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 …

This plan closed to new enrollments effective 4/30/2011. Plan participants enrolled in coverage before this date may continue to be enrolled in the plan. MetLife's long-term care insurance coverage is guaranteed renewable. This means that as long as your premiums are paid on time, coverage cannot be cancelled.

What happens to your benefits when ...

For more information about what happens to your long-term care insurance benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in 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 the certificate and this summary, the certificate of insurance will govern.)

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

This plan closed to new enrollments effective 4/30/2011. Plan participants enrolled in coverage before this date may continue to be enrolled in the plan.

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 MetLife directly.

If you pay MetLife directly, you may be billed quarterly, semiannually 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 following 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 Washington. Residents of this state will have an enhanced transition expense 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 enrollment in the plan. 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 (1-800-438-6388) to initiate the benefit authorization process. A nurse at MetLife will review your situation with you and 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, MetLife will authorize plan benefits.

MetLife will notify you as to your authorization for benefits within 10 working days after receiving the necessary information. If you are not authorized for benefits, MetLife 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

Long-term care benefits will be reduced by the dollar amount payable by any of the following, to the extent that the combination of your benefit and amounts payable or amounts which would be payable by any of the following exceeds 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.

How the Plan Works (cont'd.)

Concurrent Review

While you receive covered services, MetLife reviews your condition to determine whether the authorization for benefits can be continued. This review may require that MetLife examine your medical records or request additional information from your doctor or other care provider. You and your doctor will be notified if MetLife 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 MetLife, which will notify you if the change is approved, what your change in premium will be, and when the change becomes effective.

Inflation Increases

At least once every 3 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, your coverage may be reinstated within 12 months of the date coverage ended if you submit all past due contributions with proof of good health to MetLife.

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.

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 calendar year.

Assisted Living Facility Services

The plan will pay 100% of the cost, up to the maximum daily benefit shown in the Benefits Schedule (as shown in the Certificate of Coverage provided by MetLife) 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, a 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 30 days per calendar year are covered under the respite care benefit.

Transition Benefit

The plan will pay 100% of the charges incurred, up to five times the daily benefit amount 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 MetLife within 90 days after the end of the calendar year in which you receive the covered services.

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 MetLife at the address printed on the form.
3. You will receive payments after the waiting period from MetLife 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.

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 MetLife.

If any premiums are owed to MetLife 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

What The Plan Does Not Cover

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 payer under applicable law.
- Services for which no charge is normally made in the absence of insurance.

When Coverage Ends

Your coverage under the plan ends on the earliest of:

- when you reach your total lifetime limit
- at your death
- on the last day of the month your cancellation notice is received by MetLife (you may be eligible for coverage under the non-forfeiture feature as previously described)
- if you fail to pay your premiums within 35 days after MetLife sends a written notice of termination of your coverage as stated in the grace period (you may be eligible for coverage under the non-forfeiture feature as previously described)
- the date the group policy ends, subject to the provisions in "Continuation Coverage"
- the date your employment with the group policyholder terminates, subject to the provisions in "Continuation Coverage"
- if you are an eligible employee or eligible family member of an eligible employee, the date the eligible employee's employment with the group policyholder terminates along with a group of employees as a result of corporate restructuring, acquisition, spinoff, or similar circumstances, subject to the provisions in "Continuation Coverage."

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 MetLife. 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 MetLife.

Continuation Coverage

You have the right to continue coverage even if your coverage ends, except as stated below. This is called "Continuation Coverage," and it requires that you pay contributions to MetLife directly when they are due. You will automatically be provided Continuation Coverage unless you or your representative notifies MetLife that you do not want it.

Continuation Coverage is not available to the following categories of persons:

Category 1: Your coverage ends because you failed to make any required payment or contribution when due or you notified MetLife that you want to end your coverage;

or

Category 2: You have already received benefits that count toward your total lifetime benefit that are equal to your total lifetime benefit;

or

Category 3: The group policy terminates, and coverage is replaced (within 31 days after termination) by other group coverage that:

- is effective on the day following termination of coverage and provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the group policy;

  and

- calculates the premium based on your age at inception of coverage under the group policy.

  or

When Coverage Ends (cont'd.)

Category 4: Your employment with the Company terminates or, if you are an eligible family member of an eligible employee, that eligible employee's employment with the Company terminates along with a group of employees as a result of corporate restructuring, acquisition, spinoff, or similar circumstances and coverage is replaced (within 31 days after termination) by other group coverage that:

- is effective on the day following your termination of coverage

  and

- provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the group policy

  and

- calculates premium based on your age at inception of coverage under the group policy.

MetLife may, at its discretion, offer Continuation Coverage to all persons in Categories 3 and/or 4. In this event, you will be notified in writing of MetLife's offer.

Certificate of Insurance

In case of conflict among the terms contained in this summary plan description and the Certificate of Insurance, the Certificate of Insurance will govern.

Administrative Information

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