

2009

**Employee
Benefits Program**

Long-Term Care

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Long-Term Care

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Important Information

This Is Only A Summary

This booklet is a summary of the Long-Term Care Plan (“plan”), which is a component benefit program under the Travelers Non-Trusteed Employee Benefit Plan. The plan operates under a detailed legal document and a group insurance contract. A summary cannot deal with every set of circumstances. If this summary is incomplete in some respect, or can be read to be inconsistent with the legal document or the insurance contract, the legal document or insurance contract will control (see the section titled “Role of Insurer” later in this booklet for more information). A copy of the legal document and the insurance contract are available for review from the Travelers Employee Services Unit.

It Describes Current Plan Terms

This booklet describes the terms of the plan in effect as of January 1, 2009.

Not An Employment Contract

The plan is not a contract of employment or a guarantee of continued employment for any definite period of time.

Right To Interpret

Travelers, its Administrative Committee, and others have broad discretionary authority to make factual determinations and to interpret the plan.

Administrative Committee

The “Administrative Committee” is a person or committee appointed to this position in accordance with the terms of the plan. Currently, the Administrative Committee consists of a single person – the Executive Vice President – Human Resources of Travelers.

Oral Or Other Unofficial Modifications Are Not Permitted

The legal document governing the plan cannot be modified by oral statements made by anyone, or by unofficial communications (such as e-mail or mailings) or any other contracts (such as employment contracts or stock or asset purchase agreements). The plan can only be amended by official amendments. Amendments can only be adopted by authorized persons, such as the Board of Directors, the Chief Executive Officer, or others to whom the Board or the Chief Executive Officer has delegated amendment authority.

Eligibility

Employees And Retirees

You are eligible to participate in the plan if you are:

- A regular status, full-time or part-time salaried employee of Travelers or a participating affiliate; or
- A retiree from Travelers as defined by the Travelers Pension Plan (generally, you must have terminated at or after: age 55 with 10 years of service, age 62 with 1 year of service or age 65).

The “participating affiliates” currently are:

- Travelers Indemnity Company
- The Premier Insurance Company of Massachusetts (also known as Travelers of Massachusetts)
- First Floridian Auto and Home Insurance Company (also known as Travelers of Florida)
- TCI Global Services, Inc.

The following groups of people are not eligible to participate in the plan:

- Any employee classified as an “intern”
- Any employee who is:
 - Paid from a payroll system other than the U.S. payroll system of Travelers
 - A citizen of another country who is not working in the United States
 - A citizen of another country on temporary assignment in the United States (except in very limited circumstances)
- Individuals employed with, performing services through, or paid by a third-party (such as an employee leasing or staffing agency)
- Individuals performing services pursuant to a contract or agreement (whether verbal or written) which provides that he or she is an independent contractor or a consultant

Family Members

Your family members are also eligible for coverage under the plan if you meet the eligibility criteria above.

Eligible family members include:

- Your spouse (or surviving spouse)
- Your domestic partner (same or opposite sex) to the extent permitted by state insurance regulations and subject to satisfying the MetLife domestic partner application form
- Your parents and parents-in-law
- Your grandparents and grandparents-in-law

Please note that MetLife’s definition of domestic partner may differ from the definition of domestic partner Travelers uses for its other benefit plans. Please refer to the MetLife insurance certificate and contact MetLife directly with any inquiries you may have about whether an individual would qualify as a domestic partner under this plan.

“You” And “Your”

Throughout this summary, references to “you” and “your” generally mean “the insured,” which may include the Travelers employee or retiree, or eligible family member who has elected and enrolled in the plan. However, where it is appropriate, “you” and “your” may mean only the Travelers employee or retiree.

When Coverage Begins/Participation

Enrollment

You can enroll on-line through MetLife's website available on the Benefits Web site or by completing a paper enrollment form. Family members enroll by completing a paper enrollment form. Enrollment kits will be sent by MetLife. To request a kit for yourself or your eligible family member(s), you can call MetLife directly at 800.438.6388 (800.GET.MET8).

Evidence Of Insurability: Statement Of Health

You can enroll without submitting a Statement of Health if you enroll within 90 days of your date of hire.

If you do not enroll within 90 days of your hire date, you must complete a Statement of Health. Family members must always complete a Statement of Health.

Effective Dates

If you are a new hire and you enroll within 90 days of your date of hire, your Long-Term Care Insurance coverage will be effective the first of the month following your acceptance into the plan. For family members enrolling, Long-Term Care Insurance coverage will be effective the first of the month following acceptance of the family member's application by MetLife.

If you are not required to submit a Statement of Health, you must be actively at work on your effective date of coverage. If you are not at work on your scheduled effective date, coverage becomes effective on the first day of the month following your return to work.

Cost

Long-Term Care premiums are based on your coverage selections and your age on the effective date of your coverage. The younger you are when you enroll, the lower your premium. Once you are enrolled, premiums under the plan do not increase because you get older, your health changes, or you are receiving benefits from the plan.

Your premium is based on your age as of the date your coverage becomes effective. It is also based on the plan options and daily benefit you select.

Premiums will increase if you elect to increase your coverage.

Payroll Deduction/Direct Bill

If you enroll yourself for coverage, you must pay your premiums post-tax via payroll deduction. You may elect to pay your spouse's premiums via post-tax payroll deduction as well.

Family members (including your spouse, unless you elect to pay your spouse's premium via post-tax payroll deduction) will be billed directly by MetLife. Available payment options include:

When Coverage Begins/Participation

- Monthly Checking Account Deduction
- Quarterly direct bill
- Semi-annual direct bill
- Annual direct bill

Premium Waiver

Once you have been authorized to receive benefits under the plan and have fulfilled the 90 day waiting period, MetLife will waive your premium as of the first of the following month. Premium payments will resume on the first day of the month after you are no longer eligible for long-term care benefits assuming you have not exhausted your benefits.

Reinstatement

If coverage is canceled for non-payment of premium, you may request reinstatement within 12 months of the cancellation date. You must provide MetLife with a Statement of Health and pay all past due premiums.

If non-payment of premium was caused by a cognitive impairment or loss of functional capacity, you may request reinstatement within 5 months of the cancellation date without having to provide a Statement of Health. You must provide MetLife with proof of the cognitive impairment or loss of functional capacity and pay all past due premiums.

Coverage Changes

You may request to change your Long-Term Care Insurance coverage as follows:

Change	Statement of Health	When Effective
Increase Daily Benefit [(e.g. \$100 to \$150)]	Required	The first day of the month following the date MetLife approves the request.
Increase Coverage Level [(e.g. Facilities Only to Comprehensive)]	Required	Same as above.
Decrease Daily Benefit [(e.g. \$150 to \$100)]	Not required	The first day of the month following the date MetLife receives the request.
Decrease Coverage Level [(e.g. Comprehensive to Facilities Only)]	Not required	Same as above.
Add Nonforfeiture	Not required	Same as above.
Drop Nonforfeiture	Not required	Same as above.

Any change in the cost of coverage will become effective on the first day of the month following the date MetLife approves the request. If the daily benefit is increased, the cost for the incremental increase will be based on your age on the date the change is effective. For all other coverage increases, the new coverage will be based on your age on the date the change is effective. If coverage is decreased, the new cost is based on the age used to determine your previous coverage.

When you increase your daily benefit, the total amount of coverage also increases.

Coverage Options And Covered Services

Coverage Options

When enrolling, you must select among certain options.

Facilities Only Or Comprehensive Coverage

You must select Facilities Only Coverage or Comprehensive Coverage. Facilities Only Coverage provides coverage for care in a nursing home, assisted living facility, and in-patient hospice facility. The Facilities Only Coverage option also includes an Initial Care Advisory Visit and Transition Expense Benefit. The Facilities Only Coverage option is not available to residents of Vermont. The Comprehensive Coverage option includes all of these benefits, plus Home Care, At-Home Hospice Care, Adult Day Care, Respite Services, Ongoing Care Advisory Services, and Alternate Plan of Service.

Daily Benefit Options

When enrolling in either Facilities Only or Comprehensive Coverage, you must also select a daily benefit. The daily benefit is the maximum amount of daily coverage available for nursing home, in-patient hospice care, assisted living facility, and respite services. The daily benefit options are:

- \$100;
- \$150;
- \$200; or
- \$250.

Total Lifetime Benefit

The total lifetime benefit is the maximum amount of benefits the plan will pay. The plan provides for a maximum 5-year duration (1,825 times the daily benefit selected). However, the maximum duration can be extended based on the cost of your care, how frequently services are needed, what types of services are used, and optional inflation increases.

For example, if you select the \$150 daily benefit and you enter a nursing home that only costs \$125 per day, the difference of \$25 remains in your total lifetime maximum and extends the duration of the plan. Or, if you receive care in your home and are reimbursed at 50% of the daily benefit, the other 50% of the daily benefit remains in your total lifetime benefit.

Non-Forfeiture

When enrolling, you must select whether to include a non-forfeiture feature. The non-forfeiture feature allows you to stop paying premiums and still keep a portion of your coverage. If you have paid premiums for at least 3 years and elect to stop making payments, you will be entitled to receive a reduced level of coverage. The feature provides the full daily benefit with a total lifetime benefit based on the amount of premium paid. The total lifetime benefit will be at least 30 times the daily benefit.

Coverage Options And Covered Services

Covered Services

The following services are available under both Comprehensive and Facilities Only Coverage:

- **Initial Care Advisory Visit.** Once you are eligible for benefits, a professional care advisor can visit your home and help you assess your long-term care needs and preferences, as well as explore resources and providers in your community. The Initial Care Advisory Visit does not reduce your Total Lifetime Benefit.
- **Nursing Home Services.** Coverage includes all levels of care, skilled to custodial, received in a licensed nursing home or Alzheimer's facility.
- **Assisted Living Facility.** Coverage includes licensed facilities providing 24-hour care and other services required by individuals who are unable to perform activities of daily living or who demonstrate severe cognitive impairment.
- **In-Patient Hospice Care.** Coverage includes health care and support services provided in a licensed hospice facility for those who are terminally ill.
- **Transition Expense Benefit.** This is a benefit equal to 10 times the daily benefit. It can be useful for items such as durable medical equipment or an emergency response system. It is payable after completion of the waiting period and it does not reduce the total lifetime benefit. The transition expense benefit is not available if you are in non-forfeiture status.

The following services are only available under Comprehensive Coverage:

- **Home Care.** Coverage includes care received at home from a nurse, home health aide, homemaker and/or a physical, occupational, respiratory, or speech therapist from a licensed home care agency. Care can also be received from a nurse (R.N., L.P.N., or L.V.N.) or therapist who is not from a licensed agency.
- **At-Home Hospice Care.** Coverage includes health care and support services provided at home for those who are terminally ill.
- **Adult Day Care.** Coverage includes any licensed facility offering care, health support, and rehabilitative services for adults during the day.
- **Respite Services.** Provides relief for the primary caregiver. Coverage includes care from licensed providers for 14 days per calendar year.
- **On-going Care Advisory Services.** Coverage includes coordination of care and monitoring of the care you are receiving and assistance with altering your care plan as your needs change.
- **Alternate Plan of Service.** A MetLife care manager can authorize benefits for services that are not specifically defined as covered under the plan. The service must meet your needs and may be a cost-effective alternative to services otherwise covered under the plan.

Additional Plan Features

- **Inflation Protection.** At least once every three years, you will be given the option to increase coverage without providing proof of good health as long as you have not declined two previous consecutive offers to increase your coverage. The amount of the increase to the daily benefit will be 5% compounded annually. Any increase in your daily benefit will also increase your total lifetime maximum. The cost for this increase will be based on your age as of the effective date of the inflation offer.
- **Return of Premium on Death.** If you die prior to age 65, all premiums paid, minus any benefits received, will be returned to your estate. The amount of the refund will reduce by 10% per year from age 65 up to age 75. At age 75, the return of premium on death feature expires and no premiums will be returned. This feature is not available to residents of the state of Washington.
- **Non-forfeiture.** This feature allows you to stop paying premiums and still keep a portion of your coverage. If you have paid premiums for at least 3 years and elect to stop making payments, you will be entitled to receive a reduced level of coverage. The feature provides your full daily benefit with a total lifetime benefit based on the amount of premium paid. The total lifetime benefit will be at least 30 times the daily benefit.

Coverage Options And Covered Services

- **Bed Reservation Benefit.** If you require hospitalization, the plan will continue to pay the daily benefit for up to 21 days per calendar year to hold the bed in the nursing home, hospice facility, or assisted living facility, if required.
- **Portability.** You can continue coverage at the same premium rate even when you retire or leave employment with Travelers. In that case, your premium must be paid directly to MetLife.
- **Guaranteed Renewable.** As long as you continue to pay premiums, MetLife cannot cancel your coverage.
- **Provider Discounts.** Discounts with nursing homes, home health care agencies and medical equipment providers are available throughout the country. All MetLife insureds are entitled to these discounts, which can allow your total lifetime benefit to last longer.
- **Restoration of Benefits.** This provision requires that you have not been benefit eligible for the prior two years. Under this provision, your total lifetime benefit would be restored if all of the following conditions were met:
 - The total lifetime benefit has not been exhausted;
 - Premium payments have been made for a continuous period of 2 years from the date you were no longer chronically ill, and;
 - Satisfactory proof has been provided to a licensed health care practitioner (employed or retained by MetLife), stating that you have not been chronically ill at any time during a specified time period.
- **International Coverage.** If you are eligible for benefits and are outside of the United States, MetLife will pay a per diem benefit upon completion of the waiting period. For comprehensive coverage, the per diem benefit will be equal to 50% of the home care daily benefit. For facilities only coverage, the per diem benefit will be equal to 25% of the nursing home daily benefit. The per diem benefit will be paid in U.S. dollars. This benefit will be paid up to a maximum of 10 years while the insured is outside the United States.

What The Plan Does Not Cover

The plan does not provide benefits for the following:

- Care in a facility that provides services primarily 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 (except as provided under “International Coverage”);
- 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;
- 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;
- 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 co-payment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payer under applicable law; and
- Services for which no charge is normally made in the absence of insurance.

Qualifying For Benefits

Benefit Eligibility

You will be considered eligible for benefits when you have been certified by a licensed health care practitioner as being chronically ill. Chronically ill means:

- being unable to perform, without substantial assistance from another individual, at least two out of six of the following Activities of Daily Living for at least 90 days due to a loss of functional capacity:

Bathing	Dressing
Toileting	Continence
Eating	Transferring

OR

- requiring substantial supervision to protect from threats to health and safety due to a cognitive impairment.

Benefits will be paid for services included in a plan of care prescribed by a licensed health care practitioner.

If you have a disability resulting from organic brain diseases including Alzheimer's disease or a similar disorder, you are eligible for benefits. The plan also pays benefits in cases where your dependency results from mental or nervous disorders.

You, your doctor, or representative must contact MetLife and request a determination of benefit eligibility based on your inability to perform activities of daily living on your own. MetLife must approve the request for benefit eligibility, and in so doing, may also require access to your medical records.

Waiting Period

The waiting period is 90 calendar days. Covered services do not need to be received during the waiting period. No benefits can be paid until this waiting period is satisfied.

Denial Of Eligibility For Benefits

If you are not certified as chronically ill, you are not eligible for benefits. MetLife will follow the claims procedure outlined on the next page of this publication when it notifies you of the denial of your eligibility for benefits. You appeal MetLife's decision by following the appeals procedure on the next page.

Ongoing Review

When you are receiving covered services, MetLife will review your case from time to time to see that the standards for benefit eligibility are still being met. MetLife may review records and/or contact you, your doctor or someone else familiar with your condition. If it is determined that you are no longer eligible for benefits, you will be notified by MetLife.

Claims Process

How To Submit A Claim

MetLife will pay benefits only upon receipt of adequate written proof that expenses for covered services were incurred. You must submit written proof of claim no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit proof of claim within the time limit may result in a claim denial unless you can show that it was not reasonably possible to provide the proof of claim within the time period or that the proof of claim was submitted as soon as reasonably possible.

You can get a claim form from MetLife by calling 800.438.6388 (800.GET.MET8). Send your claim form to the address on the claim form.

Approval Of Claims

If MetLife approves a claim for benefits, MetLife will send written notice of the decision no later than 10 working days after all necessary information is received.

How Benefits Are Paid

After MetLife has approved the claim, reimbursement for covered services will be paid directly to you. Payments for most services can be made directly to the provider at the request of you and your provider. Payments for alternate plan of service and/or transition benefits cannot be made to anyone other than you.

Amount Of The Benefit

The daily benefit you selected determines the maximum amount that can be received each day. If the cost of service per day is less than your daily benefit amount, MetLife will pay up to the cost of service per day.

Initial Review Procedure

Your written proof of claim is considered a “claim for benefits” and will be fully and fairly reviewed by MetLife. If your request is wholly or partially denied, you will be furnished with a written notice of the denial that will cover:

- Specific reasons for the denial;
- Plan provisions on which the denial is based;
- Additional material or information needed to make the request for benefits acceptable and the reason it is necessary; and
- The procedure for appealing the denied request for benefits.

MetLife has 90 days to respond to your written claim. This deadline may be extended for an additional 90 days if necessary. If MetLife determines that an extension is necessary, you will be furnished with a written notice of the extension prior to the end of the initial 90-day response period. This notice will indicate the special circumstances requiring an extension of time and the date by which MetLife expects to make a determination.

Claims Process

Appeal Procedure

If your claim is denied, in whole or in part, and you want to pursue the matter further, you or your authorized representative must appeal the decision and request further review. You must file your written appeal with MetLife no later than 60 days after you receive written notification of the denial of your claim. Your written appeal must describe all the reasons why you believe the claim denial was in error, and should include copies of any documents you want to have considered in support of your appeal. Your appeal will be decided based on all available information, and the information you submit will be considered even if it wasn't considered in the initial determination. So you should make sure that your submission is complete.

During the 60-day period you have to file your appeal, you will have the opportunity to review upon request documents, records and other information relevant to your claim for benefits. You may also request copies (free of charge).

A decision on your appeal will normally be made within 60 days of the date your appeal is received. You will receive a written decision including the specific reason(s) and plan references on which the decision is based. If MetLife determines that an extension is necessary, you will be furnished with a written notice of the extension prior to the end of the initial 60-day period. The total review period on appeal cannot be longer than 120 days.

Legal Action

If your appeal is denied in whole or in part, you have the right to file a lawsuit challenging the denial. The claims procedures described above are required by federal law and are designed to ensure that disputes regarding the plan are decided by MetLife. Therefore, courts almost always require that a claimant exhaust a plan's claims procedures (filing an initial claim, and proceeding through both levels of appeal) before filing suit. If you fail to do so, the court will likely dismiss your lawsuit.

In a lawsuit, the court generally will review the decision MetLife made based on the evidence and arguments that were presented. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything you believe supports your position is submitted to MetLife during the claims process.

You may pursue legal action only after you have completed the claims process described above. In addition, if you have completed the claims process above and you want to bring a lawsuit, you must do so within one (1) year of the final denial of your claim. Failure to file a lawsuit within one year will cause your rights to expire.

When Coverage Ends

Terminating Coverage

You can cancel your long-term care coverage at any time. This cancellation will be effective at the end of the month in which cancellation is requested.

The following chart shows the circumstances under which long-term care coverage will end and when the termination is effective:

Circumstance Causing Coverage to End	When Coverage Ends
You request cancellation of your coverage.	At the end of the month in which you notify MetLife that you wish to terminate your coverage.
This coverage is replaced by another substantially similar plan, and you become eligible for that coverage.	On that date.
You do not pay the costs for coverage or Travelers does not forward payment to MetLife.	On the last day of the month in which MetLife received payments.
Your death.	On that date.
You reach your total lifetime benefit.	On that date.

Continuation Of Coverage

If the plan ends, you will be able to continue your coverage directly with MetLife if:

- The plan is not being replaced with a substantially similar plan;
- The plan is being replaced with a substantially similar plan, but you are not eligible under the new plan; or
- You are no longer an eligible employee or eligible family member under the plan.

To continue coverage, you must pay the required premiums directly to MetLife.

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under ERISA - the Employee Retirement Income Security Act of 1974.

ERISA provides that all plan participants shall be entitled to:

Receive information about your plan and benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the claims procedures outlined in this publication, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact MetLife at 800.438.6388. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Information

Plan Name

The name of the plan is the Travelers Long-Term Care Plan, which is a component program under the Travelers Non-Trusteed Employee Benefit Plan.

Type Of Plan

The plan is a welfare benefit plan.

Plan Sponsor And Administrator

Travelers is the “sponsor” and the “administrator” of the plan for purposes of ERISA. Benefits under the plan are insured by Metropolitan Life Insurance Company. Travelers acts as administrator through its Administrative Committee. Travelers is responsible for determining who is eligible for coverage, choosing the insurance carrier, deciding the terms of coverage, and collecting and forwarding premiums. The insurance carrier – currently MetLife – is responsible for deciding whether benefits are due and the amount of benefits, and for paying those benefits.

As administrator, Travelers and its Administrative Committee have the discretionary authority to make various determinations under the plan. The decisions made by Travelers and its Administrative Committee are final and binding, subject to your rights to file a lawsuit under ERISA. The decision-making authority is very broad and is limited only by the duties under ERISA, and the decisions of the Administrative Committee are intended to be given deference by courts to the maximum extent allowed under ERISA.

Insurer

Metropolitan Life Insurance Company insures the benefits under the plan. MetLife’s address is:

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

Role Of Insurer

The plan is insured by MetLife. MetLife is the plan fiduciary and guarantees payment of benefits for all eligible expenses incurred while the contract is in force. If there are any discrepancies between the information in this section and the MetLife insurance certificate, the insurance certificate will govern.

Medium For Providing Benefits

Benefits under the plan are provided through a group insurance contract.

Source Of Contributions

Premiums for the group insurance contract are paid by employee contributions.

General Information

Plan Year

The plan year is the calendar year.

Plan Number

The Non-Trusteed Employee Benefit Plan has been assigned the following identification number: 509.

Employer Identification Number

Travelers' federal employer identification number is 41-0518860.

Agent For Service Of Legal Process

Legal process may be served on Travelers at the following address:

The Travelers Companies, Inc.
c/o Corporate Secretary
385 Washington Street, 9275-NB16A
St. Paul, MN 55102



The Travelers Indemnity Company
and its property casualty affiliates
One Tower Square
Hartford, CT 06183

travelers.com

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