

STATE OF MICHIGAN  
DEPARTMENT OF MANAGEMENT AND BUDGET  
PURCHASING OPERATIONS  
P.O. BOX 30026, LANSING, MI 48909  
OR  
530 W. ALLEGAN, LANSING, MI 48933

July 10, 2008

**CHANGE NOTICE NO. 3**  
to  
**CONTRACT NO. 071B2001237**  
between  
**THE STATE OF MICHIGAN**  
and

|   |   |
|---|---|
| NAME & ADDRESS OF VENDOR<br><br><b>Metropolitan Life Insurance Company</b><br><b>10 South Lasalle Street</b><br><b>Suite 3350</b><br><b>Chicago, IL 60603</b><br><b>gmccreary@metlife.com</b> | TELEPHONE <b>Gina McCreary</b><br><b>(908) 253-2915</b> |
|   | VENDOR NUMBER/MAIL CODE                                 |
|   | BUYER (517) 373-1080<br><b>Melissa Castro</b>           |
| Contract Compliance Inspector: Susan Kant<br><b>Group Long Term Care Insurance – DCS</b>  |   |
| CONTRACT PERIOD: From: <b>October 1, 2001</b> To: <b>September 30, 2011</b>   |   |
| TERMS<br><b>N/A</b>   | SHIPMENT<br><b>N/A</b>                                  |
| F.O.B.<br><b>N/A</b>  | SHIPPED FROM<br><b>N/A</b>                              |
| MINIMUM DELIVERY REQUIREMENTS<br><b>N/A</b>   |   |

**NATURE OF CHANGE (S):**

Effective immediately, the vendor contact for this Contract is changed to:

**Gina McCreary**  
Phone: (908) 253-2915  
Email: gmccreary@metlife.com

Additionally, the DMB Buyer for this Contract is now Melissa Castro and the Contract Compliance Inspector is now Susan Kant. All other terms, conditions, specifications, and pricing remain unchanged.

**AUTHORITY/REASON:**

Per agency/vendor agreement and DMB/Purchasing Operations.

**TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$1.00**

STATE OF MICHIGAN  
 DEPARTMENT OF MANAGEMENT AND BUDGET  
 PURCHASING OPERATIONS  
 P.O. BOX 30026, LANSING, MI 48909  
 OR  
 530 W. ALLEGAN, LANSING, MI 48933

June 27, 2006

**CHANGE NOTICE NO. 2**  
 to  
**CONTRACT NO. 071B2001237**  
 between  
**THE STATE OF MICHIGAN**  
 and

|   |   |
|---|---|
| NAME & ADDRESS OF VENDOR<br><br><b>Metropolitan Life Insurance Company</b><br><b>10 South Lasalle Street</b><br><b>Suite 3350</b><br><b>Chicago, IL 60603</b> | TELEPHONE <b>Susan Olson</b><br><b>(312) 425-3418</b> |
|   | VENDOR NUMBER/MAIL CODE                               |
|   | BUYER (517) 241-1647<br><b>Irene Pena</b>             |
| Contract Administrator: Peggy Moczul<br><b>Group Long Term Care Insurance – DCS</b>   |   |
| CONTRACT PERIOD: From: <b>October 1, 2001</b> To: <b>September 30, 2011</b>   |   |
| TERMS<br><b>N/A</b>   | SHIPMENT<br><b>N/A</b>                                |
| F.O.B.<br><b>N/A</b>  | SHIPPED FROM<br><b>N/A</b>                            |
| MINIMUM DELIVERY REQUIREMENTS<br><b>N/A</b>   |   |

**NATURE OF CHANGE (S):**

**Please note: Effective 10/1/2006 this Contract is hereby EXTENDED through September 30, 2011. All other terms, conditions, specifications and pricing remain unchanged.**

**AUTHORITY/REASON:**

**Per agency/vendor agreement and DMB/Purchasing Operations.**

**TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$1.00**

STATE OF MICHIGAN  
DEPARTMENT OF MANAGEMENT AND BUDGET  
ACQUISITION SERVICES  
P.O. BOX 30026, LANSING, MI 48909  
OR  
530 W. ALLEGAN, LANSING, MI 48933

March 24, 2003

**CHANGE NOTICE NO. 1**  
to  
**CONTRACT NO. 071B2001237**  
between  
**THE STATE OF MICHIGAN**  
and

|   |   |
|---|---|
| NAME & ADDRESS OF VENDOR<br><br><b>Metropolitan Life Insurance Company</b><br><b>10 South Lasalle Street</b><br><b>Suite 3350</b><br><b>Chicago, IL 60603</b> | TELEPHONE <b>Susan Olson</b><br><b>(312) 425-3418</b> |
|   | VENDOR NUMBER/MAIL CODE                               |
|   | BUYER (517) 241-1647<br><b>Irene Pena</b>             |
| Contract Administrator: Peggy Moczul<br><b>Group Long Term Care Insurance – DCS</b>   |   |
| CONTRACT PERIOD: From: <b>October 1, 2001</b> To: <b>September 30, 2006</b>   |   |
| TERMS<br><b>N/A</b>   | SHIPMENT<br><b>N/A</b>                                |
| F.O.B.<br><b>N/A</b>  | SHIPPED FROM<br><b>N/A</b>                            |
| MINIMUM DELIVERY REQUIREMENTS<br><b>N/A</b>   |   |

**NATURE OF CHANGE (S):**

**The contract administrator is now:**

**Peggy Moczul, DCS**  
**Director, Employee Benefits Division**  
**Department of Civil Service**  
**(517) 373-1846**

**TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$1.00**

STATE OF MICHIGAN  
DEPARTMENT OF MANAGEMENT AND BUDGET  
OFFICE OF PURCHASING  
P.O. BOX 30026, LANSING, MI 48909  
OR  
530 W. ALLEGAN, LANSING, MI 48933

January 16, 2002

NOTICE  
OF  
CONTRACT NO. 071B2001237  
between  
THE STATE OF MICHIGAN  
and

|   |   |
|---|---|
| NAME & ADDRESS OF VENDOR<br><br><b>Metropolitan Life Insurance Company</b><br><b>10 South Lasalle Street</b><br><b>Suite 3350</b><br><b>Chicago, IL 60603</b> | TELEPHONE <b>Susan Olson</b><br><b>(312) 425-3418</b> |
|   | VENDOR NUMBER/MAIL CODE                               |
|   | BUYER (517) 241-1647<br><b>Irene Pena</b>             |
| Contract Administrator: Rita Swanson<br><b>Group Long Term Care Insurance – DMB, Office of State Employer</b>   |   |
| CONTRACT PERIOD: From: <b>October 1, 2001</b> To: <b>September 30, 2006</b>   |   |
| TERMS<br><b>N/A</b>   | SHIPMENT<br><b>N/A</b>                                |
| F.O.B.<br><b>N/A</b>  | SHIPPED FROM<br><b>N/A</b>                            |
| MINIMUM DELIVERY REQUIREMENTS<br><b>N/A</b>   |   |

The terms and conditions of this Contract are those of **ITB #071I1000497**, this Contract Agreement and the vendor's quote dated **8/23/01**. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: **\$1.00**

STATE OF MICHIGAN  
 DEPARTMENT OF MANAGEMENT AND BUDGET  
 OFFICE OF PURCHASING  
 P.O. BOX 30026, LANSING, MI 48909  
 OR  
 530 W. ALLEGAN, LANSING, MI 48933

**CONTRACT NO. 071B2001237**

**between  
 THE STATE OF MICHIGAN  
 and**

|  |  |
|--|--|
| NAME & ADDRESS OF VENDOR<br><br><p style="text-align: center;"><b>Metropolitan Life Insurance Company<br/>         10 South Lasalle Street<br/>         Suite 3350<br/>         Chicago, IL 60603</b></p>  | TELEPHONE <b>Susan Olson<br/>         (312) 425-3418</b><br><br>VENDOR NUMBER/MAIL CODE<br><br>BUYER (517) 241-1647<br><b>Irene Pena</b> |
| Contract Administrator: Rita Swanson<br><p style="text-align: center;"><b>Group Long Term Care Insurance – DMB, Office of State Employer</b></p>   |  |
| CONTRACT PERIOD: From: <b>October 1, 2001</b> To: <b>September 30, 2006</b>  |  |
| TERMS<br><p style="text-align: center;">N/A</p>  | SHIPMENT<br><p style="text-align: center;">N/A</p>   |
| F.O.B.<br><p style="text-align: center;">N/A</p>   | SHIPPED FROM<br><p style="text-align: center;">N/A</p>   |
| MINIMUM DELIVERY REQUIREMENTS<br><p style="text-align: center;">N/A</p>  |  |
| MISCELLANEOUS INFORMATION:<br><p><b>The terms and conditions of this Contract are those of <a href="#">ITB #071I1000497</a>, this Contract Agreement and the vendor's quote dated 8/23/01. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.</b></p> <p><b>Estimated Contract Value: \$1.00</b></p> |  |

**THIS IS NOT AN ORDER:** This Contract Agreement is awarded on the basis of our inquiry bearing the [ITB No. 071I1000497](#). A Purchase Order Form will be issued only as the requirements of the State Departments are submitted to the Office of Purchasing. Orders for delivery may be issued directly by the State Departments through the issuance of a Purchase Order Form.

**All terms and conditions of the invitation to bid are made a part hereof.**

|                                  |  |
|----------------------------------|--|
| <b>FOR THE VENDOR:</b>           | <b>FOR THE STATE:</b>  |
| Firm Name                        | Signature<br><b>Irene Pena, Buyer</b>                        |
| Authorized Agent Signature       | Name<br><b>Technology and Professional Services Division</b> |
| Authorized Agent (Print or Type) | Title  |
| Date                             | Date   |



**OFFICE OF PURCHASING  
STATE OF MICHIGAN**

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**DEFINITION OF TERMS**

| <b>TERMS</b>                  | <b>DEFINITIONS</b>   |
|-------------------------------|--|
| <b>Contract</b>               | A binding agreement entered into by the State of Michigan resulting from a vendor’s proposal; see also “Blanket Purchase Order.”   |
| <b>Contractor</b>             | The successful vendor who is awarded a Contract.   |
| <b>DMB</b>                    | Michigan Department of Management and Budget   |
| <b>RFP</b>                    | Request For Proposal - A term used by the State to solicit proposals for services such as consulting. Typically used when the requesting agency requires vendor assistance in identifying an acceptable manner of solving a problem. |
| <b>ITB</b>                    | Invitation to Bid - A generic form used by the Office of Purchasing to solicit quotations for services or commodities. The ITB serves as the document for transmitting the RFP to interested potential vendors.                      |
| <b>Successful Vendor</b>      | The vendor(s) awarded a Contract as a result of a solicitation.  |
| <b>State</b>                  | The State of Michigan<br><br>For Purposes of Indemnification as set forth in section I-J, State means the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents.             |
| <b>Blanket Purchase Order</b> | Alternate term for “Contract” used in the State’s Computer system (Michigan Automated Information Network [MAIN])  |
| <b>Expiration</b>             | Except where specifically provided for in the Contract, the ending and termination of the contractual duties and obligations of the parties to the Contract pursuant to a mutually agreed upon date.                                 |
| <b>Cancellation</b>           | Ending all rights and obligations of the State and Contractor, except for any rights and obligations that are due and owing.   |



**DEFINITION OF TERMS** (*con't.*)

| <b>TERMS</b>        | <b>DEFINITIONS</b>   |
|---------------------|--|
| <b>Work Product</b> | Work Product means any data compilations, reports, and any other media, materials, or other objects or works of authorship created or produced by the Contractor as a result of and in furtherance of performing the services required by this Contract. |



**SECTION I  
CONTRACTUAL SERVICES TERMS AND CONDITIONS**

**I-A PURPOSE**

The purpose of this Contract is to provide a Group Long-Term Care Insurance Plan for the State of Michigan employees, retirees, spouses (or surviving spouses), parents, parents in-law, **grandparents, and grandparents-in-law.**

This Contract will be fully funded by State of Michigan employees choosing to enroll.

**I-B TERM OF CONTRACT**

The State of Michigan is not liable for any cost incurred by any vendor prior to signing of a Contract by all parties. The activities (be sure to spell out activity) in the proposed Contract cover the period **10/01/01 through 09/30/06 (planning and marketing activities may begin on October 1, 2001, with initial participant enrollment beginning April 1, 2002). The policy effective date will be April 1, 2002, with the initial enrollment period from January 2, 2002 through February 28, 2002.** This Contract may be renewable, based on acceptable renewal rates and plan performance, for an indefinite number of extensions of up to five years each beyond this period. The State fiscal year is October 1st through September 30<sup>th</sup>. **-Since this is a voluntary benefit, this last sentence does not appear to apply.**

**I-C ISSUING OFFICE**

This Contract is issued by the State of Michigan, Department of Management and Budget (DMB), Office of Purchasing, hereafter known as the Office of Purchasing, for the State of Michigan, **Office of State Employer.** Where actions are a combination of those of the Office of Purchasing and Office of State Employer, the authority will be known as the State.

**The Office of Purchasing is the sole point of contact in the State with regard to all procurement and contractual matters relating to the services described herein.** The Office of Purchasing is the only office authorized to change, modify, amend, alter, clarify, etc., the prices, specifications, terms, and conditions of this Contract. The OFFICE OF PURCHASING will remain the SOLE POINT OF CONTACT throughout the procurement process, until such time as the Director of Purchasing shall direct otherwise in writing. See Paragraph II-C below. All communications concerning this Contract must be addressed to:

**Irene Pena, Buyer**  
 Technology and Professional Services Division  
 DMB, Office of Purchasing  
 2nd Floor, Mason Building  
 P.O. Box 30026  
 Lansing, MI 48909  
 Email: [Penai1@state.mi.us](mailto:Penai1@state.mi.us)  
 Phone: (517) 241-1647



**I-D CONTRACT ADMINISTRATOR**

Upon receipt at the Office of Purchasing of the properly executed Contract Agreement, it is anticipated that the Director of Purchasing will direct that the person named below or any other person so designated be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of this Contract implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications herein. That authority is retained by the Office of Purchasing. The Contract Administrator for this project is:

**Rita Swanson, Director  
Employee Benefits Division  
Office of State Employer  
Department of Management and Budget  
400 S. Pine Street  
4<sup>th</sup> Floor  
Lansing, MI 48933**

**I-E COST LIABILITY**

The State of Michigan assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of this agreement. Total liability of the State is limited to the terms and conditions of this Contract.

**I-F CONTRACTOR RESPONSIBILITIES**

The Contractor will be required to assume responsibility for all contractual activities offered in their proposal whether or not that Contractor performs them. Further, the State will consider the Prime Contractor to be the sole point of contact with regard to contractual matters, including but not limited to payment of any and all costs resulting from the anticipated Contract. If any part of the work is to be subcontracted, the contractor must notify the state and identify the subcontractor(s), including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The State reserves the right to approve subcontractors for this project and to require the Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

**I-G NEWS RELEASES**

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the program are to be released without prior approval of the State and then only to persons designated.



**I-H DISCLOSURE**

All information in a vendor’s proposal and any Contract resulting from the Invitation to Bid (ITB) is subject to the provisions of the Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, *et seq.*

**I-I ACCOUNTING RECORDS**

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the State of Michigan, its designees, or the Michigan Auditor General at any time during the Contract period and any extension thereof, and for three (3) years from the expiration date and final payment on the Contract or extension thereof.

**I-J INDEMNIFICATION**

1. General Indemnification

The Contractor shall indemnify, defend and hold harmless the State from and against all lawsuits, liabilities, damages and claims or any other proceeding brought against the State by any third party (which for the purposes of this provision shall include, but not be limited to, employees of the State, the Contractor and any of its subcontractors), and all related costs and expenses (including reasonable attorneys’ fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

- (a) any breach of this Contract or negligence or intentional tortious act by the Contractor or any of its subcontractors, or by anyone else for whose acts any of them may be liable, in the performance of this Contract;
- (b) the death or bodily injury of any person or the damage, loss or destruction of any real or personal property in connection with the performance of this Contract by the Contractor, or any of its subcontractors, or by anyone else for whose acts any of them may be liable provided, and to the extent that the injury or damage was caused by the fault or negligence of the Contractor.
- (c) any act or omission of the Contractor or any of its subcontractors in their capacity as an employer in the performance of this Contract;
- (d) any claim, demand, action or legal proceeding against the State arising out of or related to occurrences, if any, that the Contractor is required to insure against as provided in this Contract.

Without waiver of these provisions, the State may remove the lawsuit to federal court, as otherwise allowable, and/or obtain extensions to avoid default. Provided the State timely tenders its defense to the Contractor, the Contractor will also indemnify the



State for any reasonable and necessary legal fees, costs and expenses it incurs prior to the Contractor's accepting the tender. "Timely" shall mean that the Contractor is given sufficient notice so that its ability to defend the lawsuit is in no way prejudiced.

Notwithstanding the foregoing, the State shall be solely responsible for its own legal fees, costs and expenses and damages, assessments and penalties to the extent the lawsuit has as its basis a claim that the State interfered with the third party's submission of a claim or otherwise acted in a negligent, fraudulent, or criminal manner.

2. Indemnification Obligation Not Limited

In any and all claims against the State by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or any other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.

3. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and effect, notwithstanding the expiration or early cancellation of the Contract, with respect to any claims based on facts or conditions that occurred prior to expiration or cancellation.

**I-K LIMITATION OF LIABILITY**

Except as set forth herein, neither the Contractor nor the State shall be liable to the other party for indirect or consequential damages, even if such party has been advised of the possibility of such damages. Such limitation as to indirect or consequential damages shall not be applicable for claims arising out of gross negligence, willful misconduct, or Contractor's indemnification responsibilities to the State as set forth in Section I-J with respect to third party claims, action and proceeding brought against the State.

**I-L NON INFRINGEMENT/COMPLIANCE WITH LAWS**

The Contractor warrants that in performing the services called for by this Contract it will not violate any applicable law, rule, or regulation, any contracts with third parties, or any intellectual rights of any third party, including but not limited to, any United States patent, trademark, copyright, or trade secret.



**I-M WARRANTIES AND REPRESENTATIONS**

The Contract will contain customary representations and warranties by the Contractor, including, without limitation, the following:

1. The Contractor will perform all services in accordance with high professional standards in the industry;
2. The Contractor will use adequate numbers of qualified individuals with suitable training, education, experience and skill to perform the services;
3. The Contractor will use its best efforts to use efficiently any resources or services necessary to provide the services that are separately chargeable to the State;
4. The Contractor will use its best efforts to perform the services in the most cost effective manner consistent with the required level of quality and performance;
5. The Contractor will perform the services in a manner that does not infringe the proprietary rights of any third party;
6. The Contractor will perform the services in a manner that complies with all applicable laws and regulations;
7. The Contractor has duly authorized the execution, delivery and performance of the Contract;
8. The Contractor has not provided any gifts, payments or other inducements to any officer, employee or agent of the State;

**I-N TIME IS OF THE ESSENCE**

The Contractor agrees that time is of the essence in the performance of the Contractor's obligations under this Contract.

**I-O STAFFING OBLIGATIONS**

The State reserves the right to approve the Contractor's assignment of Key Personnel to this project and to recommend reassignment of personnel deemed unsatisfactory by the State.

The Contractor shall not remove or reassign, without the State's prior written approval any of the Key Personnel until such time as the Key Personnel have completed all of their planned and assigned responsibilities in connection with performance of the Contractor's obligations under this Contract. The Contractor agrees that the continuity of Key Personnel is critical and agrees to the continuity of Key Personnel. Removal of Key Personnel without the written consent of the State may be considered by the State to be a material breach of this Contract. The prohibition against removal or reassignment shall not apply where Key Personnel must be replaced for reasons beyond the reasonable



control of the Contractor including but not limited to illness, disability, resignation or termination of the Key Personnel's employment.

The State and the Contractor agree that the following personnel are Key Personnel for purposes of this Contract:

Name: **Diane Turro** Title: Account Manager

**I-P WORK PRODUCT AND OWNERSHIP**

1. Work Products shall be considered works made by the Contractor for hire by the State and shall belong exclusively to the State and its designees, unless specifically provided otherwise by mutual agreement of the Contractor and the State. If by operation of law any of the Work Product, including all related intellectual property rights, is not owned in its entirety by the State automatically upon creation thereof, the Contractor agrees to assign, and hereby assigns to the State and its designees the ownership of such Work Product, including all related intellectual property rights. The Contractor agrees to provide, at no additional charge, any assistance and to execute any action reasonably required for the State to perfect its intellectual property rights with respect to the aforementioned Work Product.
2. Notwithstanding any provision of this Contract to the contrary, any preexisting work or materials including, but not limited to, any routines, libraries, tools, methodologies, processes or technologies (collectively, the "Development Tools") created, adapted or used by the Contractor in its business generally, including any all associated intellectual property rights, shall be and remain the sole property of the Contractor, and the State shall have no interest in or claim to such preexisting work, materials or Development Tools, except as necessary to exercise its rights in the Work Product. Such rights belonging to the State shall include, but not be limited to, the right to use, execute, reproduce, display, perform and distribute copies of and prepare derivative works based upon the Work Product, and the right to authorize others to do any of the foregoing, irrespective of the existence therein of preexisting work, materials and Development Tools, except as specifically limited herein.
3. The Contractor and its subcontractors shall be free to use and employ their general skills, knowledge and expertise, and to use, disclose, and employ any generalized ideas, concepts, knowledge, methods, techniques or skills gained or learned during the course of performing the services under this Contract, so long as the Contractor or its subcontractors acquire and apply such information without disclosure of any confidential or proprietary information of the State, and without any unauthorized use or disclosure of any Work Product resulting from this Contract.



**I-Q CONFIDENTIALITY OF DATA AND INFORMATION**

1. All financial, statistical, personnel, technical and other data and information relating to the State’s operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State’s procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor’s data and information are deemed by the State to be adequate for the protection of the State’s confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this section.
  
2. The Contractor shall not be required under the provisions of this section to keep confidential, (1) information generally available to the public, (2) information released by the State generally, or to the Contractor without restriction, (3) information independently developed or acquired by the Contractor or its personnel without reliance in any way on otherwise protected information of the State. Notwithstanding the foregoing restrictions, the Contractor and its personnel may use and disclose any information which it is otherwise required by law to disclose, but in each case only after the State has been so notified, and has had the opportunity, if possible, to obtain reasonable protection for such information in connection with such disclosure.

**I-R REMEDIES FOR BREACH OF CONFIDENTIALITY**

The Contractor acknowledges that a breach of its confidentiality obligations as set forth in section I-Q of this Contract, shall be considered a material breach of the Contract. Furthermore the Contractor acknowledges that in the event of such a breach the State shall be irreparably harmed. Accordingly, if a court should find that the Contractor has breached or attempted to breach any such obligations, the Contractor will not oppose the entry of an appropriate order restraining it from any further breaches or attempted or threatened breaches. This remedy shall be in addition to and not in limitation of any other remedy or damages provided by law.

**I-S CONTRACTOR'S LIABILITY INSURANCE**

The Contractor shall purchase and maintain such insurance as will protect him/her from claims set forth below which may arise out of or result from the Contractor's operations under the Contract (Purchase Order), whether such operations be by himself/herself or by any subcontractor or by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable:



- (1) Claims under workers' disability compensation, disability benefit and other similar employee benefit act. A non-resident Contractor shall have insurance for benefits payable under Michigan's Workers' Disability Compensation Law for any employee resident of and hired in Michigan; and as respects any other employee protected by workers' disability compensation laws of any other State the Contractor shall have insurance or participate in a mandatory State fund to cover the benefits payable to any such employee.
- (2) Claims for damages because of bodily injury, occupational sickness or disease, or death of his/her employees.
- (3) Claims for damages because of bodily injury, sickness or disease, or death of any person other than his/her employees, subject to limits of liability of not less than \$300,000.00 each occurrence and, when applicable \$1,000,000.00 annual aggregate, for non-automobile hazards and as required by law for automobile hazards.
- (4) Claims for damage because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than \$50,000.00 each occurrence for non-automobile hazards and as required by law for automobile hazards.
- (5) Insurance for Subparagraphs (3) and (4) non-automobile hazards on a combined single limit of liability basis shall not be less than \$300,000.00 each occurrence and when applicable, \$1,000,000.00 annual aggregate.

The insurance shall be written for not less than any limits of liability herein specified or required by law, whichever is greater, and shall include contractual liability insurance as applicable to the Contractor's obligations under the Indemnification clause of the Contract (Purchase Order).

**BEFORE STARTING WORK THE CONTRACTOR'S INSURANCE AGENCY MUST FURNISH TO THE DIRECTOR OF THE OFFICE OF PURCHASING, ORIGINAL CERTIFICATE (S) OF INSURANCE VERIFYING LIABILITY COVERAGE. THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING.** These Certificates shall contain a provision that coverage's afforded under the policies will not be canceled until at least fifteen days prior written notice bearing the Contract Number or Purchase Order Number has been given to the Director of Purchasing.

**I-T NOTICE AND RIGHT TO CURE**

In the event of a curable breach by the Contractor, the State shall provide the Contractor written notice of the breach and a time period to cure said breach described in the notice. This section requiring notice and an opportunity to cure shall not be applicable in the event of successive or repeated breaches of the same nature or if the State determines in its sole discretion that the breach poses a



serious and imminent threat to the health or safety of any person or the imminent loss, damage or destruction of any real or tangible personal property.

**I-U CANCELLATION**

The State may cancel this Contract without further liability or penalty to the State, its departments, divisions, agencies, offices, commissions, officers, agents and employees for any of the following reasons:

1. **Material Breach by the Contractor.** In the event that the Contractor breaches any of its material duties or obligations under the Contract, which are either not capable of or subject to being cured, or are not cured within the time period specified in the written notice of breach provided by the State, or pose a serious and imminent threat to the health and safety of any person, or the imminent loss, damage or destruction of any real or tangible personal property, the State may, having provided written notice of cancellation to the Contractor, cancel this Contract in whole or in part, for cause, as of the date specified in the notice of cancellation.

In the event that this Contract is cancelled for cause, in addition to any legal remedies otherwise available to the State by law or equity, the Contractor shall be responsible for all costs incurred by the State in canceling the Contract, including but not limited to, State administrative costs, attorneys fees and court costs, and any additional costs the State may incur to procure the services required by this Contract from other sources. All excess reprocurement costs and damages shall not be considered by the parties to be consequential, indirect or incidental, and shall not be excluded by any other terms otherwise included in the Contract.

In the event the State chooses to partially cancel this Contract for cause charges payable under this Contract will be equitably adjusted to reflect those services that are cancelled.

In the event this Contract is cancelled for cause pursuant to this section, and it is therefore determined, for any reason, that the Contractor was not in breach of contract pursuant to the provisions of this section, that cancellation for cause shall be deemed to have been a cancellation for convenience, effective as of the same date, and the rights and obligations of the parties shall be limited to that otherwise provided in the Contract for a cancellation for convenience.

2. **Cancellation For Convenience By the State.** The State may cancel this Contract for it convenience, in whole or part, if the State determines that such a cancellation is in the State's best interest. Reasons for such cancellation shall be left to the sole discretion of the State and may include, but not necessarily be limited to (a) the State no longer needs the services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Contract services no longer practical or feasible, and (c) unacceptable prices for additional services requested by the State. The State may cancel the Contract for its convenience, in whole or in part, by giving the Contractor written notice 30 days prior to the date of cancellation. If the State chooses to cancel this Contract in part, the charges payable under this Contract shall be equitably adjusted to reflect those services that are cancelled.



3. Non-Appropriation. In the event that funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available. The Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this project. If funds are not appropriated or otherwise made available, the State shall have the right to cancel this Contract at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of cancellation to the Contractor. The State shall give the Contractor written notice of such non-appropriation or unavailability within 30 days after it receives notice of such non-appropriation or unavailability.
  
4. Criminal Conviction. In the event the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which in the sole discretion of the State, reflects upon the Contractor's business integrity.
  
5. Approval(s) Rescinded. In the event any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Constitution 1963, Article 11, section 5, and Civil Service Rule 4-6. Cancellation may be in whole or in part and may be immediate as of the date of the written notice to the Contractor or may be effective as of the date stated in such written notice.

**I-V RIGHTS AND OBLIGATIONS UPON CANCELLATION**

1. If the Contract is canceled by the State for any reason, the Contractor shall, (a) stop all work as specified in the notice of cancellation, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Work Product or other property derived or resulting from the Contract that may be in the Contractor's possession, (c) return all materials and property provided directly or indirectly to the Contractor by any entity, agent or employee of the State, (d) transfer title and deliver to the State, unless otherwise directed by the Contract Administrator or his or her designee, all Work Product resulting from the Contract, and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or cancellation settlement costs, to the maximum practical extent, including, but not limited to, canceling or limiting as otherwise applicable, those subcontracts, and outstanding orders for material and supplies resulting from the canceled Contract.
  
2. In the event the State cancels this Contract prior to its expiration for its own convenience, the State shall pay the Contractor for all charges due for services provided prior to the date of cancellation and if applicable as a separate item of



payment pursuant to the Contract, for partially completed Work Product, on a percentage of completion basis. In the event of a cancellation for cause, or any other reason under the Contract, the State will pay, if applicable, as a separate item of payment pursuant to the Contract, for all partially completed Work Products, to the extent that the State requires the Contractor to submit to the State any such deliverables, and for all charges due under the Contract for any cancelled services provided by the Contractor prior to the cancellation date. All completed or partially completed Work Product prepared by the Contractor pursuant to this Contract shall, at the option of the State, become the State's property, and the Contractor shall be entitled to receive just and fair compensation for such Work Product. Regardless of the basis for the cancellation, the State shall not be obligated to pay, or otherwise compensate, the Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

3. If any such cancellation by the State is for cause, the State shall have the right to set-off against any amounts due the Contractor, the amount of any damages for which the Contractor is liable to the State under this Contract or pursuant to law and equity.
4. Upon a good faith cancellation, the State shall have the right to assume, at its option, any and all subcontracts and agreements for services and materials provided under this Contract, and may further pursue completion of the Work Product under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

**I-W EXCUSABLE FAILURE**

1. Neither party shall be liable for any default or delay in the performance of its obligations under the Contract if and to the extent such default or delay is caused, directly or indirectly, by: fire, flood, earthquake, elements of nature or acts of God; riots, civil disorders, rebellions or revolutions in any country; the failure of the other party to perform its material responsibilities under the Contract (either itself or through another contractor); injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of such party; provided the non-performing party and its subcontractors are without fault in causing such default or delay, and such default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans. In such event, the non-performing party will be excused from any further performance or observance of the obligation(s) so affected for as long as such circumstances prevail and such party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay provided such party promptly notifies the other party in writing of the inception of the excusable failure occurrence, and also of its abatement or cessation.
2. If any of the above enumerated circumstances substantially prevent, hinder, or delay performance of the services necessary for the performance of the State's functions for more than 14 consecutive days, and the State determines that performance is not



likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State’s option: (a) the State may procure the affected services from an alternate source, and the State shall not be liable for payments for the unperformed services under the Contract for so long as the delay in performance shall continue; (b) the State may cancel any portions of the Contract so affected and the charges payable thereunder shall be equitably adjusted to reflect those services canceled; or (c) the Contract will be canceled without liability of the State to the Contractor as of the date specified by the State in a written notice of cancellation to the Contractor. The Contractor will not have the right to any additional payments from the State as a result of any excusable failure occurrence or to payments for services not rendered as a result of the excusable failure condition. Defaults or delays in performance by the Contractor which are caused by acts or omissions of its subcontractors will not relieve the Contractor of its obligations under the Contract except to the extent that a subcontractor is itself subject to any excusable failure condition described above and the Contractor cannot reasonably circumvent the effect of the subcontractor’s default or delay in performance through the use of alternate sources, workaround plans or other means.

**I-X ASSIGNMENT**

The Contractor shall not have the right to assign this Contract or to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State. Any purported assignment in violation of this section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without the prior written consent of the State Purchasing Director.

**I-Y DELEGATION**

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the State Purchasing Director has given written consent to the delegation.

**I-Z NON-DISCRIMINATION CLAUSE**

In the performance of any Contract or purchase order resulting herefrom, the vendor agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual’s ability to perform the duties of the particular job or position. The vendor further agrees that every subcontract entered into for the performance of any Contract or purchase order resulting herefrom will contain a provision requiring non-discrimination in employment, as herein specified, binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 Public Act 453, as amended, MCL 37.2101, *et seq*, and the Persons with Disabilities Civil Rights Act, 1976 Public Act 220, as amended, MCL 37.1101, *et seq*, and any breach thereof may be regarded as a material breach of the Contract or purchase order.



**I-AA MODIFICATION OF SERVICE**

The Director of Purchasing reserves the right to modify this service during the course of this Contract. Such modification may include adding or deleting tasks that this service shall encompass and/or any other modifications deemed necessary.

This Contract may not be revised, modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

The State reserves the right to request from time to time, any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. The Contractor shall provide a change order process and all requisite forms. The State reserves the right to negotiate the process during contract negotiation. At a minimum, the State would like the Contractor to provide a detailed outline of all work to be done, including tasks necessary to accomplish the deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

1. Within five (5) business days of receipt of a request by the State for any such change, or such other period of time as to which the parties may agree mutually in writing, the Contractor shall submit to the State a proposal describing any changes in products, services, timing of delivery, assignment of personnel, and the like, and any associated price adjustment. The price adjustment shall be based on a good faith determination and calculation by the Contractor of the additional cost to the Contractor in implementing the change request less any savings realized by the Contractor as a result of implementing the change request. The Contractor's proposal shall describe in reasonable detail the basis for the Contractor's proposed price adjustment, including the estimated number of hours by task by labor category required to implement the change request.
2. If the State accepts the Contractor's proposal, it will issue a change notice and the Contractor will implement the change request described therein. The Contractor will not implement any change request until a change notice has been issued validly. The Contractor shall not be entitled to any compensation for implementing any change request or change notice except as provided explicitly in an approved change notice.
3. If the State does not accept the Contractor's proposal, the State may:
  - a) withdraw its change request; or
  - b) modify its change request, in which case the procedures set forth above will apply to the modified change request.

If the State requests or directs the Contractor to perform any activities that are outside the scope of the Contractor's responsibilities under the Contract ("New Work"), the Contractor must notify the State promptly, and before commencing performance of the requested activities, that it believes the requested activities are New Work. If the Contractor fails to so notify the State prior to commencing performance of the requested



activities, any such activities performed before notice is given by the Contractor shall be conclusively considered to be In-scope Services, not New Work.

If the State requests or directs the Contractor to perform any services or functions that are consistent with and similar to the services being provided by the Contractor under the Contract, but which the Contractor reasonably and in good faith believes are not included within the scope of the Contractor's responsibilities and charges as set forth in the Contract, then prior to performing such services or function, the Contractor shall promptly notify the State in writing that it considers the services or function to be an "Additional Service" for which the Contractor should receive additional compensation. If the Contractor does not so notify the State, the Contractor shall have no right to claim thereafter that it is entitled to additional compensation for performing such services or functions. If the Contractor does so notify the State, then such a service or function shall be governed by the change request procedure set forth in the preceding paragraph.

IN THE EVENT PRICES ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT SHALL BE SUBJECT TO COMPETITIVE BIDDING BASED UPON THE NEW SPECIFICATIONS.

**I-BB NOTICES**

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party as addressed below upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

For the Contractor: *Susan J. Olson*  
*Metlife Insurance Company*  
*10 South LaSalle St.*  
*Suite 3350*  
*Chicago, IL 60603*

For the State: *Irene Pena, Buyer*  
*State of Michigan*  
*Office of Purchasing*  
*530 W. Allegan*  
*Lansing, MI 48933*

Either party may change its address where notices are to be sent giving written notice in accordance with this section.

**I-CC ENTIRE AGREEMENT**



The contents of this Contract agreement, the ITB/RFP document and the vendor's proposal will become contractual obligations upon execution of this agreement. Failure of the Contractor to accept these obligations may result in cancellation of the award.

This Contract agreement shall represent the entire agreement between the parties and supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties relating to this subject.

**I-DD NO WAIVER OF DEFAULT**

The failure of a party to insist upon strict adherence to any term of this Contract shall not be considered a waiver or deprive the party of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

**I-EE SEVERABILITY**

Each provision of the Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions of the Contract shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

**I-FF HEADINGS**

Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

**I-GG RELATIONSHIP OF THE PARTIES**

The relationship between the State and the Contractor is that of client and independent Contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this Contract.

**I-HH UNFAIR LABOR PRACTICES**

Pursuant to 1980 Public Act 278, as amended, MCL 423.231, et seq, the State shall not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled pursuant to section 2 of the Act. This information is compiled by the United States National Labor Relations Board.

A Contractor of the State, in relation to the Contract, shall not enter into a Contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Pursuant to section 4 of 1980 Public Act 278, MCL 423.324, the State may void any Contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer or supplier of the Contractor appears in the register.



**I-II SURVIVOR**

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to the Contractor’s indemnity and other obligations shall survive the expiration or cancellation of this Contract for any reason.

**I-JJ GOVERNING LAW**

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan. Any dispute arising herein shall be resolved in the State of Michigan.

**I-KK YEAR 2000 SOFTWARE COMPLIANCE**

The Contractor warrants that services provided under this Contract including but not limited to the production of all Work Products, shall be provided in an accurate and timely manner without interruption, failure or error due the inaccuracy of Contractor’s business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom.

**I-LL CONTRACT DISTRIBUTION**

The Office of Purchasing shall retain the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by the Office of Purchasing.

**I-MM STATEWIDE CONTRACTS**

If the contract is for the use of more than one agency and if the goods or services provided under the contract do not meet the form, function and utility required by an agency, that agency may, subject to state purchasing policies, procure the goods or services from another source.

**I-NN TRANSITION ASSISTANCE**

If this Contract is not renewed at the end of this term, or is canceled prior to its expiration, for any reason, the Contractor must provide for up to 60 days after the expiration or cancellation of this Contract, all reasonable transition assistance requested by the State, to allow for the expired or canceled portion of the Services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such services to the State or its designees. Such transition assistance will be deemed by the parties to be governed by the terms and conditions of this Contract, (notwithstanding this expiration or cancellation) except for those Contract terms or conditions that do not reasonably apply to such transition assistance. The State shall pay the Contractor for any resources utilized in performing such transition assistance at the most current rates provided by the Contract for Contract performance. If the State cancels this Contract for



cause, then the State will be entitled to off set the cost of paying the Contractor for the additional resources the Contractor utilized in providing transition assistance with any damages the State may have otherwise accrued as a result of said cancellation.



**SECTION II**

**WORK STATEMENT**

**II-A BACKGROUND/PROBLEM STATEMENT**

The State does not currently provide or sponsor an LTC program for State employees and pension recipients of State agencies, and their eligible spouses, parents, and parents-in-law. The proposed program would be sponsored by the State, but would be **paid entirely by the participants, and would be entirely voluntary** (i.e., no costs, other than the cost of performing payroll deductions and certain program oversight functions, would be borne by the State).

The State agencies involved include the following:

- State Employees (including State Library and Legislative Service Bureau employees)
- State Employee Pension Recipients in the SERS (State Employees Retirement System)
- State Police Employees
- State Police Pension Recipients in the SPRS (State Police Retirement System)
- Retired Judges in the JRS (Judges Retirement System)
- Retired Public School Teachers in MPSERS (Michigan Public School Employee Retirement System)

There are approximately 61,000 active state employees, including active Library, Legislative Service Bureau and State Police.

There are approximately 164,000 pension recipients in the various groups, including 36,000 in the SERS, 2,200 in the SPRS, 520 in the JRS, and 125,600 in MPSERS.

(Note: Active public school employees are NOT included in this proposal)

Eligible spouses, parents, and parents-in-law would be in addition to the numbers given above. The total eligible population may exceed 500,000 members.

Appendix C contains a summary of census data. Census data for current active employees and pension recipients is also available on CD-ROM.

The following State agencies may decide at a future date to be covered by this contract: Active members of the Judicial Branch of State Government; and active and retired members of the Legislative Branch of State Government. At that time, notification will be provided to the successful vendor, and a Change Notice will be created to include these other agencies.

As part of the State's requirements, this program will be periodically rebid. The communications and marketing process for this plan would begin October 1, 2001. Rate quotes are requested for an effective period of April 1, 2002 through September 30, 2006.



**II-B OBJECTIVES**

The objectives of this LTC program is to:

- make available an LTC program to active employees, pension recipients, spouses, parents and parents-in-law as described in Sec. II-A;
- obtain competitive pricing and effective care management for LTC program services;
- maintain a high level of member satisfaction with the program;
- obtain timely utilization reporting; and
- provide quality customer service and account service features, including performance guidelines.

The objective of this Contract is to provide and manage the administration of the LTC benefit program for the State.

**II-C TASKS/PLAN REQUIREMENTS**

The Contractor must meet the following requirements.

**1. Plan Design**

The vendor will be asked to provide the plan designs shown in Appendix A. The program will be federally qualified and HIPAA compliant.

Eligibility should include current active employees, pension recipients (i.e., ex-active employees receiving retirement benefits), spouses of actives and pension recipients, surviving spouses, parents, parents-in-law, grandparents, and grandparents-in-law.

The effective date of the contract will be October 1, 2001, with an expected date of commencement of enrollment of April 1, 2002. The policy effective date is April 1, 2002, with the initial enrollment period from January 2, 2002 through February 28, 2002. During this initial six-month period, it is expected that the vendor (with assistance from the State) will conduct an extensive, focused marketing, communication and education effort to promote this plan.

**2. Covered Services**

Covered services are described in the benefit summaries attached as Appendix A.

**3. Administrative Services**

Administrative services must include, but need not be limited to, the following:

Information Systems:

- Ability to accept premium deduction and eligibility information from the State for active employee participants (and their participating spouses) in the form of magnetic



tapes, diskette, CD-ROM, or a dial-up connection or the Internet. Data for active participants will be supplied through the Human Resource Management Network (HRMN) (format attached as Appendix B).

- Ability to accept eligibility information from the State for pension recipients (and their participating spouses) in the form of magnetic tapes, diskette, CD-ROM, or a dial-up connection or the Internet. See Appendix B for the pension payroll layout. At some future date, it may be possible to offer pension recipients the option to perform the premium deductions from the State pension system. It is expected that the vendor will be able to accept a feed from this system, when available.
- Ability to accept eligibility information, by electronic data interchange (EDI), by [April 1, 2002](#).
- Ability to administer eligibility and claims administration in accordance with the plan design.
- Confidentiality of all data by the vendor.
- Maintenance of records for auditing and management information reporting and analysis.
- Monthly, quarterly and annual reporting, on an accurate, timely basis, of plan activity and experience data to the State.

Financial Arrangements:

- Competitive rates, based on the age of the participant and program option selected.
- Ability to bill directly participants other than active employees and their participating spouses, at no additional cost to participants on direct billing.

Participant Services:

- Customized participant communications (with all communications subject to the State's approval).
- Customer service activities to include but not be limited to:
  - Access, at a minimum, for extended hours on business days and limited weekend hours on weekends,
  - a single front-end toll-free telephone number with touch-tone routing (if necessary) for member services to respond to requests for participating provider locations, authorizations for care, inquiries on claims, and complaints about provider practices and services,
  - a voice response system (if necessary) with a user-friendly menu that customers find easy to understand, and
  - development of some services through the Internet.
- Initial credentialing, monitoring, auditing, and re-credentialing of network providers (for vendors with network arrangements).
- Comprehensive patient and provider education services.

Account Management:

- An assigned account representative, and assigned service representatives, responsive to inquiries, requests and issues raised by the State.



- A clinician (such as an RN or a MSW) available to provide a reasonable amount of clinical advice to the State.

**4. Subcontracting**

Provisions regarding use of subcontractors are given in Section I-D. The State expects that all essential services associated with delivery of this program will be provided directly by the vendor, and that use of subcontractors will be minimal, with the possible exception of certain peripheral services such as printing, communications design, etc.

**5. Funding**

The LTC program will be funded entirely by the premium payments of the program participants. No expenses will be billed to the State.

**6. Eligibility**

Eligibility information will be maintained by the vendor. Premium deduction and eligibility information for active employees and their participating dependents will be transferred by the State via tape, diskette, CD-ROM, EDI, Email or the Internet no less frequently than on a bi-weekly basis. Eligibility information for pension recipients will be transferred by the Office of Retirement via tape, diskette, CD-ROM, EDI, Email or the Internet on a monthly basis. The bidder must have the capabilities to accept electronic data transfer, and to administer membership information in compliance with HIPAA requirements. The data format for active employees is attached under Appendix B.

**7. Performance Standards**

The State will require the vendor to contractually agree to Performance Standards. Failure to adhere to these standards, or to take corrective action to meet these standards, may result in termination of the contract. The objective of these standards is to encourage an acceptable level of performance in key contract administration areas. These include:

- Eligibility,
- Claim turnaround time,
- Claim payment accuracy on both a dollar and per occurrence basis,
- Member satisfaction, and
- Inquiry handling.

a. Eligibility

The Contractor will update (i.e., additions, deletions, corrections of addresses, names, social security numbers, etc.) eligibility files with the State eligibility input within 2 business days of receipt.



b. Claim Turnaround Time

1. The maximum time period between date of receipt of billings by the Contractor and the date of payment (or denial) is expected to be no greater than 10 business days for 85% of all claims, and 20 business days for 99%. Requests for additional data from either the beneficiary or the provider shall be within the same standards.
2. The Contractor must ensure that the performance guarantees are measurable using the vendor’s standard systems in place.

c. Claims Accuracy

The State shall audit the Contractor’s administration of claims for accuracy. The State’s approach has been to audit two (2) Plan Years at one time, conducted within 12 months of the end of the second year audited. This approach may change without prior notice.

The Contractor will not be liable for errors caused by the State, nor will the State be liable for errors caused by the Contractor. The errors will be established by using statistically significant sampling methods resulting in a 95% confidence level with precision of +/- 3%. The State will include adjustments made up to four months after the close of the audited year. If claims samples are selected using a financially stratified methodology, the results will be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.

Financial Payment Accuracy: measures the dollar value of errors. Calculated as total audited paid dollars minus the absolute value of over- and underpayments, divided by total audited paid dollars. The acceptable error rate for the first year of the contract will be 1% (i.e., a 99% accuracy rate), and 0.7% for subsequent contract years (99.3% accuracy rate).

The acceptable error value is the acceptable error rate multiplied by net paid claims during the review period. The standards are as shown below:

**FINANCIAL PAYMENT ACCURACY**

| <b>Review Period</b>      | <b>Error Standard as a % of Dollars Paid</b> |
|---------------------------|--|
| Year One                  | 1.0% of net claims                           |
| Year Two                  | 0.7% of net claims                           |
| Year Three and Thereafter | 0.7% of net claims                           |

Payment Incidence Accuracy: Measures the incidence of claims processed without payment error. It is defined as the percentage of audited claims process without payment error. The definition of error includes any type of error (e.g., coding, procedural, system, payment, etc.) that results in a payment error. It is



calculated as the total number of audited claims minus the number of claims processed with “payment” errors, divided by the total number of audited claims. The acceptable error rate for the first year of the contract will be 3% (97% accuracy rate), and 2.5% (97.5% accuracy rate) for subsequent contract years.

Claims Processing Accuracy: Measures the overall claims processing accuracy, based on whether or not the claims was processed without an error. Claims processing accuracy is calculated as the total number of audited claims minus the number of claims with errors, divided by the total number of audited claims. The acceptable error rate for the first year of the contract will be 5% (95% accuracy rate), and 4% (96% accuracy rate) for subsequent contract years.

d. Inquiry Handling

95% of written inquiries that the Contractor receives either from the State or members will be answered within 5 business days, and 100% within 10 business days. The response time is calculated from the date of receipt by the Contractor to final resolution.

100% of phone inquiries will be returned within 24 hours.

The inquiry telephone line for members will have no more than 5% lost calls.

The inquiry telephone system must maintain sufficient staffing to respond to telephone calls by not allowing in excess of 30 seconds on hold for more than 90% of the calls received.

At least 85% of participants must be satisfied with the contractor’s customer service.

**8. Systems and Reporting Requirements**

a. Claim Information

Maintenance of detailed claims information is necessary to facilitate claims review and cost containment functions. It is also essential to produce reports to be submitted to the State for use in effectively administering the program.

Data collected on behalf of the State program is not to be distributed to any party without the written consent of the State and is not to be used by the Contractor for any purposes unless specifically approved by the State. All data identifying specific enrollees or their dependents are highly confidential and are to be treated accordingly.

b. Contractor/State Interface

The following are additional Contractor requirements related to the necessary systems interface between the selected Contractor and the State.



1. Capability to accept the State's computerized enrollment files (see Appendix B) and pension recipient data and process change transactions to maintain up-to-date information for claims certification.
2. A staff of systems professionals to provide timely programming required to implement system changes and produce reports.
3. Designation of a high-level management staff member to serve as liaison for systems related matters.
4. Ability to interface directly with the State's personnel information system, through a secure access method implemented with the State. The pension payroll will not be accessible.

c. Reports.

The State expects that the following reports will be available upon request or on a scheduled basis, for no additional cost:

- Premiums collected by type of participant (e.g. employee, spouse, pension recipient, pension recipient's spouse, parents & parents-in-law.
- Number (age, gender) of enrollees by eligible class. Additionally, for employees by each geographic location.
- Number of applicants denied coverage.
- Number, type and amount of claims payments (separate new and continuing claims) by type of participant.
- Closed claims, including reconciliation of reserves.
- Information on claims that were denied, including appeals made.
- Number of enrollees whose coverage has lapsed.
- Reserve amount, interest earned, how invested, comparison of actual reserve to expected.
- Detail on all retention or administrative charges or expenses.
- A full financial reconciliation.
- Number of enrollees purchasing optional inflation protection, by amount and type of protection.
- Utilization of the eldercare information and referral number.
- Utilization of case management services.

The State expects to receive the Contractor's standard report package and those reports described below.

- Monthly reports, including:
  - A brief summary (in letter form) of significant activities, issues or problems identified or addressed during the month, or anticipated in subsequent months,
  - Number of participants in claimant status, by plan option,



- Claims Report, showing claims paid in the month, showing number of facility admissions, days/visits/services, charges, and plan payments, split by facility and non-facility services, by plan option,
  - Number of participants covered, split between actives, pension recipients, and dependent categories, by plan option,
  - Produced within 30 calendar days of the end of the month.
- Quarterly reports, including:
    - Quarterly and YTD summaries of Monthly Claims Report.
    - Produced within 30 calendar days of the end of the quarter.
- Annual Report (results through June 30th), including:
    - Management summary,
    - Full financial and enrollment experience, including the items shown in monthly and quarterly reports, summarized to an annual basis,
    - Produced within 60 calendar days of the end of the year.

The State is *very* interested in on-line or electronic reporting capabilities. A description of capabilities will be requested as part of the RFP response, and will be included in the evaluation of the proposal.

**9. Network Match**

The vendor may propose a network of preferred LTC providers in areas where State employees and pension recipients reside. Appendix C contains counts by zip codes for all eligible employees and pension recipients.

General standards are at least one LTC facility within 10 miles in urban areas, 20 miles in suburban areas and 40 miles in rural areas (see Section IV-D, 5). GeoAccess reports should be run separately for active employees, MPSERS pension recipients, and all other pension recipients, and separately for LTC facilities (nursing homes, etc.) and assisted daily living facilities.

**10. Communication Materials**

The vendor will be expected to implement a comprehensive and effective plan to market this program to employees, pension recipients, and their spouses and parents. This process is expected to include focused marketing efforts, including flyers, brochures, stuffers, mail-outs, posters, articles for inclusion in regular State newsletters, etc. over a six-month period. It is also expected that educational meetings directed at active and retired employees will be held throughout the State (up to 15 for actives and up to 30 for pension recipients; the State will provide suitable meeting spaces).

Within this communications process, it may be expected that communications materials and market targeting will differ somewhat for the different State agencies, such as State employees, State Police, Judges, and MPSERS—retired public school personnel.



The vendor will prepare and cover the cost of all announcements, letters, notices, brochures, forms, postage and other supplies and services for U.S. mail distribution to employees' and pension recipients' residences.

All information/material must be approved by the State prior to use, and must comply with all applicable laws, regulations and requirements of the State of Michigan. Anticipating the possibility that Michigan may adopt the NAIC LTC Model Regulations, communication materials should anticipate compliance with these model regulations.

**11. Audits**

It is the State's intention to periodically (no less often than once every three years) perform on-site audits of plan administrators. The vendor will make records associated with the administration of the State plan available to, and must cooperate with, such auditors and audits as the State may designate. The State's current approach as been to audit two (2) Plan Years at one time, conducted within 12 months of the end of the second year audited. For example, for plan years October 1, 2001 through September 30, 2003, the State would request an audit of LTC claims to be completed by September 30, 2004. This approach may change without prior notice.

**12. Administrative Requirements Checklist**

In summary, the following are considered to be required services:

- A. Communications
  - Highlights Brochure for eligibles
  - Plan Booklet (SPD) for enrollees
  - Enrollment Meeting Materials
  - Generic Internet site on LTC
  - Internet or Intranet site customized for SOM
  - Video for Employees
  - Training of Benefits Staff
  - Interactive Voice Response enrollment
- B. Toll free line for potential enrollees and for insured's
- C. Enrollment Assistance
  - Meet with employees in (up to 15) major work locations, and with pension recipients in (up to 30) specified locations (all in Michigan)
  - Answer employee questions
  - Mail materials to all pension recipients
  - Mail materials to parents, parents-in-law, and other eligible family members on request
- D. Mail all plan materials (including enrollment material) to the homes of employees/pension recipients



- E. Provide distribution-ready plan materials to employer for distribution to employees
- F. Directly accept all enrollment forms
- G. Provide all required medical underwriting
- H. Check applicant eligibility and confirm with the State if necessary
- I. Notify applicants of acceptance or denial decisions
- J. Notify new hires on an ongoing basis of their right to enroll in the plan
- K. Claims services
  - Eligibility Verification
  - Confirmation of Benefit Trigger
  - Claims Payment
  - Claims Tracking
  - Review of Claims Appeals
- L. Advise the State of the amount to deduct from payroll for each enrollee
- M. Data reports
- N. Direct Billing and Reminder Notices to:
  - Pension recipients and their spouses
  - Employees on unpaid leave
  - Parents, parents-in-law and other family members
  - Terminated employees and their spouses
  - Divorced and widowed spouses
- O. Notify all enrollees of additional buy-up purchase opportunities, process requests received as a result, and notify the State of changes in payroll deduction amounts.

**II-D PROJECT CONTROL AND REPORTS**

- 1. Project Control
  - a. The Contractor will provide these services under the direction and control of the Office of the State Employer.
  - b. Although there will be continuous liaison with the Contractor team, the contract director will meet quarterly during the first contract year as a minimum, with the Contractor's project manager for the purpose of reviewing progress and providing necessary guidance to the Contractor in solving problems which arise.
  - c. The Contractor will submit, as part of the monthly report (see II-C 8.c) brief written summaries of significant activities during the month, issues or problems, real or anticipated, which should be brought to the attention of the client agency's project director, and significant activities anticipated for subsequent months.
  - d. Within five (5) working days of the award of the Contract, the Contractor will submit to the Contract Administrator, for final approval, an implementation plan. This final implementation plan must be in agreement with Section IV-C



subsection 2 as proposed by the bidder and accepted by the State for Contract, and must include the following:

- (1) The Contractor's project organizational structure.
- (2) The Contractor's staffing table with names and titles of personnel assigned to the State's account, and expected percentage of their time dedicated to this contract. This must be in agreement with staffing of accepted proposal. Necessary substitutions due to change of employment status and other unforeseen circumstances may only be made with prior approval of the State.
- (3) The project breakdown showing sub-projects, activities and tasks, and resources required and allocated to each.
- (4) The time-phased plan in the form of a graphic display, showing each event, task, and decision point in your implementation plan.

**II-E PRICE PROPOSAL**

All rates quoted in bidder's response to this will be firm for the duration of the Contract. No price changes will be permitted.

**II-F CONTRACT PAYMENT SCHEDULE**

The specific payment schedule for any Contract(s) entered into, as the result of this Contract will be mutually agreed upon by the State and the Contractor(s). The schedule should show due dates for premiums withheld for active employees. As a general policy statements shall be forwarded to the designated representative by the 15th day of the following month.

Vendors must have the capability to accept electronic fund transfers weekly for premium amounts withheld for active employees.

**II-G Bidder's Authorized Expeditor**

**Include the name and telephone number of person(s) in your organization authorized to expedite any proposed Contract with the State.**

Joyce Ruddock, Vice President, is the Authorized Expeditor of contracts for our company. Her address is 57 Greens Farms Road, Westport, CT 06880. Joyce may be reached at (203) 221-3300. Please reference the invitation to bid in the separately sealed price proposal for this information.



QUESTIONNAIRE

1. COMPANY OVERVIEW

**A. Provide a brief history of your organization. Describe the number of years your organization has been in business, the number of years it has been providing LTC benefit services, when you first introduced an employer-sponsored group LTC plan, and the number of covered members in each of the past three years. Indicate how many claimants have filed claims under your entire employer-sponsored group LTC plans combined, showing the number of claims paid, denied, or pending decision.**

MetLife's Long-Term Care Group is differentiated from other long-term care insurance carriers at the corporate level. MetLife is distinguished by its more than 130 years of innovation in products and services, quality customer service, strong leadership, and financial strength. Our history in the field of long-term care insurance is a prime example of the type of innovativeness which is characteristic of MetLife. MetLife consistently receives high ratings from all of the major rating organizations in categories such as claims paying ability, financial strength, and financial size. With total capital and surplus in excess of \$6 billion, MetLife is one of the strongest financial service organizations in the country.

In 1983, MetLife established the Long-Term Care Group, a dedicated unit of professionals and specialists, to design its long-term care insurance program. We offered the nation's first group long-term care insurance plan in 1986, and were the first carrier to use Activities of Daily Living (ADLs) as criteria for benefit eligibility. Changes in social demographics, employer-employee relationships, technology, health care delivery systems, and health care funding have been dramatic over the past decade. Accordingly the long-term care programs offered by MetLife are of significant importance. MetLife's Long-Term Care Group has maintained its position as a market leader by understanding the changing needs of our customers and by developing and enhancing our products to meet those needs. We work in partnership with our customers to provide benefits that their employees and family members will highly value.

For the past three years, the number of insured's covered under MetLife's employer sponsored group long-term care insurance plan is as follows:

| Year | Number of Insured's |
|------|---------------------|
| 2000 | 102,285             |
| 1999 | 116,986             |
| 1998 | 96,735              |



The following is claims information for our employer-sponsored group long-term care plans as of April 30, 2001:

|                                 |        |
|---------------------------------|--------|
| Total number of claimants:      | 1,968  |
| Total number of claims paid:    | 23,425 |
| Total number of claims denied:  | 38*    |
| Total number of claims pending: | 0      |

\*Participants must be approved for benefits (benefit authorized) before they can file a claim. If the insured is not benefit authorized, the insured is not eligible to submit a claim. However, if an insured is benefit authorized and submits a claim for a service that is not covered under his or her plan, the claim is processed as an uncovered service. The above total represents the total number of instances where insured's were declined at the benefit authorization level.

**B. Is LONG-TERM CARE a separate division in your company? Describe the staff (including number of people and experience) that underwrite, develop, and market employer-sponsored group LONG-TERM CARE policies.**

Yes, MetLife's Long-Term Care Group is the fully integrated long-term care insurance unit of the Metropolitan Life Insurance Company. As a division within MetLife's Institutional Department, the Long-Term Care Group is comprised of over 200 dedicated professionals who work on the development, marketing, and administration of long-term care insurance products. Administrative functions such as information systems, underwriting, benefit authorization, and claims were designed specifically for long-term care insurance. MetLife has provided quality service, strong leadership, sound investment strategy, and innovative products and services for 130 years.

**C. How many employer-sponsored group LONG-TERM CARE plans are you currently underwriting? How many employees, spouses, retirees, retiree spouses, parents/parents-in-law are enrolled in these plans? What is your current annual LONG-TERM CARE premium for these plans?**

**As of April 30, 2001 MetLife underwrites 121 employer-sponsored group long-term care plans which insure 123,667 individuals. Please refer to the following table for a breakdown of enrollment by category of enrollees.**



|                                     |         |
|-------------------------------------|---------|
| Employer sponsored plans            | 121     |
| Current total <i>enrolled</i> lives |         |
| Employee                            | 65,712  |
| Spouses                             | 16,723  |
| Parents/In-laws                     | 2,451   |
| Retirees/Spouses                    | 38,781  |
| Total                               | 123,667 |

The total annualized group long-term care insurance premium generated by covered insured's of employer sponsored plans is \$74 million, as of April 30, 2001.

**D. Provide your current standings on the following measures:**

- **A.M. Best rating and financial size category, and history of these over the last 5 years,**
- **Standard and Poor's claims paying ability or qualified solvency rating,**
- **Moody's financial strength,**
- **Fitch claims paying ability (formerly, Duff and Phelps)**

MetLife's most recent financial ratings from A.M. Best over the last 5 years are listed in the chart below. Our current A.M. Best financial size category is XV.

Our Standard and Poors claims paying ability rating is AA. In addition, our Moody's financial strength rating is Aa2, and our current Fitch (formerly Duff and Phelps) claims paying ability rating is AA.

| Year        | A.M. Best Rating |
|-------------|------------------|
| <b>2000</b> | A+ Superior      |
| <b>1999</b> | A+ Superior      |
| <b>1998</b> | A+ Superior      |
| <b>1997</b> | A+ Superior      |
| <b>1996</b> | A+ Superior      |

**E. Describe your company's LONG-TERM CARE philosophy, and approaches to provider contracting, administration, quality control and customer service.**

The cornerstone of MetLife's philosophy is to provide superior service to all of our customers. It is our vision to serve each of our customers as a partner, to be recognized by them as making a valued contribution to their business success, and to deliver quality service that meets their expectations. We achieve this in part by having well trained Long-Term Care Insurance Consultants and the latest state-of-the-art technology. The \$2 million training grant provided to our customer service operation can evidence MetLife's commitment to high quality service. Our recent investment of over \$60M in state-of-the-art customer response center is another example of this commitment.



MetLife aims to ensure the satisfaction of your insured's in all aspects of their interface with us. Our Customer Service Unit is the primary mechanism for delivery of prompt service by a staff of caring employees. Your insured's can expect a high degree of satisfaction when they call for information about the plan or need assistance in accessing their benefits.

Our toll-free number is available to employees and their families prior to enrollment and on an ongoing basis. Our customer service consultants are equipped to answer a wide range of questions about plan features and benefits. In addition, our care managers are available to assist callers with questions about benefits, to address concerns about care management, and to help identify appropriate resources.

MetLife's goal is 100% customer satisfaction. We strive to attain this goal by having well-trained customer service consultants available to answer questions, and by having state-of-the-art technology to support them. For example, we have an automated traffic management center and a forecasting scheduling system to ensure that service levels are met. In addition, all plan information can be accessed on-line through a Windows-based system.

To provide enhanced service to our clients, MetLife's program offers extended hours of operation for our toll-free number; hours are extended on an ongoing basis, not just during the enrollment periods. The hours of operation are:

|                   | EASTERN         | CENTRAL         | MOUNTAIN        | PACIFIC         |
|-------------------|-----------------|-----------------|-----------------|-----------------|
| MONDAY – THURSDAY | 8 AM to 10 PM   | 7 AM to 9 PM    | 6 AM to 8 PM    | 5 AM to 7 PM    |
| FRIDAY            | 8 AM to 9 PM    | 7 AM to 8 PM    | 6 AM to 7 PM    | 5 AM to 6 PM    |
| SATURDAY          | 9 AM to 4:30 PM | 8 AM to 3:30 PM | 7 AM to 2:30 PM | 6 AM to 1:30 PM |

After-hours callers can leave a message in our voice mailbox. All calls are returned by a Long-Term Care Insurance Consultant on the next business day.

MetLife can accommodate callers with special communications needs. We are equipped to answer calls placed through a TDD, a communication device for the hearing impaired. For non-English speaking callers, we use an AT&T service that can translate over 140 different languages.

The Customer Service Unit maintains an active quality assurance program. Call Center Supervisors monitor Customer Service Consultants for quality and accuracy on a daily basis. In addition, a customer satisfaction survey is conducted on a randomly selected sample of callers to assess their satisfaction with the service they received when they called our toll-free line. The replies to date have been overwhelmingly favorable. More than 90% of survey respondents have been satisfied with the overall service we provide. A copy of this survey and its results are included in Part IV of this proposal.

MetLife offers care management as part of its long-term care plan. Our approach to care management encourages insured's to participate in the decisions which affect their lives and seek to foster their self sufficiency for as long as possible. Our "total person" approach incorporates three elements: benefit authorization, onsite voluntary care advisory services,



and elder care resource services. We have also found that collaboration between MetLife's care managers and independent care advisors results in the best plan of care for the insured.

Care managers from MetLife's Long-Term Care Benefit Administration Department conduct benefit authorization and ongoing reviews. Our care managers are registered nurses with experience in both long-term care and acute care nursing. They have experience working in adult day care centers, nursing homes, hospitals, and home care agencies.

Training and quality assurance programs for MetLife's care managers are managed by the manager of MetLife's benefit administration department.

MetLife believes that the first step in properly training care managers is through proper recruitment. We hire registered nurses with experience in fields such as aging, family issues, provider networks, patient referral, adult day care centers, nursing homes, hospitals, and home care agencies. This previous experience provides them with insight into the issues and emotions of our insured's and their families.

Once hired, our care managers undergo a formal classroom training program that includes written, verbal, and video instruction. This instruction includes in-depth information on plan provisions, benefit eligibility, and care management. Our care managers rely on an extensive procedure manual which is introduced and studied throughout this training. Upon completion of the formal training program, one-on-one supervision from an experienced staff member provides new care managers with on-the-job training in actual situations.

On an ongoing basis, weekly staff meetings and outside seminars are used to keep our care managers current on long-term care issues, product changes, and specific case situations.

We currently send a quality assurance survey with every benefit authorization letter. These surveys allow us to monitor our insured's' satisfaction with the benefit authorization process. Results from these surveys have been overwhelmingly positive. Internally we audit 20% of our insured's files for accuracy of the benefit eligibility determination and appropriateness of the care management. Samples of this survey and its results are included in Part IV of this proposal.

We have contracted with LifePlans, a nationwide network of local community-based organizations, which provides on-site long-term care case management services. Each participating agency has a staff of experienced, well-trained professionals who are certified with R.N. or B.S.W. degrees. All receive specialized training in long-term care case management. The staff's training and credentials are guaranteed through contractual agreement by LifePlans. LifePlans currently has more than 800 agencies nationwide. MetLife's contract with LifePlans outlines performance guarantees and quality assurance guidelines. The director of the Long-Term Care Group's Benefit Administration Department, develops and monitors the quality assurance program for LifePlans.



**MetLife has discounts with nursing homes, home care agencies, and durable medical equipment providers nationwide. The discount varies by provider and type of service and will generally be between 5% and 30% of the provider's usual fee. Insured's will be informed of the availability of discounted providers in their area and the fee, but are free to choose any provider. Discounts can be accessed by calling our toll-free telephone line and speaking with our care managers. Provider discounts provide a means to help the insured extend benefit payments under the plan and are available to MetLife insured's on a voluntary basis. The use of participating providers would not affect long-term care policy benefit payments and/or the maximum duration of benefits.**

MetLife currently has over 3,300 providers in our provider discount network. This includes nursing homes, assisted living facilities, home care agencies, durable medical equipment providers, and speech/occupational/physical therapists. The vendor we use for these discounts is HealthCare Synergy's, Inc. Some of the major chains that are part of the network include: Beverly Health and Rehab, Manor HealthCare Systems, Interim Healthcare, Kelly Assisted Living, and Manor Care Health services.

**F. Describe any features of your organization that distinguish it from your competitors, and why the State should consider selecting your organization over other LONG-TERM CARE vendors.**

We believe the following attributes of our organization distinguish MetLife from our competitors and also provide important advantages as a long-term care insurance provider:

OUR COMPANY

MetLife's Long-Term Care Group is differentiated from other long-term care insurance carriers at the corporate level. MetLife is distinguished by its more than 130 years of innovation in products and services, quality customer service, strong leadership, and financial strength. Our history in the field of long-term care insurance is a prime example of the type of innovativeness which is characteristic of MetLife. MetLife consistently receives high ratings from all of the major rating organizations in categories such as claims paying ability, financial strength, and financial size. With total capital and surplus in excess of \$6 billion, MetLife is one of the strongest financial service organizations in the country.

OUR COMMITMENT TO LONG-TERM CARE INSURANCE

In 1983, MetLife established the Long-Term Care Group, a dedicated unit of professionals and specialists, to design its long-term care insurance program. We offered the nation's first group long-term care insurance plan in 1986, and were the first carrier to use Activities of Daily Living (ADLs) as criteria for benefit eligibility. Changes in social demographics, employer-employee relationships, technology, health care delivery systems, and health care funding have been dramatic over the past decade. Accordingly the long-term care programs offered by MetLife are of significant importance. MetLife's Long-Term Care Group has maintained its position as a market leader by understanding the changing needs of our customers and by developing and enhancing our products to meet those needs. We work in partnership with our customers to provide benefits that their employees and family members will highly value.



Our current client base is comprised of some of the nation’s largest and most well known companies. Many have been MetLife clients for other lines of coverage for several decades. The confidence, partnership, and satisfaction built through these relationships has led some employers to enhance their traditional benefits programs with MetLife’s expanding array of voluntary benefits, such as group long-term care insurance. We value these long-standing relationships and are committed to providing all of our clients with superior customer service.

Our successful bid for the business of the American Association of Retired Persons, our award of the National Long-Term Care Coalition, and our entry into the individual marketplace further strengthen our position as a leading carrier of this coverage. MetLife has worked with employers in diverse industries and has offered coverage to more than two million eligible individuals.

COMMITMENT THAT GOES BEYOND JUST OFFERING A PRODUCT

MetLife has further demonstrated its commitment to providing products and services for the mature market with the formation of the Mature Market Group in 1995. This business unit was responsible for the development and distribution of products for the senior market, and for identifying alternative sources of funding for new and existing products being marketed to seniors. An outgrowth of this unit is MetLife’s *Mature Market Institute*. Headed by an experienced gerontologist, Sandra Timmermann, and staffed by dedicated professionals, the goal of the Mature Market Institute is to focus on aging issues and the impact of these issues to employers, their employees, and their family members.

MetLife is constantly focusing our research and development efforts on ways to provide innovative products to the senior marketplace. These efforts were recognized by the American Society on Aging (the foremost gerontological organization in the country) when MetLife was given the *Business of the Year Award* in 1992 and again in 1998. This award recognizes the exemplary policies, programs and/or products designed to meet the needs of older people and their families, expand public sector awareness of private sector involvement with older persons, and provide models for other companies to emulate. *MetLife is the only company with over 1,000 employees to receive this award a second time.*

MetLife is a co-sponsor of the annual Memory Walk to raise money for Alzheimer’s disease each year, and encourages its employees to participate. Employees who are part of the Long-Term Care Group also participate in the AmeriCares HomeFront Program on an annual basis. Home repairs are made for elderly families who are financially and physically unable to do the needed repairs themselves. This program reminds employees of the importance of the long-term care insurance product and of our commitment to the population in need of long-term care. As we continue our volunteer efforts, we will also seek other opportunities to work closely with the population long-term care insurance is targeted to help.

MetLife has commissioned several studies on caregiving and its impact on employers and employees over the past several years. Most recently, in 2001, MetLife published *The MetLife Study of Employed Caregivers: Does Long-Term Care Insurance Make a Difference?* This piece describes the implications associated with dealing with employees that are faced with caregiving responsibilities, and the accommodations that must be made for these workers. The purpose of the study is to comprehend how long-term care insurance



can affect the lives of employed caregivers. In 1999, the Mature Market Institute released *The MetLife Juggling Act Study* which was produced by the National Alliance for Caregiving and the Center for Women and Aging at Brandeis University. It found that working caregivers often must resign from their jobs, give up promotions, and retire early, resulting in a lifetime of lost wages, social security and pensions of more than \$659,000. In 1997, MetLife produced *The MetLife Study of Employer Costs for Working Caregivers*. The study identified and quantified the "hidden" costs to an employer for their employees who have caregiving responsibilities and provided a template so employers could estimate the lost productivity costs within their own companies. The study updated a 1995 analysis which MetLife commissioned, drawing on the expertise of the Washington Business Group on Health. MetLife also co-sponsored a major national caregiver survey in 1997, *Family Caregiving in the U.S.: Findings from a National Survey*. The study, which was produced by the National Alliance for Caregiving and AARP, provided benchmark data and analysis of America's caregivers.

During the past few years, the Mature Market Institute has produced a variety of resources in electronic and print format such as an analysis of Baby Boomers, financial gerontology columns, guidelines for communicating with the mature market, and monthly electronic QuickFacts. The Institute has also sponsored conferences and seminars for human resources professionals on corporate eldercare and family caregiving. These events, publications, and studies have attracted the attention of the media including the *New York Times*, the *Wall Street Journal*, *USA Today*, and ABC-TV's *World News Tonight*, as well as *Employee Benefit News*, *HR Magazine* and others. As the Baby Boomers contemplate retirement and our population ages, the Mature Market Institute plays an increasingly important role in identifying emerging issues, monitoring trends and developing strategies to enable MetLife, its customers, and business partners be better informed about aging, retirement and long-term care.

The initiatives of the MetLife Foundation and the volunteer efforts of our employees also demonstrate MetLife's commitment to the age 50 and over market. The MetLife Foundation Awards for Medical Research recognize those scientists whose work has significantly contributed to the understanding of Alzheimer's Disease. A total of \$7 million has been awarded since the inception of the program.

RATE STABILITY

MetLife is focused on preserving the long-range rate stability of its plans. We periodically use the services of outside actuarial consultants to review the appropriateness of our pricing assumptions and rates. Further, by continually evaluating the financial basis of our plans, we have been able to reduce premiums for five of our customers' plans, by 11% on average, where analyses have shown that our claims experience was better than initially expected.

The State can be assured we will work with them to make certain the plan remains state-of-the-art and competitive as changes take place in the long-term care delivery system and new features are developed. This is demonstrated by enhancements we have made to existing plans. To date we have increased the home care reimbursement level, added assisted living facilities, hospice care, a transition expense benefit, a bed reservation benefit, and a premium waiver to some of our older plans. MetLife has done this on a guaranteed issue basis *for all insured's without increasing premiums*.



OUR PLAN

MetLife’s goal is to offer one set of rates nationwide with minimal plan design variation. Long-term care insurance is a highly regulated product and all 50 states have adopted laws and regulations relating to long-term care insurance. Our approach is to design provisions that will meet the requirements of as many states as possible, thereby reducing the number of state-specific plan variations. This allows us to maintain actuarial equivalence so that there is no impact on premium. This approach also simplifies communications regarding the program and allows for uniform plan design and uniform rates to individuals in all states.

Enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has resulted in more uniformity among state regulations; however, variations continue to center around four key areas: Inflation protection, return of premium on death, exclusion of mental and nervous conditions, and nonforfeiture.

INFLATION PROTECTION FEATURE

MetLife’s inflation protection offer is extended to all insured’s regardless of age, claim status, claim history, or length of participation in the plan as long as the insured has selected the offer once in every two offers. Other carriers may restrict this offer to individuals under age 80 and who have not been benefit eligible in the last six months. MetLife’s approach meets the requirements of all states.

RETURN OF PREMIUM ON DEATH

Not all carriers offer this feature. The return of premium on death feature will return all premiums paid by the insured, up to age 65, to the insured’s estate upon death, less benefits received. The amount will reduce by 20% per year up to age 70. Due to state regulations, this feature is not available to residents of Washington. In order to maintain uniform premium rates, residents of Washington will have a respite services benefit equal to 42 days per calendar year.

NO EXCLUSION FOR MENTAL AND NERVOUS DISORDERS

MetLife covers long-term care services that are required as the result of organic brain diseases, including Alzheimer’s disease and similar disorders. The plan also covers services required as the result of brain diseases, which are not organically based, as long as the insured meets the benefit eligibility criteria. MetLife does not attempt to identify the cause of disability or mental disorder. The presence of many interrelated factors makes it difficult to isolate cause and thus, to administer a plan which excludes mental or nervous disorders.



NONFORFEITURE FEATURE

MetLife’s plan includes a nonforfeiture feature as an option for participants to select.

**Shortened Benefit Period – Benefit Bank**

Insured’s who have paid premiums for at least three years and elect to stop making payments will be entitled to receive some nonforfeiture coverage. The feature provides the full daily benefit with a total lifetime benefit based on the amount of premiums paid. The total lifetime benefit will be at least 30 times the daily benefit. Based on current state and federal requirements, this nonforfeiture feature has the advantage that it can be offered in all 50 states.

VALUE-ADDED PROGRAMS AND SERVICES

MetLife offers the following value-added programs and services at no cost to our customers and their employees. We believe these are unique in the industry:

The *Mature Market Institute* conducts training programs and seminars on elder care issues (e.g., *Managing Employees Who Have Elder Care Issues* and *Caring for Aging Parents*). The Institute’s programs can also be made available to employees who are not enrolled in the long-term care plan.

*Life Advice*<sup>tm</sup> is a series of educational pamphlets about a wide range of life events. MetLife’s Consumer Education Center, in conjunction with nationally recognized experts, has designed the *Life Advice*<sup>tm</sup> pamphlets to help people better understand the issues they are facing, what their choices and opportunities are, and how they can move through these life events as smoothly as possible. These pamphlets are available to you at no cost. This program is the recipient of numerous awards including the Consumers’ Choice Award in 1998 and 1999 for outstanding educational service to the American public.

SIMPLE PROCESSES FOR INSUREDS

We focus on making processes for insured’s as easy as possible. Telephonic requests for coverage changes and benefit eligibility make it easy for insured’s to update their coverage periodically and to access their benefits. Insured’s may also request inflation increases over the telephone without having to fill out any forms.

When individuals need to access their coverage, they can initiate the authorization process by making a phone call to our care managers. A person can be authorized to receive benefits without submitting any written documentation. Once authorized for benefits, the insured only needs to submit a single claim form per provider, as benefits can be assigned. These processes make it easy for the insured and allow us to respond to their requests in a prompt and personal manner.



**2. LEGAL/COMPLIANCE/CONTRACTUAL ISSUES**

**A. Describe the contractual relationship between you and individual insured’s.**

All of the participants in the State’s plan will be issued individual certificates under the State’s group insurance policy. A copy of a sample certificate is included in Part IV of this proposal.

**B. Describe the contractual relationship between you and the State. Itemize all conditions under which you could terminate your contract with the State. Under what conditions could the State terminate the contract with you?**

MetLife will issue the State a group long-term care insurance policy. The State will be the policyholder. All of the participants in the State’s plan will be issued individual certificates under the State’s group insurance policy. A copy of a sample certificate is included in Part IV of this proposal.

**MetLife’s plan is guaranteed renewable. As long as premiums are paid, coverage for existing insured’s cannot be canceled. If the State decides to cancel sponsorship of the plan, coverage will continue for all insured’s who choose to continue their coverage with MetLife.**

MetLife may terminate the group policy if required to do so by law. In this event, MetLife will give the State at least 30 days written notice prior to the date the group policy is to be terminated. The group policy will be considered terminated as of the last day of the calendar month in which the State received this written notice.

MetLife may also terminate the group policy if the State fails to remit premium within the 31 day grace period. In this event, unless otherwise required by law, the group policy will automatically terminate effective the last day of the grace period.

If MetLife terminates the policy for one of the above listed reasons, existing insured’s will continue to be covered under the plan; however, no new enrollees will be accepted.

If it becomes in our best financial interest to do so, MetLife reserves the right to refuse to enroll additional eligibles provided that we provide 90 days advance written notice to the State of our intention to exercise this right.

The State can terminate the contract for any reason. MetLife would require 90 days written notice of intention to terminate.

**C. Itemize any conditions under which you could refuse to accept new State insured’s while continuing to cover existing insured’s.**

MetLife may terminate the group policy if required to do so by law. In this event, MetLife will give the State at least 30 days written notice prior to the date the group policy is to be



terminated. The group policy will be considered terminated as of the last day of the calendar month in which the State received this written notice.

**MetLife may also terminate the group policy if the State fails to remit premium within the 31-day grace period. In this event, unless otherwise required by law, the group policy will automatically terminate effective the last day of the grace period.**

If MetLife terminates the policy for one of the above listed reasons, existing insured's will continue to be covered under the plan; however, no new enrollees will be accepted.

If it becomes in our best financial interest to do so, MetLife reserves the right to refuse to enroll additional eligible provided that we provide 90 days advance written notice to the State of our intention to exercise this right.

MetLife agrees to consult the State prior to making changes to the plan design. However, MetLife reserves the right to make changes necessary to maintain the tax qualified status of the plan or to meet state specific regulations.

**D. Will you offer continued LONG-TERM CARE coverage to individual insured's if the State group LONG-TERM CARE policy is terminated: a) with replacement group LONG-TERM CARE coverage and b) without such replacement coverage? Describe the terms of such continued coverage (e.g. benefits, premiums, individual or group policy) in both circumstances.**

If the entire plan is terminated and another carrier is not selected, coverage will continue for all insured's that choose to continue their coverage with MetLife. However, if the entire plan is terminated and another carrier is selected, MetLife will transfer the long-term care coverage and reserves for the insured's that elect to transfer to another insurance carrier if the following provisions are met:

The State cancels its MetLife policy and contracts with a successor insurance carrier to continue the coverage for enrollees under a guaranteed renewable group long-term care insurance contract with an effective date coincident with the cancellation date of the MetLife policy;

- The successor carrier uses the transferring insured's' original ages at entry for purposes of determining the premiums charged;
- The successor carrier assumes all other contractual guarantees that MetLife made to the State and the transferring insured's;
- The successor carrier agrees to consider the period of time transferring insured's were covered under the MetLife policy when administering the plan and adjudicating the benefits of its policy;
- Where appropriate, the insurance regulatory authorities of the applicable jurisdictions approve the transfers to the successor carrier;
- The successor carrier furnishes MetLife with a hold harmless agreement which releases MetLife from all liabilities associated with the transfer of insurance coverage.



If all of the above provisions were met, MetLife would transfer the appropriate reserves to a successor carrier for all individual insured's transferring from the MetLife plan to the new group plan. We will assess termination charges, limited to that portion of the start-up expenses and ongoing acquisition expenses that we have not amortized, against any reserves transferred. We amortize acquisition costs on a straight-line basis at a rate of 10% per year for ten plan years. Acquisition expenses are those expenses associated with sales, implementation (including communications), enrollment and issue processes. Any transfer of reserves will be subject to a market value adjustment at that time.

MetLife expects to retain any liability for enrollees in claim status or in their waiting period, as well as the associated reserves. However, we might agree to an alternative arrangement if it is equitable to all parties and it maintains the guarantees made to the enrollees at the time of purchase.

MetLife would require 90 days notice of plan termination. MetLife would transfer reserves within three months from the date that we are provided with the appropriate transfer documents and hold harmless agreement, signed by the State and the successor carrier. Interest would be credited on the amount of reserves being transferred for the period between the date of calculation and the date of transfer payment.

**E. Describe the terms of continuing coverage for portable insured's (insured's under the State group contract whose relationship with the State is subsequently terminated). Are portable insured's separately rated?**

MetLife's plan is fully portable. Employees leaving the State who elect portability will pay premiums by direct bill at no additional cost. Coverage for eligible relatives can continue as well. The plan benefits and premiums available to portable insured's will be identical to those extended to the State.

**F. Are there any states or territories in which the State enrollees will need to be offered a modified version of the group plan due to extraterritorial state insurance requirements? If so, please detail. Are there any states in which you will not be able to offer any LONG-TERM CARE plan to the State eligibles?**

**MetLife's plan is available in all 50 states.**

The following describes the features and states where modifications of the State's plan design may be necessary.

**•Assisted Living Facilities**

Due to Kansas state requirements, the nursing home definition includes 100% assisted living coverage for insured's issued coverage in Kansas.



**•Return of Premium on Death**

Due to state regulations, this feature is not available to residents of Washington. In order to maintain uniform premium rates, residents of Washington will have a respite services benefit equal to 42 days per calendar year.

**G. Is the plan you are proposing for the State a “qualified” LTC contract under the Health Insurance Portability and Accountability Act of 1996?**

Yes. The plan we are proposing is intended to be a Qualified Long-Term Care Insurance Contract in accordance with the Health Insurance Portability and Accountability Act of 1996.

**3. ACCOUNT SERVICING**

**A. What office do you propose to use to service the State’s LTC plan? From which of your office(s) will claims be paid?**

Our Long-Term Care Group in Westport, Connecticut will service the State's Long-Term Care plan as well as handle the payment of claims for the State's LTC plan.

**B. Concisely describe, in two paragraphs or less each, the services you will provide in the following areas:**

**i. State staff training on benefits and administration of the LTC plan.**

Our training programs are designed to meet the needs of the State, and is tailored depending on the level of involvement you want your staff to have. Our training programs are designed to educate your benefits staff on long-term care issues in general and on the detailed provisions of the plan. This training will cover the following topics:

- General information about long-term care, as well as information about the types of services that are covered by Medicare, employer medical plans and other forms of insurance, and how these benefits differ from long-term care insurance.
- Specific details of the plan.
- Administrative procedures for enrollment.
- How to assist employees in selecting appropriate options.
- Commonly asked questions and answers.

**ii. Eligibility at initial enrollment.**

MetLife can accept employees into the plan without evidence of insurability during the initial enrollment period, provided they are actively at work on the effective date of the plan. In addition, newly hired employees will be accepted without evidence of insurability, provided they are actively at work on their effective date and they enroll within 90 days of hire. Coverage for employees who are not actively at work on their effective date will become effective on the first of the month following their return to work (provided they are actively at work on that date).



Underwriting will be required for all other eligible participants. MetLife's underwriting was expressly designed to be non-intrusive, yet comprehensive enough to obtain the information necessary to help maintain the long-term stability of the plan.

**iii. The initial and ongoing enrollment process.**

Individuals can enroll in the plan at any time after the initial enrollment period. Guaranteed issue coverage is only available to employees during the initial enrollment period or when he/she is first eligible and new hires who are actively at work on their effective date and enroll within 90 days of hire. Therefore, after the initial enrollment period employees are required to submit a health statement. The underwriting process for all other eligibles is the same as for initial enrollment.

MetLife is committed to fully supporting the initial and ongoing enrollment process. We are prepared to develop all of the communications materials and to handle the enrollment.

**iv. Ongoing eligibility verification, including your procedures to resolve missing payroll deductions for employees who do not have paychecks for any given month (e.g., on unpaid leave, termination of employment, etc.).**

The suggested procedure for the exchange of information with the State is as follows:

1. The State sends MetLife a file of eligibility changes during the first week of each month.
2. MetLife sends the State a premium deduction file to update amounts due per pay period. the State updates its long-term care payroll deduction file and takes deductions from each paycheck.
3. The State sends MetLife a file of deductions taken on a per pay period basis, and remits total premiums due by check or EFT.

Timing may vary depending on the State's payroll processing cycles. Much of the exchange of data between MetLife and the State will take place through the payroll interface. We recommend that the interface for these files be electronic. The payroll record layout includes a field for employee status. Based upon the changes to this filed (i.e., termination, unpaid leave, etc.), MetLife will transfer the employee to direct bill. MetLife has responsibility for all reconciliation.

If an incorrect payroll amount is reported, MetLife will contact the State to obtain the correct payroll amount. The corrected amount will be reflected in the following premium deduction update file. MetLife has responsibility for the reconciliation. The premium file received from the State contains a trailer with a record of total premiums deducted from individuals. A check for this amount is remitted by the State. If there is a discrepancy between the amount received and the total deducted, MetLife will request a breakdown by individual employee. If the check is for a larger amount than that deducted, MetLife will send a refund. If deductions have been missed, the premium owed will be re-spread over future pay periods.



MetLife's payroll deduction billing system specifications are located in Part IV of this proposal.

**v. Mailing and distribution of enrollment materials to the initial group of active and retired eligibles, plus supplies to each major State location.**

MetLife will work with the State to determine the best approach for distribution of communications materials. MetLife agrees to mail materials directly to employees' and retirees' homes if the company supplies MetLife with address information. There is no additional cost for this method. MetLife can also provide the State with new hire information which outlines the steps new hires should take to receive an enrollment package.

We typically mail retiree materials to their homes. Parents are reached through employees. Parents can request enrollment information by using the business reply card we include in the employee enrollment package, or by calling our toll-free number. The material is usually mailed to the employee or directly to the parent. In addition, all eligible individuals may use our toll-free number to obtain additional information.

If the State has other preferences regarding distribution of communications materials, we would be pleased to discuss alternative methods.

**vi. Mailing and distribution of enrollment materials to ongoing new hires, plus an annual supply to each major State location.**

Please refer to item v above.

**vii. Mailing communication materials to pension recipients, parents and parents-in-law.**

Please refer to item v above.

**viii. Preparation and reconciliation of the State premium statements, including participant information required from the State at the time of payroll deduction premium remittance.**

MetLife sends the State a premium deduction file for amounts due per pay period. If an incorrect payroll amount is reported, MetLife will contact the State to obtain the correct amount. Depending on the information obtained, MetLife will respond appropriately, via the next premium deduction update file. MetLife has responsibility for the reconciliation.

**ix. Premium waiver administration.**

MetLife's plan includes a premium waiver provision. Premium payments are waived on the first of the month coincident with or following the date the insured fulfills the waiting period and is chronically ill. Premium payments resume on the first of the month after the insured is no longer eligible for benefits.



During the benefit authorization process, our care managers discuss the waiver of premium provision with the insured. Once an insured fulfills the waiting period, our billing department sends a letter to the insured outlining the premium waiver and includes a refund of any overpaid premiums. When our billing department receives notification that an insured is in premium waiver, they change the status code for the insured on the remittance file. When premium payments resume, MetLife will again change the status code for that insured to notify the employer to resume payroll deductions.

**x. Direct billing of each of the following: terminated employees and their spouses, divorced and widowed spouses, employees on leave, annuitants and their spouses, parents and parents-in-law.**

Payroll deduction is required for active employees and their spouses. MetLife offers several direct billing options which are available to all other classes of eligibles. We offer the convenience of monthly automatic checking account deduction (ACAD). We can also provide direct billing on a quarterly, semiannual, or annual basis. There is no additional charge to the insured or the State for direct paper billing or electronic funds transfer (EFT).

All information for direct billing is obtained from the enrollment form. MetLife maintains premium remittance records for direct-billed insured's; the State will not have any record keeping responsibilities.

**xi. Applicant notification on the underwriting decision.**

The average turnaround time for processing applications varies with each eligible class. Applications for employees who are underwritten and spouses are typically processed within five to nine business days of receipt of all necessary information. Applications for parents and retirees are typically processed within 10 to 15 business days of receipt of all necessary information. Applications for individuals over age 80, on average, are processed between 20 and 30 business days of receipt of all necessary information.

**xii. Routine administrative support, including attendance at meetings with the State as needed.**

Our account management team will be available to provide the State administrative support, including attendance at meetings during the implementation period, and on an "as needed" basis thereafter. All enrollment activities and ongoing administration will be performed by MetLife, at virtually no cost to the State. Typically, meetings are held for locations with 500 or more employees.

**xiii. Support for future enrollment periods (if any).**

MetLife is committed to working with the State to support future enrollment periods. We suggest newsletters, short brochures, and integration of long-term care information with other benefit materials for reenrollment communications. It is our philosophy that continuous communication about the benefit is critical to the success of the plan. MetLife will create these materials or provide text for the State produced communications. As a component of MetLife's communications campaign, we have postcards that can be sent periodically to eligible employees and retirees to remind them of this benefit offering.



**C. How often would you bill enrollees not paying through premium deduction? Are additional charges levied based on the frequency of billing? Confirm that there will be no additional costs to participants on direct billing? Is Electronic Fund Transfer available for payment of premiums?**

MetLife offers several direct billing options, which are available to all classes of eligibles other than employees and spouses. Employees and spouses will remit premium payments by payroll deduction. We offer the convenience of monthly automatic checking account deduction (ACAD). We can also provide direct billing on a quarterly, semiannual, or annual basis. There is no additional charge to the insured or the State for direct billing.

All information for direct billing is obtained from the enrollment form. MetLife maintains premium remittance records for direct-billed insured's; the State will not have any record keeping responsibilities.

**D. What is the grace period for direct billing before reminders are issued? Before coverage is canceled? What is the reinstatement period if the payment is late? Is evidence of insurability required for reinstatement?**

MetLife provides several opportunities for insured's to remit unpaid premium before their coverage is canceled. Insured's are granted a 31-day grace period beyond the premium due date.

Towards the end of the grace period, the insured is sent a reminder notice. If payment is not received by the 65th day, a notice of cancellation is sent. The notice states that the insured has 12 months to apply for reinstatement in the plan at the same rate they were paying when they stopped paying premium. In addition to paying all back premiums due, they will be required to provide evidence of good health.

MetLife's reinstatement procedures have been designed to meet the requirements of HIPAA.

Those who can prove that at the time of lapse failure to pay premium was due to loss of functional capacity or cognitive impairment may be reinstated within five months without providing evidence of insurability. They will, however, be required to pay back premiums.

Insured's over age 70 who have been in the plan for at least two years will be contacted by a customer service consultant by telephone prior to cancellation. If the insured cannot be reached, the customer service consultant will call an alternate contact if the insured designated one on the enrollment form.



**4. IMPLEMENTATION AND COMMUNICATION**

- A. The State expects the vendor to recommend, implement and execute an effective and comprehensive education and promotion program to State employees and pension recipients, particularly during the initial period from July 1, 2001 through January 1, 2002. Describe the core elements and schedule of your communication strategy for the type of plan the State will offer. How will the media and the process differ for different audiences (e.g., employees, pension recipients, spouses, parents, etc.)? What is your experience with communication efforts focused or targeted at particular subgroups in the population, based on job status, age, income, etc.? (Recognize that in these efforts, the State will provide support, such as review of proposed communications items, inclusion of approved items in State newsletters and/or websites, access to worksites for promotional meetings and material, electronic lists of employees and pension recipients, etc.)**

One of the key components of MetLife’s implementation process is the communications program. Focused on educating employees, MetLife’s program is designed to engender appreciation among employees for the opportunity to purchase the benefit at group rates, to maximize participation, and to help participants make appropriate choices to increase the likelihood of retention of coverage over time.

Unlike other benefits offered through employers, long-term care insurance is a relatively new product with unique features that meets an unrecognized need. Therefore, the focus on education is an extremely important element in the communications program.

MetLife devotes considerable resources to identifying the distinct needs of employees and retirees. Recently, we completed a market research study with the Roper Starch research organization on the financial and insurance needs and preferences of employees and retirees. Our findings indicate that an employee’s need for insurance products such as long-term care, as well as his or her preference about communications and enrollment, can vary significantly based on a variety of factors such as the recent occurrence of life events and demographic characteristics. We strive to enhance participation by providing access to plan and enrollment information through a variety of mediums; by providing easy and convenient enrollment procedures; and by offering to customize campaigns for individual companies. On an ongoing basis, we track and analyze participation to support our marketing strategies.

Our communications and enrollment approach is built on four fundamental skill sets:

Product Experience

MetLife will draw on its extensive experience in long-term care insurance and the mature market to provide the State with a comprehensive communications program using the highest standards of quality and professionalism. With a 31% market share measured by enforce premium, we are a leading carrier in the employer sponsored group long-term care insurance market (IBIS Associates, 2001). We have maintained our position as an industry leader by understanding and anticipating the changing needs of our customers. MetLife has worked with employers in diverse industries and has offered coverage to more than two million eligible employees, spouses, retirees, parents, and parents-in-law. As the long-term care



insurance carrier for the American Association of Retired Persons, we cover over 90,000 members.

Communications and Enrollment Expertise

MetLife has built a team that has a proven track record in the processes of communications and enrollment. Marketing team members have strong expertise in these areas: Strategic planning; modeling and segmentation; communications; product packaging; consumer acquisition/retention; partnership/ affinity programs; and life event program development. The team has extensive experience in a variety of distribution channels: Direct mail, telephone, intranet, Internet, face-to-face meetings, and event marketing.

MetLife has experience with target marketing subgroups of the population, particularly with the AARP offering. We would be pleased to share the results with the State. We would welcome the opportunity to target market the State’s eligible population.

Database Technologies

MetLife’s Employee Marketing Database significantly enhances our ability to plan, implement, and analyze the results of our long-term care communications and enrollment campaigns. The database provides a single repository for all relevant information on employees. It is integrated with a state-of-the-art decision support system that allows our marketing managers to interface directly with the data to profile and analyze employee groups; plan and implement effective marketing campaigns; track and analyze results; and fine-tune our strategies.

Flexible Enrollment Options

One key to a successful enrollment is to make it easy, convenient, and attractive for employees to access information. Furthermore, we make it possible for eligible participants to access that information through the channels with which they feel most comfortable. MetLife has built both capability and flexibility into its portfolio of delivery channels. They include the following abilities:

*Access to Plan and Enrollment Information Through a Variety of Mediums.* To satisfy consumer preferences with respect to accessing plan information, we can provide information through several core mediums: Print materials mailed to the home and distributed at the worksite, our toll-free line, a website, enrollment meetings, and benefits fairs.

*Easy and Convenient Enrollment Procedures.* We can offer several different easy and convenient ways to enroll in the plan: Over the telephone, through our website, through the mail, in-person at enrollment meetings and benefit fairs.

*Telephonic Enrollment.* MetLife can provide telephonic enrollment for guaranteed issue employees through our toll-free customer service line. Employees calling our toll-free number can obtain answers to questions and enroll in the plan in one telephone call. In this way, a customer service consultant can assist the individual with plan option selections. Due to our strong belief in a needs based approach to enrollment, our consultative customer representatives will provide an empathetic assessment of a caller’s needs and provide guidance as the caller selects appropriate plan design options and coverage amounts.



INITIAL ENROLLMENT COMMUNICATIONS

Initial enrollment communications vehicles can incorporate print material, electronic, and personal interaction. The communications team assigned to the State will work with you to design a customized communications program. To maximize participation, we will research, analyze, and develop strategies that are consistent with your corporate culture and the methods used to communicate other company-sponsored benefits. Our approach focuses on making it easy for the applicant to understand the program and to select a coverage option. Each eligible will receive an announcement mailing and have the ability to request an enrollment kit through the mail or to go to the website. Below are samples of communications vehicles which could be used for the State:

Awareness

**Newsletter Articles**

Inserting newsletter articles in an employer's existing publications over a three-to-four month period as a supplement to the enrollment communication has proven very effective. These articles provide educational information about long-term care and explain why long-term care insurance is being offered. These articles may also be distributed using voice mail.

**Electronic Messages**

Utilizing a company's e-mail system to announce the benefit and remind individuals to enroll, is an effective means to create awareness for the program.

**Posters**

Posters are available to generate increased awareness. These items can be used to introduce the benefit and announce meetings and/or dates of the enrollment period.

**Website**

Our website can be designed to provide plan information only or to also enable employees who are eligible for guaranteed issue coverage to enroll.

Enrollment

**Enrollment Package**

Our enrollment package includes a brochure, personalized plan quote, and enrollment forms.

**Meetings**

Meetings can be very effective for stimulating awareness and increasing participation for employees and retirees. We have seen a correlation between high attendance at enrollment meetings and high participation in the plan. If the State had a positive experience with these types of informational meetings in the past, then MetLife would be happy to conduct or assist the State with these meetings. Typically, meetings are held for locations with 500 or more employees.

Reminder



This communication emphasizes the importance of enrolling during the initial enrollment period and reminds employees that the enrollment period is limited to a specific timeframe.

ONGOING COMMUNICATIONS WITH ENROLLEES

Ongoing communications with enrollees are designed to remind insured's of the value of their insurance during the many years they will be paying premium before they actually use the benefit. Ongoing communications emphasize education on an array of long-term care issues, financial planning, and healthy living.

To ensure that our ongoing communications provide valuable information to insured's, we solicit feedback from them to gauge their level of satisfaction and to learn what topics interest them. We use this feedback to modify our ongoing communications.

Our ongoing communications program incorporates a variety of materials. Following is a sample of the materials we currently use.

- Free educational brochures are available to insured's who request them. MetLife's exclusive Life Advice<sup>tm</sup> series of brochures focuses on life events such as getting married, buying a home, caring for your aging parents, and selecting nursing homes.
- A book on caregiving is offered at a discount to insured's that choose to purchase it.

COMMUNICATIONS WITH INSURED'S IN BENEFIT

When an insured becomes benefit-eligible, he or she requires very specific information and emotional support. We have found that verbal communication between MetLife's care managers and the insured and his or her family is the best way to meet the insured's needs. Our care managers are available to talk with the insured or the family, and to assist with making decisions about appropriate care and services.

REENROLLMENT COMMUNICATIONS

MetLife also has extensive experience with reenrollments. To increase participation in the program, MetLife is committed to supporting reenrollment efforts. MetLife analyzes initial enrollment results to gather data that will help maximize participation in future enrollments. To help ensure the effectiveness of our program, we use state-of-the-art database marketing techniques to refine our target marketing strategies and communications messaging. Using this technique, we have experienced a 20% and 30% increase in enrollment for two of our groups for two consecutive years, and a 65% increase in enrollment for another group.

**We have received feedback that MetLife is more successful than any other carrier in terms of retiree enrollment and reenrollment. In one case, we have maintained the retiree participation rate at over 10% for nine years. We currently have over 30,000 retirees insured under our group long-term care insurance programs.**



**B. Are your current communication materials and procedures in compliance with the requirements of the NAIC Model Regulations? If not, describe your schedule for modifying your communication materials to come into compliance with these Model Regulations.**

Yes, MetLife's current communication materials and procedures are in compliance with the requirements of the NAIC Model Regulations.

**C. Are your current communication materials and procedures in compliance with current Michigan Insurance Code requirements, which call for such specific items as a Summary of Coverage, a Shopper's Guide, and disclosure to an insured who may be replacing a previously purchased policy with a new one, with these items following formats specified in the Code? If not, describe your schedule for modifying your communication materials to come into compliance.**

Yes. MetLife's current communications materials and procedures are in compliance with current Michigan Insurance Code requirements.

**D. Recognizing that there may be limits on the resources available, describe the support from the State that you will need in the enrollment process.**

The State can count on us to handle all aspects of the program including communications, implementation, ongoing customer service, and administration. All of the services described below are provided by MetLife at no additional cost.

**E. If the plan is changed in the future, will you be responsible for communicating all plan and premium rate changes? Do you agree to allow the State to review all communication materials before these are mailed to State enrollees?**

Yes. If the plan is changed in the future, MetLife will be fully responsible for communicating all plan and premium changes to insured's. We would utilize company publications to make general announcements, as well as send personalized letters to insured's indicating the changes.

**MetLife agrees to allow the State to review all communication materials before they are mailed to the State enrollees.**



**F. Describe the implementation process and provide a detailed timetable for a July 1, 2001 implementation. Be specific with regard to the following:**

- **Timing of significant tasks**
- **Names and titles of key implementation staff**
- **Responsibilities of the State**
- **Length of time implementation team will be responsible for servicing the State**
- **Staff assigned to attend open enrollment/educational sessions at all State locations**

A detailed implementation schedule is located in Part IV of this proposal. The account team will work with the State during the implementation and on an ongoing basis.

Gina Hester is an Account Manager in MetLife's Long-Term Care Group as well as the primary account service representative for the State's account. In this capacity, she will have direct responsibility for implementation planning, communications development, and enrollment strategy. In addition, she will be responsible for the overall project management to ensure MetLife's resources are coordinated to meet your needs. After the implementation of the plan, Maureen will monitor the plan's performance, provide you with regular reports on the activity, recommend strategies to improve participation and service levels as appropriate, and keep you apprised of industry trends and regulatory activities. Additionally, she will work with you, your business partners, and internal MetLife units to assure the plan benefits keep pace with the evolving long-term care service delivery systems and that the plan maintains regulatory compliance.

Gina will have overall responsibility for the State's long-term care insurance program. Gina and the MetLife team will coordinate implementation efforts to meet your expectations regarding delivery of this program.

Elizabeth McAndrews, a long-term care account specialist, will work closely with Gina on the administrative responsibilities. She is responsible for servicing MetLife group long-term care insurance customers. In this capacity, Liz is responsible for analyzing and responding to inquiries from MetLife group customers, consultants, brokers, and other units within MetLife on matters involving group long-term care insured's. She works closely with the account manager on the implementation and installation of new group customers. Liz is the key contact with our call center on plan questions and escalated customer issues.

In order to provide the State with a superior level of service, our dedicated National Accounts Organization will coordinate all of the components necessary for a successful employee benefits program. From transition and implementation, to ongoing administration and service our National Accounts Organization, working in conjunction with the experts in the Long-Term Care Group, will guide the State through the entire process.

In an effort to consistently communicate our long-term care programs effectively, accurately, and professionally, MetLife has developed a dedicated long-term care enrollment team. Candidates for this team of duly licensed individuals are carefully screened by both the manager of the enrollment team and MetLife's long-term care product management team before being selected to participate in an intensive five day training program. Training includes a detailed look at the current long-term care market and how long-term care coverage can fill a void that often exists in many financial planning portfolios.



In addition, detailed instructions are provided on the features of the MetLife long-term care product design. (Training is supplemented by case-specific training on a case-by-case basis.)

Homework is assigned and daily testing is done throughout the training period to monitor each participant’s progress. Upon successful completion of the training course and demonstration of exceptional presentation skills, team members are contracted to provide on-site support when needed for MetLife’s long-term care clients across the country.

Team members are required to participate in “refresher” training via teleconference on a monthly basis. Each monthly session includes special modules on industry-related topics pertaining to the long-term care market.

The majority of MetLife’s dedicated long-term care enrollment team is comprised of MetLife retirees. Our retirees have proven to be an excellent long-term care enrollment resource due to their professional backgrounds, maturity, availability, and experience in working with all levels of employees in diverse industries.

MetLife's dedicated long-term care enrollment team's compensation is not based on commissions. The cost for on-site enrollment services is included in the premiums presented in this proposal.

**G. What data will you need from the State, and within what time frame, to effect implementation? Please describe your minimum data requirements and preferred data reporting format, describing any options for communicating this information between the State and your organization.**

A detailed implementation schedule is located in Part IV of this proposal. The implementation schedule provides an outline of the State's role in the implementation process. Our data requirements are described in detail in the sample eligibility file layout, sample bill file layout and sample confirmation file layout; samples of these three layouts are included in Part IV of this proposal.

MetLife has extensive experience interfacing with a variety of payroll systems and has interacted with over 600 customers to implement and administer payroll deductions. Based upon this experience we are confident in our ability to interface with any system. We have further designed our file layout with a large amount of flexibility to match the requirements of any payroll or benefits system. Our primary objective is to accommodate the State and to provide the highest level of service.



We have successfully interacted with a variety of payroll systems including:

|                   |              |                     |
|-------------------|--------------|---------------------|
| ADP               | Ceridian     | Computer Associates |
| Cyborg            | Data-tell    | Deltek              |
| Dunn & Bradstreet | First Data   | Genesys             |
| Innovative        | D Edwards    | Kean Hither         |
| Lawson            | MAPICS       | Meditech            |
| MSA Payroll       | PeopleSoft   | Pro Business        |
| Software 2,000    | State System | Tesseract           |
| Unisys            |              |                     |

**H. To what extent are you willing to tailor enrollment forms, claim forms, videos, Internet/Intranet sites, etc. to meet any special needs of the State? Is there is an additional cost for this? (Do not indicate the cost for this, outside of the Price Proposal section in IV-G)**

To maximize participation, we will research, analyze, and develop strategies that are consistent with your corporate culture and the methods used to communicate other company-sponsored benefits. MetLife will customize communications materials with the State's name, company logo, plan design, and rates.

**State regulations provide strict guidelines for our printed communications materials including enrollment forms, and as such are filed with the State Department of Insurance as advertising materials. Because our advertising is highly regulated in many states, there is limited variability.**

**I. Please provide samples for any LTC enrollee newsletters, personal financial model worksheets or tools, existing or sample internet/intranet sites, etc.**

Samples are provided in Part IV of this proposal.

**J. Describe any ongoing communications for existing employees, new hires, and family members you can provide after the initial open enrollment.**

Ongoing communications include: Lead generator brochures, reminder postcards, and new hire brochures. Please refer to question A above for a detailed explanation of MetLife's communications program. Samples are included in Part IV of this proposal.



**5. ENROLLMENT AND UNDERWRITING**

- A. What is the average participation rate in employer-sponsored group LTC plans you now underwrite? (Express the participation rate as all insured’s for the group divided by total eligible employees and pension recipients.) What is the range of participation rates in your current employer-sponsored group LTC plans? What participation rate do you anticipate for the State’s LTC plan?**

Our average participation rate, as a percentage of total eligibles, is 5.4%. The level of participation in our plans varies and is impacted by many factors. We have had enrollment results as high as 21% for some of our clients. Based on our experience, we expect approximately 5% to 8% of the State’s active employees to enroll.

- B. State examples of three LTC groups which you have enrolled that experience different enrollment patterns. Discuss why these enrollments were successful or unsuccessful.**

One key to a successful enrollment is to make it easy, convenient, and attractive for employees to access information. Furthermore, we make it possible for eligible participants to access that information through the channels with which they feel most comfortable. MetLife has built both capability and flexibility into its portfolio of delivery channels. They include the following abilities:

*Access to Plan and Enrollment Information Through a Variety of Mediums.* To satisfy consumer preferences with respect to accessing plan information, we can provide information through several core mediums: Print materials mailed to the home and distributed at the worksite, our toll-free line, a website, enrollment meetings, and benefits fairs.

*Easy and Convenient Enrollment Procedures.* We can offer several different easy and convenient ways to enroll in the plan: Over the telephone, through our website, through the mail, in-person at enrollment meetings and benefit fairs.

*Telephonic Enrollment.* MetLife can provide telephonic enrollment for guaranteed issue employees through our toll-free customer service line. Employees calling our toll-free number can obtain answers to questions and enroll in the plan in one telephone call. In this way, a customer service consultant can assist the individual with plan option selections. Due to our strong belief in a needs based approach to enrollment, our consultative customer representatives will provide an empathetic assessment of a caller’s needs and provide guidance as the caller selects appropriate plan design options and coverage amounts.

One of MetLife’s most successful enrollment campaigns was resulted in 15% participation for employees. This high participation level was due to several factors, including favorable demographics, high enrollment meeting participation, and affinity to employer. In addition, the employer was supportive and enthusiastic about this important coverage.



Another successful enrollment campaign resulted in 20% participation for our target market and an overall rate of 10%. In addition to the factors mentioned above, the high participation level was due to a simple plan design, low cost, and the effectiveness of our communications materials.

Another employer group's participation rate was lower than anticipated. We presume this was because many of the employees were young (under age 35), and had not yet begun to give thought to issues associated with estate and/or retirement planning. In addition, many employees may not have realized their future health care needs if they have not experienced the need for long-term care for their parents.

**C. Describe your application and underwriting process.**

MetLife can accept employees into the plan without evidence of insurability during the initial enrollment period, provided they are actively at work on the effective date of the plan. In addition, newly hired employees will be accepted without evidence of insurability, provided they are actively at work on their effective date and they enroll within 90 days of hire. Coverage for employees who are not actively at work on their effective date will become effective on the first of the month following their return to work (provided they are actively at work on that date).

Underwriting will be required for all other eligible participants. MetLife's underwriting was expressly designed to be non-intrusive, yet comprehensive enough to obtain the information necessary to help maintain the long-term stability of the plan.

To minimize effort for the applicant, he or she completes a self-administered enrollment form which clearly defines excludable conditions on the first page. In most cases, underwriting for spouses of employees and employees who do not enroll when initially offered coverage will be completed after the form has been evaluated by a nurse reviewer; no further contact will be required. In certain circumstances, the nurse reviewer may need to contact the applicant by telephone to complete the underwriting.

More extensive underwriting will be required for retirees and parents, where the risks of needing long-term care are higher. This process begins with the MetLife nurse reviewer's assessment of the health history submitted on the self-administered enrollment form. The nurse reviewer then conducts a brief telephone interview to clarify the medical information on the form and to administer a short mental status exam.

For applicants age 80 and over, in addition to submitting an application, medical records are requested from their personal physician and an in-home interview with a registered nurse is conducted.

MetLife's acceptance rates for each type of applicant are among the highest in the group long-term care insurance industry. For employees who are underwritten, our acceptance rate is 99%, for spouses it is more than 95%, and for retirees/parents it is 81%. We anticipate similar underwriting acceptance rates for the State.



MetLife's nurse reviewers make all underwriting decisions. They have extensive experience in the field of gerontological nursing in various settings: Acute care, home care, nursing home care, and community-based services.

**D. Provide additional detail for persons not guaranteed issuance of coverage. (Please complete the following table and provide procedural descriptions.)**

| Service             | When do you also need?  | At whose expense?<br>(carrier vs. applicant) |
|---------------------|---|--|
| Application         | Always for all eligible participants                          | MetLife                                      |
| Medical Record      | Only if we can't make a decision based on the enrollment form | MetLife                                      |
| Physician Statement | Only if we can't make a decision based on the enrollment form | MetLife                                      |
| Medical Examination | May be necessary for individuals over age 80                  | MetLife                                      |
| Telephone Interview | Retirees and spouses;<br>employee spouses if necessary        | MetLife                                      |

**E. Describe your underwriting criteria in detail. For which conditions do you always deny coverage? On what basis do you deny or approve coverage? What are your criteria for mental health conditions? Can denied applications appeal the underwriting decision or reapply at a later time?**

Our underwriting philosophy is to provide coverage to as many applicants as possible and still protect the integrity of the risk pool. MetLife's underwriting criteria are designed to assess the risk posed by medical conditions as they relate to the need for long-term care services. The following are conditions listed as automatic exclusions which render applicants ineligible for the long-term care insurance plan:

- Alzheimer's disease
- Dementia
- Parkinson's disease
- Multiple Sclerosis (MS)
- Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
- Muscular Dystrophy
- Stroke or any other type of cerebral vascular accident (CVA)
- Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC), or AIDS Related Conditions
- Cancer with metastasis or cancer treated in the past 24 months with chemotherapy, radiation, or surgery (except basal cell cancer)
- Organ transplant, past or planned/bone marrow transplant, or reinfusion
- Presently residing in a nursing home or assisted living facility or receiving home health care services



Since we would not offer coverage in these situations, we consider self-exclusion to be the most customer sensitive approach to underwriting.

Individuals with multiple medical conditions are assessed on a case-by-case basis by a care manager. Consideration is given to factors such as the stability and current functionality of the applicant, duration of illness, symptomatology and current treatment, age and lifestyle of the applicant, and risk for progression of disease processes.

For example, a person who has experienced a heart attack, continues to smoke and is overweight represents a much higher risk than someone who has controlled hypertension, has had heart bypass surgery, is asymptomatic, and is following a regular exercise program.

Similarly, the diabetic who has stable blood sugars, no complications, and regular medical follow up is less of a risk than the diabetic who has a long history of unstable laboratory values and has difficulty ambulating due to circulatory problems related to diabetic complications.

MetLife covers disabilities resulting from organic brain diseases, including Alzheimer's disease and similar disorders. The plan also covers dependencies resulting from brain diseases, which are not organically based, as long as the insured meets the benefit eligibility criteria. MetLife does not attempt to identify the cause of disability or mental disorder. The presence of many interrelated factors makes it difficult to isolate cause and thus, to administer a plan which excludes mental or nervous disorders.

The appeal process for underwriting denials is carried out between MetLife and the applicant. Our appeal procedures are described below.

MetLife sends a declination letter to every applicant who is denied coverage. This letter explains the appeals process and includes a declination inquiry form, which is used to activate the following process:

- The applicant completes the declination inquiry form, specifying the name of the physician to whom MetLife should forward the reasons for declination. If the applicant has more than one attending physician, he or she can indicate this on the form as well. Medical reports from other attending physicians can provide relevant information concerning the applicant's medical background;
- Upon receipt of the completed declination inquiry form, a nurse reviewer reviews the file and reasons for declination. The nurse reviewer sends a written explanation of the reasons for the declination, along with an appeal form, to the physician designated by the applicant. MetLife then notifies the applicant that the explanation and the appeal form have been sent to his or her physician;
- The physician is instructed to complete the appeal form if the declination was based on incorrect information or if the physician has additional information which might alter the final decision;



- Upon receipt of the appeal form, the applicant's file is reviewed at a higher level;
- The applicant and the physician are mailed a determination letter notifying them of MetLife's final decision within 10 business days.

Individuals who were previously denied coverage may reapply at any time.

**F. For your typical group LTC plan, what percentage of applicants to whom medical underwriting requirements apply do you deny coverage? If available, please give data by age group and/or family status? Do you expect the percentage of denials for the State to differ? If so, why?**

MetLife's acceptance rates for each type of applicant are among the highest in the group long-term care insurance industry. For employees who are underwritten, our acceptance rate is 99%, for spouses it is more than 95%, and for parents and retirees it is 81%. We anticipate similar underwriting rates for the State.

**G. Are there different enrollment application forms for spouses of active employees than for pension recipients or parents?**

No, enrollment application forms are the same for spouses and parents of actives and pension recipients.

MetLife can accept employees into the plan without evidence of insurability during the initial enrollment period, provided they are actively at work on the effective date of the plan. In addition, newly hired employees will be accepted without evidence of insurability, provided they are actively at work on their effective date and they enroll within 90 days of hire. Coverage for employees who are not actively at work on their effective date will become effective on the first of the month following their return to work (provided they are actively at work on that date).

Underwriting will be required for all other eligible participants. MetLife's underwriting was expressly designed to be non-intrusive, yet comprehensive enough to obtain the information necessary to help maintain the long-term stability of the plan.

To minimize effort for the applicant, he or she completes a self-administered enrollment form which clearly defines excludable conditions on the first page. In most cases, underwriting for spouses of employees and employees who do not enroll when initially offered coverage will be completed after the form has been evaluated by a nurse reviewer; no further contact will be required. In certain circumstances, the nurse reviewer may need to contact the applicant by telephone to complete the underwriting.

More extensive underwriting will be required for retirees and parents, where the risks of needing long-term care are higher. This process begins with the MetLife nurse reviewer's assessment of the health history submitted on the self-administered enrollment form. The nurse reviewer then conducts a brief telephone interview to clarify the medical information on the form and to administer a short mental status exam.



For applicants age 80 and over, in addition to submitting an application, medical records are requested from their personal physician and an in-home interview with a registered nurse is conducted.

**H. Is there a long medical questionnaire that is sent after a short form if responses on the short warrant further inquiry?**

No. If additional information is required a MetLife nurse reviewer may contact the applicant by telephone to complete the underwriting.

**I. What is your average turnaround time for processing an application for (a) employees, (b) spouses, (c) parents, and (d) pension recipients.**

The average turnaround time for processing applications varies with each eligible group. Applications for employees who are underwritten and spouses are typically processed within five to nine business days of receipt of all necessary information. Applications for parents and retirees are typically processed within 10 to 15 business days of receipt of all necessary information. Applications for individuals over age 80, on average, are processed between 20 and 30 business days of receipt of all necessary information.

**J. If an employee, pension recipient, spouse, parent or parent-in-law does not enroll when first eligible, is there a subsequent enrollment period when they can join the plan? If so, are stricter underwriting criteria or procedures applied at a later enrollment period?**

Individuals can enroll in the plan at any time after the initial enrollment. Guaranteed issue coverage is only available to employees during the initial enrollment period or when he/she is first eligible. Therefore, after the initial enrollment period employees are required to submit a health statement. The underwriting process for all other eligibles is the same as for initial enrollment.



**6. PLAN DESIGN**

- A. The State’s desired plan designs are summarized in Attachment A, and include three plans based on a Reimbursement (expense) model (Plans A, B and D), and two on a Disability model (Plans C and E). The State’s preference is to provide both models of plans, but the State recognizes that some firms do not provide both.**

**Indicate whether your firm is bidding on either the Reimbursement model plan options (A, B and D), or the Disability model plan options (C and E), or both the Reimbursement and the Disability model plan options (A through E). Where plan provisions in your plans differ from the design provisions in the plans described in Attachment A, provide a clear description of all material deviations, including the reasons for such differences.**

*Note: the State will not be engaging more than one vendor to provide LTC benefits, even if this results in sponsoring only reimbursement model plans, or only disability model plans.*

**The State also recognizes that some disability-focused vendors may offer, in addition to "pure disability" plan designs, alternate plan designs that require that institutional and/or home care charges be incurred. Similarly, some reimbursement-focused vendors may offer, in addition to "true reimbursement" plan designs, options that provide cash benefits that are not specifically tied to expenses incurred.**

**The State does not wish to exclude certain carriers or products because of varying uses and interpretations of language. Instead, we wish to focus on benefit availability and administration practices that would serve the needs of our employees, retirees and their family members.**

**If your firm’s primary plan model is a reimbursement (expense) based, but you provide certain cash benefit options, please indicate:**

- (1) To the extent that your reimbursement plans may provide cash or alternate benefits independent of professional or institutional services received, specify whether they are provided as:**
- a. A true cash benefit alternative. What is the name of this option? When must the participant select it (e.g. at time of enrollment or time of claim)? Would this option be available to all eligibles in the State group? Do any special underwriting requirements apply? What is the premium differential, if any, between this option and a more typical expense model plan? Under what circumstances is a cash benefit paid? What special claim procedures are required when the cash benefit is first provided, and thereafter?**
  - b. A special benefit sometimes provided under the alternate plan of care provision under an expense model plan. If so, what kinds of services has your plan helped pay for that are not specifically considered covered services? How do claimants or their advocates procure such benefits (administratively)? What percentage of claimants have been helped by this provision? What percentage of your claim payments have been provided under the alternate plan of care provision?**



**(2) To the extent your disability model plans may require that professional home care services be received when home care services are needed (or desired) by the claimant:**

- a. Is there an associated premium differential for this "plan" compared to the premium for a disability-only based plan?**
- b. Are there elimination period differences, benefit differences, claim administration differences, etc.? Please describe in detail.**

MetLife’s long-term care insurance proposal for the State closely adheres to the proposed plan designs. We have detailed clarifications and have included a summary of the plan features at the end of this section. The plan we are proposing is filed and approved by the necessary state insurance departments and is available in all states.

**CLARIFICATIONS**

The following provides clarification where appropriate:

- **Plan Model**

MetLife’s plan is designed as a reimbursement ("incurred") model. Under the reimbursement model, benefits are payable for the actual cost of covered services received, up to the daily benefit. By contrast, the disability model pays benefits for each day the insured is eligible for benefits whether or not covered services are received.

MetLife has chosen the reimbursement model because we believe that it is more likely to result in long-term rate stability. MetLife's reimbursement model ensures the longer-term availability of needed benefits for those with the type of chronic dependencies which long-term care insurance is designed to cover.

The reimbursement model is more likely to result in long-term rate stability because of lower utilization, and the possibility of higher returns on reserves since claim payments are extended over a longer period of time.

There is insufficient experience to reliably project the long-term impact of the disability model on premiums. In the absence of historical data, MetLife’s choice of a reimbursement model represents the more prudent approach toward addressing the issue of rate stability. In addition, assumptions about higher investment returns over time, due to later payouts, are widely accepted. MetLife strongly believes that the combined effect of these two factors carries a higher probability of ensuring the long-term rate stability which is key to the success of the insurance plan.



The reimbursement model more accurately reflects the medical and physical circumstances associated with the need for long-term care. That is, many of the health conditions which give rise to the need for services are intermittent in nature; many also become progressively worse over time. By reimbursing only the actual cost of services received, the reimbursement model helps to ensure that benefits will be available as needs change over the longer term. By contrast, under the disability model, benefits are exhausted sooner and often prior to the time when they will be most needed.

In addition, the reimbursement model's emphasis on care management provides the option of accessing the support of health care professionals who can assist with the selection of appropriate services.

• **Inflation Protection**

MetLife's plan includes an optional inflation increase feature which allows insured's to increase their coverage by a minimum of 5% per year compounded annually. This is offered at least every three plan years. The increase in coverage may be purchased without a health screen, as long as the insured has selected it once in every two offerings. MetLife may waive this requirement anytime; however, such waiver will not forfeit our right to reinstate it at a future date. Premiums for additional coverage are based on the insured's age at purchase. The inflation option is offered to insured's regardless of age, claim status, claim history, or length of participation in the plan. *Many plans restrict this offer to insured's under age 85 or those who have not received benefits in the six months prior to the offer.* MetLife's approach to the optional inflation feature meets the requirements of all states which do not permit the inflation feature to be restricted based upon age or claim history. These states include: Connecticut, Delaware, Indiana, Kansas, Kentucky, Louisiana, Nevada, New Mexico, Oklahoma, South Dakota, Texas, Utah, Washington, and West Virginia.

The State can make an automatic inflation increase feature available as an option to eligible participants. Under this feature, benefits automatically increase by 5% compounded annually, with no increase in premium. Increases are made regardless of age, claim status, claim history, or length of participation in the plan.

To date most of our customers have only offered the optional inflation increase feature. Of those who have offered the automatic inflation increase feature, on average only 5% of insured's have selected it due to its high cost. If the State requests, MetLife will provide premiums for this feature.

• **Respite Care**

The plan covers respite services up to 21 days per calendar year. These services are designed to give the primary caregiver (e.g., spouse, son, or daughter) time off from caregiving responsibilities. Respite services can be provided at home, in a nursing home, or in an assisted living facility. Informal care providers are also included under this benefit. This feature provides flexibility, as it covers care that is from either a licensed or an unlicensed provider, such as homemaker services. This allows payment for services provided by family members, neighbors, or friends. Respite services are reimbursed up to 100% of the daily benefit.



- Case Management Services

MetLife offers care management as part of its long-term care plan. Our approach to care management encourages insured's to participate in the decisions which affect their lives and seek to foster their self sufficiency for as long as possible. Our "total person" approach incorporates three elements: Benefit authorization, onsite voluntary care advisory services, and elder care resource services. We have also found that collaboration between MetLife's care managers and independent care advisors results in the best plan of care for the insured.

The following is a detailed explanation of MetLife's approach to care management.

- Benefit Authorization

Care managers from MetLife's Long-Term Care Group conduct benefit authorization. Our care managers are registered nurses with experience in both long-term care and acute care nursing. They have experience working in adult day care centers, nursing homes, hospitals, and home care agencies.

Benefit authorization begins with the initial benefit eligibility review and includes arranging for a care advisory visit (if requested by the insured) and providing information and care alternatives to the insured and his or her family. To provide continuity, the same care manager works with the insured throughout the benefit eligibility period.

Benefit Eligibility

During the initial benefit eligibility review, a care manager assesses the insured's eligibility for benefits and the anticipated duration of the eligibility period. Once an insured is in benefit, our care managers provide insured's with information about available providers and if any negotiated discounts are available.

Ongoing Review

Throughout the process of ongoing review, insured's who are receiving benefits are monitored on an ongoing basis to assess their continued eligibility for benefits. The review is initiated by a MetLife care manager who calls the insured's physician or other health care provider, such as a nurse in the nursing home or home care agency. During the call, the care manager asks questions similar to those asked during the initial benefit eligibility review. The frequency of the ongoing review depends upon the nature of the insured's condition and the prognosis for change.

- Onsite Voluntary Care Advisory Services

The plan provides onsite voluntary care advisory services to assist insured's in managing their own care. These optional services are provided by care advisors who are unaffiliated with MetLife.



Voluntary Initial Care Advisory Visit

*Insured's are entitled to one free optional initial care advisory visit.* During this in-home assessment, a care advisor helps the insured and his or her family understand their care alternatives and identifies local providers of care. The visit has three components. First, the care advisor assesses the individual's functional status and living environment. Second, a comprehensive long-term care service plan is developed. Third, providers or community resources are suggested to meet the needs outlined in the service plan, and the role of family members in the service plan is evaluated. This one-time benefit can be used anytime, once an insured is benefit-eligible. There is no waiting period to satisfy prior to its use.

To provide the initial care advisory visit, MetLife has contracted with the Family Caring Network of LifePlans, Inc. (LifePlans), a nationwide network of local community-based organizations which provide long-term care case management services. Each participating agency has a staff of experienced, well-trained professionals who are certified with R.N. or B.S.W. degrees. All receive specialized training in long-term care case management. The staff's training and credentials are guaranteed through contractual agreement by LifePlans. LifePlans currently has more than 800 agencies nationwide. *MetLife will cover 100% of the charge for this service if a LifePlans care advisor is used. If a care advisor from LifePlans is not available, MetLife will pay up to \$250 for this service. Charges for this service will not reduce the insured's total lifetime benefit.* Due to Texas state regulations, MetLife will pay up to \$275 for this service for Texas residents if a care advisor from LifePlans is not available.

LifePlans has an extensive quality assurance program which includes an initial qualification and training process for all care advisors, ongoing review of completed assessments, and inter-rater reliability audits. LifePlans may also make periodic site visits to local providers. MetLife also has the right to make site visits to LifePlans' network agencies and to conduct client satisfaction surveys.

MetLife's contract with LifePlans outlines performance guarantees and quality assurance guidelines. The manager of the Long-Term Care Group's Benefit Administration Department develops and monitors the quality assurance program for LifePlans. Each insured is contacted after the initial care advisory visit as part of the quality assurance program.

Ongoing Care Advisory Services

Ongoing care advisory services are available through LifePlans or any other care advisor unaffiliated with MetLife. Insured's may use a care advisor to coordinate various types of care, arrange for appropriate services, monitor the care being received, and assist with altering the long-term care service plan as needs change. Expenses for ongoing care advisory services are covered under the home care benefit and will reduce the insured's total lifetime benefit.

Care advisory services are designed to assist insured's in selecting the right care from appropriate providers. *Use of these services by insured's is voluntary; advice may be rejected without impacting benefits.*



- Elder Care Resource Services

Elder care resource services are provided by MetLife care managers. Care managers are available to answer general questions, address concerns about care management, and help identify appropriate resources. They maintain directories of service providers by category and utilize the Internet to locate appropriate providers and information. When appropriate, they may direct insured's to the local Area Agencies on Aging, the State Department on Aging, or providers who offer discounts.

Through the initial care advisory visit and ongoing care advisory services, insured's can select unaffiliated care advisors to answer questions, address concerns about care management, and help identify appropriate resources.

- Hospice

In-Patient Hospice Care

MetLife's plan covers health care and support services provided in a licensed hospice facility for those who are terminally ill. These services are reimbursed up to 100% of the daily benefit.

At-Home Hospice Care

MetLife's plan covers health care and support services provided at home by a licensed hospice agency for those who are terminally ill. These services are reimbursed up to 60% of the daily benefit.

- **Home Care**

The plan covers care received at home from a nurse, home health aide, homemaker, and/or a physical, respiratory, occupational, or speech therapist from a licensed home care agency. Care can also be received from a nurse (R.N., L.P.N., L.V.N.) or a therapist who is not from a licensed agency. These services are reimbursed up to 60% of the daily benefit.

- **Eldercare Information and Referral**

Elder care resource services are provided by MetLife care managers. Care managers are available to answer general questions, address concerns about care management, and help identify appropriate resources. They maintain directories of service providers by category and utilize the Internet to locate appropriate providers and information. When appropriate, they may direct insured's to the local Area Agencies on Aging, the State Department on Aging, or providers who offer discounts.

- **Bed Reservation Benefit**

While receiving daily benefits, an insured may need to be hospitalized. The nursing home, hospice facility, or assisted living facility may require the insured to pay for room and board during the stay in the hospital to ensure that a bed in the facility will be available upon return from the hospital. MetLife will pay the daily benefit for up to 21 days per calendar year to hold the bed, if required by the facility.



- **Training For Caregivers/Home Modifications/Transitional Benefit/Emergency Alert System**

MetLife realizes there may be many changes occurring in an individual's life when it is determined he or she is chronically ill. To assist insured's in adapting to their new circumstances, MetLife provides a transition expense benefit. *This benefit provides up to five times the daily benefit selected and will not be charged against the insured's total lifetime benefit.* It is available to insured's after they have completed the waiting period and have been certified as chronically ill. This benefit may be useful for offsetting costs of qualified services received during the waiting period or for items such as an emergency response system, caregiver training, or durable medical equipment. To access this benefit, proof of payment for a covered expense must be submitted to MetLife.

- **Alternative Plan of Care**

MetLife's plan includes a provision that allows a MetLife care manager to authorize benefits for a qualified long-term care service that is not specifically defined as a covered service under the plan. The service must be a qualified service, must meet the needs of the covered person, and may be a cost-effective alternative to services otherwise covered under the plan.

This feature gives us the flexibility to approve providers as changes in the delivery system occur.

- **Underwriting**

MetLife can accept employees into the plan without evidence of insurability during the initial enrollment period, provided they are actively at work on the effective date of the plan. In addition, newly hired employees will be accepted without evidence of insurability, provided they are actively at work on their effective date and they enroll within 90 days of hire. Coverage for employees who are not actively at work on their effective date will become effective on the first of the month following their return to work (provided they are actively at work on that date).

Underwriting will be required for all other eligible participants. MetLife's underwriting was expressly designed to be non-intrusive, yet comprehensive enough to obtain the information necessary to help maintain the long-term stability of the plan.

To minimize effort for the applicant, he or she completes a self-administered enrollment form which clearly defines excludable conditions on the first page. In most cases, underwriting for spouses of employees and employees who do not enroll when initially offered coverage will be completed after the form has been evaluated by a nurse reviewer; no further contact will be required. In certain circumstances, the nurse reviewer may need to contact the applicant by telephone to complete the underwriting.

More extensive underwriting will be required for retirees and parents, where the risks of needing long-term care are higher. This process begins with the MetLife nurse reviewer's assessment of the health history submitted on the self-administered enrollment form. The nurse reviewer then conducts a brief telephone interview to clarify the medical information on the form and to administer a short mental status exam.



For applicants age 80 and over, in addition to submitting an application, medical records are requested from their personal physician and an in-home interview with a registered nurse is conducted.

• **Waiver of Premium**

MetLife's plan includes a premium waiver. Premium payments are waived on the first of the month, coincident with or following the date the insured fulfills the waiting period and is chronically ill. Premium payments would resume on the first of the month after the insured is no longer eligible for benefits.

• **Other Exclusions or Limitations**

MetLife's 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 so reimbursable but for the application of a deductible or 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.

MetLife covers disabilities resulting from organic brain diseases, including Alzheimer's disease and similar disorders. *The plan also covers dependencies resulting from brain diseases which are not organically based, as long as the insured meets the benefit eligibility criteria.* MetLife does not attempt to identify the cause of disability or mental disorder. The presence of many interrelated factors makes it difficult to isolate cause and thus, to administer a plan which excludes mental or nervous disorders.

• **Portability**



MetLife's plan is fully portable. Employees leaving the State who elect portability will pay premiums by direct bill at no additional cost. Coverage for eligible relatives can continue as well. The plan benefits and premiums available to portable insured's will be identical to those extended to the State. *MetLife does not assess an additional charge if an individual leaves the company and chooses to remain insured under the plan.*

- **Nonforfeiture of Benefits**

MetLife's plan includes a nonforfeiture feature as an option for the participants to select. This feature (defined below) gives insured's the opportunity to maintain some coverage if they allow their policy to lapse.

- **Shortened Benefit Period - Benefit Bank**

Insured's who have paid premiums for at least three years and elect to stop making payments will be entitled to receive some coverage. The feature provides the full daily benefit with a total lifetime benefit based on the amount of premiums paid. The total lifetime benefit will be at least 30 times the daily benefit.

**RECOMMENDATIONS**

- **Facilities Only Plan**

In addition to the comprehensive plan, we recommend that the State offer a facilities only plan. The facilities only option can be an attractive alternative for older individuals who may wish to cover only the most catastrophic expenses and also provides a lower cost option. This option covers nursing home services, in-patient hospice care, assisted living facility care, and an initial care advisory visit. It also includes the transition expense benefit, return of premium on death, and the nonforfeiture feature. We have offered this option to many of our customers and have found that the response has been quite favorable. The premium rates for a facilities only plan would be approximately 38% lower than the comprehensive plan.

- **Choice of Daily Benefit Amount**

MetLife offers flexibility to insured's by allowing their choice of daily benefit amounts, no matter which plan they decide upon.

**A. Can an insured apply to purchase additional coverage amounts at times other than during their period of initial eligibility or scheduled buy-up offering periods? If so, please describe this process in detail. How long do you anticipate it will take to review such applications and arrive at an underwriting decision?**

Insured's can increase coverage after providing evidence of insurability at any time by calling our toll free customer service number. Premiums for additional coverage are based upon the insured's age at purchase.



The average turnaround time for processing coverage changes varies with each eligible group. Applications for employees who are underwritten and spouses are typically processed within five to nine business days of receipt of all necessary information. Applications for parents and retirees are typically processed within 10 to 15 business days of receipt of all necessary information.

**B. How will you calculate the amount of optional additional benefit coverage to offer each insured? Are there timing and/or age and/or other restrictions on the amount of additional inflation protection which each insured can buy?**

MetLife's plan includes an optional inflation increase feature which allows insured's to increase their coverage by a minimum of 5% per year compounded annually. This is offered at least every three plan years. The premiums for this increase are based upon the insured's age at the time of purchase.

**C. Under what circumstances (if any) will insured's need to provide evidence of insurability to purchase the optional additional benefit amounts?**

MetLife's plan includes an optional inflation increase feature which allows insured's to increase their coverage by a minimum of 5% per year compounded annually. This is offered at least every three plan years. The increase in coverage may be purchased without a health screen, as long as the insured has selected it once in every two offerings. MetLife may waive this requirement anytime; however, such waiver will not forfeit our right to reinstate it at a future date. Premiums for additional coverage are based on the insured's age at purchase. The inflation option is offered to insured's regardless of age, claim status, claim history, or length of participation in the plan. *Many plans restrict this offer to insured's under age 85 or those who have not received benefits in the six months prior to the offer.*

**D. Confirm that all classes of insured (including pension recipients, parents, and portable insured's) will be eligible to purchase the optional additional benefit amounts without evidence of insurability (unless noted above.)**

All classes of insured's will be eligible to purchase the inflation increase without evidence of insurability as long as the insured has selected it once in every two offerings.

**E. Describe the automatic inflation protection options you are quoting, including how maximums are calculated annually and any limitations on the automatic annual increase.**

An automatic inflation feature is available as an option to the enrollee. With this feature benefits will increase by at least 5% compounded annually with no increase in premium. Coverage automatically increases for those individuals in benefit.



If an individual enrolls in the plan effective January 1, 2001 with a \$100 daily benefit and a \$182,500 total lifetime benefit, the daily benefit and the total lifetime benefit will increase on an annual basis by 5% compounded annually. On January 1, 2002 the daily benefit will be \$105 and the total lifetime benefit will be \$191,625 (less benefits received).

To date most of our customers have only offered the optional inflation increase feature. Of those who have offered the automatic inflation increase feature, on average only 5% of insured's have selected it due to its high cost.

**F. Confirm that for the automatic inflation protection option, premiums are level.**

With the automatic inflation feature, benefits will increase by at least 5% compounded annually with no increase in premium.

**H. Describe your waiting period provision in detail. How are days “counted” toward satisfying the period? What about breaks in needing or using covered services during the waiting period?**

The waiting period is a total of 90 (Option A and B) or 60 (Option D) calendar days during which an insured is unable to perform, without substantial assistance from another individual, at least 2 ADLs or requires substantial supervision due to a severe cognitive impairment. *The insured does not need to receive a covered service for a day to count as a waiting period day.* In addition, days need not be consecutive as long as the interval is not greater than 180 days.

**I. What are your definitions of nursing home and assisted living facility for the policy you are proposing for the State? Are ancillary services in a nursing home covered under the policy?**

MetLife's definitions of nursing homes and assisted living facilities are as follows:

Nursing Home

A facility that is licensed as a nursing facility under the laws of the jurisdiction in which it is located, or other organization approved by Us, that satisfies all of the following requirements:

- Has appropriate licensure for a business under the laws of the jurisdiction in which it is located that provides Maintenance or Personal Care;
- Has 24 hour a day Nursing Care; and
- Has 24 hour a day Maintenance or Personal Care provided by a trained/certified and awake staff supervised by a Nurse; and
- Maintains a written record of services provided to each client; and



- Has formal arrangements for emergency medical care; and
- Services are not limited to provision of food, shelter and other residential services such as laundry; and
- Residents are not related to the owner or manager of the facility; and
- Is not, other than incidentally a Hospital (except a distinct part of a Hospital which is a nursing facility), a residential facility, hotel, motel, place for rest, home for the aged, sheltered living accommodation, facility for the treatment of mental illness, continuing care retirement community or similar entity, or place for drug addicts or alcoholics.

Assisted Living Facility

A facility that satisfies all of the following:

- Maintains all appropriate licensing required under the laws of the jurisdiction in which it is located to provide Maintenance or Personal Care; and
- Provides 24-hour a day care and services sufficient to assist clients with needs which result from the inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
- Whose residents are not related to the owner or manager of the facility; and
- Has a minimum of 6 residents; and
- Uses aides trained or certified to provide Maintenance or Personal Care in accordance with any laws applicable to the provision of such care; and
- Provides 24 hour supervision of clients by a trained and awake staff; and
- Has formal arrangements for emergency medical care; and
- Maintains written records of services provided to each client; and
- Provides clients with 3 meals a day; and
- Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.
- It is not other than incidentally a hotel, motel, a place for rest or a place for drug addicts or alcoholics. Retirement homes, congregate living, senior housing, or other facilities primarily intended to provide residential services but not Maintenance or Personal Care do not typically qualify as an Assisted Living Facility. If an institution has multiple licenses or purposes, only that section of the institution specifically meeting the definition of Assisted Living Facility will qualify as an Assisted Living Facility.

**Ancillary services in a nursing home are covered if part of the nursing home daily rate.**



J. Some states do not license certain types of providers, such as assisted living facilities. Address whether this causes complications under your reimbursement process. Describe any certification, review or approval process you apply to these facilities.

MetLife defines an assisted living facility as a facility that satisfies all of the following:

- Maintains all appropriate licensing required under the laws of the jurisdiction in which it is located to provide Maintenance or Personal Care;
- Provides 24-hour a day care and services sufficient to assist clients with needs which result from the inability to perform ADLs or Severe Cognitive Impairment;
- Whose residents are not related to the owner or manager of the facility;
- Has a minimum of 6 residents;
- Uses aides trained or certified to provide Maintenance or Personal Care in accordance with any laws applicable to the provision of such care;
- Provides 24 hour supervision of clients by a trained and awake staff;
- Has formal arrangements for emergency medical care;
- Maintains written records of services provided to each client;
- Provides clients with 3 meals a day; and
- Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

**It is not, other than incidentally, a hotel, motel, a place for rest or a place for drug addicts or alcoholics. Retirement homes, congregate living, senior housing, or other facilities primarily intended to provide residential services but not Maintenance or Personal Care do not typically qualify as an Assisted Living Facility. If an institution has multiple licenses or purposes, only that section of the institution specifically meeting the definition of Assisted Living Facility will qualify as an Assisted Living Facility.**

**MetLife has not had any complications with our reimbursement process due to state requirements for assisted living facilities.**



**K. What are your criteria for home health care and community based service providers to be eligible for reimbursement under the State’s plan?**

MetLife's criteria is as follows:

Home Health Care

A Hospital or other organization that:

- Is licensed or certified as a Home Health Care Agency, under the laws of the jurisdiction in which it is located, under a public health law or similar law, if licensing is required, to provide home health care services; or
- Is recognized as a home health agency by Medicare; or
- Is a Hospital or other organization that satisfies all of the following:
  - Is licensed or certified by the State to provide home care services; and
  - Develops and periodically reviews long-term care service plans at appropriate intervals; and
  - Uses aides trained or certified to provide Maintenance or Personal Care in accordance with any laws applicable to the provision of such care; and
  - Provides on-site supervision of aides by a Nurse or Social Worker; and
  - Provides on-call availability of a Nurse or a Physician in the event of a medical emergency during the hours that the aide is in the client's home; and
  - Maintains a written record of services provided to each client.

Assisted Living Facility Care

A facility that satisfies all of the following:

- Maintains all appropriate licensing required under the laws of the jurisdiction in which it is located to provide Maintenance or Personal Care; and
- Provides 24-hour a day care and services sufficient to assist clients with needs which result from the inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
- Whose residents are not related to the owner or manager of the facility; and
- Has a minimum of 6 residents; and



- Uses aides trained or certified to provide Maintenance or Personal Care in accordance with any laws applicable to the provision of such care; and
- Provides 24 hour supervision of clients by a trained and awake staff; and
- Has formal arrangements for emergency medical care; and
- Maintains written records of services provided to each client; and
- Provides clients with 3 meals a day; and
- Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

It is not other than incidentally a hotel, motel, a place for rest or a place for drug addicts or alcoholics. Retirement homes, congregate living, senior housing, or other facilities primarily intended to provide residential services but not Maintenance or Personal Care do not typically qualify as an Assisted Living Facility. If an institution has multiple licenses or purposes, only that section of the institution specifically meeting the definition of Assisted Living Facility will qualify as an Assisted Living Facility.

Adult Day Care

Adult Day Care Center means a facility operated, licensed and/or certified as an Adult Day Care Center under the laws of the jurisdiction in which it is located; or other organization that satisfies all of the following:

- Provides a program of adult day care; and
- Maintains a written record of services provided to each client; and
- Has established procedures to obtain emergency medical care; and
- Is not a place predominantly providing services for recreation or social activities; and
- Maintains a client-to staff ratio of 8 (or less) to 1 which staff includes a full-time director, 1 or more Nurses in attendance during operating hours at least 4 hours a day, and at least 2 staff members in attendance whenever clients are present.

At-Home Hospice Care

The plan covers health care and support services provided at home by a licensed hospice agency for those who are terminally ill.



Ongoing Care Advisory Services

Care Advisory Services means the following services performed by a Care Advisor:

- Assessing long-term care service needs;
- Developing a long-term care service plan;
- Requisitioning and coordinating long-term care services;
- Implementing the long-term care service plan; and
- Periodically monitoring and reassessing long-term care services.

**L. Describe your eldercare information and referral service (if any) for LTC insured. Who provides these services?**

MetLife currently provides eldercare information and referral services to insured’s and their families at no additional cost. Elder care resource services are provided by both MetLife care managers and external care advisors. Insured’s are eligible to access this service by calling our toll-free number and talking with one of our care managers. MetLife’s Long-Term Care Group care managers are available to answer general questions, address concerns about care management, and help identify appropriate resources. They maintain directories of service providers by category which are updated annually. When appropriate, they may direct insured’s to the local Area Agencies on Aging, the State Department on Aging, or providers who offer discounts. Counseling from our care managers to insured’s, family members and other caregivers pertaining to an insured’s health status and care needs is included as a service under care management.

In addition, through the free one-time Initial Care Advisory Visit and Ongoing Onsite Care Advisory Services, all insured’s can access unaffiliated care advisors to answer their questions and concerns about care management, at no additional cost. The care advisors from the Family Caring Network of LifePlans, Inc. can also help identify appropriate resources. They maintain a comprehensive, up-to-date database of local providers and resources that the insured may choose to utilize. LifePlans is a nationwide network of local community-based organizations which provide long-term care case management services. Each participating agency has a staff of experienced, well-trained professionals who are certified with R.N. or B.S.W. degrees. All receive specialized training in long-term care case management. The staff’s training and credentials are guaranteed by contractual agreement. There are currently over 800 agencies nationwide in the LifePlans network.

MetLife's eldercare information and referral services are available only to its covered individuals. Care advisory services are designed to assist insured’s in selecting the right care from appropriate providers. Use of these services by insured’s is voluntary; advice may be rejected without impacting benefits.



**M. If you exclude coverage for disabilities resulting from work-related illness or injury, how do you cover disabilities when a workers' compensation claim is disputed or denied? Describe any liberalizations of this exclusion you are willing to make for the State.**

MetLife does not exclude coverage for disabilities resulting from work-related illness or injury.

**N. Describe your coverage for custodial homemaker services, including any restrictions or limitations on access to or amount of such coverage.**

**MetLife's plan covers homemaker services from a licensed agency under the home care benefit. These services are reimbursed at 60% of the daily benefit amount. Homemaker services are covered under the respite services benefit as well as under the home care benefit. Many plans only reimburse homemaker services under the respite services benefit.**

**Homemaker means a person whose services are arranged and supervised through a home health care agency and who provides qualified long-term care services. Such services may include light housekeeping, meal preparation, or shopping for items needed for qualified long-term care services.**

**The plan also covers respite services up to 21 days per calendar year. These services are designed to give the primary caregiver (e.g., spouse, son, or daughter) time off from caregiving responsibilities. Respite services can be provided at home, in a nursing home, or in an assisted living facility. Informal care providers are also included under this benefit. This feature provides flexibility, as it covers care that is from either a licensed or an unlicensed provider, such as homemaker services. This allows payment for services provided by family members, neighbors, or friends. Respite services are reimbursed up to 100% of the daily benefit.**

**O. Describe how waiver of premium is determined (note that it is expected under the proposed plan design that waiver not be invoked by: claimants obtaining eldercare information and referral services, provision of an emergency alert system, training for caregivers, or home modifications).**

MetLife's plan includes a premium waiver. Premium payments are waived on the first of the month coincident with or following the date the insured fulfills the waiting period. Premium payments would resume on the first of the month after the insured is no longer eligible for benefits.

**P. Clearly detail all additional plan features not described above or in the matrix. DO NOT INCLUDE ADDITIONAL DESCRIPTIVE MATERIAL OUTSIDE YOUR RESPONSE TO THIS QUESTIONNAIRE AND THE MATRIX.**

Outlined below is a summary of MetLife's plan features. MetLife's plan provides insured's with comprehensive benefits covering a broad spectrum of services to meet individual needs. Benefits are payable for qualified long-term care services. Qualified services are provided



pursuant to a plan of care for a person who is chronically ill. In addition, a summary of plan features table is included at the end of this section.

Nursing Home Care

The plan covers all levels of care, from custodial to skilled, received in a licensed nursing home facility. Care provided by specialty facilities such as, but not limited to, Alzheimer's Centers are also covered under the plan provided there is 24-hour nursing supervision. The facility may be part of a nursing home or a separate facility. These services are reimbursed up to 100% of the daily benefit.

In-Patient Hospice Care

The plan covers health care and support services provided in a licensed hospice facility for those who are terminally ill. These services are reimbursed up to 100% of the daily benefit.

Assisted Living Facility Care

The plan covers services received in an assisted living facility. Assisted living facilities provide 24-hour care and other services required by individuals who are unable to perform ADLs or who demonstrate cognitive impairment. An assisted living facility must be appropriately licensed under the laws of the jurisdiction in which it is located to provide the level of care and other services rendered. Charges for assisted living facilities are reimbursed up to 60% of the daily benefit.

Retirement homes congregate living, senior housing, or facilities primarily providing residential services but not maintenance or personal care do not typically qualify for reimbursement under the plan.

Home Care

The plan covers care received at home from a nurse, home health aide, homemaker, and/or a physical, respiratory, occupational, or speech therapist from a licensed home care agency. Care can also be received from a nurse (R.N., L.P.N., L.V.N.) or a therapist who is not from a licensed agency. These services are reimbursed up to 60% of the daily benefit.

*Many plans only reimburse homemaker services under the respite services benefit. MetLife's plan covers homemaker services from a licensed agency under the home care benefit. Homemaker services are also covered under the respite services benefit.*

Adult Day Care

The plan covers the services of licensed facilities offering care, health support, and rehabilitative services for adults during the day. These services are reimbursed up to 60% of the daily benefit.

At-Home Hospice Care

The plan covers health care and support services provided at home by a licensed hospice agency for those who are terminally ill. These services are reimbursed up to 60% of the daily benefit.



Respite Services

The plan covers respite services up to 21 days per calendar year. These services are designed to give the primary caregiver (e.g., spouse, son, or daughter) time off from caregiving responsibilities. Respite services can be provided at home, in a nursing home, or in an assisted living facility. Informal care providers are also included under this benefit. This feature provides flexibility, as it covers care that is from either a licensed or an unlicensed provider, such as homemaker services. This allows payment for services provided by family members, neighbors, or friends. Respite services are reimbursed up to 100% of the daily benefit.

Alternate Plan of Service Provision

The plan includes a provision that allows a MetLife care manager to authorize benefits for a qualified long-term care service that is not specifically defined as a covered service under the plan. The service must be a qualified service, must meet the needs of the covered person, and may be a cost-effective alternative to services otherwise covered under the plan.

*The benefit payable for an alternate plan of service shall be the lesser of:*

- The actual cost of the services provided; or
- The benefit for the most closely related defined covered service, as determined by MetLife.

This feature gives us the flexibility to approve providers as changes in the delivery system occur.

The following are examples of how an alternate plan of care may be recommended and facilitated:

Our insured is an 84-year old widow who lives alone and is requesting home care assistance from a private home health aide. She is in need of daily home peritoneal dialysis, due to end-stage renal disease, which she cannot perform on her own. Normally, family members can be trained to do this task, and receive special training from the Dialysis Center. Unfortunately, the home care agency licensure does not allow their unlicensed employees (HHA) to perform this procedure.

We arranged for a specific individual who was hired to assist the insured after completing dialysis training and was certified by the RN/Home Care Coordinator. This RN/Home Care Coordinator continues to provide supervisory availability for 24 hours a day, seven days a week.

Another example is the case of a quadriplegic, who had been directing his own care for quite sometime. He required help in the early mornings to help him get up and ready for work, and then help again at night to help him get ready for bed. He also required a special bowel regime several times a week.



At the time of request for benefit authorization, he had in place two private caregivers he had hired through his church. He trained them himself, and was able to oversee his own care. The local care agencies could not provide him with help for the hours he needed. In addition, if he had used help via the agency, due to state regulations the aide would not be allowed to help him with the bowel regime. He would have required a LPN or RN for this service, and the use of a nurse several times a week would have been more costly. Because of his special needs, his request was approved through the alternate plan of care provision.

This feature gives us the flexibility to approve providers as changes in the delivery system occur.

Daily Benefit Choice

The plan offers insured's the choice of three daily benefit amounts: \$100, \$150, and \$200. These choices provide participants with flexibility in dealing with the varied cost of services around the country.

Total Lifetime Benefit

The total lifetime benefit is the amount of money available to pay benefits; it is a dollar amount equal to 3 years (1,095), 4 years (1,460), or 5 years (1,825) times the daily benefit selected. If the actual cost of services is less than the daily benefit, the remainder can be used for future benefits.

Onsite Voluntary Care Advisory Services

The plan provides onsite voluntary care advisory services to assist insured's in managing their own care. These optional services are provided by care advisors who are unaffiliated with MetLife.

Voluntary Initial Care Advisory Visit

*Insured's are entitled to one free optional initial care advisory visit. During this in-home assessment, a care advisor helps the insured and his or her family understand their care alternatives and identifies local providers of care. The visit has three components. First, the care advisor assesses the individual's functional status and living environment. Second, a comprehensive long-term care service plan is developed. Third, providers or community resources are suggested to meet the needs outlined in the service plan, and the role of family members in the service plan is evaluated. This one-time benefit can be used anytime, once an insured is benefit-eligible. There is no waiting period to satisfy prior to its use.*

To provide the initial care advisory visit, MetLife has contracted with the Family Caring Network of LifePlans, Inc. (LifePlans), a nationwide network of local community-based organizations which provide long-term care case management services. Each participating agency has a staff of experienced, well-trained professionals who are certified with R.N. or B.S.W. degrees. All receive specialized training in long-term care case management. The staff's training and credentials are guaranteed through contractual agreement by LifePlans. LifePlans currently has more than 800 agencies nationwide. *MetLife will cover 100% of the charge for this service if a LifePlans care advisor is used. If a care advisor from LifePlans is not available, MetLife will pay up to \$250 for this service. Charges for this service will not reduce the insured's total lifetime benefit.* Due to Texas state regulations, MetLife will pay



up to \$275 for this service for Texas residents if a care advisor from LifePlans is not available.

LifePlans has an extensive quality assurance program which includes an initial qualification and training process for all care advisors, ongoing review of completed assessments, and inter-rater reliability audits. LifePlans may also make periodic site visits to local providers. MetLife also has the right to make site visits to LifePlans' network agencies and to conduct client satisfaction surveys.

MetLife's contract with LifePlans outlines performance guarantees and quality assurance guidelines. The manager of the Long-Term Care Group's Benefit Administration Department develops and monitors the quality assurance program for LifePlans. Each insured is contacted after the initial care advisory visit as part of the quality assurance program.

Ongoing Care Advisory Services

Ongoing care advisory services are available through LifePlans or any other care advisor unaffiliated with MetLife. Insured's may use a care advisor to coordinate various types of care, arrange for appropriate services, monitor the care being received, and assist with altering the long-term care service plan as needs change. Expenses for ongoing care advisory services are covered under the home care benefit and will reduce the insured's total lifetime benefit.

Care advisory services are designed to assist insured's in selecting the right care from appropriate providers. *Use of these services by insured's is voluntary; advice may be rejected without impacting benefits.*

Elder Care Resource Services

Elder care resource services are provided by MetLife care managers. Care managers are available to answer general questions, address concerns about care management, and help identify appropriate resources. They maintain directories of service providers by category and utilize the Internet to locate appropriate providers and information. When appropriate, they may direct insured's to the local Area Agencies on Aging, the State Department on Aging, or providers who offer discounts.

Transition Expense Benefit

MetLife realizes there may be many changes occurring in an individual's life when it is determined he or she is chronically ill. To assist insured's in adapting to their new circumstances, MetLife provides a transition expense benefit. *This benefit provides up to five times the daily benefit selected and will not be charged against the insured's total lifetime benefit.* It is available to insured's after they have completed the waiting period and have been certified as chronically ill. This benefit may be useful for offsetting costs of qualified services received during the waiting period or for items such as an emergency response system, caregiver training, or durable medical equipment. To access this benefit, proof of payment for a covered expense must be submitted to MetLife.



Premium Waiver

MetLife's plan includes a premium waiver. Premium payments are waived on the first of the month, coincident with or following the date the insured fulfills the waiting period and is chronically ill. Premium payments would resume on the first of the month after the insured is no longer eligible for benefits.

Inflation Protection Option

MetLife's plan includes an optional inflation increase feature, which allows insured's to increase their coverage by a minimum of 5% per year compounded annually. This is offered at least every three plan years. The increase in coverage may be purchased without a health screen, as long as the insured has selected it once in every two offerings. MetLife may waive this requirement anytime; however, such waiver will not forfeit our right to reinstate it at a future date. Premiums for additional coverage are based on the insured's age at purchase. The inflation option is offered to insured's regardless of age, claim status, claim history, or length of participation in the plan. *Many plans restrict this offer to insured's under age 85 or those who have not received benefits in the six months prior to the offer.* MetLife's approach to the optional inflation feature meets the requirements of all states which do not permit the inflation feature to be restricted based upon age or claim history. These states include: Connecticut, Delaware, Indiana, Kansas, Kentucky, Louisiana, Nevada, New Mexico, Oklahoma, South Dakota, Texas, Utah, Washington, and West Virginia.

The State can make an automatic inflation increase feature available as an option to eligible participants. Under this feature, benefits automatically increase by 5% compounded annually, with no increase in premium. Increases are made regardless of age, claim status, claim history, or length of participation in the plan.

Return of Premium on Death Feature

MetLife's plan includes a return of premium on death feature. Under this feature, all premiums paid up to age 65 are returned to the insured's estate upon death, less benefits received. If the insured dies on or after the age of 65, the amount returned will be reduced by 20% per year from age 65 up to age 70, less benefits received. *Some group carriers do not generally include this feature in their plan.* Due to state regulations, this feature is not available to residents of Washington. In order to maintain uniform premium rates, residents of Washington will have a respite services benefit equal to 42 days per calendar year.

Nonforfeiture Feature

MetLife's plan includes a nonforfeiture feature for participants to select. This feature gives insured's the opportunity to maintain some coverage if they allow their policy to lapse.

**Shortened Benefit Period - Benefit Bank**

Insured's who have paid premiums for at least three years and elect to stop making payments will be entitled to receive some coverage. The feature provides the full daily benefit with a total lifetime benefit based on the amount of premiums paid. The total lifetime benefit will be at least 30 times the daily benefit.



Bed Reservation Benefit

While receiving daily benefits, an insured may need to be hospitalized. The nursing home, hospice facility, or assisted living facility may require the insured to pay for room and board during the stay in the hospital to ensure that a bed in the facility will be available upon return from the hospital. *MetLife will pay the daily benefit for up to 21 days per calendar year to hold the bed, if required by the facility.*

Reinstatement Provision

Insured's who stop paying premiums will have 12 months to apply for reinstatement in the plan at the same rate they were paying when they stopped paying premium. In addition to paying all back premiums due, they will be required to provide evidence of good health. Those who can prove that failure to pay premium at the time of lapse was due to loss of functional capacity or cognitive impairment may be reinstated within five months without providing evidence of insurability. They will, however, be required to pay back premium.

Portability

MetLife's plan is fully portable. Employees leaving the State who elect portability will pay premiums by direct bill at no additional cost. Coverage for eligible relatives can continue as well. The plan benefits and premiums available to portable insured's will be identical to those extended to the State. *MetLife does not assess an additional charge if an individual leaves the company and chooses to remain insured under the plan. Some carriers charge different rates to direct bill the insured.*

Guaranteed Renewable

MetLife's plan is guaranteed renewable. As long as premiums are paid, coverage cannot be canceled.

Facilities Only Plan

In addition to the comprehensive plan, we recommend that the State offer a facilities only plan. The facilities only option can be an attractive alternative for older individuals who may wish to cover only the most catastrophic expenses and also provides a lower cost option. This option covers nursing home services, in-patient hospice care, assisted living facility care, and an initial care advisory visit. It also includes the transition expense benefit, return of premium on death, and the nonforfeiture feature. We have offered this option to many of our customers and have found that the response has been quite favorable.

**Q. Are you willing to guarantee continued availability of your proposed plan design to State enrollees even if no longer available to new employer groups? Do you agree to not change the plan design in the future (unless legally obligated to or to maintain the tax-qualified status of the plan) without the State's consent?**

**MetLife's plan is guaranteed renewable. As long as premiums are paid, coverage for existing insured's cannot be canceled.**



**MetLife may terminate the group policy if required to do so by law. In this event, MetLife will give the State at least 30 days written notice prior to the date the group policy is to be terminated. The group policy will be considered terminated as of the last day of the calendar month in which the State received this written notice.**

**MetLife may also terminate the group policy if the State fails to remit premium within the 31-day grace period. In this event, unless otherwise required by law, the group policy will automatically terminate effective the last day of the grace period.**

**If MetLife terminates the policy for one of the above listed reasons, existing insured's will continue to be covered under the plan; however, no new enrollees will be accepted.**

If it becomes in our best financial interest to do so, MetLife reserves the right to refuse to enroll additional eligibles provided that we provide 90 days advance written notice to the State of our intention to exercise this right.

MetLife agrees to consult the State prior to making changes to the plan design. However, MetLife reserves the right to make changes necessary to maintain the tax status of the plan or to meet state specific regulations.

**R. Some State employees and pension recipients reside outside the United States (chiefly in Canada). Discuss the availability of LTC services received in Canada. Also, discuss issues relating to coordination of benefits with Canadian governmental health plans (such as OHIP).**

Due to the complex health care delivery systems overseas, there are two issues related to coverage for overseas employees. The first issue relates to offering coverage to employees who are on US payroll and reside overseas. Once we have more specific demographic data on the State's population overseas, we can work with our Legal and International departments to determine if we can extend the long-term care offering to those individuals. The second issue is related to covering services received overseas for expatriates (employees on US payroll living overseas). We are working on developing a plan that would provide coverage for services received outside of the US for insured's.

MetLife does not transact new business in Canada. This applies to long-term care as well as all other coverage. MetLife's practice is to approach Clarica in Canada and ask them if they would prepare a Canadian quote. If the answer is yes, then Clarica will quote on the basis of a Canadian contract issued on Clarica paper in Canada, administered by Clarica, premiums and benefits payable in Canadian currency. Clarica offers an individual long-term care product. MetLife's role would be limited to the initial introduction.



**S. If you have negotiated discounts with LTC providers, please identify:**

- **the numbers and types of participating providers in Michigan (by county, if it varies), Florida, Arizona and Texas**
- **the discounts offered nationally and in Michigan, Florida, Arizona and Texas, overall and by type of provider**
- **your plans to expand the discount network to areas and provider types for which it is currently unavailable**
- **whether plan enrollees have preferential access to provider services**
- **whether the use of participating providers affects LTC policy benefit payments and/or the maximum duration of benefits**
- **How you select providers with which to negotiate discounts.**

MetLife has discounts with nursing homes; home care agencies, and durable medical equipment providers nationwide. The discount varies by provider and type of service and will generally be between 5% and 30% of the provider's usual fee. Insured's will be informed of the availability of discounted providers in their area and the fee, but are free to choose any provider. Discounts can be accessed by calling our toll-free telephone line and speaking with our care managers. Provider discounts provide a means to help the insured extend benefit payments under the plan and are available to MetLife insureds on a voluntary basis. The use of participating providers would not affect long-term care policy benefit payments and/or the maximum duration of benefits.

MetLife currently has over 3,300 providers in our provider discount network. This includes nursing homes, assisted living facilities, home care agencies, durable medical equipment providers, and speech/occupational/physical therapists. The vendor we use for these discounts is HealthCare Synergy's, Inc. Some of the major chains that are part of the network include: Beverly Health and Rehab, Manor HealthCare Systems, Interim Healthcare, Kelly Assisted Living, and Manor Care Health services.

MetLife currently has 103 providers offering discounts in Michigan, 374 in Florida, 58 in Arizona, and 200 in Texas.

MetLife's provider discount network is constantly being enhanced with the addition of new providers. Should a provider call in requesting to be part of the network, this can be arranged. Conversely, if an insured is in need of a provider, it can be suggested that a provider join the network. If a care manager finds an area lacking the availability of discounting providers, we can request the network to recruit in that particular area.



**T. If your company develops an entirely new LTC product, describe how you would make it available to and transition it to current State enrollees. Would current enrollees have guarantee issue access to improved new benefits?**

MetLife has had extensive experience enhancing current plans and replacing existing plans. Since MetLife's first employer long-term care insurance policy was written in 1989, MetLife has made several enhancements to its product to provide more flexibility and more options for existing employers, employees and retirees. In the past three years, MetLife has made several enhancements to many of our existing plans on a guaranteed issue basis with no impact on premium. These enhancements were made with input and approval from our clients.

If MetLife develops an entirely new long-term care product, the State will have the opportunity to decide whether or not to offer this plan design to existing enrollees. If the new plan is an enhancement for all participants with no impact on the rates, we can implement it on a guaranteed issue basis with no health screen.

If we introduce a completely new plan, which allows individuals the right to stay in the current plan or move to the new plan, we would be responsible for all communication and administration. Our approach is to develop transition rules so individuals who are currently enrolled can transfer to comparable coverage under the new plan on a guaranteed issue basis. The communications to these individuals would be personalized according to each participant's coverage selection.

**U. The State has an interest in providing, if possible, flexibility in benefit payments to make accessible and support State initiatives as described in Appendix D. Please describe if your program will support these initiatives, or any difficulties you foresee in supporting them.**

MetLife would be happy to discuss the State's preferences in greater detail with regard to flexibility in benefit payments to make accessible and support State initiatives. We would appreciate further clarification with respect to Appendix D and these initiatives.



**7. CUSTOMER SERVICE**

- A. Describe your hours of operation, including times available:**
- a) **Member inquiries – “live” customer service representatives**
  - b) **Member inquiries - voice messages**
  - c) **Member inquiries – emergencies**
  - d) **Member inquiries – for case managers**
  - e) **Account administration – assigned client/service managers**
  - f) **Provider inquiries.**

MetLife's toll-free number is available to employees, retirees, and their families prior to enrollment and on an ongoing basis. Our customer service consultants are equipped to answer a wide range of questions about plan features and benefits. In addition, our care managers are available to assist callers with questions about benefits, to address concerns about care management, and to help identify appropriate resources.

To provide enhanced service to our clients, MetLife’s program offers expanded hours of operation for our toll-free number at all times, not just during enrollment periods. The following are the hours of operation:

|                          | <b>EASTERN</b>  | <b>CENTRAL</b>  | <b>MOUNTAIN</b> | <b>PACIFIC</b>  |
|--------------------------|-----------------|-----------------|-----------------|-----------------|
| <b>MONDAY – THURSDAY</b> | 8 AM to 10 PM   | 7 AM to 9 PM    | 6 AM to 8 PM    | 5 AM to 7 PM    |
| <b>FRIDAY</b>            | 8 AM to 9 PM    | 7 AM to 8 PM    | 6 AM to 7 PM    | 5 AM to 6 PM    |
| <b>SATURDAY</b>          | 9 AM to 4:30 PM | 8 AM to 3:30 PM | 7 AM to 2:30 PM | 6 AM to 1:30 PM |

**If an insured calls after 5:00 p.m. Eastern Standard Time or on a Saturday with care management issues, our long-term care insurance consultants are able to provide general information. If indicated, our nurse care managers who provide more extensive care management support, will call back on the next business day with any necessary clarifications or additional information. Once a nurse care manager has been in contact with an insured, subsequent calls can be scheduled at a mutually convenient time, providing flexibility for the insured and his/her family members.**

After-hours callers can leave a message in our voice mailbox. All calls are returned by a long-term care consultant on the next business day. MetLife can accommodate callers with special communications needs. We are equipped to answer calls placed through a TDD, a communication device for the hearing impaired. For non-English speaking callers, we use an AT&T service that can translate over 140 different languages.



**B. Confirm that the State will have the following:**

- a) **A toll free number**
- b) **clinician resources (may be an RN or an MSW) available for a reasonable amount of consultation.**

Please refer to item 7.a. above for a description of our toll free telephone line.

In order to provide the high level of service expected of our organization, we need to better understand the State’s requirements regarding clinician resources. We would be happy to discuss clinician resources with the State in greater detail.

**C. Do you currently provide automated interactive telephone communication service? Describe the menu available to callers and indicate if a touch-tone phone is required or if a voice-response feature is available. If available for our review, please provide the phone number, and sample id/login.**

**MetLife does not utilize an automated voice response system. Callers to our toll free telephone line are greeted by our customer service consultants who are equipped to answer a wide range of questions about plan features and benefits.**

**D. Provide information about your customer service representatives and address the following points:**

- a) **education requirement**
- b) **experience requirement**
- c) **initial training program**
- d) **on-going education**
- e) **turnover rates**

MetLife’s customer service consultants are an integral part of our long-term care insurance program. They are key to providing the high level of service we commit to our customers. Our goal is to ensure 100% satisfaction of existing and prospective insureds. Our customer service consultants are trained to listen carefully, to treat all customers with consideration, and to answer questions promptly and accurately.

We hire individuals with a background compatible with our organization and their ability to provide the type of customer service we provide to our insureds. We look for individuals with experience in customer service, insurance, and aging. Our customer service consultants understand the mature market; many have had personal experience with long-term care situations and, consequently, are particularly sensitive to the concerns of callers.

All customer service consultants undergo in-depth training. They each attend a seven week training class when hired. The topics covered in the class include general background about long-term care, the design and features of the long-term care insurance plan, services covered by Medicaid and Medicare, systems and billing procedures training, telephone etiquette and stress management. In addition, the specifics of the State long-term care insurance plan, your corporate culture, the design of your benefits program, and specific enrollment processes are covered prior to the beginning of the enrollment period.



To test their knowledge and ensure their preparedness, the customer service consultants role play and have two weeks of on the job training with live calls. They are evaluated on these exercises, and must also take a written test before they are assigned to the toll-free telephone line.

The turnover rate for customer service consultants within the Long-Term Care Call Group of MetLife’s customer response unit was 11% over the last two years. This is well below the industry average of 22%.

**E. What are your telephone standards for response time, abandonment rate and time on hold? What were your actual results compared to these standards for the last year?**

MetLife's telephone standards:

- 1. **Response time: 80 % of calls answered within 20 seconds**
- 2. Abandonment rate: Less than 2% call abandonment rate
- 3. Time on hold: 100% of calls on hold no more than 60 seconds

Actual results compared to these standards for 2000:

- 1. **Response time: 90% of all calls answered within 20 seconds**
- 2. Abandonment rate: Less than 2%
- 3. Time on hold: 100% of calls were not held more than 60 seconds

**F. Do you employ computer-assisted telephone answering capability? If so, is there default to an individual operator? If so, how long does it typically take to reach a live operator?**

**MetLife employs computer-assisted telephone answering capability. There is a default to an individual operator. It typically takes about 20 seconds to reach a live operator.**

**G. Do customer service representatives have real-time on-line access to (a) eligibility? (b) claims history/status? (c) benefit descriptions? (d) status of question/complaint?**

|                                     | YES | NO |
|-------------------------------------|-----|----|
| <b>Eligibility</b>                  | X   |    |
| <b>Claims history/status</b>        | X   |    |
| <b>Benefit descriptions</b>         | X   |    |
| <b>Status of question/complaint</b> | X   |    |



**H. Based on the potential number of eligible lives, what is your anticipated customer service unit staffing plan for both the initial enrollment, and for ongoing customer support?**

**MetLife operates its own customer service center, which can be accessed by the State employees and family members. We offer a dedicated staff of customer service consultants who will service the State’s plan during the initial enrollment period and on an ongoing basis. All plan provision information is available to customer service consultants on-line through a Windows-based system. Our consultants can provide eligibles with information regarding rate modeling, nursing home care costs, home care, claims information, and care management.**

We operate state-of-the-art telecommunications equipment to handle call activity. By routing our call activity, our management system allows MetLife to maximize productivity and ultimately better serve our customers. This system provides the data necessary to measure and analyze our service capacity as well as continually refine our process.

An essential element of our service is the responsiveness insureds can expect when they call for information about the plan or need assistance in accessing their benefits. MetLife is committed to providing the same level of service on an ongoing basis as provided during the initial enrollment process.

**I. Describe the process established to handle written inquiries from participants and plan sponsors including tracking procedures and follow-up steps.**

90% of inquiries/complaints requiring written correspondence are fully resolved within 48 hours. For the 10%, which cannot be fully resolved within 48 hours, the customer is contacted by phone and advised of the follow-up action and the date he or she can expect to receive the final resolution.

**J. Describe special customer services developed for the following participants:**

- a) Seniors**
- b) Non-English speaking**
- c) Hearing impaired**
- d) Visually impaired.**

MetLife can accommodate callers with special communications needs. We are equipped to answer calls placed through a TDD, a communication device for the hearing impaired. For non-English speaking callers, we use an AT&T service that can translate over 140 different languages.



**K. Describe your quality assurance or audit program for customer service, case management, and the grievance system that will be in place for participants. Who is responsible for the quality of the customer service unit? What monitoring results would be made available to the State?**

MetLife’s quality assurance plans for customer service and case management as well as grievance procedures are as follows:

Customer Service

Our commitment to the State’s employees and their family members is to provide the highest level of service and 100% satisfaction. We employ numerous mechanisms to ensure that we provide this level of service. MetLife uses performance standards to measure each customer services consultant’s ability to provide accurate and professional responses to all inquires.

The Long-Term Care Group uses MetLife’s performance measurement program to assess our long-term care insurance consultants’ ability to respond to inquiries accurately and in a professional manner. As part of this program, the customer service supervisor monitors actual calls to assess whether performance criteria are being met. In addition, our automated call management system monitors criteria such as average talk time, number of callers on hold and abandonment rate. All long-term care insurance consultants are given feedback on their performance daily, weekly, monthly, and annually. Weekly meetings are held to update consultants on any changes in plan design or other developments.

MetLife’s customer response unit maintains an active quality assurance program. Call center supervisors monitor customer service consultants for quality and accuracy on a daily basis. In addition, MetLife conducts a caller satisfaction survey with approximately 15% of callers to assess their level of satisfaction with the service they received when they called our toll free line. The replies received to date have been overwhelmingly favorable. The results of the survey are shared with the consultants and used to evaluate performance.

Care Management

Training and quality assurance programs for MetLife's care managers are managed by the manager of MetLife's benefit administration department.

Care managers from MetLife’s Long-Term Care Group conduct benefit authorization. MetLife believes that the first step in properly training care managers is through proper recruitment. We hire registered nurses with experience in fields such as aging, family issues, provider networks, patient referral, adult day care centers, nursing homes, hospitals, and home care agencies. This previous experience provides them with insight into the issues and emotions of our insureds and their families.



Once hired, our care managers undergo a formal classroom training program that includes written, verbal, and video instruction. This instruction includes in-depth information on plan provisions, benefit eligibility, and care management. Our care managers rely on an extensive procedure manual, which is introduced and studied throughout this training. Upon completion of the formal training program, one-on-one supervision from an experienced staff member provides new care managers with on-the-job training in actual situations.

On an ongoing basis, weekly staff meetings and outside seminars are used to keep our care managers current on long-term care issues, product changes, and specific case situations.

We currently send a quality assurance survey with every benefit authorization letter. These surveys allow us to monitor our insured's' satisfaction with the benefit authorization process. Results from these surveys have been overwhelmingly positive. Internally we audit 20% of our insured's files for accuracy of the benefit eligibility determination and appropriateness of the care management. We would be happy to share our survey results with the State.

Cindy Little, Director of group long-term care insurance Benefit Administration Department has ultimate responsibility for quality assurance.

Grievance System

An insured that has a grievance or complaint can call the toll-free telephone line and speak with a customer service consultant. In most cases, issues will be resolved over the phone. In rare instances where the insured may not be completely satisfied, the caller would first be referred to a supervisor, then to a customer service manager.

MetLife's goal is 100% customer satisfaction. We strive to attain this goal by having well trained customer service consultants available to answer questions, and by having state-of-the-art technology to support them. In the event an issue cannot be resolved within the call center, the account manager would work to resolve.

**L. Describe services available through a website, including on-line resource directories, coverage information, etc. If currently active and available for our review, provide the web address. Describe any expected enhancements.**

MetLife has developed customized websites for several of our corporate customers including JP Morgan, Texaco, Alcoa, Morgan Stanley Dean Witter, Ernst & Young, and Telcordia. Prospective enrollees are able to assess their need for long-term care insurance and obtain the following information:

- General information about long-term care, including the cost of care
- Coverage choices and rates
- Plan details
- Needs assessment tool



- Premium calculator with cost-benefit analysis
- Customer service
- Enrollment capabilities
- Request for enrollment information

MetLife can include information on how to locate providers (however, the site will not list specific providers), a resource checklist, and tips for choosing appropriate providers. We can also include a list of questions to ask potential providers that would assist employees and their families in choosing the provider best suited to meeting their needs. If the company uses an eldercare referral service, we could also provide a link to that website.

Online enrollment is available to active employees who are eligible for guaranteed issue coverage. The employee can access all plan information through the website, enroll, and receive a confirmation of his/her coverage selection.

As a sample of a customized long-term care website, the State may access the Alcoa website at <http://alcoa.metlife.com>. A password is not necessary for this site.

**M. Describe all methods used to determine participant satisfaction. Indicate the frequency of surveys. Indicate if account-specific satisfaction surveys are available. Provide results of the most recent book-of-business survey.**

At the end of the enrollment period, MetLife generally conducts an implementation survey with each of our corporate customers. MetLife maintains an open dialogue and we have formalized surveys in place. This provides us with feedback on our efficiencies in implementing the program. Approximately ten weeks after the plan’s effective date, we like to meet with our customers to review enrollment results and to develop a strategy for the coming year.

*On an ongoing basis and in addition to meetings with our customers, we conduct policyholder surveys with our customers to understand how we are managing the relationship and what we can do better. Our focus is also at the certificate level, where we conduct a variety of satisfaction surveys. The following describes our experiences and results from post-enrollment satisfaction surveys:*

*Implementation Survey*

After the effective date of the plan, MetLife will send an implementation survey to determine if our team met the State’s expectations during the implementation of this program.

**Customer Service**

Each week during the enrollment period a customer satisfaction survey is completed by approximately 15% of callers to assess their level of satisfaction with the service they received when they called our toll-free line. The replies received to date have been overwhelmingly favorable. Over 90% of survey respondents have been extremely satisfied with the overall service we provide.

**Policyholder Account Management Survey**

To be proactive with our corporate customers, we have instituted a policyholder account Management survey. This survey is conducted by a separate research group within MetLife. The survey provides us with an understanding of how our corporate customers view us in terms of our product, service, and their MetLife account manager. The results of the survey have been quite favorable. Our customers are extremely satisfied with us and view us as being proactive in keeping them informed of issues in regards to their plan and the long-term care insurance industry in general.

In addition, we have conducted a buyer/non-buyer survey on several of our corporate groups following an enrollment period. This survey was conducted over the telephone. The purpose was to understand the key difference between buyers and non-buyers. The results were qualitative.



**8. CLAIMS ADMINISTRATION**

**A. How do you define each of the ADL and cognitive impairment criteria included in the plan design? Please be specific.**

**MetLife's criteria for benefit eligibility conforms to HIPAA. We will utilize the following ADLs as defined below.**

- Bathing:** washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Dressing:** putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- 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.
- Eating:** feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table), by a feeding tube or intravenously.
- Contenance:** 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).

**Benefit payments cannot be made unless insured's meet the benefit eligibility criteria and have been certified by a licensed health care practitioner as being chronically ill. A licensed health care practitioner as defined by HIPAA is a physician, registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. Chronically ill means:**

- expected to be unable to perform (without substantial assistance from another individual) at least 2 of the 6 ADLs for a period of at least 90 days due to a loss of functional capacity,
- or**
- having a severe cognitive impairment that requires substantial supervision to protect such individual from threats to health and safety.

MetLife covers disabilities resulting from organic brain diseases, including Alzheimer's disease and similar disorders. *The plan also covers dependencies resulting from brain diseases which are not organically based, as long as the insured meets the benefit eligibility*



*criteria.* MetLife does not attempt to identify the cause of disability or mental disorder. The presence of many interrelated factors makes it difficult to isolate cause and thus, to administer a plan which excludes mental or nervous disorders.

Under the ADL trigger, MetLife's definition of "unable to perform" or "dependency" requires that an individual need human assistance in carrying out a given ADL the majority of the time he or she attempts to perform the ADL. This may include hands-on assistance or standby assistance or verbal direction. For example, a person would need substantial assistance in eating if he or she required one of the following types of assistance the majority of the time he or she performed the activity:

- 1) Requires physical assistance in bringing food to the mouth (e.g., use of utensils) or requires another person to feed him or her either by mouth or through tube feedings.
- 2) Requires stand-by assistance (e.g., high risk of choking) because the individual may, on an emergency basis, have a need for hands-on assistance during the meal.

Under the severe cognitive impairment trigger, an example would be requiring supervision or verbal direction to safely and effectively complete the meal.

Benefits will be paid for services included in a Plan of Care prescribed by a licensed health care practitioner. Ongoing recertification of the insured will be required at least every 12 months.

MetLife will authorize the payment of benefits when we receive satisfactory proof that the insured is "chronically ill" and has satisfied the waiting period.

There is no requirement that insured's be confined in a hospital prior to a request for benefits.

**B. Separately for each ADL and for cognitive impairment, describe the criteria you use to establish whether a person is unable to perform the ADL or is cognitively impaired (e.g., for bathing, alternate criteria might include: cannot bathe 50% of his/her body, cannot bathe every body part, including the back, etc.) Will you require the insured to need active human assistance to "fail" the ADL, or will standby need for assistance be sufficient?**

MetLife's definition of "unable to perform" or "dependency" requires that an individual need substantial human assistance the majority of the time. Human assistance may be hands-on or standby. Hands-on assistance means that the insured requires the physical assistance of another person without which they would be unable to perform the ADLs. Standby assistance means the insured requires the presence of another person within arms reach of them to prevent, by physical intervention, injury while they are performing the ADLs.

If the insured has a severe cognitive impairment, they must require substantial supervision to protect them from threats to health and safety. Substantial supervision means they require continual supervision (which may include cueing by verbal prompting, gestures or other



demonstrations) by another person. The following criteria are used to establish the need for substantial assistance and substantial supervision in each of the ADLs:

Bathing

- a. Requires someone to give hands-on assistance to get in and out of the tub or the shower or to wash their body.
- b. Requires someone to standby during the activity due to the individual's poor balance (because of the increased risk of falling).
- c. Requires cueing to carry out the task appropriately due to cognitive impairment, though the individual is physically independent.

Dressing

- a. Requires someone to give hands-on assistance to put on clothes or fasten closures for all or part of the task.
- b. Requires someone to standby due to the individual's poor balance or bending capability which puts them at risk for falls.
- c. Requires supervision to carry out the task appropriately due to the individual's cognitive impairment.

Toileting

- a. Is bed bound and requires total assistance with all aspects of the task.
- b. Requires hands-on assistance ambulating to and from the toilet or transferring on and off the toilet.
- c. Due to cognitive impairment, requires verbal cueing and supervision for toileting regime.

Transferring

- a. Totally dependent and is bed bound.
- b. Due to physical limitations, needs hands-on assistance for difficult maneuvers.
- c. Requires some verbal cueing and supervision to safely execute transfer due to cognitive impairment, though the individual can physically execute the task.

Eating

- a. Requires physical assistance in bringing food to the mouth (e.g., use of utensils) or requires another person to feed him or her either by mouth or through tube feedings.
- b. Requires verbal direction during the course of consuming the meal to safely and effectively complete the meal.
- c. Requires supervision because the individual may, on an emergency basis, have a need for hands-on assistance during the meal (e.g., high risk of choking).



Continence

- a. Bladder incontinence which requires hands-on assistance for hygiene/equipment.
- b. Bowel incontinence which requires hands-on assistance for hygiene/equipment.
- c. Individual is constantly or intermittently incontinent and requires supervision to carry out associated hygiene due to cognitive impairment.

Benefits will be paid for services included in a Plan of Care prescribed by a licensed health care practitioner. Ongoing certification of the insured will be required at least every 12 months.

MetLife will authorize the payment of benefits when we receive satisfactory proof that the insured meets the benefit eligibility criteria described above and has satisfied the waiting period.

There is no requirement that insured's be confined in a hospital prior to a request for benefits.

**C. What standardized tools or methods do you use to assess whether an individual is unable to perform each ADL or is cognitively impaired?**

A MetLife care manager will contact the insured's family, physician, nurse, or health care professional to request information about the insured's medical condition, ADL-dependence, and cognitive status. The insured's state, in each of these areas, is evaluated by the care manager and is recorded in our primary benefit authorization system. If deemed appropriate, MetLife may obtain medical records or will arrange for an independent evaluation by a care manager.

Our benefit authorization system, developed specifically for this purpose, scores an individual's need for assistance with ADLs, nursing care, and supervision related to cognitive disability. This system guides the MetLife care manager through the benefit authorization process.

**D. Where do you perform the claimant assessment? Can you perform assessments throughout the United States and its territories? Can you perform assessments outside the United States (e.g., Canada)? Are in-person assessments always performed, or do you sometimes rely on telephone assessments or physician statements?**

Most of our assessments are conducted over the telephone by a MetLife care manager. On a rare occasion a face-to-face assessment may be required. If a face-to-face assessment is required, the selected agency will call to make an appointment for a mutually convenient time. Assessments are performed throughout the United States and its territories.

**E. What are the qualifications of individuals performing ADL/cognitive impairment assessments? How is their performance evaluated? How are they supervised? What is their relationship to your organization (employees, independent contractors)?**



Care managers from MetLife's Long-Term Care Group conduct benefit authorization. Our care managers are registered nurses with experience in both long-term care and acute care nursing. They have experience working in adult day care centers, nursing homes, hospitals, and home care agencies.

MetLife strongly believes that the first step in ensuring that benefit authorization and care management activities are performed in a quality manner is through hiring staff with the backgrounds described above. Our care managers join MetLife with the kind of professional experience that makes them sensitive to the needs of individuals and families who are experiencing long-term care issues. When insured's request benefits, they are assigned to a care manager who will work with them throughout the benefit period.

To ensure that care management is administered in a consistent fashion, we have structured a training program that includes intensive initial training as well as ongoing in-service education. Initially, new care managers work closely on a one-on-one basis with an experienced staff member to ensure quality standards are met. In addition, supervisors keep staff apprised of changes in plan design and external care delivery issues which impact our care management services. A rigorous ongoing quality assurance program is an integral part of the staff training process.

**F. What is the waiting period for an assessment?**

**There is no waiting period for an assessment; an appointment will be made at the insured's convenience.**

**G. What guidelines do you use to determine how often a claimant needs to be reassessed once initial eligibility for benefits is established?**

Through the process of concurrent review, insured's that are receiving benefits are monitored on an ongoing basis to assess their continued ADL dependency and need for benefits. The review is initiated by a care manager who calls the insured's doctor or other health care provider, such as a nursing home or home care agency. During the call, the care manager asks questions similar to those asked during the initial benefit eligibility review. The frequency of the review depends upon the nature of the condition and the prognosis for improvement. For example, an individual with Alzheimer's disease would be reviewed less frequently than an individual with a hip fracture. All insured's who are in benefit are reviewed at least once every 12 months, without exception.

**H. Describe the claims payment process, including quality control and supervision of claims processors. Include such items as the claim submission process, who may initiate a claim, to whom is the claim submitted, the internal claim review process, the average time between submission and approval, the process of reviewing medical aspects of the claim, notification of the claimant of approval or rejection, the appeal process for rejected claims, and system security measures.**

MetLife's claims process is simple. Once an insured has fulfilled the waiting period and has received a covered service, he or she can submit a claim. Benefit payments can be assigned to the care provider. MetLife will then work directly with the provider regarding payment.



Assigning benefits eliminates the need for insured's to submit claims on a regular basis; for each provider, the insured need only submit one claim form. Claims are paid within 10 business days of receipt of all necessary information.

An insured that disputes a claim reimbursement can call the toll-free telephone line and speak with a claims approver. In most cases, issues will be resolved over the phone and a confirmation letter will be sent by the claims approver. In the event a dispute cannot be resolved in this manner, the claimant will be asked to submit the information in writing to the Long-Term Care Group. Such disputes will be reviewed by a claims manager. A decision will be made and confirmed in writing within 10 business days of receipt of all relevant information.

Our claims unit is currently staffed by a manager, supervisor, and seven claims examiners. As the volume of claims increases, we will expand our staff as needed. The claims manager is a registered nurse with an extensive background in long-term care and acute care settings. The claims supervisor has extensive experience in the administration and processing of long-term care insurance claims. In hiring claims approvers, we seek individuals with prior experience in a claims environment, strong analytical and mathematical skills and the ability to interpret contract provisions.

A Benefit Authorization & Claims Payment Process flow chart is included in Part IV of this proposal.

To initiate a claim, the insured or anyone acting on his or her behalf can contact MetLife via our toll-free telephone line (no forms are required to establish eligibility for benefits). A MetLife care manager will obtain the information needed, including ADL aspects, to determine the insured's eligibility for benefits. All of our care managers are registered nurses. In some cases, the care manager may also contact the insured's representative and/or others who may have relevant information about the insured's condition. In the rare event that we are unable to obtain the necessary information through these channels, MetLife may arrange an onsite assessment at our expense.

Insured's are notified by mail of the decision within 10 working days of receipt of all necessary information.

**I. How do you track the application of plan provisions such as the elimination period, waiver of premium, and daily and lifetime benefit maximums?**

All plan information is tracked in our state of the art long-term care system.



**J. What is the maximum period of time you allow claimants to submit a claim after the date an expense is incurred?**

**MetLife requests that insured's provide proof of service no later than 90 days after the end of the calendar year in which the covered services were received. If the insured does not give us proof by this time, the claim will not be denied or reduced because of the delay, as long as proof is given as soon as possible.**

**K. What is your average or anticipated turnaround time on LTC claims?**

MetLife's corporate standard is to pay claims within 10 business days of receipt of all necessary information.

**L. Do you agree to allow the State, or an independent auditor selected by the State, to audit your claims payment procedures and records for State enrollees?**

Yes. The State, or an independent auditor selected by the State, will be permitted to audit MetLife's procedures upon request, provided we are given sufficient notification prior to such event. MetLife has corporate guidelines for audit procedures which we will provide to the State prior to an audit. Due to client confidentiality, certain items may be excluded from the data (e.g. insured personal information), since this is an insured-pay-all coverage. We believe the claims data available for analysis will enable the State to conduct a comprehensive audit. There would be no fee associated with these requests. The turnaround time would be dependent on the form of data and the manner in which it is delivered. All audits will be conducted at the State's expense. We would be happy to discuss this in further detail with the State.

**M. Describe your LTC claim appeals process in detail. Do you require or are you willing to use arbitration?**

The following is a detailed explanation of the long-term care claims appeal process:

If benefits are denied, MetLife will send a declination letter to the insured indicating the reason for denial and explaining the process for appealing the decision. The letter includes a benefit authorization appeal form, which the insured sends to his or her physician or other health care provider to complete and return to MetLife. This appeal form, as well as the insured's file, will be reviewed by a supervising nurse in our clinical unit and/or a physician knowledgeable about long-term care needs from MetLife's Corporate Medical Department. The reassessment may include contacting the insured, the insured's representative and/or other persons who have relevant information about the insured's condition. MetLife will notify the insured of its final decision within 10 business days of receiving all necessary information.

An insured or their representative who disputes a claim reimbursement can call the toll-free telephone line and speak with a claims approver. In most cases, issues will be resolved over the phone and a confirmation letter will be sent by the claims approver. In the event a dispute cannot be resolved in this manner, the claimant will be asked to submit the information in writing to the Long-Term Care Group. Such disputes will be reviewed by a



claims supervisor or manager. A decision will be made and confirmed in writing within 10 business days of receipt of all necessary information.

At this time MetLife does not require nor have we had to use arbitration for our appeal process. We are open to discussing the use of arbitration if the State desires.

**N. Besides the specified standards of performance, what additional quality and cost management programs does your company follow?**

Our commitment to the State’s employees and their family members is to provide the highest level of service and 100% satisfaction. We employ numerous mechanisms to ensure that we do, in fact, provide this level of service. MetLife uses performance standards to measure each customer’s ability to provide accurate and professional responses to all inquires.

Customer Service

The Long-Term Care Group uses MetLife’s performance measurement program to assess our Long-Term Care Insurance Consultants’ ability to respond to inquiries accurately and in a professional manner. As part of this program, the customer service supervisor monitors actual calls to assess whether performance criteria are being met. In addition, our automated call management system monitors criteria such as average talk time, number of callers on hold and abandonment rate. All Long-Term Care Insurance Consultants are given feedback on their performance daily, weekly, monthly, and annually. Weekly meetings are held to update consultants on any changes in plan design or other developments.

MetLife conducts a caller satisfaction survey with approximately 15% of callers to assess their level of satisfaction with the service they received when they called our toll free line. The replies received to date have been overwhelmingly favorable. The results of the survey are shared with the consultants and used to evaluate performance.

Scott Hammond, call center director, has overall responsibility for our call center operations. He will be directly responsible for the quality of service provided to the State callers.

MetLife’s standards of performance are as follows:

- 80% of all calls are answered within 20 seconds.
- The abandon rate is 1.5%.
- 80% of inquiries/complaints requiring written correspondence are fully resolved within 48 hours. For the 10%, which cannot be fully resolved within 48 hours, the customer is contacted by phone and advised of the follow-up action and the date he or she can expect to receive the final resolution.

Benefit Administration

Training and quality assurance programs for MetLife's care managers are managed by the manager of MetLife's benefit administration department.



Care managers from MetLife’s Long-Term Care Group conduct benefit authorization. MetLife believes that the first step in properly training care managers is through proper recruitment. We hire registered nurses with experience in fields such as aging, family issues, provider networks, patient referral, adult day care centers, nursing homes, hospitals, and home care agencies. This previous experience provides them with insight into the issues and emotions of our insured’s and their families.

Once hired, our care managers undergo a formal classroom training program that includes written, verbal, and video instruction. This instruction includes in-depth information on plan provisions, benefit eligibility, and care management. Our care managers rely on an extensive procedure manual which is introduced and studied throughout this training. Upon completion of the formal training program, one-on-one supervision from an experienced staff member provides new care managers with on-the-job training in actual situations.

On an ongoing basis, weekly staff meetings and outside seminars are used to keep our care managers current on long-term care issues, product changes, and specific case situations.

We currently send a quality assurance survey with every benefit authorization letter. These surveys allow us to monitor our insured’s’ satisfaction with the benefit authorization process. Results from these surveys have been overwhelmingly positive. Internally we audit 20% of our insured’s files for accuracy of the benefit eligibility determination and appropriateness of the care management.

In addition, LifePlans has an extensive quality assurance program which includes an initial qualification and training process for all care advisors, ongoing review of completed assessments, and inter-rater reliability audits. LifePlans may also make periodic site visits to local providers. MetLife also has the right to make site visits to LifePlans' network agencies and to conduct client satisfaction surveys.

MetLife's contract with LifePlans outlines performance guarantees and quality assurance guidelines. The manager of the Long-Term Care Group's Benefit Administration Department develops and monitors the quality assurance program for LifePlans. Each insured is contacted after the initial care advisory visit as part of the quality assurance program.

As a public company, MetLife makes cost management an essential part of our business. We are constantly making efforts to manage costs and streamline our procedures for smart spending. Every department within MetLife is assigned a cost center code, that each person in the department is responsible for, and the director is ultimately responsible for maintaining. These cost centers allow the company to be most efficient in assuring quality control and assigning specific costs to specific departments. We are always developing new initiatives to defray higher cots items, such as travel arrangements.



**O. Provide a summary of your organization’s disaster recovery plan as it relates to equipment, software, data tapes and personnel which would be used in providing the services described in the bid specifications.**

MetLife has placed significant emphasis on establishing disaster recovery plans for each of its business operations, including the Long-Term Care Group. Formal, written disaster recovery plans from each functional area within the Long-Term Care Group have been prepared and are on file with our corporate specialists. These plans include the designation of individuals who will comprise the Disaster Recovery Coordination Team; the tasks assigned to each team member; chains of communication internally and with our business partners and customers; prioritization for the sequential restoration of functions, connections, and systems; the location of stored backup data; as well as a detailed account of the equipment, software, and personnel necessary to perform a meaningful and timely recovery.

All Long-Term Care systems data is backed up daily, with the backup data being maintained off site in secure, fireproof storage by a vendor specializing in this activity. Daily production work can be performed from our offices in Westport, Connecticut and Warwick, Rhode Island. Customer service and call center operations can be operated from our offices in Westport, Connecticut; Warwick, Rhode Island; or can be routed to one of our other three call centers.



**9. CASE MANAGEMENT**

- A. Describe in detail your case management function, from point of initial access through care coordination, including participant interface, review and approval of services, etc. Include a description of how your case management function addresses protections, monitoring, oversight, outcomes and alternative methods of care/nursing.**
- B. Describe how your case management process addresses the preference for home care over nursing home care.**
- C. Are the personnel providing ongoing case management for claimants the same as the personnel assessing the claimant on ADLs or cognitive impairment? If not, describe the qualifications of case managers and their relationship to your organization. If you use outside case managers, how do you select them? Provide the information requested in 7-D for case managers.**

MetLife offers care management as part of its long-term care plan. Our approach to care management encourages insured's to participate in the decisions which affect their lives and seek to foster their self sufficiency for as long as possible. Our "total person" approach incorporates three elements: Benefit authorization, onsite voluntary care advisory services, and elder care resource services. We have also found that collaboration between MetLife's care managers and independent care advisors results in the best plan of care for the insured.

The following is a detailed explanation of MetLife's approach to care management.

- **Benefit Authorization**

Care managers from MetLife's Long-Term Care Group conduct benefit authorization. Our care managers are registered nurses with experience in both long-term care and acute care nursing. They have experience working in adult day care centers, nursing homes, hospitals, and home care agencies.

Benefit authorization begins with the initial benefit eligibility review and includes arranging for a care advisory visit (if requested by the insured) and providing information and care alternatives to the insured and his or her family. To provide continuity, the same care manager works with the insured throughout the benefit eligibility period.

Benefit Eligibility

During the initial benefit eligibility review, a care manager assesses the insured's eligibility for benefits and the anticipated duration of the eligibility period. Once an insured is in benefit, our care managers provide insured's with information about available providers and if any negotiated discounts are available.

Ongoing Review

Throughout the process of ongoing review, insured's that are receiving benefits are monitored on an ongoing basis to assess their continued eligibility for benefits. The review is initiated by a MetLife care manager who calls the insured's physician or other health care provider, such as a nurse in the nursing home or home care agency. During the call, the care manager asks questions similar to those asked during the initial benefit eligibility review.



The frequency of the ongoing review depends upon the nature of the insured's condition and the prognosis for change.

- Onsite Voluntary Care Advisory Services

The plan provides onsite voluntary care advisory services to assist insured's in managing their own care. These optional services are provided by care advisors who are unaffiliated with MetLife.

Voluntary Initial Care Advisory Visit

*Insured's are entitled to one free optional initial care advisory visit.* During this in-home assessment, a care advisor helps the insured and his or her family understand their care alternatives and identifies local providers of care. The visit has three components. First, the care advisor assesses the individual's functional status and living environment. Second, a comprehensive long-term care service plan is developed. Third, providers or community resources are suggested to meet the needs outlined in the service plan, and the role of family members in the service plan is evaluated. This one-time benefit can be used anytime, once an insured is benefit-eligible. There is no waiting period to satisfy prior to its use.

To provide the initial care advisory visit, MetLife has contracted with the Family Caring Network of LifePlans, Inc. (LifePlans), a nationwide network of local community-based organizations which provide long-term care case management services. Each participating agency has a staff of experienced, well-trained professionals who are certified with R.N. or B.S.W. degrees. All receive specialized training in long-term care case management. The staff's training and credentials are guaranteed through contractual agreement by LifePlans. LifePlans currently has more than 800 agencies nationwide. *MetLife will cover 100% of the charge for this service if a LifePlans care advisor is used. If a care advisor from LifePlans is not available, MetLife will pay up to \$250 for this service. Charges for this service will not reduce the insured's total lifetime benefit.* Due to Texas state regulations, MetLife will pay up to \$275 for this service for Texas residents if a care advisor from LifePlans is not available.

LifePlans has an extensive quality assurance program which includes an initial qualification and training process for all care advisors, ongoing review of completed assessments, and inter-rater reliability audits. LifePlans may also make periodic site visits to local providers. MetLife also has the right to make site visits to LifePlans' network agencies and to conduct client satisfaction surveys.

MetLife's contract with LifePlans outlines performance guarantees and quality assurance guidelines. The manager of the Long-Term Care Group's Benefit Administration Department develops and monitors the quality assurance program for LifePlans. Each insured is contacted after the initial care advisory visit as part of the quality assurance program.



Ongoing Care Advisory Services

Ongoing care advisory services are available through LifePlans or any other care advisor unaffiliated with MetLife. Insured's may use a care advisor to coordinate various types of care, arrange for appropriate services, monitor the care being received, and assist with altering the long-term care service plan as needs change. Expenses for ongoing care advisory services are covered under the home care benefit and will reduce the insured's total lifetime benefit.

Care advisory services are designed to assist insured's in selecting the right care from appropriate providers. *Use of these services by insured's is voluntary; advice may be rejected without impacting benefits.*

- Elder Care Resource Services

Elder care resource services are provided by MetLife care managers. Care managers are available to answer general questions, address concerns about care management, and help identify appropriate resources. They maintain directories of service providers by category and utilize the Internet to locate appropriate providers and information. When appropriate, they may direct insured's to the local Area Agencies on Aging, the State Department on Aging, or providers who offer discounts.

Through the initial care advisory visit and ongoing care advisory services, insured's can select unaffiliated care advisors to answer questions, and address concerns about care management, and help identify appropriate resources.

**D. How is the performance of case managers evaluated? How are they managed?**

Training and quality assurance programs for MetLife's care managers are managed by the manager of MetLife's benefit administration department.

Care managers from MetLife's Long-Term Care Group conduct benefit authorization. MetLife believes that the first step in properly training care managers is through proper recruitment. We hire registered nurses with experience in fields such as aging, family issues, provider networks, patient referral, adult day care centers, nursing homes, hospitals, and home care agencies. This previous experience provides them with insight into the issues and emotions of our insured's and their families.

Once hired, our care managers undergo a formal classroom training program that includes written, verbal, and video instruction. This instruction includes in-depth information on plan provisions, benefit eligibility, and care management. Our care managers rely on an extensive procedure manual which is introduced and studied throughout this training. Upon completion of the formal training program, one-on-one supervision from an experienced staff member provides new care managers with on-the-job training in actual situations.



On an ongoing basis, weekly staff meetings and outside seminars are used to keep our care managers current on long-term care issues, product changes, and specific case situations.

We currently send a quality assurance survey with every benefit authorization letter. These surveys allow us to monitor our insured's' satisfaction with the benefit authorization process. Results from these surveys have been overwhelmingly positive. Internally we audit 20% of our insured's files for accuracy of the benefit eligibility determination and appropriateness of the care management. We would be happy to share our survey results with the State.

Cindy Little, Director of the Benefit Administration Department has ultimate responsibility for quality assurance.

**E. What specific services do case managers provide (e.g., referral to specific providers, negotiation of provider charges, care planning, assessment and monitoring of ongoing services, bill review)? Does the case manager meet with the claimant and his/her family, or are services provided by telephone?**

Please refer to question 9.C. above for a complete description of MetLife's care management.

**F. How often can claimants access case management services? How is this service accessed? What is the annual or lifetime limit on provision of case management services that is included in your rates?**

Our approach to care management encourages insured's to participate in the decisions which affect their lives and seek to foster their self sufficiency for as long as possible. We have no limit on claimant's access to care management services. Our care managers are available to assist callers free of charge with questions pertaining to benefits, to address concerns about care management, and to help identify appropriate resources and claims payment simply by calling our toll-free telephone number.

In addition, insured's are entitled to one free optional initial care advisory visit. This one-time benefit can be used anytime, once an insured is benefit-eligible. There is no waiting period to satisfy prior to its use. MetLife will cover 100% of the charge for this service if a LifePlans care advisor is used. If a care advisor from LifePlans is not available, MetLife will pay up to \$250 for this service. Charges for this service will not reduce the insured's total lifetime benefit. Ongoing care advisory services are available through LifePlans or any care advisor unaffiliated with MetLife. Insured's may use a care advisor to coordinate various types of care, arrange for appropriate services, monitor the care being received, and assist with altering the long-term care service plan as needs change. Expenses for ongoing care advisory services from an unaffiliated care advisor are covered under the home care benefit. Payment for ongoing care advisory services are reimbursed at the home care benefit level.



**G. Is case management voluntary or mandatory for the plan you are proposing for the State?**

Care advisory services are designed to assist insured's in selecting the right care from appropriate providers. Use of these services by insured's is voluntary; advice may be rejected without impacting benefits.

**H. How do you establish and update a database of LTC service providers throughout the United States and its territories for your case managers to use?**

MetLife currently provides eldercare information and referral services to insured's and their families at no additional cost. Elder care resource services are provided by both MetLife care managers and external care advisors. Insured's are eligible to access this service by calling our toll-free number and talking with one of our care managers. MetLife's long-term care group care managers are available to answer general questions, address concerns about care management, and help identify appropriate resources. They maintain directories of service providers by category which are updated annually. When appropriate, they may direct insured's to the local Area Agencies on Aging, the State Department on Aging, or providers who offer discounts. Counseling from our care managers to insured's, family members, and other caregivers pertaining to an insured's health status and care needs is included as a service under care management.

In addition, through the free one-time initial care advisory visit and ongoing onsite care advisory services, all insured's can access unaffiliated care advisors to answer their questions and concerns about care management, at no additional cost. The care advisors from the Family Caring Network of LifePlans, Inc. can also help identify appropriate resources. They maintain a comprehensive, up-to-date database of local providers and resources that the insured may choose to utilize. LifePlans is a nationwide network of local community-based organizations which provide long-term care case management services. Each participating agency has a staff of experienced, well-trained professionals who are certified with R.N. or B.S.W. degrees. All receive specialized training in long-term care case management. The staff's training and credentials are guaranteed by contractual agreement. There are currently over 800 agencies nationwide in the LifePlans network.

Care advisory services are designed to assist insured's in selecting the right care from appropriate providers. Use of these services by insured's is voluntary; advice may be rejected without impacting benefits.

MetLife subscribes to case management referral directories that are updated annually; the directories contain service providers by category. They also use the Internet to locate providers in communities throughout the country; and to gather information on local services such as meals on wheels, support groups, help organizations and financial resources. New providers are entered into the long-term care provider database on a continuous basis.

Directories that we purchase for nursing homes, assisted living, home care, and adult day care are renewed annually. Our own provider database is continually updated.



**10. FINANCIAL/RESERVE ISSUES**

**A. Please complete the Rate Quotation Form showing rates by entry age, and include in the separately sealed bid called for under IV-G below (do not include as part of the questionnaire). Rates should be quoted net of commissions.**

The Rate Quotation Form is located in Part III of this proposal.

**B. Describe your rate-setting process. What assumptions are included in your rates? Give the percentage (i.e., not the amounts) breakdown of the component costs of the rates (e.g., administration, taxes, risk charges, claims, various types of reserves, interest rate credits, lapse rates, etc.).**

MetLife uses the following assumptions in developing group long-term care insurance premiums:

**1. Enrollment Assumptions**

There are a number of factors, outlined below, which can influence the level of participation for a particular employer.

**Age:** MetLife has experienced the greatest participation among those individuals in their forties, presumably because they have begun to give thought to issues associated with estate and/or retirement planning and future health care needs.

**Salary level:** Participation tends to be higher among salaried employees who typically have a higher percentage of discretionary income than hourly employees.

**Job classification:** Participation tends to be higher among salaried employees than among union employees. For example, one employer group offered our plan to both salaried and union employees. The participation rate among salaried employees was 15%, while the participation rate for union employees was only 3%.

**Corporate culture and climate:** Participation can be negatively impacted in a climate where layoffs, cutbacks, salary freezes, or other economic instability exists. In terms of corporate culture, participation rates are higher when the sponsoring employer is perceived by the employee to be supportive and genuinely concerned about the welfare of employees and their families.

**Level of support provided by sponsoring employer:** We typically see the highest participation levels when employers enthusiastically endorse the benefit as worthwhile and valuable, and confer the same degree of emphasis and attention upon long-term care insurance as the other benefit options being presented.



**Communications Campaign:** Despite the best possible plan design, enrollment may be low if the plan is not effectively communicated to eligible participants early in the enrollment process. People must fully comprehend the advantages of long-term care insurance. MetLife has an array of communications materials, which have proven very effective in addressing most questions and concerns pertaining to long-term care insurance.

**2. Incidence Risk**

Nursing home incidence rates were derived from data in the *1985 National Nursing Home Survey* adapted by the Office of the Actuary, and are approximately equal to those of "Insurable Stays Benefit Period Concept" as shown in *The Society of Actuaries Transactions, 1988-89-90 Reports of Mortality, Morbidity, and Other Experience*. Home care prevalence rates were derived from the 1982, 1984, and 1989 *National Long-Term Care Surveys*. Incidence rates vary by age, sex, and the duration of insurance coverage.

**3. Length of Stay/Duration of Care (Continuance Tables)**

The lengths of stays for people in a nursing home were derived from data in the *1985 National Nursing Home Survey*. For an individual receiving home care, the duration of care is assumed to be the same as for the person in the nursing home who is the same age and who has the same level of disability.

**4. Mortality Rates/Lapse Rates (Termination Rates)**

Mortality rates were based on the 1983 Group Annuity Mortality Table, adjusted to remove loading. Lapse rates were assumed to be 5.5% in year one, grading down to an ultimate rate of 4.5% in year ten and thereafter.

**5. Interest Rate**

The interest rates used for discounting future paid premiums, paid claims, and paid expenses, average 6%.

**6. Rating**

Our prospective rating is based upon full recognition of all expected future claims and expenses in all years.

MetLife's rates are broken down into the following component costs:

- Administrative: 8% of premium
- Certificate Charge: \$10 per insured annually
- Other Expenses: 40% of first years' premium
- Taxes: 4% of premium
- Risk Charge: 4% of premium



- Claims Expense: 5% of claims
- Various types of Reserves: Please refer to question H for a full description

C. Please show your current target loss ratio and provide the components of your loss ratio calculation. Confirm that your target loss ratio meets all legally mandated loss ratio requirements in all states, as required.

**The loss ratio is a calculated result that depends on the expense, claim, interest, demographic, and reserve assumptions.**

The NAIC Long-Term Care Model Regulation specifies that “benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided. The expected loss ratio is at least sixty percent (60%).” The NAIC Long-Term Care Insurance Experience Reporting Forms are designed to monitor compliance with this lifetime loss percentage standard by comparing actual loss percentages to those anticipated at the time the policy is priced. This analysis is performed on a cumulative basis, as well as for each calendar duration, and excludes the change in policy (active life) reserves. The cumulative loss ratio for a given experience period is calculated as the actual incurred claims divided by the actual earned premiums for that entire experience period. The details of this calculation require that actual earned premiums and actual incurred claims be interest-adjusted using the appropriate interest rate from the calendar year in which the premiums were earned or the claims were incurred to the end of the experience period. While we expect some variation in loss ratio due to variations in coverage provisions, risk characteristics, and underwriting standards, we expect the loss ratio over the lifetime of our proposed group long-term care plan to be approximately 75%.

MetLife confirms that our target loss ratio meets all legally mandated loss ratio requirements.

**D. Show your projected loss ratio for your employer-sponsored group LTC book of business over a ten-year period. Identify the ratio with and without the change in the active life reserve in the numerator. In both cases, include paid claims and the change in the claim reserve in the numerator. Assume a closed book of business and assume that duration one is the end of the first year of issue.**

The chart below is the projected durational loss ratio for our employer-sponsored group LTC book of business over the next 10 years. We typically do not include the change in the active life reserve in the numerator. Inclusion of the change in the Active Life Reserve (ALR) in the numerator would not be consistent with the definition used in the NAIC Long-Term Insurance Experience Reporting Forms.



| Duration | Durational loss ratio without change in ALR | Durational loss ratio with change in ALR |
|----------|---|--|
| 1        | 36%   | 148%                                     |
| 2        | 44%   | 152%                                     |
| 3        | 52%   | 157%                                     |
| 4        | 61%   | 162%                                     |
| 5        | 72%   | 167%                                     |
| 6        | 81%   | 171%                                     |
| 7        | 91%   | 177%                                     |
| 8        | 103%  | 182%                                     |
| 9        | 116%  | 187%                                     |
| 10       | 129%  | 193%                                     |

**E. Describe the methodology you would use to determine rate adjustments at renewal. Show weightings given to actual State experience, pooled experience and other factors. Would the experience of the State be pooled with the experience of other groups, or will ongoing rates be solely reliant on State experience? What combination of time and participation do you anticipate before the State plan would be 100% credible for rate-setting purposes?**

At the end of the initial five-year rate guarantee period, MetLife will set renewal rates by evaluating the past and probable future experience of the insured's covered. Unlike term insurance rates which cover claims for only a given coverage period, long-term care insurance rates are designed to remain level and to cover claims for the duration of the insured's lifetime maximum. Therefore, experience extending far into the future must be considered. The expected future morbidity, mortality, lapse rates, plan expenses, and investment income are analyzed with consideration given to:

- 1.The estimated experience used to set the initial rates (including morbidity factors based on non-insured experience).
- 2.The aggregate experience of the long-term care insurance industry (to the extent that credible industry experience emerges that is relevant to the coverage being offered).
- 3.The experience of the MetLife long-term care block and the experience of specific group customers.
- 4.The level of random fluctuations expected in long-term care experience.



The methodology used to set new premium rates is to equate the sum of the present value of future gross premiums and existing reserves to the present value of future benefits, expenses, and margins. The present values will be computed using current knowledge and assumptions about benefits, expenses, lapse and death rates, and interest. Based on this methodology, MetLife will decide if a rate adjustment, if necessary, should be implemented immediately and in full, or in incremental amounts over a period of years.

While we will compare the actual experience with our expectations, we will make our judgements in the context of our increasing knowledge of the entire long-term care insurance environment. Past claims experience is often the primary source used to predict future experience for setting renewal rates on insurance coverage's. Long-term care insurance rates require using information from many other sources for three reasons:

1. Since the future long-term care experience to be predicted extends well beyond the next rate guarantee period, it is much further in the future than for other coverage's and it is less likely to be predicted by past experience.
2. Because early long-term care claim levels are expected to be low, they will be greatly affected by statistical fluctuations and will be less useful for predicting future claim levels than for other coverage's.
3. Long-term care experience is more likely to change with time than other coverage's, since it will be influenced by a number of uncertain factors:
  - the evolution of the long-term care delivery system (including the availability, cost, and quality of different types of providers)
  - shifts in the demand for long-term care services
  - changes in medical technology
  - other dynamics unique to long-term care

If the experience of the State is pooled with other groups, the premium rates will only be increased or decreased when the rates for the entire pool are adjusted. At the end of a rate guarantee period, MetLife will set renewal rates for the pool by evaluating the probable future experience of the insured's covered under the pool. Unlike term insurance rates which cover claims for only a given coverage period, long-term care insurance rates are designed to remain level and to cover claims for the entire lives of the insured's. Therefore, the scope of the assessment of future experience must include the remainder of the lives of all current insured's. The factors that are examined include the expected morbidity, mortality, lapse rates, plan expenses, and investment income during that entire period.

If the State chooses to be experience rated, MetLife will maintain a fund to support the State's long-term care program. The fund will grow as premiums (net of a retention charge) are added and investment income is credited. The initial premium rates presented to the State are guaranteed for five years from the plan's effective date. At the end of the initial rate guarantee period, MetLife will set renewal rates by evaluating and comparing the probable future experience of the insured's covered to the amount of excess in the State fund. The renewal rates will be guaranteed for at least one year. The amount of excess funds is determined by subtracting the actuarial liabilities (difference between the present value of



future benefits and the present value of future net premiums for all plan participants) from the accumulated fund.

**Premiums cannot be adjusted for an individual insured due to age or health condition. Separate rating classes are established only for each issue age and coverage choice. Separate rate adjustments will be set for each rating class based on how these factors affect future expected claims.**

**In the event of a rate increase, the State will be given a minimum of 180 days notice, and the new rates will be guaranteed for at least one year.**

**F. How often do you propose to reassess rates on an ongoing basis? How much notice would you give for proposed rate adjustments? (Note: At least 180 days written notice is preferred by the State.)**

After our initial five-year rate guarantee, rates can be adjusted annually. In the event of a rate increase, the State will be given 180 days notice, and the new rates will be guaranteed for at least one year.

**G. Are you willing to negotiate the form and level of proposed rate increases with the State, and what could the State expect as an outcome of the negotiations?**

Yes. MetLife is willing to negotiate proposed rate increases with the State. We do, however, have statutory and actuarial guidelines that we are required to adhere to. If rates need to be adjusted, we will work with the State to determine the appropriate timing and amount. We realize it is difficult to implement large rate increases without long term implications for the plan.

**H. Describe your statutory reserving practices for group LTC plans, including the types of reserves you establish. Describe any tables used to calculate reserves. How are claim costs determined for reserve setting? How much reserve information is released at renewal and at year-end accounting?**

**Reserves are calculated prospectively using assumptions which reflect our best estimate of future experience, when setting those assumptions. Reserves are calculated for every individual and accumulated for the entire block of insured's being considered.**

Active life reserves are calculated to reflect the prefunding inherent in level premium pricing. In calculating active life reserves, the expected future benefits, expenses and premiums are discounted to recognize the time value of money. Active life reserves are set equal to the expected value of future benefits and expenses, less the present value of future premiums.



Initially, the assumptions used in the active life reserve calculation closely track the pricing assumptions, typically with some measure of conservation or some margin for adverse deviation.

Claim reserves are equal to the disabled life reserves (DLR) plus the reserve for claims which have been incurred but are not yet reported (IBNR). Disabled life reserves are established for the future long-term care services of enrollees currently in benefit status (including enrollees in the waiting period). The DLR is a function of the daily benefit amount and the claimant's expected future "length of stay." Length of stay projections are calculated using the age, sex, and claim duration of the known claimants. Length of stay will be derived using data from the 1985 *National Nursing Home Survey* until such time as credible industry experience or credible company experience is available.

IBNR reserves are currently set equal to expected claims for a period equal to the waiting period plus one month, and represent reserves for services received by benefit-eligible insured's which have not yet been submitted for reimbursement, as well as reserves for insured's who are benefit-eligible but have not yet submitted requests for benefit authorization.

The DLR and IBNR reserves are also discounted with interest. Claim reserves are further augmented for claims that are pending but not approved and claims that are denied but resisted. An explicit expense reserve for claim-related expenses such as ongoing review and claim adjudication is also used.

Standard actuarial practice requires performing follow-up studies to test the reasonableness of prior liability estimates. We will utilize the results of such studies when determining future reserves. These steps are very important for long term care insurance policies, since there is little historical evidence to be used for setting current reserve levels. As our long-term care policies generate more claims experience over time, we expect to revisit our procedures for setting reserves.

Information regarding active life reserves, disabled life reserves and IBNR reserves associated with the coverage will be released at renewal time and as needed between renewals. For most groups, a single year is not sufficient time to develop information needed for decision-making purposes. Unlike term and accumulation products, the rating, reserving, and financial analysis of a long-term care plan takes into account a considerably longer time frame.

**I. Do you track reserves on individual policyholders, or only for the group as a whole? If by individual, describe how the reserve is released or reassigned at death or recovery.**



Disabled life reserves for the group as a whole are directly related to the individual claimant within the group. At the inception of a claim, reserves are established based on a number of factors, such as the age of the claimant, the gender of the claimant, and the average length of claim associated with the particular claim type. As a block of claims becomes older, some claims are recognized as being shorter than average because the claimants die or recover. As the reserves for these claims are “released,” additional reserves need to be established for the remaining claims, which are being recognized as longer than average. As the block of claims approaches the maximum lifetime limit, the claims still remaining are recognized as being claims that will reach that maximum, and the reserves held will approach the discounted value of the remaining lifetime limit.

**J. Will reserves for the State LTC Plan be held in a special trust or otherwise separated from your general assets? If so, please describe accounting and banking arrangements in detail.**

The reserves associated with the State's long-term care insurance plan are to be part of a specific group long-term care insurance sub-account of MetLife's General Account.

**K. Describe your guidelines for investment of the State's LTC reserves. Are certain categories of investment excluded as too risky or uncertain? What rate of return do you expect to generate on the State's LTC reserves? Will you allow the State any control over how LTC reserves are invested?**

The reserves associated with the State's long-term care insurance plan are to be part of a specific Group Long-Term Care Insurance subaccount of MetLife's General Account, as governed by state insurance law. The primary investment in the subaccount is and will remain investment grade corporate bonds of medium duration.

With MetLife as the State's long-term care insurance carrier, the State can be assured that it will benefit greatly from the training, analysis, and experience of MetLife's Portfolio Strategies Department, the group responsible for the General Account. The funds associated with the long-term care insurance plan will be invested appropriately so that risk and return are prudently balanced.

The interest rate credited on reserves is determined by an actuarial formula. For pricing purposes, the interest rates used for discounting future paid premiums, paid claims, and paid expenses average 6%.

Since MetLife assumes the financial risk of the long-term care plan, we must retain full discretion over the setting of premiums and reserves. Policies and procedures with respect to the management of reserves must conform with MetLife's corporate standards. The appropriateness of these policies and standards have been corroborated by independent industry experts.

**L. Describe in detail how interest on the assets supporting reserves will be credited. Are credited reserves determined by actual interest earned during a particular time period, or by actuarial formula? What interest rate are you currently crediting on employer-**



**sponsored group LTC reserves? Will this reserve rate also apply to this client? If not, why not?**

The interest credited on reserves is determined by actuarial formula. For pricing purposes, the interest rates used for discounting future paid premiums, paid claims, and paid expenses average 6%.



**M. If another insurance carrier replaces you and your contract is terminated, confirm you are willing to transfer all reserves to the other insurance carrier. Under what conditions would you make such a transfer? How would you determine the level of reserves for purposes of such a transfer? In what time frame would reserves be returned?**

If the entire plan is terminated, coverage will continue for all insured's who choose to continue their coverage with MetLife. However, MetLife will transfer the long-term care coverage and reserves for the insured's that elect to transfer to another insurance carrier if the following provisions are met:

1. The State cancels its MetLife policy and contracts with a successor insurance carrier to continue the coverage for enrollees under a guaranteed renewable group long-term care insurance contract with an effective date coincident with the cancellation date of the MetLife policy;
2. The successor carrier uses the transferring insured's' original ages at entry for purposes of determining the premiums charged;
3. The successor carrier assumes all other contractual guarantees that MetLife made to the State and the transferring insured's';
4. The successor carrier agrees to consider the period of time transferring insured's were covered under the MetLife policy when administering the plan and adjudicating the benefits of its policy;
5. Where appropriate, the insurance regulatory authorities of the applicable jurisdictions approve the transfers to the successor carrier;
6. The successor carrier furnishes MetLife with a hold harmless agreement which releases MetLife from all liabilities associated with the transfer of insurance coverage.

If all of the above provisions are met, MetLife would transfer the appropriate reserves to a successor carrier for all individual insured's transferring from the MetLife plan to the new group plan. We will assess termination charges, limited to that portion of the start-up expenses and ongoing acquisition expenses that we have not amortized, against any reserves transferred. We amortize acquisition costs on a straight line basis at a rate of 10% per year for ten plan years. Acquisition expenses are those expenses associated with sales, implementation (including communications), enrollment and issue processes. Any transfer of reserves will be subject to a market value adjustment at that time.

MetLife expects to retain any liability for enrollees in claim status or in their waiting period, as well as the associated reserves. However, we might agree to an alternative arrangement if it is equitable to all parties and it maintains the guarantees made to the enrollees at the time of purchase.

MetLife would require 90 days notice of plan termination. MetLife would transfer reserves within three months from the date that we are provided with the appropriate transfer documents and hold harmless agreement, signed by the State and the successor carrier. Interest would be credited on the amount of reserves being transferred for the period between the date of calculation and the date of transfer payment.



**N. If you transfer reserves to another carrier, is there a withdrawal charge? Are there any restrictions or conditions on the transfer of reserves to another carrier?**

Please see our response to Question M (above) for an explanation of our transfer provisions.

**O. Please confirm that in the event the State’s group contract is terminated and not replaced with another group contract, you will allow covered individuals group contract to convert to individual coverage with no loss of benefits or increase in premiums.**

MetLife’s plan is fully portable. In the event that the State's group contract is terminated and not replaced with another group contract, covered individuals who elect portability will pay premiums by direct bill at no additional cost. Coverage for eligible relatives can continue as well. The plan benefits and premiums available to portable insured’s will be identical to those extended to the State.

**P. If a major breakthrough in medical treatment lowers the risk of future LTC expenditures for most policyholders, or if a major new government program to cover LTC costs is installed, what is your strategy for use of excess reserves. Please describe this in detail.**

If a major breakthrough in medical treatment lowers the risk of future LTC requirements for most certificate holders, or a federal program is established, MetLife is fully committed to modifying the plan in an appropriate manner. MetLife will comply with the new regulations and will adjust existing and future policies in order to eliminate any duplication or gaps in coverage. MetLife will not use a new federal program as a means to enhance its profitability.

We would offer several alternatives to insured’s, depending on their individual situations. The plan's benefits could either be reconfigured to cover co-payments and deductibles required under the public program, or are used to extend total coverage. Premium holidays, to the extent permitted by law or regulation, could be used to reconcile the insured’s’ prefunding with the new plan design.

**Q. To what extent are your expense/profit loadings guaranteed? If not guaranteed, is there a minimum loss ratio to which you will manage the State’s policy?**

The expense/profit loadings are guaranteed for the initial rate guarantee period. Please refer to question C for a description of MetLife's loss ratio.



**R. What is the maximum rate guarantee period that you will offer to the State? With respect to premiums beyond the guarantee period, are there any limits on the frequency and/or the extent of the future rate increases? Are you willing to limit the maximum increase that can be imposed at any one time?**

MetLife is willing to guarantee the rates for five years from the effective date of the plan. After our initial rate guarantee, rates can be adjusted annually. In the event of a rate increase the State will be given 180 days notice, and the new rates will be guaranteed for at least one year.

MetLife is unable to limit the maximum amount of increase that can be applied at any one time or over the life of the policy. However, it would be difficult to implement large increases without long-term implications for the plan. If a rate increase is too great, we would most likely see a large number of lapses and anti-selection, as the only individuals who would retain their coverage would be those who need it most. To date, we have never increased premiums for any of our employer-sponsored long-term care insurance plans. In fact, we were able to lower premiums on five of our plans.

**S. Comment on the legality of return in reserves to the State if the group later chooses to self-insure LTC coverage. Would you be willing to transfer reserves to the State in the event it elects self-insurance?**

MetLife's plan is guaranteed renewable. Should the State elect to self-insure a long-term care insurance plan, to the extent permitted by law, the State would need to obtain approval from all insured's to transfer from the MetLife plan. At such time, the State would be required to furnish MetLife with a hold harmless agreement. The State would also be required to offer transferring insured's a guaranteed renewable long-term care insurance plan that charges premiums based on original entry age and is approved by the applicable regulatory authorities.

**T. Will you have reinsurance for the State's LTC plan on its effective date? If so, describe such coverage (amount of risk transferred, types if reinsurance, name of reinsurer, criteria for selecting reinsurer, credit ratings of reinsurer). If not, do you anticipate acquiring such reinsurance in the future?**

MetLife does not reinsure its group long-term care insurance product.

**U. Have you increased or decreased premium rates since the inception of your employer-sponsored group LTC program? If yes, please describe the conditions and circumstances and the level of change in LTC premium rates.**

MetLife has never increased premium rates for any of our employer group long-term care insurance plans to date. We have reduced premium rates on average by 11% on five of our plans where our claims experience was better than initially expected. However, MetLife is unable to make any guarantees as to future premium rate adjustments. We have also made enhancements to many of our plans on a guaranteed issue basis for all insured's without an increase in premium rates.



**V. Provide the following pricing assumptions (by age, sex, class of participant and separately for each of the plans) regarding your initial premium rates:**

- i. Incidence of confinement to nursing home facilities and separately, the incidence of other covered services**
- ii. Continuance tables for nursing home confinements and separately, for other covered services (or net annual claim costs, if more appropriate, for other covered services)**
- iii. Continuance Effect of policy duration on the previous two items**
- iv. Average benefit payment assumed for nursing home claims and separately for other covered services.**
- v. Mortality rates**
- vi. Lapse rates**
- vii. Discount rate used to compute present values**

MetLife has used the following assumptions in developing premiums. These assumptions are based upon an assumed distribution at issue of 55% female and 45% males for all ages.

- Incidence and Continuance Rates

| Issue Age | Nursing Home                 |  | Home Care*                     |
|-----------|------------------------------|--|--------------------------------|
|           | Incidence Rate (Per Hundred) | Continuance Rates (Average Length of Stay) | Prevalence Rates (Per Hundred) |
| 35        | 0.01                         | 1,080                                      | 0.23                           |
| 45        | 0.03                         | 1,223                                      | 0.30                           |
| 55        | 0.06                         | 1,027                                      | 0.65                           |
| 65        | 0.25                         | 797  | 1.29                           |
| 75        | 1.42                         | 601  | 3.70                           |

\*MetLife utilizes prevalence rates for home health care.

- Effect of Policy Duration

The nursing home incidence rates are reduced to 30% of the number otherwise expected in the first year after the policy is issued. This reduction becomes less significant over time. In the sixth year after the policy is issued, no reduction is assumed.

Home care utilization is reduced to 5% of the number otherwise expected in the first year after the policy is issued. This reduction becomes less significant over time. In the eighth year after the policy is issued, no reduction is assumed.



- Average Benefit Payment

The average benefit payment is dependent upon the daily benefit amount chosen, the average length of stay for nursing homes and the average number of days of care for home care.

- Mortality Rates

Mortality rates are based on the 1983 Group Annuity Mortality Table, adjusted to remove loading. Sample mortality rates per 1,000 lives are as follows:

| Age | Rate  |
|-----|-------|
| 35  | 0.81  |
| 45  | 1.92  |
| 55  | 5.19  |
| 65  | 13.62 |
| 75  | 41.58 |

- Lapse Rates

Lapse rates vary by duration and are assumed to be the same for all issue ages.

| Policy Year | Lapse Rate |
|-------------|------------|
| 1           | 5.50%      |
| 2           | 5.30%      |
| 3           | 5.10%      |
| 4           | 4.90%      |
| 5           | 4.80%      |
| 6           | 4.70%      |
| 7           | 4.65%      |
| 8           | 4.60%      |
| 9           | 4.55%      |
| 10+         | 4.50%      |

The interest rate used for discounting future paid premiums, paid claims, and paid expenses, averages 6%.



**A. How will the active lives reserves be computed for each of the plans in the program? Please provide sufficient details as to the discount rate, mortality rates, morbidity rates, withdrawal rates, average claim costs by duration and the formulae that will be used to determine the reserve levels to be established.**

Active life reserves are calculated to reflect the prefunding inherent in level premium pricing. In calculating active life reserves, the expected future benefits, expenses and premiums are discounted to recognize the time value of money. Active life reserves are set equal to the expected value of future benefits and expenses, less the present value of future premiums.

Initially, the assumptions used in the active life reserve calculation closely track the pricing assumptions, typically with some measure of conservation or some margin for adverse deviation.

Please refer to question V above for a complete description of MetLife's rate setting process.

**B. How will the claim reserves of individuals currently receiving benefits be computed for each of the plans in the program? Please provide sufficient details as to the discount rate, mortality rates, morbidity rates, withdrawal rates, average claim costs by duration and the formulae that will be used to determine the reserve levels to be established.**

Claim reserves are equal to the disabled life reserves (DLR) plus the reserve for claims which have been incurred but are not yet reported (IBNR). Disabled life reserves are established for the future long-term care services of enrollees currently in benefit status (including enrollees in the waiting period). The DLR is a function of the daily benefit amount and the claimant's expected future "length of stay." Length of stay projections are calculated using the age, sex, and claim duration of the known claimants. Length of stay will be derived using data from the 1985 *National Nursing Home Survey* until such time as credible industry experience or credible company experience is available.

Please refer to question V above for a complete description of MetLife's rate setting process.

**C. How will incurred but unpaid claim liabilities be computed?**

Please refer to question V above for a complete description of MetLife's rate setting process.



**11. DATA REPORTING**

- A. Provide a sample of your Standard Report Package and summarize the title, purpose and frequency of each report in a separate chart. Indicate availability of reports on tape, diskette, Internet, or on-line transmittal.**

Samples of MetLife's standard reports are included in Part IV of this proposal. We would be happy to discuss the availability of our reports with the State. Many of these reports are available through various electronic mediums.

- B. Provide a sample or description of additional reporting capabilities. Information on fees should be provided as part of the Price Proposal (IV-G).**

Additional reporting materials and capabilities are included in Part IV of this proposal.

- C. Describe on-line reporting/management capabilities. Provide sample printouts from your on-line system. Information on fees should be provided as part of the Price Proposal (IV-G).**

MetLife has full electronic data transmission capabilities. Samples of our payroll deduction billing system specifications that we can accept without incurring programming costs are included in Part IV of this proposal.

MetLife has extensive experience interfacing with a variety of payroll systems and has interacted with over 600 customers to implement and administer payroll deductions. Based upon this experience we are confident in our ability to interface with any system. We have further designed our file layout with a large amount of flexibility to match the requirements of any payroll or benefits system. Our primary objective is to accommodate the State and to provide the highest level of service.



**12. ADMINISTRATIVE REQUIREMENTS CHECKLIST**

**In summary, the following are required services. Failure to provide these services may result in the rejection of your proposal. Please affirm that you provide these services and, if not, why not, and your plan or alternative for accomplishing the objective of the service.**

|   | Yes, included | No, with explanation or alternative |
|---|---------------|-------------------------------------|
| A. Communications   |               |                                     |
| ▪ Highlights Brochure for eligibles   | 4             |                                     |
| ▪ Plan Booklet (SPD) for enrollees  | 4             |                                     |
| ▪ Enrollment Meeting Materials  | 4             |                                     |
| ▪ Generic Internet site on LTC  | 4             |                                     |
| ▪ Internet or Intranet site customized for the State  | 4             |                                     |
| ▪ Video for Employees   | 4             |                                     |
| ▪ Training of Benefits Staff  | 4             |                                     |
| ▪ Interactive Voice Response enrollment   | 4*            |                                     |
| B. Toll free line for potential enrollees and for insured's   | 4             |                                     |
| C. Enrollment Assistance  |               |                                     |
| ▪ Meet with employees in (up to 15) major work locations, and with pension recipients in (up to 30) specified locations (all in Michigan) | 4             |                                     |
| ▪ Answer employee/retiree questions   | 4             |                                     |
| ▪ Mail materials to all pension recipients  | 4             |                                     |
| ▪ Mail materials to parents, parents-in-law, and other eligible family members on request   | 4             |                                     |
| D. Mail all plan materials (including enrollment material) to the homes of employees  | 4             |                                     |
| E. Provide distribution-ready plan materials to employer for distribution to employees  | 4             |                                     |
| F. Directly accept all enrollment forms   | 4             |                                     |
| G. Provide all required medical underwriting  | 4             |                                     |
| H. Check applicant eligibility and call the State if necessary  | 4             |                                     |
| I. Notify applicants of acceptance or denial decisions  | 4             |                                     |
| J. Notify new hires on an ongoing basis of their right to enroll in the plan  | 4             |                                     |



|   | Yes, included | No, with explanation or alternative |
|---|---------------|-------------------------------------|
| K. Claims services  |               |                                     |
| ▪ Eligibility Verification  | 4             |                                     |
| ▪ Confirmation of Benefit Trigger   | 4             |                                     |
| ▪ Claims Payment  | 4             |                                     |
| ▪ Claims Tracking   | 4             |                                     |
| ▪ Review of Claims Appeals  | 4             |                                     |
| L. Advise the State of the amount to deduct from payroll for each enrollee  | 4             |                                     |
| M. Data Reports   | 4             |                                     |
| N. Direct Billing and Reminder Notices to:  |               |                                     |
| ▪ Pension recipients and their spouses  | 4             |                                     |
| ▪ Employees on unpaid leave   | 4             |                                     |
| ▪ Parents, parents-in-law, and other family members   | 4             |                                     |
| ▪ Terminated employees and their spouses  | 4             |                                     |
| ▪ Divorced and widowed spouses  | 4             |                                     |
| O. Notify all enrollees of additional buy-up purchase opportunities, process requests received as a result, and notify the State of changes in payroll deduction amounts. | 4             |                                     |

\*As an alternative to a voice-response enrollment system, MetLife provides telephonic enrollment through our toll-free customer service line to guaranteed issue employees during the initial enrollment period. Employees calling our toll-free number can obtain answers to questions and enroll in the plan in one telephone call. Our long-term care consultants can assist the individual in moving through what can be a fairly complex decision-making process.



**13. SAMPLES**

- A. Enclose samples of your standard employee communication material (including videos, if available).**

Sample employee communication materials are located in Part IV of this proposal.

- B. Provide a sample of the master contract and any attendant agreements, which would be issued to the State by your organization.**

Samples of our Application for Group Insurance, Master Contract, and Certificate are each included in Part IV of this proposal.



**14. PROVIDER NETWORKS**

**If a component of your proposed plan is a network of participating providers, please complete the questions in this section.**

MetLife does not utilize provider networks; however, we have discounts with nursing homes, home care agencies, and durable medical equipment providers nationwide. The discount varies by provider and type of service and will generally be between 5% and 30% of the provider's usual fee. Insured's will be informed of the availability of discounted providers in their area and the fee, but are free to choose any provider. Discounts can be accessed by calling our toll-free telephone line and speaking with our care managers. Provider discounts provide a means to help the insured extend benefit payments under the plan and are available to MetLife insured's on a voluntary basis. The use of participating providers would not affect long-term care policy benefit payments and/or the maximum duration of benefits.

**A. Describe your process for selecting and credentialing participating providers, including a description of professional and malpractice standards, verification of education, experience and license status, lawsuits and complaints.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**B. Describe your ongoing provider communication, education and service programs.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**C. Describe your ongoing provider monitoring programs, including policy and quality compliance, utilization profiling, and dispute resolution.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**D. Describe the qualifications of your staff members responsible for credentialing and monitoring providers.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**E. Provide provider departicipation rates for the last three years, with a breakdown by reasons for departicipation.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.



**F. What portion of current services are provided in-network, both nationally, and for Michigan, in particular (describe separately for professional vs. facility services, by type of facility)?**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**G. Complete a network Geo-analysis for your proposed network based upon minimum access standards defined in this RFP and the member residence zip code data provided. Separate analyses should be provided for Actives, for SERS, SPRS and JRS Pension Recipients, and for MPSERS Pension Recipients.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**H. For 5-digit zip codes with available providers that do not meet the specified access standard, describe the procedures and timing needed to increase network participation in order to achieve the requested standard. Describe the process which allows the State and its participants to recommend providers for addition to the network.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**I. Include a copy of the proposed network directory.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**J. Supply a sample copy of your provider contract.**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.

**K. For each county in the State of Michigan, and by state outside Michigan, show the number of each of the following for your current participating providers:**

- **Facilities (Nursing homes)**
- **Assisted daily living centers**
- **Home health care aides**

Not applicable as MetLife does not utilize a provider network for group long-term care insurance.



**GROUP LONG-TERM CARE INSURANCE SUMMARY OF PLAN FEATURES FOR  
THE STATE OF MICHIGAN**

THE PLAN DESCRIBED BELOW IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

| <b>FEATURES/<br/>PROVISIONS</b> | <b>DESCRIPTION</b>   |
|---------------------------------|--|
| <b>ELIGIBLE PARTICIPANTS</b>    | <ul style="list-style-type: none"> <li>• Employees and spouses (or surviving spouses)</li> <li>• Parents and parents-in-law</li> <li>• Retirees and spouses (or surviving spouses)</li> <li>• Grandparents and grandparents-in-law</li> <li>• No linkages for enrollment</li> <li>• No upper age limits</li> <li>• No minimum participation requirements</li> </ul>  |
| <b>UNDERWRITING</b>             | <ul style="list-style-type: none"> <li>• Guaranteed issue for employees* actively at work on the effective date of the plan</li> <li>• Guaranteed issue for new hires* within 90 days of hire who are actively at work on their effective date</li> <li>• Coverage for employees who are not actively at work on their effective date will become effective on the first of the month following their return to work (provided they are actively at work on that date)</li> <li>• Underwriting for all other eligible participants</li> </ul> <p>*Employees must work a minimum of 32 hours on a bi-weekly basis to be eligible for Guaranteed issue coverage.</p> |



| FEATURES/<br>PROVISIONS                    | DESCRIPTION  |
|--|--|
| <b>COVERED SERVICES</b>                    | <p style="text-align: center;"><b><u>Comprehensive Plan</u></b></p> <ul style="list-style-type: none"> <li>• Nursing home (skilled, intermediate and custodial care in a licensed nursing home or Alzheimer’s facility)</li> <li>• In-patient hospice care</li> <li>• Voluntary initial care advisory visit</li> <li>• Assisted living facility (or Alzheimer’s facility)</li> <li>• Home care services                             <ul style="list-style-type: none"> <li>- Services from a licensed home care agency for: R.N., L.P.N., L.V.N.; home health aide; physical, respiratory, occupational and speech therapy; and homemaker services</li> <li>- Care from a nurse (R.N., L.P.N., L.V.N.) or a licensed therapist who is unaffiliated with a licensed agency</li> <li>- Adult day care</li> <li>- At-home hospice care</li> <li>- Ongoing care advisory services</li> </ul> </li> <li>• Respite services, including informal providers (21 days per calendar year)</li> </ul> |
| <b>ALTERNATE PLAN OF SERVICE PROVISION</b> | <p>A MetLife care manager can authorize benefits for qualified long-term care services not specifically covered under the plan. Services must be qualified, must meet the needs of the covered person, and may be a cost effective alternative.</p>  |
| <b>PLAN MODEL</b>                          | <p>Reimbursement: Benefits are payable for the actual cost of services up to the daily benefit.</p>  |
| <b>DAILY BENEFITS</b>                      | <ul style="list-style-type: none"> <li>• Daily benefit choice of \$100 (Option A), \$150 (Option B), and \$200 (Option D) per day</li> <li>• Reimburses provider's charge up to 100% of the daily benefit for nursing home, in-patient hospice care, and respite services</li> <li>• Reimburses provider's charge up to 60% of the daily benefit for home care services and assisted living facilities</li> </ul>  |
| <b>TOTAL LIFETIME BENEFIT</b>              | <p>Option A: 3 years (1,095) times the daily benefit<br/>                     Option B: 4 years (1,460) times the daily benefit<br/>                     Option D: 5 years (1,825) times the daily benefit</p>   |



| FEATURES/<br>PROVISIONS                        | DESCRIPTION  |
|--|--|
| <b>BENEFIT ELIGIBILITY CRITERIA</b>            | <p>Insured's will be considered for benefit eligibility when they have been certified by a licensed health care practitioner as being chronically ill. The following means chronically ill:</p> <ul style="list-style-type: none"> <li>• Expected to be unable to perform (without substantial assistance from another individual) at least 2 of the 6 ADLs (bathing, continence, dressing, eating, toileting, transference) for a period of at least 90 days, due to a loss of functional capacity,</li> </ul> <p style="text-align: center;"><b>Or</b></p> <ul style="list-style-type: none"> <li>• Having a severe cognitive impairment that requires substantial supervision to protect such individuals from threats to health and safety.</li> </ul> <p>Benefits will be paid for services included in a Plan of Care prescribed by a licensed health care practitioner.</p> <p>MetLife covers disabilities resulting from organic brain diseases, including Alzheimer's disease and similar disorders. The plan also covers dependencies resulting from brain diseases, which are not organically based, as long as the insured meets the benefit eligibility criteria. MetLife does not attempt to identify the cause of disability or mental disorder. The presence of many interrelated factors makes it difficult to isolate cause and thus, to administer a plan which excludes mental or nervous disorders.</p> |
| <b>WAITING PERIOD FOR BENEFITS</b>             | <p>Option A and B: 90 calendar days (covered services are not required)<br/>                     Option D: 60 calendar days (covered services are not required)<br/> <a href="#">The waiting period is one per lifetime.</a></p>   |
| <b>VOLUNTARY ONSITE CARE ADVISORY SERVICES</b> | <ul style="list-style-type: none"> <li>• Initial care advisory visit</li> <li>• Ongoing care advisory services</li> </ul>  |
| <b>TRANSITION EXPENSE BENEFIT</b>              | <p>A benefit providing up to five times the daily benefit to be used for long-term care purposes, such as a personal emergency response system, caregiver training, durable medical equipment, or off setting costs of qualified services received during the waiting period. It is payable after completion of the waiting period. To access this benefit, proof of payment for a covered expense must be submitted to MetLife. It does not reduce the total lifetime benefit.</p>  |



| FEATURES/<br>PROVISIONS                     | DESCRIPTION   |
|---|---|
| <b>PREMIUM WAIVER</b>                       | Premium payments are waived the first of the month coincident with or following the date the waiting period is fulfilled and the insured is chronically ill.  |
| <b>INFLATION PROTECTION</b>                 | <ul style="list-style-type: none"> <li>• Optional inflation increase feature included in the plan:                             <ul style="list-style-type: none"> <li>- Option offered every three plan years</li> <li>- At least 5% compounded annually</li> <li>- Guaranteed issue as long as the option has been selected once in every two offerings</li> <li>- Offer is made regardless of age, claim status, claim history, or length of participation in the plan</li> <li>- Premiums for the increase are based on attained age</li> </ul> </li> </ul> <p><b>and</b></p> <p>An automatic inflation increase feature can be offered as an option</p> <ul style="list-style-type: none"> <li>• Automatic inflation increase feature:                             <ul style="list-style-type: none"> <li>- Benefits automatically increase by 5% compounded annually</li> <li>- Pre-funded so premiums do not increase as benefits do</li> </ul> </li> </ul> |
| <b>RETURN OF PREMIUM ON DEATH</b>           | Returns all premiums paid up to age 65 to the insured's estate upon death, less benefits received. The amount of the refund will decline 20% per year from age 65 up to age 70. Due to state regulations, this feature is not available to residents of Washington. Residents of Washington will receive a respite services benefit equal to 42 days per calendar year.<br><br>Not included in Option A.  |
| <b>NONFORFEITURE FEATURE</b>                | The following nonforfeiture feature can be included in the plan or offered as an option to each participant.<br><br><b><u>Shortened Benefit Period - Benefit Bank</u></b><br>Insured's who have paid premiums for at least three years and elect to stop making payments will be entitled to receive some coverage. The feature provides the full daily benefit with a total lifetime benefit based on the amount of premiums paid. The total lifetime benefit will be at least 30 times the daily benefit.   |
| <b>ADDITIONAL PLAN FEATURES/ PROVISIONS</b> | <ul style="list-style-type: none"> <li>• Coordination of benefits provision</li> <li>• Bed reservation benefit 21 days per calendar year</li> <li>• Reinstatement provision</li> <li>• Fully portable</li> <li>• Guaranteed renewable</li> </ul>  |



| FEATURES/<br>PROVISIONS   | DESCRIPTION   |
|---------------------------|---|
| <b>EXCLUSIONS</b>         | <p>MetLife’s plan does not provide benefits for the following:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Any service or supply received outside the United States or its territories.</li> <li>• Illness, treatment, or medical condition arising out of: <ul style="list-style-type: none"> <li>• War or act of war (whether declared or undeclared)</li> <li>• Participation in a felony, riot or insurrection</li> <li>• Service in the armed forces or auxiliary units</li> <li>• Attempted suicide (while sane or insane) or intentionally self-inflicted injury</li> <li>• Aviation (this applies only to non-fare paying passengers)</li> </ul> </li> <li>• Treatment provided in a government facility, unless otherwise required by law.</li> <li>• 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.</li> <li>• Any service provided by your immediate family unless the service is a covered service from an informal caregiver.</li> <li>• Any service or supply to the extent that such expenses are reimbursable under Medicare, or would be so reimbursable but for the application of a deductible or coinsurance or copayment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payer under applicable law.</li> <li>• Services for which no charge is normally made in the absence of insurance.</li> </ul> |
| <b>RATE<br/>GUARANTEE</b> | Five years from the plan’s effective date.  |



Part III. Price Proposal

Premiums are unisex and based on the individual's age at entry into the plan on his or her effective date of coverage. Premiums for additional coverage purchased at a later time are based on the age at purchase. *Some carriers determine premium based upon the insured's age as of nearest birthday which could result in the insured paying a higher premium. The age nearest birthday approach results in lower premiums for each age but approximately half of the enrollees will be a year older on the premium chart.* Premiums will be paid in full by insured's.

Premiums reflect the plan design as outlined in this proposal.

The premiums presented assume a plan effective date of January 1, 2002 and are based on an eligible group of 60,778 employees and 164,428 retirees.

Premiums are guaranteed for five years from the plan's effective date. Premiums assume payroll deduction for active employees and their spouses. MetLife reserves the right to review the premiums should the State's eligible population increase or decrease by more than 10%.

Premiums assume the experience of the State will be pooled with other groups. However, considering the size of the State, MetLife is willing to make experience rating available as well. Should the State choose to be experience rated, the premiums will increase by approximately 2%.

This cost and price analysis is submitted in full compliance with the provisions of the paragraph titled 'Independent Price Determination' in Part III of the RFP to which this proposal is a response.

Please refer to the pricing part of our proposal that is separately labeled and sealed separately from this proposal.



| <b>STATE OF MICHIGAN</b>  |                 |                 |                 |
|---|-----------------|-----------------|-----------------|
| LTC Rate Quotation, Monthly Rates<br>For the Period 1/1/2001 through 6/30/2006<br>LTC Bidder: MetLife<br>(Note: Include Only in Sealed Financial Bid) |                 |                 |                 |
| <b>Entry</b>  | <b>Option A</b> | <b>Option B</b> | <b>Option D</b> |
| <b>Age</b>  |                 |                 |                 |
| 18  | \$5.60          | \$12.60         | \$18.00         |
| 19  | 5.60            | 12.60           | 18.00           |
| 20  | 5.60            | 12.60           | 18.00           |
| 21  | 5.60            | 12.60           | 18.00           |
| 22  | 5.60            | 12.60           | 18.00           |
| 23  | 5.60            | 12.60           | 18.00           |
| 24  | 5.60            | 12.60           | 18.00           |
| 25  | 5.60            | 12.60           | 18.00           |
| 26  | 5.60            | 12.60           | 18.00           |
| 27  | 5.60            | 12.60           | 18.00           |
| 28  | 5.60            | 12.60           | 18.00           |
| 29  | 5.60            | 12.60           | 18.00           |
| 30  | 5.60            | 12.60           | 18.00           |
| 31  | 6.00            | 13.20           | 19.60           |
| 32  | 6.20            | 14.40           | 20.40           |
| 33  | 6.60            | 15.00           | 21.60           |
| 34  | 7.20            | 15.90           | 22.80           |
| 35  | 7.60            | 16.80           | 24.00           |
| 36  | 8.00            | 17.70           | 26.00           |
| 37  | 8.40            | 18.90           | 27.20           |
| 38  | 8.80            | 20.10           | 28.80           |
| 39  | 9.60            | 21.30           | 30.80           |
| 40  | 10.00           | 22.20           | 32.00           |
| 41  | 10.80           | 23.70           | 34.80           |
| 42  | 11.40           | 25.20           | 36.40           |
| 43  | 12.20           | 27.00           | 39.20           |
| 44  | 13.00           | 28.80           | 41.60           |
| 45  | 13.80           | 30.00           | 43.60           |
| 46  | 14.40           | 31.50           | 45.60           |
| 47  | 15.20           | 33.00           | 48.00           |
| 48  | 16.00           | 35.10           | 50.80           |
| 49  | 17.00           | 36.90           | 54.00           |
| 50  | 18.00           | 39.00           | 56.40           |
| 51  | 19.60           | 42.00           | 61.20           |
| 52  | 21.60           | 45.60           | 66.80           |
| 53  | 23.20           | 49.50           | 72.00           |
| 54  | 25.20           | 53.40           | 78.00           |
| 55  | 27.40           | 57.30           | 84.00           |



| <b>Entry</b> | <b>Option A</b> | <b>Option B</b> | <b>Option D</b> |
|--------------|-----------------|-----------------|-----------------|
| <b>Age</b>   |                 |                 |                 |
| 56           | 29.80           | 62.40           | 90.80           |
| 57           | 32.40           | 67.20           | 98.40           |
| 58           | 35.20           | 72.60           | 106.00          |
| 59           | 38.40           | 78.90           | 115.60          |
| 60           | 42.00           | 85.20           | 124.80          |
| 61           | 45.60           | 92.70           | 135.60          |
| 62           | 50.40           | 101.70          | 148.40          |
| 63           | 55.20           | 110.10          | 161.60          |
| 64           | 60.40           | 119.40          | 175.60          |
| 65           | 66.00           | 129.90          | 190.80          |
| 66           | 72.20           | 141.90          | 208.00          |
| 67           | 79.40           | 155.40          | 228.00          |
| 68           | 87.00           | 169.20          | 248.80          |
| 69           | 95.00           | 184.50          | 271.20          |
| 70           | 104.00          | 201.30          | 296.00          |
| 71           | 114.00          | 219.60          | 322.80          |
| 72           | 124.80          | 239.40          | 352.00          |
| 73           | 136.60          | 261.30          | 384.00          |
| 74           | 149.60          | 285.00          | 419.20          |
| 75           | 163.80          | 310.80          | 457.20          |
| 76           | 180.00          | 339.60          | 500.00          |
| 77           | 197.60          | 371.40          | 546.40          |
| 78           | 217.20          | 406.20          | 597.60          |
| 79           | 238.60          | 444.30          | 653.60          |
| 80           | 262.00          | 485.70          | 714.40          |
| 81           | 288.00          | 533.40          | 784.40          |
| 82           | 316.40          | 585.30          | 860.80          |
| 83           | 347.80          | 642.90          | 944.80          |
| 84           | 382.20          | 705.60          | 1,036.80        |
| 85           | 420.00          | 774.90          | 1,138.00        |
| 86           | 461.60          | 850.80          | 1,249.20        |
| 87           | 507.20          | 934.20          | 1,371.20        |
| 88           | 557.40          | 1,025.70        | 1,504.80        |
| 89           | 612.80          | 1,126.20        | 1,652.00        |
| 90           | 673.40          | 1,236.60        | 1,813.60        |
| 91           | 740.80          | 1,360.20        | 1,994.80        |
| 92           | 814.80          | 1,496.10        | 2,194.40        |
| 93           | 896.20          | 1,645.80        | 2,414.00        |
| 94           | 985.80          | 1,810.50        | 2,655.60        |
| 95           | 1,084.40        | 1,991.70        | 2,921.20        |
| 96           | 1,192.80        | 2,190.90        | 3,213.20        |
| 97           | 1,312.00        | 2,409.90        | 3,534.40        |



| <b>Entry</b> | <b>Option A</b> | <b>Option B</b> | <b>Option D</b> |
|--------------|-----------------|-----------------|-----------------|
| <b>Age</b>   |                 |                 |                 |
| 98           | 1,443.20        | 2,650.80        | 3,888.00        |
| 99           | 1,587.60        | 2,916.00        | 4,276.80        |
| 100          | 1,746.40        | 3,207.60        | 4,704.40        |
| 101          | 1,921.00        | 3,528.30        | 5,174.80        |
| 102          | 2,113.20        | 3,881.10        | 5,692.40        |
| 103          | 2,324.60        | 4,269.30        | 6,261.60        |
| 104          | 2,557.00        | 4,696.20        | 6,887.60        |
| 105          | 2,812.80        | 5,165.70        | 7,576.40        |
| 106          | 3,094.00        | 5,682.30        | 8,334.00        |
| 107          | 3,403.40        | 6,250.50        | 9,167.60        |
| 108          | 3,743.80        | 6,875.70        | 10,084.40       |
| 109          | 4,118.20        | 7,563.30        | 11,092.80       |
| 110          | 4,530.00        | 8,319.60        | 12,202.00       |