

Duke Long Term Care Insurance Program





Duke Long Term Care Insurance Program

An accident or illness may strike at any age and at any time, leaving you or a loved one disabled and in need of long term care services. Disability coverage, which is designed to replace a portion of earnings lost due to disability, might cover your normal living expenses but may not be enough to pay someone to take care of you. Medicare and private health care plans pay for hospitalization and other medically necessary expenses, but typically do not cover extended long term care costs.

Group long term care coverage is designed specifically to cover the costs associated with extended long term care, including a variety of services for people who are unable to care for themselves. Long term care services include home health care, care in a community-based setting such as an adult day care or assisted living facility, and care in a nursing home.

Like other types of insurance, group long term care coverage is intended to protect you and your family from financial hardship as a result of an unexpected event. That's why Duke makes group long term care coverage available to you. Your spouse, same-sex spousal equivalent, parents, parents-in-law, grandparents, and grandparents-in-law and adult children age 20 and older may also apply.

Duke's Long Term Care Program is provided under a group insurance policy which is underwritten by Aetna Life Insurance Company.

The term "Duke" is used throughout this document. For purposes of this Benefit Program Description, "Duke" refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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Eligibility and Enrollment

Eligibility for Coverage

You are eligible for coverage if you are a Duke employee or House Staff scheduled to work at least 20 hours per week. The following members of your extended family also are eligible to apply:

- Your spouse or same-sex spousal equivalent,
- Your parents and parents-in-law, and
- Your grandparents and grandparents-in-law.
- Your adult children, age 18 and older.
- Employee late applicants and other eligible family members may enroll at any time by completing a medical questionnaire which must be approved by Prudential.

How to Enroll

You can enroll at any time by completing an enrollment form. If you enroll during your initial enrollment period (within 60 days of your date of hire or benefit eligibility), you are guaranteed coverage regardless of your health status, as long as you are actively at work when your coverage goes into effect.

If you are interested in participating in the Long Term Care Program, an enrollment kit is available from the Benefits Office or from Prudential. Online enrollment is also available at www.prudential.com/gltc (Group Name: dukeltc; Password: enrollment). Please contact the Benefits Office or Prudential at the following addresses:

Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708
(919) 684-5600

or

The Prudential Insurance Company of America
751 Broad St
Newark, NJ 07102-3777
(800) 732-041
www.prudential.com/gltc

If you wait to enroll, you will have to complete a medical questionnaire detailing your health and medical history and be approved by Prudential (coverage is not guaranteed). The form is available online at www.prudential.com/gltc (Group Name: dukeltc; Password: enrollment), the Human Resource Information Center (HRIC) at (919) 684-5600, or by calling Prudential at (800) 732-0416.

Adult children age 18 and older of employees, parents, parents-in-law, grandparents, and grandparents-in-law are required to complete a medical questionnaire and must be approved by Prudential (coverage is not guaranteed). Please note that not all medical conditions will disqualify you or your family members for coverage.

Spousal Discount

Rates for married persons or same-sex spousal equivalents are discounted 10%. Enrollment is not required for the spouse/same-sex spousal equivalent.

Free Look Provision

You have the right to cancel your coverage within 30 days for a refund of the initial premium if you are not satisfied with the coverage.

When Coverage Begins

Your coverage begins on the first day of the month following the date the insurer processes your application, provided your enrollment form is received by the insurer within 60 days following your date of hire.

If you wait until after the initial enrollment period to apply, coverage for you and your spouse/same-sex spousal equivalent will begin on the first day of the month following the date the insurance company gives its written approval. Coverage for an adult child age 18 and older, parent, parent-in-law, grandparent or grandparent-in-law will begin on the first day of the month following the date Aetna gives its written approval.

When Coverage Ends

Your coverage under the Duke group long term care policy and/or that of your family members will end if any of the following events occur:

- You or your family member cancels the coverage,
- You die,
- You or the family member ceases paying premiums for the coverage,
- You have reached your lifetime maximum benefit level, or
- The plan is terminated (see “Coverage Continuation,” below).

Coverage Continuation

If you or your spouse/same-sex spousal equivalent leave employment with Duke, you may continue coverage by paying premiums directly to the insurer. Coverage will be continued under the policy with the same benefits and provisions.

As long as you continue paying your premiums and your lifetime maximum has not been exhausted, you will continue to be insured.

Coverage Continuation After Death, Divorce, or Termination of Domestic Partner Relationship

If you are no longer eligible for coverage due to the death of, or divorce from, your spouse, or the termination of your same-sex spousal equivalent relationship, your coverage can continue in force for as long as you continue to pay the premiums directly to the insurer.

Paying for Coverage

Employees and their spouse or same-sex spousal equivalent are able to choose from three different payment options: payroll deduction, electronic funds transfer from a checking or savings account, or direct billing on a quarterly, semi-annual, or annual frequency. There is a 2.83% premium discount with the semi-annual direct billing option and a 5.58% premium discount with the annual direct billing option.

Parents, parents-in-law, grandparents, grandparents-in-law, and adult children age 18 and older will receive a bill for premiums at their home address. The family member will be given the option of having monthly automatic checking or savings account deductions (EFT), or direct billing on a quarterly, semi-annual, or annual frequency. Premiums discounts described above are also available for family members.

Eligibility and Enrollment

Premiums are based on the benefit plan chosen and on your age at the time Prudential receives your application. If the insured chooses a voluntary buy up offer or otherwise purchases additional coverage at a later age, additional premium will be required. Buying additional coverage will not change the premium for current coverage.

For premium rates to change, the insurer would have to change rates for everyone in your age category who has the kind of coverage plan that you do. You can never be singled out for a rate increase because you get older, become ill, or file claims under the plan.

No Cancellation for Any Reason

As long as you keep paying your premiums and you haven't received benefits up to your lifetime maximum, your coverage cannot be cancelled.

Waiver of Premium

Your premiums will be waived after you have met the 90 days Benefit Waiting/Elimination Period. Payment of premiums will resume at the end of the close of 90 consecutive days during which the covered family member has not had a loss of functional capacity.

Loss of Benefits

You may experience a reduction or loss of benefits in any of the following circumstances:

- You fail to follow the plan's procedures,
- You fail to pay the required premiums,
- You are found to have committed a material misrepresentation of fact or a fraudulent act against the plan including, but not limited to, the fraudulent filing of a claim for benefits, or
- The plan is amended or terminated and you do not elect to continue coverage, but only with respect to expenses incurred after the amendment or termination becomes effective, unless the claim continues without interruption.

How the Group Long Term Care Insurance Program Works

Long term care refers to a very broad range of medical, personal and social services provided to people who are unable to care for themselves over a relatively long period of time. It usually involves assistance in performing everyday functions such as, toileting, bathing, eating and dressing. You must have a certified loss of functional capacity to receive benefits under this plan.

Long term care services can be provided in nursing home or assisted living facilities or at home by care-givers such as home health care workers, nurses or therapists, or in community-based settings such as adult day care centers.

Long term care insurance helps you pay for costs associated with these kinds of services, whether at

home, in an assisted living facility or adult day care center, or in a nursing home.

The ultimate purpose of long term care insurance is to help individuals retain their independence as long as possible, help assure that they may have freedom and choice in where they receive assistance, and help preserve their assets.

Benefit Coverage

You may select different levels of coverage under the plan, based on three variables:

- The daily nursing home benefit (which determines the home and community-based care benefit),

Sample Plan Options

	Option 1	Option 2	Option 3
Daily Benefit Maximum (DBM)*	\$100	\$150	\$200
Nursing Home Care, Hospice Facility Care, Assisted Living Facility Benefit: The maximum amount of coverage your plan could provide each day.	100% of DBM	100% of DBM	100% of DBM
Home & Community-Based Care Benefit and Adult Day Care The amount you would receive each day you receive community-based, home health care or Adult Day Care (automatically 75% of the daily nursing home care benefit).	75% of DBM	75% of DBM	75% of DBM
Lifetime Maximum Benefit: Total benefits payable under the plan. Based on when and where you receive care, your Lifetime Maximum Benefit could be paid out in a minimum of the years on which your plan is based, or in a much longer period of time.	3 Years*		
	\$109,500	\$164,250	\$219,000
	10 Years*		
	\$365,000	\$547,500	\$730,000

*You may choose a daily benefit amount between \$100– \$350 and a lifetime maximum of 3, 5, 10 years, or an unlimited lifetime maximum. For additional options visit www.prudential.com/gltc (Group Name: dukeltc; Password: enrollment) or call (800) 732-0416.

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- The lifetime maximum benefit, and
- The inflation protection options
 - voluntary increase (standard)
 - automatic increase (additional premium required).

All of the options in the table on the preceding page include the following benefits:

- **Respite Benefit** – Provides for substitute at-home care while your usual caregiver takes a break from providing care or otherwise is not attending to the covered family member's needs. The benefit pays up to 21 days per calendar year, 100 days per lifetime and will pay up to the Nursing Home Daily Maximum regardless of the type of services used.
- **Bed Reservation Benefit** – While you are receiving Long Term Care services in a Nursing Home or an Assisted Living Facility, you may incur charges for Bed Reservation by that institution to retain your bed while you are confined in an acute care facility for 24 hours or more. Benefits for eligible charges will be paid up to 21 days per calendar year. You must satisfy the Benefit Waiting/ Elimination Period before benefits are payable.

- **Informal Caregiver Training** – Coverage is provided for training if someone will be providing care for the insured and requires training in how to be a caregiver. Benefits for eligible charges will be paid up to 5 times the Nursing Home Daily Benefit Maximum.

Benefit Waiting/ Elimination Period

A 90 Day Benefit Waiting/ Elimination Period must be met once during your lifetime before benefits are payable. This plan has one combined Benefit Waiting/ Elimination Period for all covered services to which it applies. This is a period, counted in calendar days, which begins on the date you are assessed, if that assessment results in eligibility for benefits, and continues as long as you have a Chronic Illness or Disability. You do not need to incur charges to satisfy the Benefit Waiting/ Elimination Period. The Benefit Waiting/ Elimination Period can be satisfied over multiple periods of Chronic Illness or Disability.

What are activities of daily living?

You are considered to have a qualifying loss of functional capacity if you are unable to perform at least two of the following activities described below without substantial assistance (i.e., Hands-On Assistance and Standby Assistance) of another person each time the activity is performed:

- **Bathing** — Washing yourself by sponge bath; or washing yourself in a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence** — The ability to maintain control of bowel and bladder functions; and, when unable to maintain control, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
- **Dressing** — Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating** — Feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting** — Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring** — Moving into or out of a bed, chair, or wheelchair.

How You Qualify for Claim (Benefit Eligibility)

You are eligible to receive benefits if you are assessed by an Assessor (a Licensed Health Care Practitioner who is qualified to evaluate conditions relevant to your functional or cognitive ability. Qualifications are based on training and experience, and may include health care industry, state or national standards) and confirmed as having a Chronic Illness or Disability. A Chronic Illness or Disability is one in which there is:

- A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living. This loss must be expected to continue for 90 days. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting, and Transferring.

Or

- A severe Cognitive Impairment which requires Substantial Supervision to protect you from threats to health or safety.

Substantial Assistance is the physical assistance of another person without which you would not be able to perform an Activity of Daily Living or the constant presence of another person within arms reach which is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living.

Substantial Supervision is continual oversight that may include cueing by verbal prompting, gestures or other demonstrations by another person and which is necessary to protect you from threats to your health or safety.

What is severe cognitive impairment?

Severe cognitive impairment is a loss or deterioration in your intellectual capacity that is measured by clinical evidence and standardized tests that reliably measure impairment in the following areas:

- Short-term or long-term memory,
- Orientation as to people, places, or time, and
- Deductive or abstract reasoning, or judgment as it relates to safety awareness.

Nursing Home Care

When independent living is no longer an option, a Nursing Home may be necessary. A Nursing Home is a facility that provides skilled, intermediate, or custodial care and meets at least one of the following criteria:

- Is Medicare-approved as a provider of skilled nursing care services
- Is licensed by the state in which it is located as a skilled nursing home, an intermediate care facility, or a custodial care facility
- Meets all of the following criteria
 - Its main function is to provide skilled, intermediate or custodial nursing care
 - It is engaged in providing continuous room and board accommodations for three or more persons
 - It has a physician on staff or available to it under contract
 - It is under the supervision of a Registered Nurse or Licensed Practical Nurse
 - It maintains medical records for each patient
 - It maintains control of and records of all medications dispensed.

Assisted Living/Residential Care Facility

For an Assisted Living/Residential Care Facility that is located in a state that licenses or certifies such a facility, an Assisted Living/Residential Care Facility is one which is licensed or certified by the state in which the facility is located. For facilities located in states that do not license or certify Assisted Living/Residential Care Facilities, an Assisted Living/Residential Care Facility is one that meets, in Prudential's judgment, the following minimum criteria:

- It is a group residence that maintains records for services to each resident
- It provides services and oversight on a 24-hour a day basis, which support a resident in a manner that promotes dignity, independence, and privacy

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- It provides a combination of housing, supportive services, and personal assistance designed to respond to the resident's need for help with the Activities of Daily Living and instrumental activities of daily living
- It provides, at a minimum, assistance with Bathing, Dressing, and help with medications
- It is NOT licensed as a Nursing Home.

Home and Community-Based Care

Home and Community-Based Care is Home Health Care or Personal Care received from a Home Health Care Agency, a licensed Referral Agency, a licensed Nurse Registry or Informal Caregiver, or provided by an Independent Health Care Professional and Adult Day Care received from an Adult Day Care Facility.

Cash Alternative Benefit

Under this benefit, at your option, your coverage will pay a monthly fixed benefit to you in lieu of reimbursement for eligible charges for Home and Community-Based Care as stated above. The Cash Alternative Benefit may be used for informal care services, which provides for personal care in your home by family members, neighbors or other private-hire caregivers. The Cash Alternative Daily Benefit is payable for each day in the month in which you have Chronic Illness or Disability, after you satisfy the Benefit Waiting/Elimination Period. The Cash Alternative Daily Benefit is equal to 50% of your Daily Maximum for Home Health Care and reduces your Lifetime Maximum.

Hospice Care

Hospice care refers to the special attention those in the late stages of a terminal illness need. This care tries to help the whole person by alleviating physical discomfort and providing emotional, social, and spiritual comfort.

Benefits for eligible charges will be paid up to 100% of the Nursing Home Daily Maximum for institutional and non-institutional care. The Benefit Waiting/ Elimination Period does not apply to Hospice Care benefits.

Private Care Management

This feature provides coverage for a Private Care Manager to provide information, resources or to coordinate your Long Term Care. You must first meet the Benefit Eligibility Criteria in order to use this benefit. Benefits for eligible charges will be paid up to 12 times the Daily Benefit Maximum per calendar year. No Benefit Waiting/ Elimination Period applies to Private Care Management benefits.

Alternate Plan Benefit

Due to emerging trends on the delivery of long term care, this plan takes into account the current institutional and Home Health Care Based settings that are available. Prudential will consider a claim for benefits for care received in an alternate setting or non-institutional services designed to help an eligible person remain independent in his or her home. You must satisfy the Benefit Waiting/ Elimination Period before benefits are payable.

Inflation Protection

So that your plan coverage can keep up with inflation, you periodically will be given opportunities to increase your benefit amount on a guaranteed-issue basis.

You determine which option:

Voluntary Increase – (Standard feature) You may purchase increases in your coverage every 3 years without proof of good health to help keep pace with the rising cost of long term care. You may increase your coverage through this feature even if you are in claim status as long as you have not turned down two consecutive previous offers. The amount that you will be able to purchase is 5% of your current Daily Benefit Maximum compounded annually for the previous three years.

Automatic Increase – (Optional for additional initial premium) Your coverage will automatically be increased every year without proof of good health to help keep pace with the rising cost of long term care. The amount of increase will equal

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5% of your daily benefit maximum compounded yearly. Your coverage will be increased through this feature even if you are in claim status.

Coverage Exclusions

This Plan does not provide benefits for any of the following:

1. **Work-connected Conditions Charge.** A charge covered by a workers' compensation law, occupational disease law or similar law.
2. **Government Plan Charge.** A charge for a service or supply:
 - a. furnished by or for the United States government or any other government, unless payment of the charge is required by law. Or
 - b. to the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered. This (b) does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. When this (b) applies to Medicare, the benefits provided by Medicare will be deemed to include any amount that would have been payable by Medicare in the absence of a deductible or coinsurance requirement under that program.
3. **War, Felony, Riot or Insurrection.** Charges for a condition due to war or any act of war while you are insured or due to your participation in an act of felony, riot or insurrection. "War" means declared or undeclared war and includes resistance to armed aggression. "Riot" means a wild, violent, public disturbance of the peace.
4. **Self-inflicted Injury or Suicide.** Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or suffering from inorganic based insanity.

5. **Services and Supplies Outside the United States.** Charges for services or supplies outside of the United States and its possessions except as described in the International Coverage benefit.
6. **Treatment for Chronic Alcoholism or Chemical Dependency.** Charges in connection with the treatment of chronic alcoholism or chemical dependency.

Lifetime Maximum Benefit

Not more than the Lifetime Maximum Benefit may be paid under this Plan to any one Covered Family Member, in the aggregate, during the lifetime of such Covered Family Member.

At the end of a Benefit Period, your Lifetime Maximum Benefit will be restored to its original value when you recover and resume premium payments, as long as the total Lifetime Maximum Benefit has not been exhausted. The restored amount may not be used to pay benefits for any expenses incurred prior to the date the Lifetime Maximum Benefit is restored.

Other Limitations

The plan may not cover all the expenses associated with your long term care needs.

Relationship of Cost of Care and Benefits

Because the costs of long term care will likely increase over time, you should consider whether and how the benefit level is guaranteed to increase over time.

How to File a Claim

It is important that you start the process of using your Coverage by calling the Prudential Long Term Care Customer Service Center at 1-800-732-0416. You are encouraged to call Prudential before you begin using Long Term Care services so that you know in advance whether your benefits will be available. Either you or your authorized or legal representative may call.

Prudential will arrange for a trained Assessor to assess you or you may select your own Assessor. As part of the assessment process, you and your caregiver may be interviewed. If Prudential arranges the assessment, the interview may be by telephone or in-person depending on your condition. The assessment will be based on objective standards of measurement.

If you wish to select your own Assessor, you must notify Prudential when you call our Long Term Care Customer Service Center. Prudential will send you an assessment form that your Assessor must complete and return to Prudential at the following address:

**The Prudential Insurance Company
of America
751 Broad St.
Newark, NJ 07102**

Based on the information obtained during the assessment, your eligibility will be confirmed or denied based on Prudential's use of objective standards of measurement. These may include the "Katz Index of ADL's," "Folstein's Mini-Mental Examination," or any other equivalent objective standard of measurement currently in use at the time of assessment and acceptable to Prudential, subject to the terms and conditions of the Certificate. You will be sent a written notice to confirm your eligibility. If you are not eligible, you will be sent a written notice explaining the reasons you were not eligible.

If you are eligible, you will need a Plan of Care. Your Plan of Care will be used to determine benefits based on the Plan you have chosen.

You will be reassessed periodically to determine if you are still eligible for benefits.

To comply with federal income tax requirements, you must be assessed at least once each year.

Appealing Decisions about Eligibility

You have the right to appeal decisions made about your eligibility for benefits. When you are determined to be ineligible for benefits, you will be sent a notice that explains why you are not eligible. This notice will also explain the procedure you should follow if you choose to appeal the decision. Prudential will send you a written acknowledgment of your appeal. If no additional information is required and the appeal is denied, the acknowledgment will include a detailed explanation of the reason(s) for the denial. If additional information is required, Prudential will explain what information is needed. Upon receipt and review of the additional information, Prudential will notify you in writing of the results of the review.

If you still disagree with the appeal decision, you can request in writing within 60 days of the decision that the matter be submitted to the Benefit Appeal Committee. This Committee includes, but is not limited to, clinical consultants, legal consultants, and product management staff. After a thorough review, the Committee will send you written notification of its decision.

Your Rights Under ERISA

For a summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), please refer to the “General Information” section in this booklet.



Other Important Information

Family and Medical Leave Policy

Employees who are eligible for this plan are subject to a federal law called the Family and Medical Leave Act (FMLA). Your Duke long term care coverage will continue for the duration of your approved leave of absence under FMLA, provided you continue to pay any required premiums. If you choose not to continue your long term care coverage, you won't receive benefits for any condition that occurs during the leave. When you return to work, the long term care coverage that was discontinued or terminated will be reinstated only if you request reinstatement within 30 days of your return.

Tax Information

The Duke Long Term Care Insurance Program is a tax-qualified plan. This means that the plan must meet certain federal standards. It also means that, if you itemize deductions on your federal income tax return, you may be able to deduct your premiums for this coverage as a qualified medical expense (subject to federal tax limitations).

Long term care benefits paid from a tax-qualified plan generally are not taxable as income. See your tax adviser for additional information.

Claims for the Long Term Care Insurance Program should be sent to the insurer at the address listed on the claim form.

This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefit Plan along with the underlying insurance contracts, shall constitute the written plan document for the Duke Long Term Care Insurance Program. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Long Term Care Insurance Program. The written plan documents for the Duke Long Term Care Insurance Program are not employment contracts or any type of employment guarantee.