

Plan Summary



When you ^{don't} have your health you ^{can still} have everything.

LEWIS & CLARK COLLEGE

LONG-TERM CARE INSURANCE (LTCI) PLAN SUMMARY

You may be unfamiliar with long-term care insurance.

This plan summary is designed to help you understand the coverage by providing you with:

- An overview of plan benefits
- Instructions on how to apply for coverage
- A description of how benefit eligibility is determined
- A list of coverage exclusions

You will have 4 choices to make for your coverage:

1. Daily Benefit (DB) – \$100, \$150, \$200, \$250 or \$300
2. Benefit Period (BP) – 3-year or 6-year
3. Nonforfeiture Benefit – Yes or No
4. Inflation Protection – Compound Inflation Coverage (CIC) or Guaranteed Purchase Option (GPO)

Your coverage choices are described in greater detail in this plan summary. We hope that once you know more about the Lewis & Clark College LTCI Plan, you will consider it a valuable addition to your other insurance protection.

Who is eligible to apply?

Eligible participants include:

- All eligible, actively-at-work, full-time and part-time employees of the employer, who are regularly scheduled to work at least 17.5 hours per week and are on U.S. payroll
- Spouses or qualified domestic partners* of eligible employees
- Parents and parents-in-law of eligible employees
- Siblings and their spouses of eligible employees and of their spouses or qualified domestic partners
- Adult children and their spouses of eligible employees and of their spouses or qualified domestic partners
- Grandparents and grandparents-in-law of eligible employees

**Coverage is not available to domestic partners residing in Louisiana.*

Applicants must remain eligible under these requirements as of the date coverage is scheduled to become effective. (See "When will my coverage become effective?")

All members of the eligible group, other than eligible actively-at-work employees, must be between the ages of 18 and 84 in order to apply for coverage.

All applicants must reside in the U.S. (50 states or the District of Columbia) on the date of application and on their effective date of coverage. This requirement does not apply to eligible active employees and their spouses or qualified domestic partners. All applicants must have a U.S. address on the date of application and on the date coverage is to become effective. Foreign nationals residing outside the U.S. on U.S. payroll are not eligible.

Eligible family members may apply for coverage regardless of whether the eligible active employee applies.

What does the plan cover?

While plan requirements are met, the plan provides benefits for the cost of the covered services outlined below:

- **Nursing Home Care** – the plan will pay up to the Daily Benefit (DB) for skilled, intermediate, and custodial care provided by a qualified nursing home to inpatients.
- **Alternate Care Facility Care (ACFC)** – the plan will pay up to the DB for care provided by a qualified care facility to inpatients. Assisted living facilities may be qualified for payment under this benefit.
- **Community Based Professional Care (CBPC)** – the plan will pay up to the DB for services rendered by a qualified provider. CBPC services include home health care, homemaker services, and hospice care, provided in the insured's home or adult day care provided by a qualified adult day care center.
- **Informal Care** – the plan will pay up to the Informal Care DB for custodial care and homemaker services provided in the insured's home. Homemaker Services are non-medical support services that can help an individual remain at home. They include supervision of self-administration of medication, meal preparation, and light housekeeping. Informal care can be provided by a person without professional skills or training, including family members, whether or not that person ordinarily resides in the insured's home, subject to certain plan provisions. A calendar year limit of 30 times the Informal Care DB applies to this benefit.

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What levels of coverage are available?

This chart summarizes the benefits payable under the plan. The Daily Benefit (DB) is the most the plan will pay for the cost of all covered services received on a given day. The DB that you choose is used to calculate the Certificate Limit (CL). The CL is the total amount of benefit money available to you while insured, for the cost of services covered by your long-term care insurance plan. The CL is calculated by multiplying the DB you select by the Benefit Period (BP): 1095 (the number of days in 3 years) or 2190 (the number of days in 6 years)

DB Options	Informal Care DB*	Certificate Limit Options		
		(3-Year BP)	or	(6-Year BP)
\$100	\$25.00	\$109,500	or	\$219,000
\$150	\$37.50	\$164,250	or	\$328,500
\$200	\$50.00	\$219,000	or	\$438,000
\$250	\$62.50	\$273,750	or	\$547,500
\$300	\$75.00	\$328,500	or	\$657,000

*The total benefits payable for all informal care received in any calendar year is 30 times the Informal Care DB.

What other services does the plan cover?

- **Respite Care Benefit** – While you are determined to be benefit eligible and you have met the Elimination Period requirement, the plan will pay for covered services, provided on a short-term basis, that are designed to give your unpaid caregiver temporary relief from caregiving duties. The reimbursement level that applies is determined by the type and site of service you receive. Any benefits paid will reduce your CL.

- **Hospice Care Benefit** – The plan will pay for both inpatient and community based hospice care, if you have been diagnosed to be terminally ill.* Hospice care benefits can be paid during the Elimination Period (EP), but will not count toward satisfaction of the EP service day requirement. The EP is described in greater detail in the section of the plan summary that addresses benefit eligibility.

*Life expectancy of six months or less, as estimated by physician

- **Temporary Bed-Holding Benefit** – The plan will pay to hold your bed in a nursing home, alternate care facility, or inpatient hospice facility for up to 30 days per calendar year, if you are receiving plan benefits and if your stay is interrupted for any reason.

- **Stay at Home Benefit** – The plan will pay up to 30 times the DB for:

- a Care Planning Visit,
- Home Modifications,

- an Emergency Medical Response System,
- Durable Medical Equipment,
- a Home Safety Check,
- a Provider Care Check, and
- Caregiver Training (the maximum that will be paid for Caregiver Training is 5 times the DB)

The Stay at Home benefit can be paid during the Elimination Period and does not reduce your CL, but a day on which benefits are paid for Stay at Home services will not count toward satisfaction of the EP service day requirement. It is not available if your coverage is in reduced paid-up status (see Nonforfeiture Benefit).

- **Return of Premium at Death Benefit** – The Return of Premium at Death Benefit will pay to your estate an amount equal to the sum of the premiums you paid, less any benefits paid or payable, should you die before age 70, while covered under the plan. No benefits are payable should death occur at age 70 or after. The Return of Premium at Death Benefit does not apply if your coverage is in reduced paid-up status (see Nonforfeiture Benefit).

What additional features are included?

- **Waiver of Premium** – You do not have to pay premiums for the coverage on the first day of the month after you are determined to be benefit eligible and have satisfied the plan's 90 service day Elimination Period requirement. The waiver will end and you will resume paying premiums once you are no longer benefit eligible.

- **Portability** – The group long-term care insurance coverage is portable. This means that if you retire or leave your employer, for any reason, you can continue your coverage. Portability also applies to your family members.

Once you port your coverage, you will be billed directly or have premiums deducted from your checking account. Coverage will be continued at group rates as long as premiums are paid when due and you have not used up your CL.

- **International Coverage** - The plan will pay for certain services received outside of the United States, as long as specific conditions are met. Some limitations and plan modifications apply to the benefit. No benefits are available during the Elimination Period. No benefits are payable under the Stay at Home Benefit, or for respite care.

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What are the optional features?

You can also apply for the following features at enrollment for additional premium.

- **Nonforfeiture Benefit** - This benefit allows you to stop paying premiums for any reason, after three or more years of continuous coverage, and still retain some of your coverage. If you exercise this benefit, you will keep your full DB amount, but your CL will be reduced. Your reduced CL will be equal to 30 times your DB or the sum of the premiums you have already paid, whichever is greater. If exercised after a minimum of 10 years of continuous coverage, the reduced CL will equal the greater of 90 times your DB or the sum of the premiums paid. If you exercise this benefit, your coverage will be in reduced paid-up status.

If you choose not to purchase the Nonforfeiture Benefit option, your coverage will include the Contingent Nonforfeiture Benefit.

This benefit allows you to keep reduced paid-up coverage with the full DB amount and a reduced CL equal to the total amount of premiums paid since the coverage was issued, only in the event of a substantial premium increase. The reduced CL will not be less than 30 times the DB. Additional details are provided in the Certificate of Insurance that you will receive when you are approved for coverage. If you exercise this benefit, your coverage will be in reduced paid-up status.

- **Inflation Protection** – You will have the choice of including the Compound Inflation Coverage (CIC) at enrollment for an additional cost. If you do not elect this option, the Guaranteed Purchase Option (GPO) provision will be included in your coverage.

Under the CIC, your DB will automatically increase each year at an annual rate of 5% compounded, regardless of your age or claim status, with no annual increase in premium. The remaining CL will increase in proportion to the increase in the DB. Automatic increases will cease if your coverage is in reduced paid-up status.

Under the GPO, you will be offered additional amounts of coverage every three years, which you can accept or decline to purchase. The amount of each available addition will increase the DB by at least 5% compounded annually over the three-year period. The remaining CL will increase in proportion to the increase in the DB.

You will not have to provide proof of good health in order to purchase the additional coverage. If you refuse an addition when offered, you will continue to receive offers, unless you become benefit eligible. You will not be eligible for an inflation increase if your coverage is in reduced paid-up status.

How do I apply for coverage?

You apply for coverage by completing the forms applicable to you included in this kit and returning them directly to John Hancock in the enclosed envelope. You can determine which form you need to complete, by determining whether you are eligible for automatic acceptance, or whether you will need to provide proof of good health as described below.

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Will I be automatically accepted for coverage?

The following groups will be automatically accepted for coverage:

- Eligible, actively-at-work employees between the ages of 18 – 69 who enroll during the designated 2009 enrollment period, March 23, 2009 – April 24, 2009
- Eligible employees between the ages of 18 – 69 who were on a leave of absence or disability during the designated 2009 enrollment period who enroll within 31 days of returning to work on a regular basis
- Newly hired eligible or newly eligible, actively-at-work employees between the ages of 18 – 69 who enroll within 31 days of first becoming eligible for this benefit

If you are a member of one of these groups, there are 2 ways you can enroll:

- Complete the enclosed Enrollment Form and return it to John Hancock
- Visit the Lewis & Clark College Long-Term Care Web site at: <http://enroll.jhcorpchoice.com> (username: lewisclark; password: mybenefit) and enroll online.

Please Note: For automatic acceptance, you must be an actively-at-work employee on the date your coverage is scheduled to become effective. (See “When will my coverage become effective?”)

Do I need to provide proof of good health?

The following groups will need to provide proof of good health:

- Eligible, actively-at-work employees who apply after the designated 2009 enrollment period, other than those individuals who meet the criteria for automatic acceptance, as described above
- Eligible, actively-at-work employees age 70 or older or under age 18
- Eligible spouses or qualified domestic partners of eligible, actively-at-work employees applying at any time
- All other eligible family members who apply at any time, including during the designated 2009 enrollment period

Members of these groups can apply by completing the enclosed Application, including the Statement of Health, and returning it to John Hancock. Before you complete the entire application, you may want to know whether you have a condition that will automatically prohibit you from obtaining coverage. For this reason, John Hancock has included the health questions in Section 1 of the application. If you answer “yes” to any of the questions in that section, you are advised not to complete the rest of the application, because you will not meet John Hancock underwriting guidelines. If you answered “no” to all of the questions, you should proceed with completing the entire application.

For your convenience, applications may also be downloaded from the Lewis & Clark College Long-Term Care Web site at: <http://enroll.jhcorpchoice.com> (username: lewisclark; password: mybenefit). Just print out, complete, and sign the application and return it to John Hancock.

John Hancock Long-Term Care Insurance (LTCI) Department:
Call 1-800-711-9407

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When will my coverage become effective?

Your effective date of coverage will be the first of the month after your application is approved, but in no event earlier than June 1, 2009, subject to the following exceptions:

- If you are an eligible employee who is not actively at work on the date your coverage would have otherwise become effective, your coverage will not become effective until the first of the month following your return to work on a regular basis.
- If you are an eligible person other than an eligible employee and you are disabled on the date your coverage would otherwise have become effective, your coverage will not become effective until the first of the month following the date you are no longer disabled, provided you are still eligible.

How do I calculate my premium rate?

The enrollment kit includes rate sheets for the available coverage choices. Once you have made your final coverage choices, look for the premium next to your issue age. Your issue age is your age on the later of June 1, 2009 (plan effective date) or the date your application is received by John Hancock. Premiums will not be increased because of age, illness or use of benefits. Premiums can be adjusted but only if they are changed for an entire group or class.

If your effective date of coverage is postponed, your issue age will be your age on the date your coverage becomes effective.

How will I pay my premiums?

Active employees and their spouses or qualified domestic partners will have their premium payments deducted from the employee's paycheck. All other participants will have the option of paying premiums directly to John Hancock, or through automatic bank withdrawal from a bank account.

Can I pay my premiums from the funds in my Health Savings Account (HSA)?

As provided under Medicare Prescription Drug Improvement and Modernization Act of 2003 and Section 7702B of the Internal Revenue Code (IRC) of 1996, as amended individuals under age 65 can pay for unreimbursed long-term care services and their qualified long-term care insurance premiums through disbursements from an HSA, even if the HSA is funded through a cafeteria plan.*

**Tax-free reimbursement cannot exceed the annually adjusted "eligible long-term care insurance premiums" listed in the IRC. You should consult your tax advisor for additional guidance.*

Is the LTCI tax-qualified?

The group policy is intended to be a qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1996, as amended. Subject to specified dollar limits that vary depending on your age, you may be able to include your LTCI premium in your itemized deduction on your federal income tax return, if your total medical expenses, including the allowable portion of your premium, exceed 7.5% of your adjusted gross income. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly. The benefits you receive under the policy are generally not considered taxable income. Please consult your tax advisor if you have any questions or need further details.

How do I become eligible for benefits?

Contact John Hancock as soon as you think you may be in need of long-term care services so that you can be qualified for benefits. Once qualified, you must then satisfy the Elimination Period requirement before most benefits are payable.

A licensed health care practitioner must certify that you require substantial assistance (hands on or stand by) from another person to perform at least two activities of daily living (ADLs) due to loss of functional capacity, which is expected to continue for at least 90 days or that you need substantial supervision due to a cognitive impairment.

The six ADLs are:

- Bathing
- Dressing
- Eating
- Maintaining continence
- Toileting
- Transferring

Cognitive impairment is deterioration or loss of intellectual capacity that is comparable to and includes Alzheimer's disease and similar forms of irreversible dementia. The need for substantial supervision due to severe cognitive impairment must be established by clinical evidence and standardized tests that reliably measure impairments in a person's short-term or long-term memory; orientation as to person, place, or time, or deductive or abstract reasoning or judgment as it relates to safety awareness.

A John Hancock Care Coordinator must verify that you meet the benefit eligibility requirements under the policy and you must have completed the Elimination Period before most benefits are payable.

What is the Elimination Period?

The Elimination Period (EP) is the number of days on which you incur a charge for a covered service, for other than Informal Care, for which John Hancock will not pay benefits. You must be benefit eligible during this time.

- The EP is 90 service days and needs to be met only once, as long as you remain continuously insured.

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- The days do not need to be consecutive and may be accumulated under separate claims.

The policy will pay benefits for covered charges you incur after the EP is met, as long as you remain eligible for benefits. Once you have met the EP requirement, your premiums will be waived for as long as you remain benefit eligible.

The policy can pay benefits for the Stay at Home Benefit and Hospice Care during the EP, but days on which only those covered services are received will not count toward satisfaction of the EP service day requirement. No date may be counted more than once toward the satisfaction of the EP.

A day on which you receive care or services due to a pre-existing condition will not qualify as a service day and will not count towards satisfaction of the Elimination Period until all the requirements of the pre-existing condition clause have been met.

What is the Pre-Existing Condition Clause?

The Pre-Existing Condition Clause applies only to those individuals who are automatically accepted for coverage. A Pre-Existing Condition is defined as any condition (illness, disease, injury, or symptom) that, during the six months just prior to the effective date of your coverage, causes you to:

- Consult a Licensed Health Care Professional; or
- Seek diagnosis or medical advice or receive medical care or treatment; or
- Undergo hospital admission or a Health Care Professional's visit for testing or for diagnostic study; or
- Obtain services, supplies, prescription drugs or medicines.

If, within the first six months after the effective date of coverage, you need:

- Substantial assistance to perform at least two of the Activities of Daily Living; or
- Substantial supervision to protect yourself from threats to health and safety due to the presence of a Severe Cognitive impairment;

that is caused or contributed to by a Pre-Existing Condition, John Hancock will not reimburse expenses for care, services, or treatment due to that same Pre-Existing Condition while the substantial assistance or substantial supervision continues, or if you recover, later becomes needed due to the same Pre-Existing Condition.

Are there any exclusions under the plan?

Conditions resulting from the following are not eligible for coverage:

- Your intentionally self-inflicted injury;
- War, whether declared or not, or any act of war, or service in any armed forces or auxiliary units;
- Your commission of or attempt to commit a felony;
- Your engaging in an illegal occupation; or
- Your participating in an insurrection or riot.

The policy does not cover:

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- care, services or treatment specifically provided for detoxification or rehabilitation for alcohol or drug addiction; or
- charges normally not made in the absence of insurance; or
- except under the Informal Care Benefit, care, treatment or charges provided by a member of your immediate family or by a person who ordinarily resides in your home; minor exceptions apply, or
- care, services or supplies furnished by or covered as a benefit under a program of any government or its subdivisions or agencies, except as required by law and except:
 1. program established by the federal government for its civilian employees;
 2. Medicare; and
 3. Medicaid (This means any state medical assistance program under Title XIX of the Social Security Act as amended from time to time); or
- any service or supply to the extent that charges for it are reimbursable under Medicare, or would be so reimbursable but for the application of a deductible or coinsurance or co-payment amount under Medicare. This exclusion will not apply in those instances where Medicare is determined to be secondary payor under applicable law.

No benefit is payable under the Policy for care received outside the United States (50 states and the District of Columbia) except as described in International Coverage.

These exclusions may not apply in all states and may vary depending on the state in which you live. The Certificate of Insurance you receive once you are approved for coverage will outline the exact exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance was originally delivered to you will apply. Long-term care providers must meet the qualifications specified in the Certificate of Insurance and services and supplies must be provided in accordance with a plan of care prescribed by a licensed health care practitioner.

Does the Lewis & Clark College LTCI Plan coordinate with other plans?

Yes. To prevent duplication of benefits, the Lewis & Clark College LTCI Plan contains a coordination of benefits provision (COB).^{*} If you are covered under two or more plans, such as group health or another LTCI plan, COB may reduce or eliminate the benefits otherwise payable under the Lewis & Clark College Long-Term Care Insurance Plan to the extent those services are covered under the other plan. The Lewis & Clark College LTCI Plan does not coordinate with Medicare, Medicaid (In California, Medi-Cal) or any non-group insurance plan, including non-group long-term care insurance.

^{*}Connecticut does not permit a Coordination of Benefits provision.

John Hancock Long-Term Care Insurance (LTCI) Department:
Call 1-800-711-9407

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What is the 30-Day Free Look?

Once you receive your Certificate of Insurance, you have 30 days to decide whether to continue with the plan. If you decide not to take the coverage, you must return the Certificate to John Hancock within this timeframe, and any premiums paid will be refunded in full. The Certificate will be treated as if it had never been issued.

Whom can I call with questions?

You may call the John Hancock Customer Service Center at **1-800-711-9407**. Call center hours are Monday through Friday, between 8:30 a.m. and 6:30 p.m., Eastern Time, except holidays. The toll-free number for the hearing impaired is 1-800-255-1808. If you are calling from outside the United States, the number is 617-572-0048.

You can also send us an e-mail at jhcorpchoice.contact@jhancock.com or visit the Lewis & Clark College Long-Term Care Web site at:

<http://enroll.jhcorpchoice.com>

(username: lewisclark; password: mybenefit).

Notice

This is only a summary of the Lewis & Clark College LTCI Plan; it does not cover all the details. The Certificate of Insurance that is issued to you when you become approved for coverage contains a more detailed statement of the terms and conditions of your insurance coverage. If there is any conflict between this plan summary and the Certificate of Insurance, the Certificate will control. Please note that plan provisions may be changed or deleted in order to satisfy state or other legal requirements, and Lewis & Clark College reserves the right to end or amend the plan for any reason. If Lewis & Clark College discontinues the plan, existing insureds will be allowed to continue coverage through John Hancock.

Coverage is provided under Policy # 30578-LTC issued on form P-FACE(2004) to Lewis & Clark College.

Long-Term Care Insurance is underwritten by

John Hancock Life Insurance Company, Boston, MA 02117