

# Long Term Care



Long Term Care Insurance can help you or an eligible family member pay for costly Long Term Care assistance when you can no longer function independently.

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# Highlights



## Your Long Term Care Insurance Benefits...

...Protect you and your family from the potentially high costs associated with long term care.

...Help you maintain your independence.

...Provide care that will be comfortable for you and your family.

...Protect your assets and savings, which may include, for example, 401(k) investments.



### What happens to your benefits when...

For more information about what happens to your long term care insurance benefits when you have a qualifying life event, see the "About Your Benefits" section.



# About Long Term Care Benefits

The long term care insurance plan sponsored by the Company can help you or an eligible family member pay for costly long term care assistance when you can no longer function independently.

Long term care can be as simple as having help in your home with the activities of daily living or as complex as the constant supervision provided in a nursing home from a health care professional.

Long term care is different from acute medical care, which treats temporary conditions from which you recover such as broken bones or a heart attack. Most long term care services are not covered by other Company medical benefit plans for employees or by Medicare.

This summary reviews the long term care insurance benefits offered under the plan, including important information about eligibility, coordination of benefits, continuation of coverage, and other plan features.

The plan is governed by the certificate of insurance, which is an insurance contract between MetLife and the insured. (In the event of any conflict between this and the summary, it is the certificate of insurance that must be followed.)

The Company reserves the right to end or change the benefit program at any time within the terms of the group policy. These changes may affect the benefits provided or the contribution required from participants.

## How the Plan Works

### Eligibility

You are eligible to purchase long term care insurance on your first day of work if you are a full-time employee, a temporary full-time employee hired to work at least 12 months, or a part-time employee working 50% of a regular full-time schedule.

These eligible family members may also request enrollment:

- spouses or surviving spouses
- parents and parents-in-law
- grandparents and grandparents-in-law.

You do not have to be enrolled in the plan in order for your spouse, parents, and grandparents to participate. This plan is also available to retirees of the Company. Spouses or surviving spouses of retirees may also participate.

### Enrollment

As an eligible employee, you will not have to complete a statement of health for your coverage if you enroll within 30 days of the date you are hired and you are actively-at-work on your effective date of coverage.

If you do not enroll within 30 days of the date you are hired, you must complete a statement of health. Eligible family members must also complete a statement of health when they request enrollment.

To obtain an enrollment package for yourself or an eligible family member, call MetLife at 1-800-GET-MET8. The enrollment package will include the statement of health and a premium chart. If you complete a statement of health and your request for enrollment is denied by the insurance company, the notice of denial will include instructions on how to appeal the decision.



# How the Plan Works (cont'd.)

## When Coverage Begins

As an eligible employee who enrolls without completing a statement of health, your coverage begins on the first day of the month after your request for enrollment has been received, as long as you are actively at work (or on vacation or holiday absence) on that day. If you are not actively at work (or on vacation or holiday absence), your coverage will begin the first of the month after you return to work.

If you enroll with a statement of health, your coverage will begin the first of the month following the date the insurance company accepts your request for enrollment.

If you enroll with a statement of health and you are accepted into the plan, once you are authorized for benefits and have completed the waiting period, benefit payments will begin even if you have a pre-existing condition.

## Premium Payments

You pay the full cost of your coverage. The cost of your coverage depends on the daily benefit and lifetime benefit you chose, and your age as of the time your coverage began.

Employees and spouses pay for their coverage by having their premiums deducted from the employee's paycheck on an after-tax basis. All other eligible family members will pay the insurance company directly.

If you pay the insurance company directly, you may be billed quarterly, semi-annually or annually, or you may have monthly deductions taken directly from your checking account. You will have a 31-day grace period. If you do not pay within that grace period, your coverage will be canceled as of the last day of the month in which you paid your last contributions.

### ...Changes in Premiums

When you enroll, your premiums will be based on your age as of the time your coverage becomes effective. Except for changes in premium rates for all enrollees, which may occur from time to time, your premiums remain the same as you get older. If you increase your coverage, your contributions for the additional coverage will be based on your age at the time the change is effective.

### ...No Premiums While Benefits are Paid

You will not be required to pay premiums during any period in which you are receiving benefits. Premiums are waived as of the first day of the month on or after the date you begin receiving benefits. Your premiums will resume as of the first of the month on or after the date your eligibility for benefits ceases. If you die while covered by the plan, all or a portion of your premiums may be returned to your estate.

If you die before age 65, your estate will receive the contributions you paid up until the date of your death, less any benefits you had received.

If you die after age 65, your estate will receive the contributions you paid up to age 65, less any benefits you had received. This amount will be reduced by approximately 20% each year after age 65. There will be no return of premium if death occurs after age 70.

**Note:** Due to state insurance regulations this feature is not available to residents of Arkansas, Pennsylvania, and Washington. Residents of these states will have an enhanced respite services benefit instead of this feature.

### ...If You Stop Paying Premiums

If you stop paying premiums, your coverage will terminate if you have paid premiums for less than 3 years.

If you pay premiums for 3 years or more and then stop, you will still have some coverage. The non-forfeiture feature allows you to maintain some coverage even if you choose to cancel your coverage. The feature provides the full daily benefit with a total lifetime benefit based on the greater of the total paid contributions amount or 30 times the daily benefit in effect immediately prior to the non-forfeiture date.

# How the Plan Works (cont'd.)

## When Benefits are Paid

Once enrolled in the plan, if you think you need benefits, you or your designated representative may call MetLife at 1-800-GET-MET8 to initiate the benefit authorization process. A nurse at the insurance company will review your situation with you, your doctor or other care provider to determine the extent to which you are unable to perform, without substantial assistance from another individual, the following activities of daily living:

- bathing
- dressing
- transferring (moving between a bed and a chair, for example)
- toileting
- continence
- eating.

If you are certified by a licensed health care practitioner, e.g., your doctor, or a nurse, as being unable to perform at least two of these activities of daily living for a period of 90 days, or you require substantial supervision to protect yourself from threats to your health and safety due to a severe cognitive impairment, the insurance company will authorize plan benefits.

The insurance company will notify you as to your authorization for benefits within ten working days after receiving the necessary information. If you are not authorized for benefits, the insurance company will explain the reasons for the denial and instruct you how to appeal the decision.

## Waiting Period

Because this is long term care insurance, payments begin after you have established a need for extended care. You must satisfy a waiting period of 90 days. Any day paid by your group medical plan or by Medicare will count as a waiting period day. During this waiting period, you will pay for services covered by the plan. Once the waiting period is over, you will then begin to receive benefit payments for covered services. You will not have to fulfill another waiting period unless you have gone for more than 180 days without being eligible for benefits.

## What the Plan Pays

After you satisfy the waiting period, the plan pays benefits up to a daily benefit amount. The daily benefit is the maximum amount of reimbursement that you can receive for each day you are eligible for benefits. There is a daily benefit for nursing home care and respite care services and another daily benefit for home care services and assisted living facilities. The total lifetime benefit is the maximum amount of benefits you can receive from the plan.

You choose one of three nursing home daily benefit amounts. The nursing home daily benefit amount you choose will determine your home care daily benefit amount and your total lifetime benefit.

If you choose this nursing home daily benefit	Your home care/assisted living daily benefit will be	Your total lifetime benefit will be
\$100	\$ 60	\$182,500
\$150	\$ 90	\$273,750
\$200	\$ 120	\$365,000

When the total amount of benefits you have received equals your total lifetime maximum amount, your coverage ends.

## Coordination of Benefits

We will reduce your benefits by the dollar amount payable by any of the following, to the extent that the combination of your benefit and amounts payable or which would be payable by any of the following exceed 100% of the actual charge for the covered expenses:

- any federal, state or other government health care plan or law (except Medicaid or Medicare)
- any state or federal workers' compensation law
- any employer's liability or occupational disease law
- any motor vehicle no-fault law
- any other plan which any employer contributes to or sponsors.



# Covered Services

## Initial Care Planning Visit

You are covered for one initial care planning visit from a care advisor, a long term care professional who can help you explore issues and aid your decision-making. The care advisor helps you:

- determine what type of care is necessary
- identify options and resources, including providers, available in your area (but the choice of providers is always yours)
- develop an ongoing care plan for your consideration.

The plan covers the full cost of the initial visit if you use a designated care advisor. However, if there is no care advisor in your area, the plan also pays the cost of the initial visit to any professional long term care advisor, up to \$250.

## Nursing Home Care

Benefits are paid toward the cost of care provided in a licensed skilled nursing facility or intermediate care facility, including:

- room and board
- custodial care services.

It also includes hospice care services received in an inpatient hospice.

If you are hospitalized while receiving benefits and you are required to pay ongoing room and board charges to guarantee a bed in the nursing home, assisted living facility or hospice facility when you are discharged, the plan will cover those charges for up to 21 days per year.

## Assisted Living Facility Services

The plan will pay 100% of the cost, up to the maximum daily benefit shown in the Benefits Schedule for the plan option you have chosen, for the following qualified long term care services provided in an assisted living facility:

- room and board accommodations
- nursing care, maintenance or personal care, therapy services, and hospice care provided by a formal caregiver
- bed reservation charges for up to 21 days per calendar year. The bed reservation shall not exceed the benefit payable if you had been confined in the assisted living facility on that day.

## Home Care Services

Sometimes, care can be provided best at home rather than in a nursing home. The plan covers nursing care and custodial care services provided:

- by a licensed home health care agency
- by a licensed nurse
- by a licensed adult day care center.

It also includes:

- care advisory services provided by a licensed care management organization which are received after the initial care planning visit
- hospice care services received at home
- homemaker services provided by a licensed home health care agency which include light housekeeping, meal preparation and shopping
- services provided by a licensed physical therapist, a licensed speech therapist, licensed respiratory therapist, or a licensed occupational therapist through a home health care agency.

## Respite Care Services

Respite care includes covered nursing home or home care services which temporarily substitute for regular home services. Up to 21 days per calendar year are covered under the respite care benefit.

## Transition Benefit

The plan will pay 100% of the charges incurred, up to \$500, for expenses incurred while chronically ill for items that were required to provide qualified services during and after the waiting period. Such expenses may include personal emergency response systems or durable medical equipment. However, the plan will not pay for home modifications that would otherwise qualify as covered expenses if they would increase the value of your home.

# Claiming Benefits Once You Are Authorized

To be reimbursed for your authorized covered services, you must file a claim with the insurance company within 180 days after the end of the calendar year in which you receive the covered services. Here's how to file a claim:

1. You will receive a claim form with your authorization letter.
2. When you have received covered services, complete the form and mail it to the insurance company at the address printed on the form.
3. You will receive payments after the waiting period from the insurance company, unless you have asked for your provider to be paid directly by filling out an area of the claim form for assigning benefits to your provider.
4. You will receive each benefit payment.

Once the waiting period has been satisfied, as you submit claims, benefit payments will be made within 10 working days of the receipt of all necessary information by the insurance company.

If any premiums are owed to the insurance company at the time you submit your claim, the amount you owe will be subtracted from the benefit payment for which you are eligible.

If a claim is denied, you have 60 days to appeal the decision by writing to MetLife at the following address:

MetLife Long Term Care  
PO Box 937  
Westport, CT 06880

## To File a Claim

1. You will receive a claim form with your authorization letter.
2. When you have received covered services, complete the form and mail it to the insurance company at the address printed on the form.
3. You will receive payments after the waiting period from the insurance company, unless you have asked for your provider to be paid directly by filling out an area of the claim form for assigning benefits to your provider.
4. You will receive each benefit payment.



This plan does not provide benefits for the following:

- Care specifically provided for detoxification of or rehabilitation for alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of or while being treated by a Physician for an injury or sickness.
- Any service or supply received outside the United States or its territories.
- Illness, treatment or medical condition arising out of:
  - war or act of war (whether declared or undeclared)
  - participation in a felony, riot or insurrection
  - service in the armed forces or auxiliary units
  - attempted suicide (while sane or insane) or intentionally self-inflicted injury
  - aviation (this applies only to non-fare paying passengers).
- Treatment provided in a government facility, unless otherwise required by law.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital which is licensed as a nursing home or hospice.
- Any service provided by your immediate family, unless the service is a covered service from an informal caregiver.
- Any service or supply to the extent that such expenses are reimbursable under Medicare, or would be reimbursable but for the application of a deductible, coinsurance or copayment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payor under applicable law.
- Services for which no charge is normally made in the absence of insurance.

## Concurrent Review

While you receive covered services, the insurance company reviews your condition to determine whether the authorization for benefits can be continued. This review may require that the insurance company examine your medical records or request additional information from your doctor or other care provider. You and your doctor will be notified if the insurance company made a determination to change your benefit eligibility.

## Changing Your Selections

The plan permits you to increase or decrease your daily benefit amounts. You must apply to the insurance company, who will notify you if the changes are approved, what your change in premium will be and when the change becomes effective.

## Inflation Increases

At least once every three years, you can increase your daily benefit amount by a specified dollar amount to protect against inflation. You may make this change without providing a statement of health as long as you have accepted this offer at least once during the last two consecutive offerings.

## Reinstatement

If your coverage ends because you fail to pay the required premium, and you have not paid the premium for at least 36 months, your coverage may be reinstated within 12 months of the date coverage ended if you submit all past due contributions, along with proof of good health to the insurance company.

However, if you can prove that you didn't pay your premium due to a cognitive impairment or loss of functional capacity, you can request reinstatement within 5 months of the date coverage ended by paying all past due premiums. In this situation, you will not have to submit proof of good health to have your coverage reinstated.

# When Your Coverage Ends

Your coverage under the plan ends:

- when you reach your total lifetime limit
- at your death
- on the last day of the month your cancellation notice is received by the insurance company (you may be eligible for coverage under the non-forfeiture feature as previously described)
- if you fail to pay your premiums within 31 days after they are due (you may be eligible for coverage under the non-forfeiture feature as previously described).

If you leave the Company for any reason while participating in the plan, you can take your coverage with you by simply making payments directly to the insurance company. Even if you leave, you will still pay the same group rate.

In the event this group long term care insurance policy ends, you have the option of continuing your coverage at the same rate by making payments directly to the insurance company.



## Administrative Information

Information about the administration of your long term care insurance can be found in the section entitled "Administrative Information."

