JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)

**[333 West Everett Street
P.O. Box 2986
Milwaukee, WI 53203
1-800-711-9181]**

An Approved Participant In

CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

COMPREHENSIVE LONG-TERM CARE INSURANCE POLICY
OUTLINE OF COVERAGE
POLICY FORM CAP-06 10/11

THE BENEFITS PAYABLE BY THIS POLICY QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. ELIGIBILITY FOR MEDI-CAL IS NOT AUTOMATIC.

IF AND WHEN YOU NEED MEDI-CAL, YOU MUST APPLY AND MEET THE ASSET STANDARDS IN EFFECT AT THAT TIME. UPON BECOMING A MEDI-CAL BENEFICIARY, YOU WILL BE ELIGIBLE FOR ALL MEDICALLY NECESSARY BENEFITS MEDI-CAL PROVIDES AT THAT TIME, BUT YOU MAY NEED TO APPLY A PORTION OF YOUR INCOME TOWARD THE COST OF YOUR CARE. MEDI-CAL SERVICES MAY BE DIFFERENT THAN THE SERVICES RECEIVED UNDER THE PRIVATE INSURANCE.

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

CAUTION: The issuance of this long term care insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, the company has the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the company at this address: [John Hancock Life Insurance Company (U.S.A.), 333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203 or call Us at 1-800-711-9181].

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care incurred by You during the period of coverage. You are advised to review carefully all Policy limitations.

1. This Policy is an individual policy of insurance which is issued in the State of California.

2. **PURPOSE OF OUTLINE OF COVERAGE**

   This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY!

3. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUMS REFUNDED**

(a) **THIRTY DAY FREE LOOK.** If You are not completely satisfied with this Policy for any reason, You may return it within 30 days from the date it was delivered to You. We will then refund any premium paid, and the Policy will be treated as if it had never been issued.

(b) **REFUND OF UNEARNED PREMIUMS.** Upon receipt of notice that You have died, We will refund the premium paid for any period beyond the date of death.

4. **THIS IS NOT A MEDICARE SUPPLEMENT POLICY**

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from John Hancock. Neither John Hancock Life Insurance Company (U.S.A.) nor its agents represent Medicare, the federal government or any state government.

5. **LONG TERM CARE COVERAGE**

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Facility, in the community, or in the home.

This Policy provides coverage for actual charges incurred for care up to the applicable Daily or Monthly Benefit for covered long term care expenses, subject to Policy limitations and requirements.

6. **BENEFITS PROVIDED BY THIS POLICY**

Benefit Limits Selected:	**Nursing Facility Daily Benefit**	[$_____
	Residential Care Facility Percentage	_____%
	Home & Community Based Care Percentage	_____%
	Benefit Period	_____
	Elimination Period	_____-days
	Inflation Coverage	_____
	Optional Benefits	_____ _____]

(a) Subject to Policy conditions, requirements and limitations, this Policy provides benefits for actual charges incurred for:

- a confinement in a Nursing Facility for room and board and care services;
- confinement in a Residential Care Facility for room and board and care services; and
- Home and Community-Based Care.

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

We will not pay benefits for charges during the Elimination Period, except for Care Management Services, the Additional Stay at Home Benefit (if included in the Policy) and Respite Care. The Elimination Period means the total number of days that covered, Formal Long Term Care Services must be received after You are determined to be a Chronically Ill Individual and before the benefits covered by the Policy are payable. The

number of days may be accumulated over any period of time after You have been determined to be a Chronically Ill Individual. The number of days can be accumulated before the filing of a claim if You can establish that You were a Chronically Ill Individual before filing a claim.

The Elimination Period need only be met once during a lifetime. Any day when covered services are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period.

We will not pay benefits in excess of the Policy Limit as shown in the Policy Schedule. However, benefits for Care Management Services and the Additional at Home Benefit (if included in the Policy) will not reduce the Policy Limit.

(b) **Institutional Benefits:**

(1) **Nursing Facility Benefit.** We will pay the actual charges incurred for confinement in a Nursing Facility up to the Nursing Facility Daily Benefit Amount. Actual charges include: room and board, ancillary services and supplies and Nursing Care charged by the Nursing Facility, as well as services that are available under the Home and Community-Based Care Benefit.

In addition, if Your stay in a Nursing Facility is interrupted for any reason and a benefit is payable under this Policy, We will continue to pay the actual charges for up to 60-days in any calendar year in order to reserve Your bed during Your absence.

(2) **Residential Care Facility Benefit.** We will pay the actual charges incurred for confinement in a Residential Care Facility up to the Residential Care Facility Daily Benefit Amount. Actual charges include: care and services provided by the Residential Care Facility, all other care and services covered under other benefits of the Policy, and any other care and services that are needed to assist You with the disabling conditions that caused You to be a Chronically Ill Individual.

In addition, if Your stay in a Residential Care Facility is interrupted for any reason and a benefit is payable under this Policy, We will continue to pay the actual charges for up to 60-days in any calendar year in order to reserve Your bed during Your absence.

(c) **Non-institutional Benefits:**

(1) **Home and Community-Based Care Benefit.** We will pay the Home and Community-Based Care Monthly Benefit Amount if You are receiving Home and Community-Based Care. Home and Community-Based Care includes: Home Health Care, Adult Day Care, Homemaker Services, Hospice Care, Personal Care and Respite Care. The Home and Community-Based Care Monthly Benefit Amount is equal to the Nursing Facility Daily Benefit Amount multiplied by the Home and Community-Based Care Percentage that You selected on Your application for this Policy, multiplied by 30-days.

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

Note - Respite Care is paid under the Respite Care Benefit. The Respite Care Benefit is equal to 21-days times the Nursing Facility Daily Benefit Amount per calendar year. You do not have to satisfy the Elimination Period to receive this benefit. Benefits paid under the Respite Care Benefit reduce the Policy Limit.

Types of Home and Community-Based Care Defined

- *Home Health Care* means skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker. Home Health Care must be provided by a licensed Home Health Agency or a professional such as a: registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, medical social worker or registered dietitian.
- *Adult Day Care* means a structured, comprehensive program which provides a variety of community-based services including health, social, and related supportive services in a protective setting on a less than 24-hour basis. These community-based services are designed to meet the needs of functionally impaired adults through an individualized service plan, and include the following:
  - personal care and supervision as needed;
  - the provision of meals as long as the meals do not meet a full daily nutritional regimen;
  - transportation to and from the service site;
  - and social, health, and recreational activities.
- *Personal Care Services* means:
  - *Ambulation assistance*, including help in walking or moving around (i.e. wheelchair) outside or inside the place of residence, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.
  - *Bathing and grooming* including cleaning the body, using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.
  - *Dressing* including putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
  - *Bowel, bladder and menstrual care* including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

- *Repositioning, transfer skin care, and range of motion exercises*, including moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e. the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.
- *Feeding, hydration assistance*, including reaching for, picking up, grasping utensil and cup; getting food on utensil; bringing food, utensil, cup to mouth, and manipulating food on plate. Cleansing face and hands as necessary following meal.
- *Assistance with self-administration of medications*.
- *Assistance with Instrumental Activities of Daily Living*, which include:
  - domestic or cleaning services;
  - laundry services;
  - reasonable food shopping and errands;
  - meal preparation and cleanup;
  - transportation assistance to and from medical appointments; and,
  - heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt; and,
  - using the telephone.

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

- *Homemaker Services* means assistance with activities necessary to or consistent with Your ability to remain in Your residence, that is provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner. Homemaker Services cannot be restricted to licensed providers or Medicare-certified providers.
- *Hospice Services* are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a *Plan of Care* developed by a Physician or a multidisciplinary team under medical direction. "Terminally disease" means that there is no reasonable prospect of cure and You have a life expectancy, as estimated by a Physician, of 12 months or less. Hospice Services also include supportive care to Your primary caregiver and Your family.

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

(2) **Care Management Services Benefit.** Before We can determine whether You are eligible to receive covered benefits under this Policy, We require that an approved Care Management Provider Agency conduct an assessment of Your condition. All Care Management Services that You receive must be provided by a Care Management Provider Agency that is selected by Us and approved by the California Partnership for Long Term Care.

We will arrange for:

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

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

We will pay for all initial assessments, reassessments and Plans of Care, including a discharge plan and transition plan. You may also choose to have the Care Management Provider Agency, that We arranged for You, coordinate Your care or monitor the services You receive, if determined necessary by the Care Management Provider Agency. None of these services are subject to Your Elimination Period, nor will any days You receive Care Management Services count toward satisfying Your Elimination Period or apply toward the Policy Limit.

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

- the performance of a comprehensive, individualized, face-to-face, initial assessment to determine Your eligibility for benefits which is conducted in Your place of residence;
- the development of Your initial Plan of Care when You are eligible for benefits;
- providing the initial written Certification to Us and thereafter, a written recertification every 12 months, that You are a Chronically Ill Individual:
- the performance of all comprehensive, individualized reassessments which will occur at least every six months while You are receiving benefits;
- the development of all subsequent Plans of Care as needed per the results of any reassessments. In addition, please note that You have a right to a discharge plan when the Care Management Provider Agency services are about to be terminated. If You are immediately eligible for Medi-Cal, the Care Management Provider Agency will prepare a transition plan. The transition plan and/or discharge plan must be provided to You within 30 days after receipt of notification from Us that coverage will be exhausted; and
- when desired by You and determined necessary by the Care Management Provider Agency, coordination of appropriate services and ongoing monitoring of the delivery of such services.

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

(d) **Additional Benefits:**

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

  If You die before Your 65th birthday, We will pay to Your beneficiary a Return of Premium upon Death Benefit if Your Policy is in force on the date of Your death. The Return of Premium upon Death Benefit will be calculated by subtracting the sum of all benefits paid under Your Policy for charges incurred prior to the date of Your death from the sum of all premiums paid for Your Policy (accumulated without interest).

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

(e) **How to Qualify for Benefits**

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

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

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

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

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

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

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

Activities of Daily Living means the following activities:

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

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

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

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

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

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

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

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

(f) **Conditions.** To receive benefits under this Policy:

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

(g) **Optional Benefits.** You may elect any of the optional benefits listed. You must pay an additional premium for any of the optional benefits elected.

- **[SharedCare Benefit**. The SharedCare Benefit Rider allows Your Partner to access benefits under Your Policy if Your Partner first exhausts the available benefits payable under his or her policy. You and Your Partner may both receive benefits under Your Policy at the same time. In no event will We pay benefits that exceed the maximum Policy Limits of both policies combined. Your Partner must also have added an identical SharedCare Benefit Rider to their policy naming You as Covered Person for that policy.

- **Survivorship and Waiver of Premium Benefit.** The Survivorship and Waiver of Premium Benefit rider provides that Your premiums will be waived in the event Your Partner dies or goes on claim after both policies have been inforce for at least 10 years and no claims were payable in the first 10 years. Payments will resume if Your Partner's premiums are no longer waived or Your Partner's policy terminates.

- **Enhanced Home and Community-Based Care Benefit.** This Rider provides two important features that will enhance Your home care.

  (1) **Zero-Day Elimination Period for Home and Community-Based Care**. We will waive the requirement that you satisfy the Elimination Period if You are receiving Home and Community-Based Care. The Elimination Period must still be satisfied before benefits are payable for confinement in a Nursing Facility or a Residential Care Facility. However, days for which the Home and Community-Based Care Elimination Period is waived will count toward meeting the Elimination Period.

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

  (i) Home Modifications to Your Home;
  (ii) Emergency Medical Response Systems;
  (iii) Durable Medical Equipment;
  (iv) Caregiver Training; and
  (v) Home Safety Check

  The Additional Stay at Home Lifetime Benefit Amount is equal to 30-times the Nursing Facility Daily Benefit Amount. You do not have to satisfy the Elimination Period to receive this benefit. Benefits paid under the Additional Stay at Home Benefit will not reduce the Policy Limit.

- **Nonforfeiture Benefit.** If Your Policy lapses because You have not paid the premium within the Grace Period, after being in force at least three years, it will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. This means that a reduced benefit will be payable instead of the full Policy Limit. All benefit limits will continue to increase annually due to the inflation coverage provision included in Your Policy.

7. LIMITATIONS AND EXCLUSIONS

In addition to the Conditions to qualify for benefits set forth above, the following limitations and exclusions apply to the Policy.

(a) **Exclusions.** This Policy does not cover care or treatment:

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

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

(b) **Non-Duplication of Benefits.** This Policy will only pay covered charges in excess of charges covered under any of the following:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amounts).
- any other governmental program (except Medicaid).
- any other health insurance or health plan, subscriber contract, HMO plan or prepayment plan or other long term care insurance policies or certificates.
- any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law.

(c) **Charges not Covered.** We will not pay for any of the following: Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; medical supplies; and items and services furnished at Your request for beautification, convenience or entertainment.

(d) **Coordination with Other John Hancock Individual Long-Term Care Insurance Policies.** We may reduce benefits payable under this Policy for Long-Term Care Services if We also pay benefits for such services under any other individual long-term care policy issued by Us. This includes policies providing Nursing Facility, Residential Care Facility and/or Home and Community-Based Care coverage whether payable on an expense reimbursement, indemnity or any other basis.

Benefits will be reduced under this Policy, only when payment under this Policy and all other John Hancock individual long-term care policies combined would exceed the actual

amount You incur for Long-Term Care Services. In no event will We pay under this Policy more than the difference between Your actual expenses and the amount payable by Your other policies with Us.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**

(a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means You have the right, subject to the terms of Your Policy to continue this Policy as long as You pay Your premiums on time. John Hancock cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY. However, any change in the premium rates must be approved by the California Department of Insurance and the change can only be approved if rate increases are needed on all other Partnership policies sold in California.

(b) **WAIVER OF PREMIUM.** We will waive the payment of premiums under this Policy if You have received services for which benefits are payable under the Nursing Facility Benefit, the Residential Care Facility Benefit, or the Home and Community-Based Care Benefit; and You have satisfied Your Elimination Period. The waiver period will start the day after Your Elimination Period has been satisfied and will end on the date when benefits are no longer payable.

(c) **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. We reserve the right to increase Your premium as of any premium due date; however, any changes in premium rates must apply to all similar policies issued in Your state on this Policy form. This means We cannot single You out for an increase because of any change in Your age or health. However, Your rates may go up based on the experience of all policyholders with a policy similar to Yours.**

9. **RELATIONSHIP OF COST OF CARE AND BENEFITS**

Because the costs of long term care services will likely increase over time, You should consider whether and how the benefits of this Policy may be adjusted. The California Partnership for Long Term Care requires your Policy include 5% compound inflation coverage unless You are at least 70 years old. If You are 70 years or older, You may elect for 5% simple inflation coverage in lieu of 5% compound inflation coverage. Annual inflation increases will not be affected by the payment of claims. The inflation coverage options are described at the end of this Outline of Coverage.

10. **ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND RELATED MENTAL DISEASES**

We cover insureds clinically diagnosed as having Alzheimer's Disease, organic disorders or related degenerative and dementing illnesses that result in a Cognitive Impairment or inability to perform Activities of Daily Living which are diagnosed by a Physician after the Date of Issue.

11. **PREMIUMS**

The total premium for Your Policy as well as a breakdown of the premium by base policy and optional benefits are found below.

	Annual Premium
Base Policy (includes inflation)	**[$**_____
• SharedCare Benefit	**$**_____
• Enhanced Home and Community-Based Care Benefit	**$**_____
• Survivorship & Waiver of Premium Benefit	**$**_____**]**
• Nonforfeiture Benefit	**$**_____
Premium Credit (if any) due to replacement coverage	**$**_____
Total Annual Premium	**$**_____

Your premium will be $ _____ on a _____ basis.**

** You may elect to pay Your premium on an annual, semi-annual, quarterly or monthly basis. Please note that the more often you pay, the higher your premium amount will be per year. Additional premium charges are included for semi-annual, quarterly, and monthly premiums. These charges are called "modal fees". These fees are based upon the following modal factors and are used to determine the premium amount for all payment options. The modal factors are 1.00 for annual, .52 for semi-annual, .2625 for quarterly and .0875 for monthly. To calculate Your approximate total annual premium payment based on Your current policy selection:

- Multiply the "Total Annual Premium" as shown in the box above by the factor associated with Your selected mode of payment, and then
- Multiply that result by the number of payments required in a year based upon Your selected payment mode.

12. **ADDITIONAL FEATURES**

(a) Issuance of Your coverage may depend upon certain medical information about You. This is generally known as medical underwriting.

(b) **Added Protection Against Lapse**. You may name as many as three persons on the application to receive a termination notice 30 days after the premium due date. If Your Policy terminates because You did not pay a premium while You would meet the eligibility requirements for the payment of benefits, it may be reinstated within 5 months of the date of termination if:

- You give Us proof of the Severe Cognitive Impairment or Your inability to perform 2 of the Activities of Daily Living without Substantial Assistance; and
- You pay all the unpaid overdue premiums.

(c) **Your Right to Increase Benefits**. On each Policy anniversary, you have the right to: increase your Nursing Facility Daily Benefit Amount in $10 increments; or increase Your Policy Limit. A request for an increase is subject to our underwriting approval and the premium for the increase will be based upon your attained age.

(d) **Your Right to Decrease Benefits**. After your first policy anniversary, or in the event of a premium increase, you have a right to lower the premiums for this Policy in no fewer than in the following ways:

- by reducing the Nursing Facility Daily Benefit Amount (but not less than the minimum daily benefit amount set by the California Partnership for Long-Term Care for the current year).
- reducing Your Policy Limit (but not less than the dollar equivalent of one-hundred eight-two (182) times seventy percent (70%) of the average daily private pay rate for nursing facility care applicable to the current year set by the California Partnership for Long-Term Care); or
- converting this Policy to a Nursing Facility and/or Residential Care Facility Only policy, if We are then offering such policies for sale in California.

If you request a decrease in benefits, your premium will be based upon the reduced amount of coverage and your original issue age.

(e) **Upgrade Privilege**. The Upgrade Privilege allows you to keep your long term care coverage current with the latest product innovations. When we develop new benefits or benefit eligibility criteria that are not included in your Policy or if we market a new policy in California, we will notify you of the availability of the new benefits, benefit eligibility criteria or new policy within 12 months after receiving approval from the California Department of Insurance. This offer will not be available to you if you are receiving benefits under this policy or are within an Elimination Period at the time of the offer. The terms of the upgrade offer will be determined at the time of the upgrade.

(f) **Duplication of Benefits by Certain Programs**. In the event that a non-Medicaid national or state long term care program created through public funding substantially duplicates benefits covered by your policy, you will be entitled to select either a partial refund of premiums paid or an increase in future benefits.

(g) **International Coverage Benefit.** - ***Important Notice*** - *Any benefits paid under the International Coverage Benefit will* ***not*** *accrue asset protection under the California Partnership for Long-Term Care.*

The International Coverage Benefit provides that we will pay actual charges incurred for covered Long-Term Care Services up to the International Coverage Benefit for care received outside the United States. This benefit will reimburse actual expenses up to 75% of the applicable Benefit Amount

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

14. **Information and Counseling**. The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222. In addition, you can contact the HICAP office nearest to you at:

Name of Office: _____

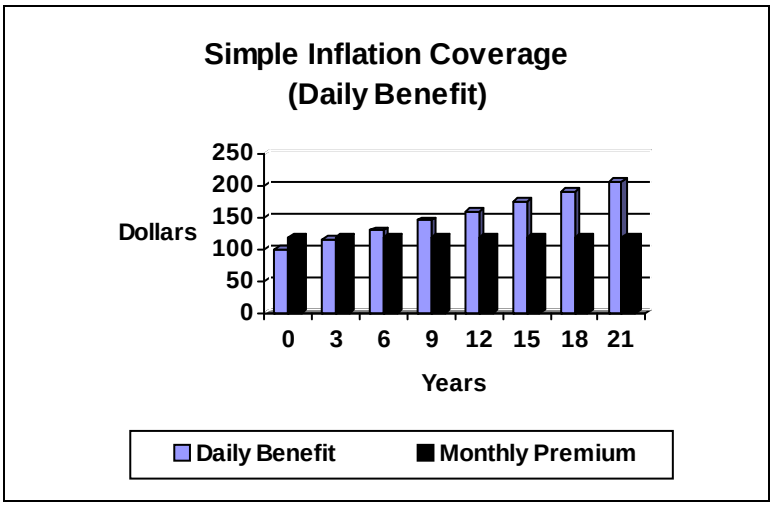
Address: _____

Phone Number: _____/____/_____

INFLATION PROTECTION AVAILABLE FOR YOUR LONG-TERM CARE POLICY

Simple Inflation Coverage. Your Benefit Amounts will increase by an amount equal to 5% of the Benefit Amount in effect when the Policy was issued. When the Benefit Amounts are increased, the original Policy Limit will be increased by the same percentage as the increase in the Benefit Amounts and rounded to the nearest dollar. This annual increase is automatic and will occur on each Policy anniversary. The premium for Simple Inflation Coverage is included in the Policy premium. Your premium will not change, except as described in the Policy.

The graphs below show the change in the daily Benefit Amount and the monthly premium under Simple Inflation Coverage. The graphs illustrate a policy which has been issued to a person who is age 60 and has chosen a Nursing Facility Daily Benefit Amount of $160 and a 4-year Benefit Period.



Compound Inflation Coverage. Your Benefit Amounts will increase by an amount equal to 5% of the Benefit Amount in effect during the prior Policy year. The annual increase is automatic and will occur on each Policy anniversary. When the Benefit Amounts are increased, the original Policy Limit will be increased by the same percentage as the increase in the Benefit Amounts and rounded to the nearest dollar. The premium for Compound Inflation Coverage is included in the Policy premium. Your premium will not change, except as described in the Policy.

The graphs below show the change in Nursing Facility Daily Benefit Amount and the monthly premium under Compound Inflation Coverage. The graphs illustrate a policy which has been issued to a person who is age 60 and has chosen a Nursing Facility Daily Benefit Amount of $160 and a 4-year Benefit Period.