

FLTCIP 3.0

The Federal Long Term Care Insurance Program
Benefit Booklet



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

**BENEFIT BOOKLET
FLTCIP 3.0**

**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: U.S. Office of Personnel Management
Insurer: John Hancock Life & Health Insurance Company
Federal Long Term Care Insurance Program
Administrator: Long Term Care Partners, LLC**

Group Policy Number: 900-003

NOTICE: 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 of Benefits, 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, NH 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 10% 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 Long Term Care Insurance Program (FLTCIP) 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 FLTCIP 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.

If you are a new FLTCIP 3.0 enrollee, you may cancel your coverage within 30 days after you receive this Benefit Booklet 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 you paid that covers a period after the effective date of your cancellation. If you die within 30 days of receiving this Benefit Booklet, we will refund any premium you paid to your estate. The refund of premium death benefit, as part of the Premium Stabilization Feature, will not be payable.

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 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 U.S. Office of Personnel Management (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.

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INTRODUCTION

Thank you for selecting the FLTCIP to help meet your long term care insurance needs.

Your coverage under the FLTCIP includes as Covered Services those you receive while in a Nursing Home, Assisted Living Facility, or Hospice facility, plus those you receive at Home or at an Adult Day Care Center. This Benefit Booklet describes your coverage. Your Schedule of Benefits provided with this Benefit Booklet shows the amounts of coverage that you have.

Long Term Care Partners, LLC, is the FLTCIP 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 FLTCIP 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 (John Hancock). All other words that have special definitions in this Benefit Booklet begin with capital letters and are defined in the “Definitions” section or in the section where they appear.

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, in the situations described below, your coverage will not go into effect, or else your Original Effective Date will change, as indicated.

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 FLTCIP.

Your coverage goes into effect on your Original Effective Date if you are an Employee or Member of the Uniformed Services who was involuntarily separated, 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 FLTCIP, 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 FLTCIP. 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 that 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 FLTCIP.

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 first 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 service (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.

CONDITIONS FOR PAYMENT OF BENEFITS

We will pay benefits for services if:

- you receive the services after your coverage becomes effective (please see the Original Effective Date shown on your Schedule of Benefits and the “Effective Date of Coverage” section);
- you are eligible for benefits (please see the “Eligibility for Benefits” section);
- you receive the services after satisfying any required waiting period (please see the “Waiting Period” section);
- they are Covered Services (please see the “Covered Services” section);
- you submit Written proof of actual charges you incur for Covered Services (see the “Claims: How to be Reimbursed for 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 two 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;
- we agree with that certification; and
- we approve a Plan of Care established for you by a Licensed Health Care Practitioner or one of our care coordinators.

Benefit Eligibility Determination

If you believe you may be eligible for benefits, you or your representative must submit a claim for our review.

If we need more information to make our determination:

- we may contact you, your Physician, or other persons familiar with your condition;
- 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. If you refuse to have an examination or assessment at that time, we will be unable to process your claim determination.

If there is a conflict between the information you provided on your Application for coverage and what is documented in your medical records gathered as part of the benefit eligibility assessment, your benefit eligibility decision may be delayed while we review these records.

If you have questions about benefit eligibility, you may contact FLTICIP Customer Service at **1-800-LTC-FEDS** (1-800-582-3337), **TTY** 1-800-843-3557.

Reassessment of Your Benefit Eligibility

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. It is your responsibility to notify us if your condition changes.

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 instructions on how to submit claims for reimbursement.

If we determine that you are not eligible for benefits, the notice will provide the reason(s) for the denial. If you or your representative disagree with our reasoning, you may request a review of a denial decision 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, upon 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 instructions on how to submit claims for reimbursement. If, upon review, we uphold the initial denial and you want to pursue your request further, our Written notice will tell you how to file an appeal. Please see the “Appeals” section.

WAITING PERIOD

The waiting period is the number of calendar days during which you must be eligible for benefits before we will pay benefits. We do not pay benefits for services you receive during your waiting period, except for Hospice Care, Respite Services and the Stay-At-Home Benefit. You only have to satisfy the FLTCIP 3.0 waiting period once in your lifetime. 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.

COVERED SERVICES

Your Schedule of Benefits shows the benefit options and amounts you selected.

If you are eligible for benefits (see the “Eligibility for Benefits” section) and if you have satisfied the applicable waiting period, the FLTCIP provides reimbursement for actual charges you incur up to the Benefit Amount shown in your Schedule of Benefits for the following

Qualified Long Term Care Services. Please see the “Exclusions” section for information on those services and supplies that are not covered under the FLTCIP.

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;
- 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;
- 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.

Services Provided by a Formal Caregiver at Home

We will pay for Qualified Long Term Care Services provided to you by a Formal Caregiver at Home: Nursing Care, Maintenance or Personal Care and Therapy Services. A Formal Caregiver may include Family Members provided:

- the Family Member is one of the following professionals: a Nurse, Therapist, Social Worker or registered dietician;
- the Family Member is a regular employee of a Nursing Home, Assisted Living Facility, Adult Day Care Center or Home Care Agency;
- 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; and
- the Family Member did not live in your Home at the time you became eligible for benefits (See the “Eligibility for Benefits” section).

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);
- approved by one of our care coordinators as part of your Plan of Care; and
- provided by a person who did not 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 500 days in your lifetime. Any day during which you receive any amount of Informal Caregiver services from a Family Member counts toward the 500 days.

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.

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.

Stay-at-Home Benefit

We will pay actual charges you incur for Stay-at-Home services up to the Stay-at-Home Benefit lifetime amount shown on your Schedule of Benefits as part of your Plan of Care. Stay-at-Home services consist of expenses for:

- Care Planning Visits;
- Home Modifications;
- Emergency Medical Response Systems;
- Durable Medical Equipment;
- Caregiver Training; and
- Home Safety Checks.

The maximum amount payable in your lifetime for the Stay-at-Home Benefit is 30 times your Daily Benefit Amount. The Stay-at-Home Benefit lifetime amount is shown in your Schedule of Benefits.

We reserve the right to limit the amount payable for Home Modifications to an amount appropriate for similar work in your geographic area. We will consider a county or such greater area as is needed to establish a representative cross section of providers who regularly furnish the type of Home Modification for which the charge is made.

The waiting period does not apply to the Stay-at-Home Benefit. Except for Care Planning Visits, you must be living at Home in order to be eligible for the Stay-at-Home Benefit. You may receive the services of a Formal Caregiver or an Informal Caregiver, or Hospice Care at Home while receiving benefits under the Stay-at-Home Benefit. You may use any unused portion of this Benefit Amount for future Stay-at-Home services and new episodes of care. Benefits paid under the Stay-at-Home Benefit will not reduce your Maximum Lifetime Benefit.

The maximum amount payable in your lifetime for Caregiver Training is seven times your Daily Benefit Amount. Amounts paid for Caregiver Training count toward the Stay-at-Home Benefit lifetime amount.

The Stay-at-Home Benefit will not be available to you beginning on the earliest of the following dates:

- the date you no longer are eligible for payment of benefits;
- the date you no longer reside at Home (excluding Care Planning Visits);
- the date you exhaust your Stay-at-Home Benefit lifetime amount; or
- the date your coverage ends.

Additional Covered Services and Benefits

Bed Reservations

We will pay for actual charges you incur for Bed Reservations, up to the maximum amount shown in your Schedule of Benefits. 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 60 days per calendar year.

Respite Services

We will pay for Respite Services:

- provided in a Nursing Home, Assisted Living Facility, or Hospice facility;
- 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.

The waiting period does not apply to Respite Services.

Alternate Plan of Care

We may approve alternatives to your Plan of Care that we deem to be both appropriate for you and cost-effective for the FLTCIP.

An Alternate Plan of Care is one that:

- is designed specifically for you;
- is primarily being made to improve your ability to perform one or more Activities of Daily Living;
- is mutually agreed upon by you, a Licensed Health Care Practitioner and us;
- contains recommendations for alternate services, supplies or licensed and regulated facilities for you that are not otherwise covered under your Benefit Booklet; and
- may be modified as appropriate.

We will base our review of a request for an Alternate Plan of Care on the following:

- your medical status;
- current and future care plans;
- long term cost projections for current and future care plans and the Alternate Plan of Care; and
- the suitability and effectiveness of the Alternate Plan of Care.

You may choose not to accept the final terms of the Alternate Plan of Care. The Alternate Plan of Care may not be used:

- to pay for any charges for services or supplies described in the “Exclusions” section;
- to supplement the maximum amount for any benefit under your Benefit Booklet; or
- to pay for expenses covered under the Stay-at-Home Benefit.

Benefits payable for charges incurred for services and supplies provided under the Alternate Plan of Care will not exceed the lesser of: the actual charges; or the appropriate charges for such services or supplies.

We will deem a charge appropriate only if it does not exceed the general level of charges being made by others in your area when furnishing like or similar services or supplies. In determining appropriateness, we will consider a county or such greater area as is needed to establish a representative cross section of providers who regularly furnish the type of service or supply for which the charge is made.

Your receipt of services for your care under an Alternate Plan of Care will be subject to the waiting period (see the “Waiting Period” section). The benefits we will pay for such services will be subject to the “Maximum Benefit We Will Pay” section.

International Benefits

We will pay benefits for Covered Services you receive outside the United States up to the Benefit Amount shown on your Schedule of Benefits for those Covered Services. Any benefit paid will reduce your Maximum Lifetime Benefit. You will be reimbursed in U.S. currency.

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

SERVICES NOT COVERED

We will not pay for any charges other than for Covered Services. These charges include, but are not limited to, the following incurred by you:

- medical services (e.g., X-rays, laboratory fees, Physician charges);
- Informal Caregiver services while residing in a facility;
- transportation, mileage, or gasoline;
- fees beyond usual and customary room and board charges (e.g., move-in or entry fees, security deposits, finance charges);
- room and board for independent living quarters in a continuing care retirement community, rest home, or similar entity;
- services or items that are not related to the provision or support of long term care services (e.g., beauty or barber services, cable, furniture rentals, vacations, guest meals);
- any type of residential upkeep, construction, renovation, or home maintenance (e.g., painting, plumbing), except that which is covered as a Home Modification under the Stay-at-Home Benefit;
- lawn care; snow removal; or vehicle or equipment upkeep;
- second occupant fees for individuals not eligible for FLTCIP benefits;
- no-show fee;
- care or services that are not included in or are inconsistent with your Plan of Care.

Please see the “Exclusions” section for additional services and supplies not covered.

MAXIMUM BENEFIT WE WILL PAY

All benefit payments, except those under the Stay-at-Home Benefit, are limited by your Maximum Lifetime Benefit (see “Stay-at-Home Benefit” section).

Except for services you receive under the Stay-at-Home Benefit, 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.

CARE COORDINATION SERVICES

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

- provide general information about long term care services;
- assess and approve your need for long term care services;
- develop a plan for long term care services;

- monitor and reassess from time to time the long term care services that you receive; and
- provide access to discounts for services, when available in your area.

Our care coordinators will also provide the services described above for your Qualified Relatives. These services will be provided regardless of whether your Qualified Relatives are enrolled in the FLTCIP, 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 FLTCIP.

The FLTCIP does not pay benefits for any of the following:

- illness, treatment or medical condition arising out of:
 - your participation in a felony, riot, or insurrection;
 - your attempted suicide, while sane or insane; or
 - injuries you intentionally inflict on yourself;
- care or treatment for alcoholism or drug addiction;
- care or treatment provided in a government facility, including a U.S. Department of Defense or U.S. Department of Veterans Affairs facility, unless otherwise required by law;
- care you receive while in a Hospital, except in a unit specifically designated as a Nursing Home or Hospice facility;
- 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
- services or supplies for which you are not obligated to pay in the absence of insurance;
- services provided by any person who lived in your Home at the time you became eligible for benefits; or
- services provided by your spouse or domestic partner.

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 FLTCIP 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 FLTCIP 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 may 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.

Although we do not coordinate benefits with Medicaid, we may be required by state law to notify your state Medicaid office about your coverage under the FLTCIP. In addition, we reserve the right to notify your applicable state Medicaid office about your FLTCIP coverage as may be appropriate.

If the FLTCIP 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.

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 FLTCIP. Please see the "Exclusions" section, which excludes payment of benefits for care provided in a government facility.

CLAIMS: HOW TO BE REIMBURSED FOR COVERED SERVICES

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 Written proof acceptable to us that you have incurred charges for Covered Services. For example, if you use an Informal Caregiver, you must submit invoices for actual charges you incurred for Covered Services as well as proof of payment.

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.

If any portion of the refund of premium death benefit has been paid, and a claim for reimbursement for Covered Services is subsequently submitted, we will reduce any claim benefit amount by the total amount available under the refund of premium death benefit. If any claim is received for Covered Services prior to payment of the refund of premium death benefit, we will process and pay the benefits for the claim for Covered Services first.

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. If you disagree with our reasoning, 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, upon review, 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: How to Be Reimbursed for Covered Services" section, the FLTCIP 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 will 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 five out of six Activities of Daily Living.

The following is an example of when a denial by the appeals committee will not 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 FOR COVERED SERVICES

All benefits will be paid in U.S. 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. You may not assign benefits other than to the provider who provided the long term care Covered Services. 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 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 that you chose 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 (as well as other remaining Benefit Amounts listed in the Schedule of Benefits) will automatically increase at the Automatic Compound Inflation rate shown on your Schedule of Benefits, compounded annually. 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" and "When We May Increase Your Premium" sections.

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 that you chose this option.)

Under the Future Purchase Option, your premium will increase for each inflation increase under this option unless you decline the offer; 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.

Every two years, we will increase your Daily Benefit Amount and the remaining portion of your Maximum Lifetime Benefit (as well as other remaining Benefit Amounts listed in the Schedule of Benefits), except as described below. We will send notice of the increases every two years prior to the increase effective date. Increases will be effective on the January 1 following the notice. 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 U.S. Department of Labor's Consumer Price Index for All Urban Consumers (CPI-U), 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 and the "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.

Increases under this option do not require you to provide evidence of your good health.

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 the "Eligibility for Benefits" section or if you declined a total of three prior increases. However, if you are insured for less than 24 months, 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.

If you declined a total of three 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.

If you receive an increase and it was determined that you were eligible for benefits on the date that increase went into effect, the increase will be removed.

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 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 FLTCIP options available under this Benefit Booklet 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. It must be paid in U.S. currency. Premium payment options and requirements are on your Application and on the FLTCIP website. If you elect to pay your premium via automatic bank withdrawal, we reserve the right to collect any past due premium by withdrawing up to two months of premiums from your bank account each month until current.

If we are unable to collect premium via automatic bank withdrawal or deductions from your payroll or annuity/pension, or if you choose not to pay via these methods, we may send you direct bills for the premium amount due.

The amount of your premium when coverage first goes into effect is based on your original issue age and the coverage that you chose, as shown on your Schedule of Benefits. Your premium rate will not change because you get older, your health declines, or for any other reason related solely to you. However, the amount of premium that you need to pay may change over time based on changes to your benefits. See the “Benefit Changes” section.

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 change. Please see the “When We May Increase Your Premium” section.

How Benefit Changes Affect your Premium

Your premiums may increase as described under the “Premiums” and “When We May Increase Your Premium” sections.

If you selected the Automatic Compound Inflation Option, your premium is designed to include all future annual inflation increases 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 paragraphs and the “When We May Increase Your Premium” section.

If you request and we approve any coverage increases, 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.

Contingent Benefit Upon Lapse

We will provide a contingent benefit upon lapse as identified in the Group Policy. If you are among a group of enrollees whose premium is determined to be inadequate and a rate increase for FLTCIP 3.0 is approved, you may choose this benefit. This benefit allows you to stop paying premiums and provides paid-up coverage with a reduced level of benefits.

If you elect the contingent benefit upon lapse, the Premium Stabilization Feature will terminate.

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 U.S. mail. You will have 35 days from the date of the termination letter to pay your premium; otherwise, your FLTCIP coverage will end. (Please see the “When Your Coverage Will End” section for more information.)

Protection Against Unintended Lapse

To help protect you from the 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 if you want to change the person that you name or if there are changes to that person’s contact information.

WAIVER OF PREMIUM

You will not have to pay your premium if you are eligible for benefits and have satisfied the waiting period. See the section entitled “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;
- the date of your death;
- the end of the period covered by your last premium payment if you do not pay the required premium when due;
- 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 FLTCIP 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;
- 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 your coverage 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 FLTCIP 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;
- 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 six months of the date of the Written notice that your coverage has 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 of the Written notice that your coverage has ended, you:

- request reinstatement;
- 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.

PREMIUM STABILIZATION FEATURE

Under the Premium Stabilization Feature (PSF), there is an adjustable amount that is calculated as a percentage of premiums paid under the FLTCIP 3.0 Group Policy. This feature is designed to reduce the potential need for future premium increases. Under certain conditions, this amount may be used to offset your future premium payments or provide a refund of premium death benefit.

The PSF has no cash surrender value or other monetary value except as a premium offset or refund of premium death benefit as described in this Benefit Booklet. The PSF terminates and no PSF Amount is available or payable on your election of the contingent benefit upon lapse, your voluntary lapse of coverage, or termination of your coverage for reasons other than death, including termination due to nonpayment of premium.

Premium Stabilization Feature Amount

The portion of premium available as your Premium Stabilization Feature Amount (PSF Amount) is equal to:

- the total amount of premium you paid multiplied by the current PSF Percentage defined below; less
- benefit amounts paid on your behalf for FLTCIP claims; and less
- any prior uses of the PSF Amount to pay premiums for you as a premium offset.

The PSF Amount is reduced dollar-for-dollar by benefit amounts paid on your behalf, so your PSF Amount may be reduced to zero regardless of the PSF Percentage.

Premium you paid means the total amount of premium you paid out-of-pocket for FLTCIP 3.0, and the amount of any premium offset used for you under the PSF.

Premium Stabilization Feature Percentage

The Premium Stabilization Feature Percentage (PSF Percentage) is used to calculate the amount of premium paid that may be available under the PSF. We may adjust the PSF Percentage due to actual and projected FLTCIP experience. The PSF Percentage will be changed no more than once annually. The PSF Percentage will not exceed 100%, and it will not be less than 10%. You will be notified when a PSF Percentage change occurs. The PSF Percentage is shown on your Schedule of Benefits. While the Group Policy is in effect, OPM must approve the change in the PSF Percentage.

Premium Offset

The premium offset will be used as described below unless you opt out of the premium offset at any time by contacting us, in Writing. Under the premium offset, your PSF Amount will be used to pay for 50% of your monthly FLTCIP premium obligation when you have met the following:

- you have attained the age of 85;
- you have been enrolled in the FLTCIP 3.0 for at least 10 years;
- you have sufficient PSF Amount available to pay 50% of your monthly premiums for at least the next 12 months based on current premium; and
- you have not opted out of the premium offset.

The premium offset will continue until:

- there is insufficient PSF Amount available to pay 50% of your monthly premium due; or
- you contact us, in Writing, and request to stop using this premium offset.

In the event that the premium offset is discontinued, we will provide you with Written notice that you will be responsible for 100% of your monthly premium obligations.

If your premium is waived under the Waiver of Premium provision (see section entitled "Waiver of Premium"), the premium offset will not apply.

Refund of Premium Death Benefit

If your FLTCIP coverage is in force on your date of death, a refund of premium death benefit may be payable. Any PSF Amount available will be paid as a refund of premium death benefit to your estate or a beneficiary you designated in Writing and on file with us, if the beneficiary is alive on your date of death.

The refund of premium death benefit will be based on the PSF Percentage in effect on your date of death. To determine the amount available, we will process any outstanding claims received and recoup any claims overpayments. Any remaining PSF Amount will be paid to your estate or the beneficiary you designated.

You may change your beneficiary at any time by completing and submitting a beneficiary change form. The beneficiary change must be received before your date of death and will take effect on the date

the completed form is received by the FLTCIP administrator. This change will not apply to any payment we made or any action we may have taken before your Written request was received.

The beneficiary must be deemed, in our sole discretion, entitled to the payment. If a PSF Amount is available as a refund of premium death benefit, and a beneficiary predeceases you, the refund of premium death benefit will be divided equally among any remaining living beneficiaries.

If no beneficiary is alive on your date of death, and a PSF Amount is available as a refund of premium death benefit, the amount will be payable to your estate or, if there is no estate, to an alternative payee(s). The alternative payee(s) must be a person(s) who is(are) deemed, in our sole discretion, entitled to the payment. Neither the FLTCIP administrator nor we will be liable as a result of any payment made in good faith under this provision.

If any portion of the refund of premium death benefit has been paid, and a claim for reimbursement for Covered Services is subsequently submitted, we will reduce any claim benefit amount by the total amount available under the refund of premium death benefit. If any claim is received for Covered Services prior to payment of the refund of premium death benefit, we will process and pay the benefits for the claim for Covered Services first.

Important Notice Regarding Federal and State Tax Law
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The payment of the PSF Amount as a refund of premium death benefit may have federal and state tax implications for your estate or beneficiary. You may want to review this benefit with a qualified tax professional or attorney to determine any such tax impact.
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GENERAL PROVISIONS

Statements Made by You Relating to Insurability

No statement made by you that 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 six months, we may Void your coverage upon a showing of Misrepresentation by you.

If your coverage has been in force for at least six months but less than two 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 two 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 your coverage is Voided, no claims for benefits will be paid, and the "Notice and Review of Claim Determination" and "Appeals" sections 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.

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 FLTCIP 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 FLTCIP 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 FLTCIP may be started against us or the FLTCIP administrator:

- before you have exhausted the appeals process described in the “Appeals” section; or
- more than two 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 FLTCIP 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 FLTCIP, the amount of recovery shall be limited to the benefit that would be payable under the FLTCIP. No extra-contractual, punitive, compensatory, or consequential damages shall be recoverable under the FLTCIP.

The FLTCIP shall supersede and preempt any state or local law, regulation, or requirement as permitted by the Act or any FLTCIP 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;
- after the effective date of your cancellation of coverage; or
- during which your premium is waived. Please see the “Waiver of Premium” section.

For information regarding the refund of premium death benefit available as part of the Premium Stabilization Feature, see the “Premium Stabilization Feature” section.

Payments on Your Death

For anything other than any PSF Amount payable as a refund of premium death benefit, if, at the time of your death, any portion of benefits is payable or any overpayment of premium is to be refunded as described under the “Refund of Premiums” section, we will pay such amount to your estate or, if there is no estate, to an alternative payee(s). The alternative payee(s) must be a person(s) who is(are) deemed, in our sole discretion, entitled to the payment. Neither the FLTCIP administrator nor we will be liable as a result of any payment made in good faith under this provision.

Also see the “Premium Stabilization Feature” section.

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;
 - getting out of a tub or shower;
 - 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);
- continence:
 - maintaining control of bowel and bladder function; and
 - 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);
- 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);
- 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); and
 - 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);
- toileting:
 - getting to and from the toilet;
 - 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);

- 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).

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;
- maintains a Written record of services provided to each client;
- has established procedures to get emergency medical care;
- 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, one or more Nurses in attendance during operating hours at least four hours a day, and at least two 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 FLTCIP regulations (5 CFR Part 875), as amended.

Application means an application for insurance under the FLTCIP submitted in connection with this Benefit Booklet.

Assisted Living Facility means a facility that is licensed under the laws of the jurisdiction in which it is located, or other facility approved by us, which 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;
- 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;
- has a minimum of three residents;
- uses aides trained or certified to provide Maintenance or Personal Care consistent with any laws applicable to the provision of such care;
- provides 24 hour supervision of residents by a trained and awake staff;
- has formal arrangements for emergency medical care;

- maintains Written records of services provided to each resident;
- provides residents with three 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 Living 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. Your Benefit Amounts are shown on your Schedule of Benefits.

Benefit Booklet means a coverage booklet issued to you under the FLTCIP. This Benefit Booklet, together with your Schedule of Benefits and your Application, describes your coverage under the FLTCIP.

Benefit Period means the length of time your coverage will last if we pay your full Daily Benefit Amount every day. 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 while you reside at Home. **The term includes** training of an Informal Caregiver or a caregiver whose services are not covered under the FLTCIP (such as your spouse or another person who lived with you at the time you became eligible for benefits).

Care Planning Visit means a visit by a provider acceptable to us who will:

- assess your needs for health care and related services; and
- assist you in developing a care plan to meet your care needs; and
- identify appropriate resources available in your community.

Covered Services means those Qualified Long Term Care Services listed in the “Covered Services” section for which coverage is provided under the FLTCIP.

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.

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

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.

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

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

FLTCIP 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 FLTCIP are set forth in FLTCIP 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.

Group Policy means group long term care insurance policy number 900-003 issued by John Hancock to the U.S. 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. During the visit providing your Maintenance or Personal Care, this individual may also provide additional incidental support services such as meal preparation, laundry, or light housekeeping. If Maintenance or Personal Care is not provided during the visit, incidental support services are not covered.

Home Modifications mean minor 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 of doorways, and other similar accessibility modifications. Home Modifications do not include hot tubs, swimming pools, home repair or maintenance, bathroom or other room additions, or other modifications that may increase the value of your Home by more than a nominal amount.

Home Safety Check means a written evaluation of the safety of your Home by a Home Health Agency or other qualified professional agency or individual acceptable to us. Examples of the home items that may be evaluated include: furniture arrangement, doorway and hallway width, and the need for safety bars in the bathroom.

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 that 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 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 an individual with needed assistance with their Activities of Daily Living or providing protection from threats to health and safety due to a 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. Your Maximum Lifetime Benefit is not reduced by any amount paid under the Stay-at-Home Benefit.

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 FLTCIP regulations (5 CFR Part 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.

Nurse means a registered professional nurse (RN), licensed nurse practitioner (APN), licensed practical nurse (LPN), or licensed vocational nurse (LVN), 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, which 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;
- provides access to 24-hour-a-day Nursing Care;
- provides 24-hour-a-day Maintenance or Personal Care using trained or certified staff that is supervised by or has access to a Nurse;
- maintains a Written record of services provided to each resident;
- 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 any of the following:**

- a Hospital (except a distinct part of a Hospital that is a Nursing Home);
- 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;
- 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.

Original Effective Date means the date that your coverage first became effective under this Benefit Booklet. 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 (MD) or doctor of osteopathy (DO) practicing within the scope of his or her license issued by the jurisdiction in which the services are provided.

Plan of Care means a Written plan for long term care services prescribed by a Licensed Health Care Practitioner for you that identifies ways of meeting your needs for Qualified Long Term Care Services and specifies the type, frequency, and providers of all the services you require. The Plan of Care is subject to change as your condition and service requirements change. No more than one Plan of Care may be in effect at a time.

Qualified Long Term Care Services means necessary, diagnostic, preventative, therapeutic, curing, treating, mitigating, 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. § 9001 and the FLCIP regulations (5 CFR Part 875), as amended.

Respite Services means services that provide your primary caregiver with temporary relief from his or 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 FLCIP regulations (5 CFR Part 875), as amended.

Schedule of Benefits means the customized listing of your coverage under the FLCIP.

Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that a) places a person in jeopardy of harming him- or 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 in the jurisdiction in which services are provided.

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 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.

Substantial Supervision means that you require ongoing, uninterrupted 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 six 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.

U.S. means the United States, its territories, and its 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.

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

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

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, under a group long term care insurance policy, and administered by Long Term Care Partners, LLC.

