representative:

- submit evidence satisfactory to us that you suffered a cognitive impairment or loss of functional capacity before the expiration of the 30-day grace period for payment of your premium (the standard of proof we will require will be no more restrictive than the requirements to establish eligibility for benefits); and
- submit all past due premiums to us.

If your coverage ends because you canceled it or did not pay your premium when due, your coverage will be reinstated as of the date it ended, if within 12 months of the date coverage ended you:

- request reinstatement; and
- submit, at your expense, evidence of your good health that is satisfactory to us; and
- submit all past due premiums to us.

If your coverage is reinstated, your premium will be based on your age as if your coverage had continued without interruption.

GENERAL PROVISIONS

Statements Made by You Relating to Insurability

No statement made by you which relates to insurability will be used by us to Void your coverage or to deny an otherwise valid claim, unless the statement was contained in a Written form that you signed and a copy of such form was provided to you.

If your coverage has been in force for less than 6 months, we may Void your coverage upon a showing of Misrepresentation by you.

If your coverage has been in force for at least 6 months but less than 2 years, we may Void your coverage upon a showing of Misrepresentation that pertains to the condition for which benefits are sought.

If your coverage has been in force for 2 years or more, we may Void your coverage only upon a showing that you knowingly and intentionally, by statement or omission, provided false or misleading information Material To Your Insurability.

If we Void your coverage, no claims for benefits will be paid, and the Notice and Review of Claim Determination and Appeals section will not apply. If we Void your coverage, our letter notifying you will explain the process for requesting review of our decision. If you believe that your coverage was Voided in error, you may request that we review our decision. You must submit your request in writing to us within 30 days of the date of the letter Voiding your coverage.

If you request a change in coverage, a reinstatement of coverage, or an increase in benefits and the information provided in support of your request contains a Misrepresentation, we may Void the change, reinstatement or increase or deny any changed, reinstated, or increased benefits on an otherwise valid claim in accordance with the above provisions, provided that the time limits shall refer to the time period that the change, reinstatement, or increase in benefits has been in effect.

For purposes of determining how long your coverage has been in force, your coverage under any prior Benefit Booklet issued to you under the Federal Program will be considered.

Age

If your date of birth is not correct as shown on your Application, we may make a retroactive adjustment in premium and/or benefits that we deem appropriate, based on the correct information.

No Cash Surrender Value

Your coverage has no cash surrender value or other monetary value that can be paid, assigned, borrowed, or pledged as collateral for a loan.

Insurer

Your coverage is underwritten by John Hancock Life & Health Insurance Company.

Right to Change Contract Provisions

We reserve the right to make changes in this Benefit Booklet, the Group Policy, or the administration of the Federal Program consistent with applicable laws or regulations. Any such change will be made in consultation with OPM and will apply to all enrollees who have received affected Benefit Booklets. We will give you Written notice of any change to this Benefit Booklet as soon as is reasonably possible.

Interpretation of Terms, Conditions and Provisions

The Group Policy, this Benefit Booklet and your Schedule of Benefits determine the governing contractual provisions. We will apply them consistent with the Act and Federal Program regulations. We have discretion to interpret the terms, conditions and provisions of the Group Policy, this Benefit Booklet and the Schedule of Benefits. OPM may consult with us about our interpretation.

Limits on Legal Actions

No legal action or suit under the Federal Program may be started against us or the Federal Program administrator:

- before you have exhausted the appeals process described in the Appeals section; or
- more than 2 years from the date of the notice of final benefit or claim denial on appeal.

No legal action or suit to recover benefits under the Federal Program may be started against OPM or the independent third party that reviews a denial on appeal.

In any action at law or in equity that relates to the Federal Program, the amount of recovery shall be limited to the benefit that would be payable under the Federal Program. No extra-contract, punitive, compensatory, or consequential damages shall be recoverable under the Federal Program.

The Federal Program shall supersede and preempt any state or local law, regulation, or requirement as permitted by the Act or any Federal Program regulations.

Refund of Premiums

We will refund any premium that you paid and that has not already been refunded to cover any period:

- after the date of your death; or
- after the effective date of your cancellation of coverage; or
- during which your premium is waived. Please see the Waiver of Premium section.

Payments on Your Death

If, at the time of your death, any portion of benefits is payable or any premium is to be refunded as described under the Refund of Premiums subsection, we will pay such amount to your estate or to an alternative payee. The alternative payee must be a person who is deemed, in our sole discretion, to be justly entitled to the payment. Neither the Federal Program administrator nor we will be liable as a result of any payment made in good faith under this provision.

DEFINITIONS

Act means the Long Term Care Security Act, 5 U.S.C. §§ 9001-9009.

Actively at Work or **Active Work** means:

- for an Employee, that you meet all of the following conditions:
  - you are reporting for work at an approved work location and work at least ½ of your regularly scheduled hours for that day; and
  - you are able to perform all the usual and customary duties of your employment on your regular work schedule;
- for a Member of the Uniformed Services, that you are on active duty and are physically able to perform the duties of your position.

Activities of Daily Living means:

- bathing:
  - getting into a tub or shower; and
  - getting out of a tub or shower; and
  - washing your body in a tub, shower or by sponge bath; and
  - washing your hair in a tub, shower or sink.

  (If you need Substantial Assistance from another person to complete any one of these activities, you are dependent for bathing);
- dressing:
  - putting on any necessary item of clothing (including undergarments) and any necessary braces, fasteners or artificial limbs; and
  - taking off any necessary item of clothing (including undergarments) and any necessary braces, fasteners or artificial limbs.

  (If you need Substantial Assistance from another person to complete any one of these activities, you are dependent for dressing);
- transferring:
  - getting into a bed, chair or wheelchair; and
  - getting out of a bed, chair or wheelchair.

  (If you need Substantial Assistance from another person to complete any one of these activities, you are dependent for transferring);
- toileting:
  - getting to and from the toilet; and
  - getting on and off the toilet; and
  - performing associated personal hygiene.

  (If you need Substantial Assistance from another person to complete any one of these activities, you are dependent for toileting);
- continence:
  - maintaining control of bowel and bladder function; or
  - when unable to maintain control of bowel or bladder function, performing associated personal hygiene (including caring for catheter or colostomy bag).

  (If you cannot maintain control of bowel or bladder function and in addition you need Substantial Assistance from another person to perform the associated personal hygiene, you are dependent for continence);

- eating:
  - feeding yourself by getting food into your mouth from a container (such as a plate or cup), including use of utensils when appropriate (such as a spoon or fork); or
  - when unable to feed yourself from a container, feeding yourself by a feeding tube or intravenously.

  (If you need Substantial Assistance from another person to complete any one of these activities, you are dependent for eating).

Adult Day Care Center means any facility operated, licensed and/or certified as an Adult Day Care Center under the laws of the jurisdiction in which it is located, or other facility that satisfies all of the following:

- provides a program of adult day care; and
- maintains a Written record of services provided to each client; and
- has established procedures to get emergency medical care; and
- is not a place that predominantly provides services for recreation or social activities; and
- maintains a client-to-staff ratio of 8 (or less) to 1 including a full-time director, 1 or more Nurses in attendance during operating hours at least 4 hours a day, and at least 2 staff members in attendance whenever clients are present.

Annuitant means a person as defined by the Act at 5 U.S.C. § 9001, and the Federal Program regulations (5 CFR Part 875, as amended).

Application means an application for insurance under the Federal Program, whether submitted in connection with this Benefit Booklet or any prior Benefit Booklet issued to you under the Federal Program.

Assisted Living Facility means a facility that satisfies all of the following:

- maintains all appropriate licensing required under the laws of the jurisdiction in which it is located to provide Maintenance or Personal Care; and
- provides care and services 24 hours a day sufficient to assist residents with needs which result from the inability to perform Activities of Daily Living or from Severe Cognitive Impairment; and
- has a minimum of 3 residents; and
- uses aides trained or certified to provide Maintenance or Personal Care consistent with any laws applicable to the provision of such care; and
- provides 24 hour supervision of residents by a trained and awake staff; and
- has formal arrangements for emergency medical care; and
- maintains Written records of services provided to each resident; and
- provides residents with 3 meals a day; and
- has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

The term includes any such facility that specializes in the care of persons with Alzheimer's disease and other dementias. **The term does not include:**

- any facility used primarily to provide residential services and not Maintenance or Personal Care, such as congregate living, sheltered living, home for the aged, retirement homes, senior housing, or the independent living units of a continuing care retirement community or similar entity; or
- a place for the treatment of drug addiction or alcoholism; or
- a facility where most of the residents are related to the owner or manager.

If a facility has more than one license or purpose, only that section of the facility specifically meeting the definition of Assisted Facility will qualify as an Assisted Living Facility.

Bed Reservations means, if you are in a Nursing Home, Assisted Living Facility, or Hospice facility, and you leave the facility, paying to hold a space in the facility to enable you to return to it.

Benefit Amount means:

- the maximum we will pay for a Covered Service per day; or
- if you selected the Comprehensive Option with a Weekly Benefit Amount, the maximum we will pay for a Covered Service per Week.

Your Benefit Amounts are shown on your Schedule of Benefits.

Benefit Booklet means a coverage booklet issued to your under the Federal Program. This Benefit Booklet, together with your Schedule of Benefits, describes your coverage under the Federal Program, and replaces any prior Benefit Booklet issued to you under the Federal Program.

Benefit Period means the length of time your coverage will last if we pay your Daily Benefit Amount everyday. Your Benefit Period is shown on your Schedule of Benefits.

Caregiver Training means the training of a caregiver, other than a Formal Caregiver, to perform Maintenance or Personal Care Services for you at Home. **The term includes** training of an Informal Caregiver or a caregiver whose services are not covered under the Federal Program (such as your spouse or another person who normally lives with you).

Comprehensive Option means the Federal Program option that includes as Covered Services those provided in a Nursing Home, Assisted Living Facility or Hospice facility, Bed Reservations, Caregiver Training and Respite Services plus those provided at Home or in an Adult Day Care Center.

Covered Services means those Qualified Long Term Care Services listed in the Covered Services section under the option you selected (Facilities-Only Option or Comprehensive Option) for which coverage is provided under the Federal Program.

Daily Benefit Amount means the dollar amount you select that is used as the basis for determining your Benefit Amounts and Maximum Lifetime Benefit. Your Daily Benefit Amount is shown on your Schedule of Benefits.

Employee means a person as defined by the Act at 5 U.S.C. § 9001and the Federal Program regulations (5 CFR Part 875), as amended.

Existing Enrollee means a person who first became insured under the Federal Program by an "Early Enrollment Benefit Booklet" or "Benefit Booklet-FO/Comp" that was issued prior to this Benefit Booklet.

Facilities-Only Option means the Federal Program option that includes as Covered Services only those provided in a Nursing Home, Assisted Living Facility or Hospice facility, Bed Reservations, Caregiver Training and Respite Services in a Nursing Home, Assisted Living Facility or Hospice Facility.

Family Member means your: spouse, child (natural, step or adopted), parent, sibling, parent in-law, sibling in-law, or grandchild for purposes of determining whether benefits are payable for Formal Caregivers and Informal Caregivers.

Federal Program means the Federal Long Term Care Insurance Program as established by the Act at 5 U.S.C. § 9002. The rules for the administration of the Federal Program are set forth in the Federal Program regulations (5 CFR Part 875), as amended.

Formal Caregiver means any of the following providers:

- a Home Health Aide or Homemaker whose services are arranged and supervised by a Home Care Agency;
- a Nurse; or
- a Therapist.

The term does not include Family Members, even if they meet the above requirements for a Formal Caregiver. For example, if your grandchild is a registered nurse and cares for you, those services would not be covered as Formal Caregiver services. They could be covered as Informal Caregiver services if your grandchild did not normally live in your Home at the time you became eligible for benefits.

Group Policy means group long term care insurance policy number 900-003 issued by John Hancock to the United States Office of Personnel Management under which you are insured.

Home means your place of residence. Home does not include a Hospital, Nursing Home, Hospice facility or Assisted Living Facility.

Home Care Agency means an organization that:

- is licensed or certified as a Home Care Agency under the laws of the jurisdiction in which it is located, or under a public health law or similar law, if licensing is required, to provide home care services; or
- is recognized as a Certified Home Health Care Agency by Medicare; or
- is an organization that satisfies all of the following:
  - is licensed or certified by the jurisdiction in which it is located to provide home care services; and
  - develops and periodically reviews long term care service plans at appropriate intervals; and
  - uses Home Health Aides trained or certified to provide Maintenance or Personal Care consistent with laws applicable to the provision of such care; and
  - provides on-site supervision of Home Health Aides by a Nurse or Social Worker; and
  - provides on-call availability of a Nurse or a Physician in the event of a medical emergency during the hours that the Home Health Aide is in the client's home; and
  - maintains a Written record of services provided to each client.

Home Health Aide means a person whose services are arranged and supervised by a Home Care Agency and whose main function is to provide assistance with Activities of Daily Living. The person must be appropriately licensed or certified in the jurisdiction where services are to be performed if that jurisdiction requires such licensure or certification.

Homemaker means a person who provides Maintenance or Personal Care services that are necessary for you to stay at Home. Such services may include light housekeeping, meal preparation, or shopping for items needed to provide Maintenance or Personal 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 comparably licensed under applicable laws to provide care or management of the Terminally Ill.

Hospice Care means services provided by a Hospice for the care or management of a Terminal Illness.

Hospital means a facility that is licensed as a hospital which provides a broad range of 24-hour-a-day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of Physicians, and provides Nursing Care 24 hours a day.

Informal Caregiver means a person providing Maintenance or Personal Care who is not a Formal Caregiver. **The term includes** a Homemaker whose services are not arranged and supervised by a Home Care Agency. **The term does not include** anyone who normally lived in your Home at the time you became eligible for benefits. For example, if your child or your housekeeper is living with you at the time you become eligible for benefits, care they provide to you would not be covered as Informal Caregiver services.

Licensed Health Care Practitioner means a Physician, any registered professional nurse, a licensed Social Worker, or other person who meets such requirements as may be prescribed by the U.S. Secretary of the Treasury.

Maintenance or **Personal Care** means any care with the primary purpose of providing needed assistance that results in or from:

- your inability to perform, without Substantial Assistance from another person, at least 2 Activities of Daily Living for an expected period of at least 90 days due to a loss of functional capacity; or
- your Severe Cognitive Impairment.

Material To Your Insurability means we would not have issued your coverage had the facts, as shown in your medical records, been disclosed to us before your Original Effective Date.

Maximum Lifetime Benefit means the total amount of money that we may pay for charges you incur for Covered Services. Your Maximum Lifetime Benefit is equal to your Benefit Period (in days) multiplied by your Daily Benefit Amount and is shown in your Schedule of Benefits. It may increase or decrease, as described in this Benefit Booklet, and is reduced as benefits are paid. If you have an unlimited Benefit Period, your Maximum Lifetime Benefit is also unlimited.

Medicare means the Health Insurance for the Aged and Disabled provisions of Title XVIII of the Social Security Act, as amended from time to time.

Member of the Uniformed Services means a person as defined by the Act at 5 U.S.C. § 9001 and the Federal Program regulations (5 CFR 875), as amended.

Misrepresentation means a statement or omission of information Material To Your Insurability that occurred with or without your knowledge of the facts as shown in your medical records.

New Enrollee means a person who first becomes insured under the Federal Program by this Benefit Booklet, FLTCIP 1.0.

Nurse means a registered professional nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) who is currently licensed in the jurisdiction in which the services are provided.

Nursing Care means services requiring the professional skills of a Nurse, which are provided by a Nurse under the orders of a Physician for the purpose of improving or maintaining your health.

Nursing Home means a facility that is licensed as a nursing facility under the laws of the jurisdiction in which it is located, or other facility approved by us, that satisfies all of the following:

- has an appropriate license under the laws of the jurisdiction in which it is located and provides Maintenance or Personal Care; and
- provides 24-hour-a-day Nursing Care; and
- provides 24-hour-a-day Maintenance or Personal Care using a trained/certified and awake staff supervised by a Nurse; and
- maintains a Written record of services provided to each resident; and
- has formal arrangements for emergency medical care; and
- provides residential services including, but not limited to, provision of food, shelter and laundry.

The term includes any such facility that specializes in the care of persons with Alzheimer's disease and other dementias. **The term does not include:**

- a Hospital (except a distinct part of a Hospital that is a Nursing Home); or
- any facility used primarily to provide residential services and not Maintenance or Personal Care, such as congregate living, sheltered living, home for the aged, retirement homes, senior housing, or the independent living units of a continuing care retirement community or similar entity; or
- a place for the treatment of drug addiction or alcoholism; or
- a facility where most of the residents are related to the owner or manager.

OPM means the United States Office of Personnel Management.

Original Effective Date means the date that your coverage first became effective under this Benefit Booklet or a prior Benefit Booklet issued to you under the Federal Program. Your Original Effective Date is shown on your Schedule of Benefits, but may be changed to a later date according to the Effective Date of Coverage section.

Physician means a 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 provided.

Plan of Care means a plan that is prescribed by a Licensed Health Care Practitioner that identifies ways of meeting your needs for Qualified Long Term Care Services if:

- you are unable to perform, without Substantial Assistance from another person, at least 2 Activities of Daily Living for an expected period of at least 90 days due to a loss of functional capacity; or

- you require Substantial Supervision due to your Severe Cognitive Impairment.

Qualified Long Term Care Services means necessary, diagnostic, preventative, therapeutic, curing, treating, mitigating or rehabilitative or Maintenance or Personal Care Services, which are required by a person who is eligible for benefits. Services that are primarily for companionship are not Qualified Long Term Care Services.

Qualified Relative means a person as defined by the Act at 5 U.S.C. § 9001and the Federal Program regulations (5 CFR 875), as amended.

Respite Services means services that provide your primary caregiver with temporary relief from his/her caregiving responsibilities.

Retired Member of the Uniformed Services means a person as defined by the Act at 5 U.S.C. § 9001 and the Federal Program regulations (5 CFR 875), as amended.

Schedule of Benefits means the customized listing of your coverage under the Federal Program.

Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that (a) places a person in jeopardy of harming him/herself or others and, therefore, the person requires Substantial Supervision by another person; and (b) is measured by clinical evidence and standardized tests which reliably measure impairment in: (1) short or long term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media and is consistent with applicable law.

Social Worker means a person who has been issued a license, certificate, or similar authorization to act as a social worker by a jurisdiction or a body authorized by a jurisdiction to issue such authorization.

Substantial Assistance means Hands-On Assistance or Standby Assistance. **Hands-On Assistance** means physical help by another person without which you would not be able to perform the Activities of Daily Living. **Standby Assistance** means that you require the presence of another person within arm's reach of you to prevent, by physical intervention or cueing, injury to you while you are performing the Activities of Daily Living.

Substantial Supervision means that you require continual monitoring by another person (which may include cueing by verbal prompting, gesture, or other demonstrations) to protect you from threats to your health and safety, for instance, while wandering.

Terminal Illness or **Terminally Ill** means an illness or injury determined by a Physician to be likely to result in your death within 6 months.

Therapist means a person who is licensed or certified to provide Therapy Services in the jurisdiction in which the services are provided.

Therapy Services means physical, respiratory, speech, or occupational therapy services provided by a Therapist.

United States means the United States, its territories and possessions.

Void or **Voided** means to retroactively cancel your coverage as if it had never been issued, in which case we will return all the premiums you paid.

Week means a consecutive seven-day period that begins on a Sunday at 12:01 a.m.

Weekly Benefit Amount means an amount equal to 7 x your Daily Benefit Amount. We will pay benefits up to a percentage of the Weekly Benefit Amount instead of the Daily Benefit Amount for Covered Services if you selected the Weekly Benefit Amount. If you selected the Weekly Benefit Amount, your Schedule of Benefits lists that amount.

Workforce means, collectively, Employees, Annuitants, Members of the Uniformed Services, and Retired Members of the Uniformed Services.

Written or **Writing** means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, offered by John Hancock Life & Health Insurance Company, Boston, MA 02117, and administered by Long Term Care Partners, LLC