

Navigating Long-Term Care Insurance

This resource guide provides information that is designed to help you navigate long-term care Insurance (LTCI). The guide will give you an overview of LTCI, help you better understand the policy benefits, help you determine care needs and provide you tips to initiate a claim. This guide also has resources for family members that can help to manage the stresses of caregiving and ways caregivers can start planning for successful aging.



The content of this document is intended for general informational and educational purposes only. This guide is not and should not be construed as insurance, legal, tax, financial or any other advice. As insurance policies and state insurance laws vary, Home Instead Senior Care franchise offices should refer any client with questions about his or her long-term care insurance policy -- including whether a franchise office would be considered a covered provider as defined by the client's policy -- to the insurance company that issued the client's policy and the client's insurance, legal, tax, financial or other advisor for more information. Home Instead, Inc. expressly disclaims any and all liability with respect to the content and recommendations provided in this document.

Each Home Instead Senior Care® franchise office is independently owned and operated. © 2018 Home Instead, Inc. All Rights Reserved.

**Home
Instead**
SENIOR CARE®
To us, it's personal.

Table of Contents

- 1** What is Long-term Care Insurance?
Determining if You Have a Policy and Locating It
- 2** Determining Level of Care Needed
- 3** Interpreting Your Policy
- 4** Finding a Care Provider
- 5** I Know What Type of Care I Need, Now What?
- 6** Informing Care Provider That You Have a Long-Term Care Policy
Assignment of Benefits
- 7** What if My Claim is Denied?
Appeals Process
- 8** Family Caregiver Support and Resources
- 9** Looking Ahead
- 10** Long-Term Care Insurance Glossary

We wish to acknowledge Bill Comfort, CSA, CLTC, LTCCP(R) of Comfort Assurance Group, LLC for his expertise and contribution to this guide.

What is Long-term Care Insurance?

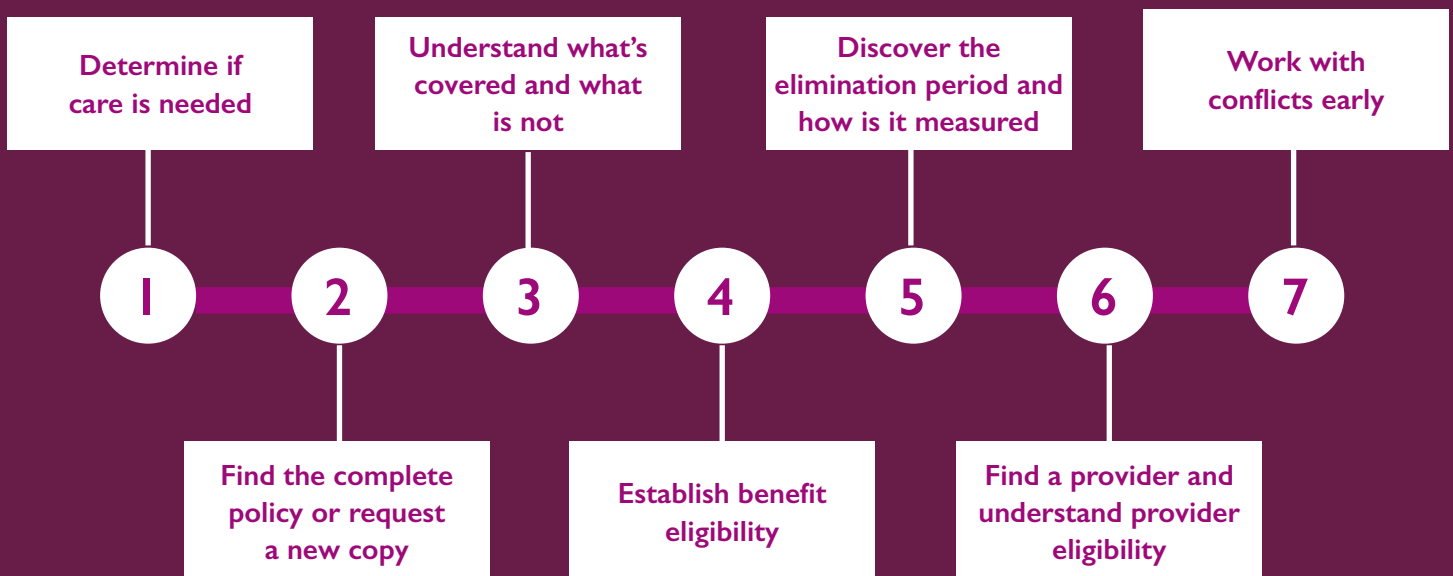
Long-term care insurance (LTCI) is a form of insurance that is generally intended to cover services needed to care for a person in later life.

If a person chooses to purchase a LTCI policy, the policyholder pays premiums over time (typically over the course of many years and sometimes even decades). When the policyholder reaches a point where they want to use their LTCI policy, they can make a claim on the LTCI policy. Generally, the LTCI policy is a signed contract between the insurance provider and the policyholder. Each policy's provisions and policies are unique to the person and because of that, it is likely that no two policies are the same and even policies within the same insurance provider may be different. To get the most out of the benefits offered, it is best to review each LTCI policy individually with the policyholder to understand their policy's covered benefits and policies.

A person typically goes on claim when he or she needs assistance with at least two Activities of Daily Living (ADLs) or is cognitively impaired (typically caused by Alzheimer's or another dementia). ADLs can be described as basic physical activities and functions performed on a daily basis that are usually done without assistance. ADLs for LTCI are: eating; dressing; bathing; toileting; transferring and continence. The long-term care services that are covered by your LTCI policy may include home care, skilled care at home, assisted living, adult daycare, respite care and nursing home care.

General LTCI Claim Timeline

Now that you know what LTCI is, this graphic will give you an idea of a general LTCI claim timeline. The remainder of the guide will go into depth on each step of the claim process.





Determining if You Have a Policy and Locating It

If you have a LTCI policy, it is best to get a copy of the entire policy. You may have to contact the LTCI provider to receive a new copy. The policy will help you to better understand the benefits you are eligible for. If you are unsure of where your copy of the policy is located, here are a few tips of places to look: safety deposit box, household safe or filing cabinet, contact your insurance agent and/or financial advisor or try to find a past billing statement.

I Don't Have a Policy, What are the Options?

If you do not have a LTCI policy you may or may not be eligible for LTCI. If you are under the age of 84 and you are in relatively good health, you are more likely to qualify. Contact your financial advisor or insurance agent to learn more.

If you are in need of services, it is too late to purchase a LTCI policy. However, there are alternative options for funding long-term care. To learn more about these and other funding options, download this [Funding Solutions Guide](#).



Determining Level of Care Needed

Once you have located the policy, you might consider assessing the individual's care needs. If the person is living independently, you might consider the following 10 signs that can help indicate whether it might be time for some extra assistance in the home. You may also start to notice changes in the person's physical Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) or cognitive functioning that could indicate the need for additional support.

1. **Household bills piling up.** Seniors can feel overwhelmed by the simple task of opening and responding to daily mail.
2. **Reluctance to leave the house.** Rather than ask for help, seniors who are having trouble with such functions as walking, remembering and hearing will pull away from their community and isolate themselves.
3. **Losing interest in meals.** Seniors who suddenly find themselves alone, perhaps after the death of a spouse, can be easily discouraged by such tasks as cooking and tend not to eat properly.
4. **Declining personal hygiene.** Changes in appearance or hygiene, such as unkempt hair and body odor, failing to change clothes for days on end or wearing clothes that are inappropriate for the weather, are among the more obvious signs that a senior may need assistance.
5. **Declining driving skills.** Look for evidence of parking or speeding tickets, fender-benders, dents and scratches on the car.
6. **Scorched pots and pans.** Cookware left forgotten on top of an open flame may be a sign of short-term memory loss or even dementia.
7. **Possible signs of depression.** Feelings of hopelessness and despair, listlessness, fewer visits with friends and family, a change of sleeping patterns and lack of interest in the usual hobbies and activities may be indicators of depression.
8. **Missed doctors' appointments and social engagements.** These may be signs of depression or forgetfulness. But the signs may also be the result of no longer having a driver's license and not knowing how to get alternative transportation.
9. **Unkempt house.** Changes in housekeeping may come about because the senior is physically tired. This could also result from depression.
10. **Losing track of medications.** Seniors often take multiple prescriptions for various health conditions. Keeping track without reminders and assistance can be confusing.

ADLs are basic activities and functions performed on a daily basis that are usually done without assistance.

The six ADLs are:

- eating
- dressing
- bathing
- toileting
- transferring
- continence

IADLs, on the other hand, are those activities instrumental to our daily routines such as:

- driving
- preparing meals
- doing housework
- shopping
- managing finances
- managing medication
- using the telephone

(Help with IADLs alone does NOT qualify for LTCI benefit payments, but these services are covered if otherwise benefit eligible.)

If you would like a free care consultation with a local Home Instead Senior Care representative, call

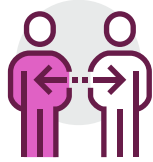
(888) 230-8075.

Interpreting Your Policy

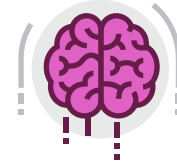
Once you have determined your care needs, you may want to understand the LTCI policy and the services covered. Here are some key areas of the policy to consider reviewing:

First Things First - Benefit Eligibility

Nothing happens in a LTCI policy until the policyholder is considered “benefit eligible” - think of this as a degree of “disability.” To “trigger” benefits most policies look at either:



Needing assistance with at least 2 out of the 6 physical ADLs



Needing supervision because of a “cognitive impairment”, such as Alzheimer’s disease or related dementias

Most policies consider ADL assistance to be at least “stand-by” help to make sure the policyholder remains safe. A few policies require the help to be fully “hands-on” before becoming benefit eligible. See the **Glossary** for more details on Benefit Triggers.



The Elimination Period

Understanding the elimination period will help you determine when your policy will start covering the cost of care. The elimination period must be met before a policyholder receives benefit payments. It is similar to a deductible and is usually expressed as the number of days that must pass before actual benefit dollars are paid. In other words, you must pay out of pocket for the care during the elimination period before the benefit kicks in. While most policies measure a number of days – 20, 30, 60, 90, 100, and 180 days are common examples – it is not accurate to think of the elimination period simply as a “waiting period.”

EXAMPLE

If an individual receives covered home care services 3 days a week with a policy requiring a 90-day elimination period, it could take more than 7 months for the client to accumulate the 90 days if only measuring the “days of service.”

For an elimination period to begin, the client must be determined to be eligible for benefits and receiving covered care according to a written plan of care. The shorter the elimination period, the less money an individual typically pays out of pocket; therefore, there is generally a lower “deductible”. Shorter elimination periods are comparatively more expensive to purchase.

For most policies, if the in-home care provider does not meet the specified definition of a covered service provider, then those days of care from the in-home care provider generally do not count toward the elimination period.

Most policies count only days of covered “service” which can be a problem for home care as noted in the example above. Some policies have an elimination period “credit”, meaning that, if 1 to 3 days of covered care are received in a week, then all 7 days in the week are credited. This can be an easier elimination period to fulfill, but it is still important that the in-home care provider is defined as a covered, approved provider in the policy.

In some rare circumstances, a policy will require only a “calendar day” elimination period, which is a true waiting period that begins as soon as basic benefit eligibility is established, no matter who provides care. While this type of elimination period is not common, people tend to imagine that this is how the elimination period works.

Home Modifications and Durable Medical Equipment

Often times there are benefits that are not necessarily considered to be care needs but could help you stay safe at home. Some policies have extra benefits that can be used to make modifications to your home. For example, installing a walk in shower, grab bars, or wheelchair ramp. Some policies may also have a benefit for durable medical equipment (DME) that would help to make life at home a little easier. For example, a toilet seat riser, walker or wheelchair. If available, these benefits can often be paid during the elimination period, but the policyholder must still be benefit eligible to receive this coverage.

Finding a Care Provider

If you are still living at home and needing assistance with ADLs and IADLs, home care is a solution that provides professionally trained caregivers to assist with your care needs while helping you to remain independent and safe at home.

Professional caregivers can generally be grouped into three different categories: agency employee, independent contractor with a registry and independent caregivers. As there may be different business models for each caregiver category in the marketplace, the following information is intended as a general summary of typical differences between these categories. This is not intended as an exhaustive description of every home care model. To confirm whether the descriptions below apply to the caregiver you are considering, please consult with the caregiver and/or the referring agency or registry.

Agency Employees



Most agencies (such as Home Instead Senior Care) hire caregivers who are screened, trained and insured. Caregivers are generally employees of the individual company for which they work. As the agency pays these caregivers, it also typically handles all payroll-related taxes and other employment obligations such as obtaining workers' compensation and liability coverage and addressing performance issues. The third party agency usually provides additional support between the family, caregiver and client.

Independent Contractor with a Registry



An independent contractor with a registry is usually recruited, screened and referred to the client. Depending on the registry's business model, the older adult may become the employer and may then become responsible for labor-related responsibilities such as hiring, scheduling, handling performance issues, and paying/reporting applicable taxes. The older adult may assume risk if the independent contractor is not covered by workers' compensation, liability and bond insurance. While the contractor may have had a criminal background check and reference checks, he or she may not be receiving support, training and continuing education. A replacement caregiver may be unavailable depending on the registry's model.

Independent Caregivers



The independent caregiver is usually responsible for marketing themselves and finding their own clients. Most LTCI policies do not cover independent caregivers. On a case-by-case basis, independent caregivers may have criminal background checks, reference checks and training history. The older adult may become the employer and may then be responsible for all employment responsibilities such as hiring, scheduling, handling performance issues and paying/reporting applicable taxes. The older adult may assume the risk as the employer since the independent caregiver may not be covered by workers' compensation, liability and bond insurance. The independent caregiver may not receive support, training and continuing education, nor may a replacement caregiver be available should the independent caregiver become unavailable.

The following, are the questions to ask each type of provider:

- Is the individual an agency employee (recommended arrangement), an independent contractor with a registry, or are they working independently?
- Have the caregivers been trained? Do they receive ongoing training? By whom? Extent of training? Does this training include special dementia or Alzheimer's training?
- Have the caregivers undergone and passed a criminal background check and drug screening, and have personal references been secured on all caregivers?
- Are the caregivers bonded and insured? This means the company covers claims and insurance, so the home owner is not liable should something happen.
- Does the caregiver have workers' compensation coverage?
- Can you check references on the company?
- Does the agency or registry offer back-up / replacement caregivers?
- How much input will you have in selecting the caregivers?
- Who pays the caregiver and pays/reports any applicable taxes?
- What restrictions (if any) apply to the services provided? Hours of service? Lifting restrictions?
- How much flexibility will you have in setting a schedule for services? Who schedules the caregiver?
- How much notice does the agency or registry need to begin or cancel service?
- What is the cost of service including: Minimum hours of service per visit / week / month? Special overnight rates?
- Does the agency or registry maintain a quality assurance or supervisory program?
- What is the agency's or registry's communication plan to keep families informed?
- Is a service deposit required and, if so, how much is it?
- Does the home care agency or registry offer the personal care services the patient needs, like assistance with bathing, dressing, and using the bathroom?
- Are patients' special needs accommodated?

I know what type of care I need, now what?

Once you have determined the type of care that you need, it is best to fully understand the benefits of your policy and the eligibility criteria.

Questions you might consider asking your LTCI carrier to better understand coverage:

- What services are covered?
- How much does the policy pay per day, week or month for each type of service?
- How long will the benefit last?
- Does the policy ever expire? Is there a maximum lifetime benefit?
- Does the policy have a maximum length of coverage period for each service?
- What are the terms of the elimination period? In other words, how many days must I wait before benefits begin for the different types of services? Do I pay for the services out of pocket during the elimination period? Is there a buyout fee for the elimination period?
- How is cognitive impairment such as Alzheimer's disease or dementia covered?
- Does the policy require an assessment, physician referral, prior hospital stay or other prerequisites for benefits to kick in?
- Does the policy have an alternate plan of care provision or exchange benefit?

Informing Care Provider That You Have A Long-term Care Policy

Once you have selected the provider for your long-term care needs, it is best to inform them of your LTCI policy. There is often times a good deal of paperwork that the care provider will need to supply in order to help you initiate the claim. In some cases the care provider may initiate the claim; in other cases, you or a family member may be responsible for initiating the claim.

The Billing Process

It is important to clearly communicate with the care provider about LTCI payment. You want to be sure that you and the care provider fully understand the elimination period process and the possibilities of payment delays under your specific policy. This is important so that you and your family can plan for realistic cash flow and payments for care.

How Are Benefits Paid?

LTCI policies generally pay benefits using one of three different methods: the expense-incurred method, the indemnity method, or the disability method.



EXPENSE-INCURRED METHOD

This “reimbursement” method pays benefits only when the insured receives eligible services. The LTCI company determines benefit eligibility and if the claim is for eligible services. Any benefits are paid either to the insured or the provider. The coverage typically pays for either the expense or the dollar limit of the policy, whichever is less. Most policies bought today pay benefits using the expense-incurred method.



INDEMNITY METHOD

For this method, the benefit is a set dollar amount. The benefit is not based on the specific services received or on the expenses incurred. Rather, the insurance company only needs to determine eligibility and if the policy covers the services being received. Once it makes that decision, the insurance company pays that set amount directly to the insured (up to the limit of the policy). This may also be called “daily” or “professional” indemnity.



DISABILITY METHOD

This method only requires that the insured meet the benefit eligibility criteria. Once the insured has met the criteria, the full daily or monthly benefit is received, even if he or she is not receiving any paid long-term care services. This is also called “cash benefit.”

Assignment of Benefits

Your long-term care insurance policy is a contract between you and the insurance company. They pay you (until you assign benefits to the provider), which gives you control. Assignment of benefits can make your life easier once you are settled into a caregiving routine which you don't expect to change. Assignment of benefit allows the insurance company to pay your care provider directly. Keep in mind that most care providers will not accept Assignment of Benefits until you have met the elimination period and the LTCI insurance company has started paying.

Don't jump into an assignment of benefits if you think your care provider might change. If you make changes after you have assigned benefits, you would have to coordinate the stop of your initial assignment of benefits and have the benefits payable either to you, or to your new provider.

What if My Claim is Denied?

It is possible that your benefit claim could be denied. The two most common reasons are: A) the policyholder is not yet benefit eligible, or B) the care provider is not covered by the policy's definitions.

Denied Due to Benefit Eligibility

In this case, seek to clarify the types of impairments and help needed; work with your health care provider to show in detail how the assistance or supervision needed meets the policy's benefit eligibility definitions.

Denied Due to Provider

Provider eligibility is especially problematic for home care. If the initial claim filing is contested because the LTCL company does not view the provider as a qualifying provider, you may want to contact your LTCL company directly or designate a legal representative to work directly with the insurance company. When contacting the company, explain the care circumstances and your desire to use the provider's services. Read the policy's provider definition very carefully.

It may be that the language in your policy may specify that it only covers care from a "licensed" agency. This policy requirement often leads to potential issues if the provider is in a state that has no licensing requirement for the services they provide. Providing simple, clear documentation about the provider, what the provider does, and how the provider is viewed professionally by the state compared to licensed agencies, can present your case more effectively.

Look for "exception" language in the policy's definition of a covered home care agency. Some policies require an agency to be licensed only if mandated by the state. If applicable, work with the provider to document for the LTCL company that the provider satisfies the policy criteria.

Most policies have a provision for an "Alternate Plan of Care" (APoC) which allows for a negotiation regarding care providers. The insurance company has to agree, but an APoC may allow for the provider you want to use even if not explicitly covered.

Appeals Process

If your LTCL claim has been denied, you may have the option to initiate an appeals process. You may consider reviewing your specific policy for the appeal terms. Then you may need to develop a letter of appeal which will explain why you are appealing the claim denial. This letter may need to be submitted in writing or, you may be able to initiate over the phone to the claims department; however most policies require you to make the appeal case in writing. It is best to follow the instructions outlined in the policy or the instructions from the claims department.

Family Caregivers

Support and Resources

Your local Home Instead Senior Care office provides support for the entire family. We offer family caregiver education in person and online at no additional cost. We give you practical tips for caring for your loved one, as well as yourself, and help you connect with other family caregivers to share your experience and find support. We invite you to visit the following websites to learn more.



CaregiverStress.com

CaregiverStress.com

This site strives to help you care for your senior loved one through helpful caregiver resources, while helping you spot signs of stress on your emotional and stressful caregiving journey.



Funding Solutions Guide

CaregiverStress.com

When it comes to long-term care for aging adults, consumers have more choices than ever before. This guide can help seniors and their families determine which type of care is best and various ways to fund it.



Making Home Safer for SeniorsSM

MakingHomeSaferForSeniors.com

This program provides a home safety checklist to ensure an older adult's home is safe from the pitfalls that could put them at risk for falls and injuries.



HelpforAlzheimersFamilies.com

HelpforAlzheimersFamilies.com

The go-to website for families affected by Alzheimer's or other forms of dementia. Here you'll find: in-depth learning resources, family caregiver training, a network of support, live chats with Alzheimer's and caregiving experts, and tools to locate service providers in your area.



Simple Meds[®]

SimpleMeds.com

Each month, all medications are pre-sorted into packets according to the day and time they should be taken. No need to juggle multiple prescription bottles or pill box organizers.



Stages of Senior Care

StagesofSeniorCare.com

This book will guide readers through the process of caring for your aging loved ones by providing a clear and practical presentation of the options, the pros and cons of each, the relative costs, what to look for, what to avoid, the pitfalls, how to pay for services and how to deal with family conflict and caregiver stress.

Looking Ahead

Planning for Your Own Long-Term Care Needs

Will I need long-term care in the future?

It is hard to say whether or not you will need long-term care in the future. However, it is a known fact that 70% of Americans age 65 and older will need assistance at some point during their older years. It is also known that 40% of those 65 and older will need daily assistance. So the chances of you needing some sort of long-term care in the future are pretty good. It is also a possibility to need long-term care if you are injured and rehabilitating after a serious injury.

What does it cost?

The cost of long-term care varies based on a number of factors including the level of care needed. But trends have shown the costs of long-term care is steadily increasing year over year. Even part-time home care can cost thousands a month.

Who pays?

Many Americans have the misconception that government funding will cover their long-term care needs as they age. That is not the case for the majority of the population. Long-term care needs are generally paid for out of pocket or through a LTCI policy. Programs like Medicare and Medicaid are limited in what they will cover. Medicare covers skilled health care needs and some short-term rehab care (whether at home or in a facility). Medicaid has limited coverage for long-term care for those that cannot afford care or for those that spend down assets to qualify. Medicaid primarily pays for care in a nursing home.

Where can I get LTCI?

There are several avenues to purchase LTCI. The most common is through your financial advisor. Your financial advisor may sell LTCI or can connect you with an agent who is a LTCI specialist. While not common, ask your employer if LTCI is available to you as an employee benefit.

What are the types of LTCI policies?

There are now several ways to buy LTCI. The “traditional” type of coverage allows you to design the benefits you want, for example, how much daily or monthly benefit, the inflation increase percentage, the total benefit period or maximum pool of money, and the elimination period. You then pay an annual or monthly premium until you need coverage. These policies don’t pay anything back if you never need care, but provide the most coverage for the premium spent. A new type of policy combines LTCI with a life insurance policy or an annuity. These “hybrid” or “combo” policies provide a death benefit or cash value return if you never need care, but are also more expensive.

Do premiums increase as you get older?

Your premiums will not increase because of your age or deterioration in your health. Premiums are designed to stay level; however, from time to time, the insurance company may increase premiums for a whole class of policyholders.

What will LTCI cover?

Benefits begin when a person needs assistance with certain ADLs or is cognitively impaired (typically caused by Alzheimer’s or another dementia). Policies today cover home care, adult day care, assisted living, respite care and nursing home care.

What to know before you buy?

Eligibility



If you are between the ages of 18-84 and are in reasonably good health, you may likely qualify for LTCI. The earlier you purchase the policy, the lower your premiums are likely to be. If you have a preexisting condition, it may be more difficult to qualify for care.

Duration or dollar limitations of benefits



You may want to inquire about the maximum benefit of the policy. There may be a maximum daily dollar amount or a one-time maximum benefit period.

Renewability



All policies are guaranteed renewable which means they cannot be cancelled as long as you pay your billed premiums on time and as long as you have been truthful on your health application.

Nonforfeiture benefit



If you do happen to drop your coverage, many LTCI providers will offer some sort of benefit. They may return the premium in the form of cash or offer a shortened benefit period.

Waiver of premium



If you start to use your LTCI benefits, most policies waive, or forgive your premiums, but read the policy information carefully to see if there are any restrictions or exceptions such as during the elimination period or for home care.

Disclosure



It is important to be truthful in your medical history as this helps the company to assess your eligibility. The company may have the right to deny coverage when filing a claim if you did not provide accurate health history.

LONG-TERM CARE INSURANCE GLOSSARY

The following are common definitions typically found in long-term care insurance (LTCI) policies. As LTCI policies (and their specific definitions) and related state laws may differ, this Glossary is intended for general reference and educational purposes only. For any specific definition, the insured should consult his or her applicable LTCI policy.

ACCELERATED DEATH BENEFIT

A life insurance policy feature that lets the insured use some of the policy's death benefit prior to death. Newer life policies may offer ADB for LTC needs.

ACCUMULATION PERIOD

The period of time within which the **elimination period** must be satisfied. Not all policies have this limitation.

Example: A policy has a 90-day **elimination period** and an **accumulation period** of three-times the **elimination period**. The insured has 270 days within which to accumulate 90 days to satisfy the **elimination period**.

This provision is most important when a claim begins with home care as professional care is often not received daily, particularly in the early stages of a care need.

ACTIVITIES OF DAILY LIVING (ADLs)

These are the physical activities that policies use to measure the insured's ability – or inability – to take care of himself or herself. Every policy includes a list of ADLs and a definition of each. The most common LTCI ADLs are:

- Bathing
- Dressing
- Transferring
- Eating
- Toileting
- Continence

A few older policies added mobility (walking without assistance) which is generally not allowed under newer **tax-qualified policies** issued since 1997.

Most policies require the loss of at least two (2) ADLs for benefits to begin. Some may require only one, some three.

Not all policies list all six ADLs. Some only list five. Some older policies combined two ADLs into one, for example bathing and dressing. Generally, combined ADLs or an abbreviated list is more problematic for the client at claim time as it requires a greater degree of physical impairment before benefits begin.

The loss of an ADL is typically measured by the amount of help needed to perform it. That help can be measured as either "hands-on assistance" (more restrictive – a greater degree of loss) or "standby assistance" (more liberal – a lesser degree of loss).

ALTERNATE PLAN OF CARE

This is a contract feature offered by most LTCI policies. It allows the policyholder to negotiate with the insurance company to pay for a care service not explicitly covered by the contract. The client, the doctor and the insurance company must all agree. It is not a guarantee as the company has the right to refuse to participate. An alternate is typically approved only if it costs the company less than covered services.

BATHING

An **activity of daily living**. Bathing is the insured's ability to wash himself or herself, either in the tub, shower, or with a sponge. This includes the ability to safely get into and/or out of the tub or shower.

BENEFIT PERIOD

The benefit period begins on the first day that the insurance company begins to pay for the insured's care and ends when he or she no longer requires care or has reached the maximum benefits allowed by the policy.

Most policies do not limit benefits to a time period, but use the **benefit period** as a multiplier to produce a total **pool of money**. For example, a \$100 daily benefit with a five (5)-year **benefit period**, produces a total dollar benefit of \$182,500. A **pool of money** policy does not end after five-years, but after the total benefit dollars are exhausted if longer.

BENEFIT TRIGGERS

These are the conditions an insured must meet before the policy pays benefits.

The three most common triggers are:

1. Physical assistance as measured by a loss of ADLs
2. Supervision or assistance due to a cognitive impairment
3. Medically necessary care

It is best to have a policy that pays when any one of the conditions is met. For example, policies requiring ADL limitations AND medical necessity are less likely to pay claims. Most policies written since 1997 do not include the "medical" trigger.

CASE MANAGEMENT

Also called Care Coordination.

Some policies may require or offer case management if the insured needs care. A case manager is chosen either by the insured, the insured's family or doctor, or by the insurance company. The case manager evaluates the insured's need for care and determines the best type of care for his or her situation.

Although insurers may seek to use case management to control costs, it can also be a benefit to the insured, since managers know what care resources are available in the community and can identify options that others may be unaware of.

CASH BENEFIT

A type of **indemnity** policy that pays the full contract benefit in cash, typically monthly, regardless of actual expenses incurred AND regardless of who provides the care, where or how often. While there must be a **written plan of care**, receipts are not required for cash benefit payments. This may also be called a "disability" type of LTCI.

Some policies only pay facility benefits on an **indemnity** basis, while paying home care as a **reimbursement**.

CHRONICALLY ILL

Tax-qualified LTCI policies written since 1997 require that an insured be certified as "chronically ill" by a licensed health care practitioner. This means the insured is unable to perform without substantial assistance at least 2 ADL's for a period of at least 90 days due to a loss of functional capacity or separately has a severe cognitive impairment requiring substantial supervision.

The 90-day ADL requirement is not a waiting period, but a certification based on an "expectation of care" that is intended to separate short-term needs where recovery is expected from on-going, chronic care needs.

COGNITIVE IMPAIRMENT

A deterioration or loss in mental capacity which requires continual supervision to protect the insured or others. It is commonly measured by impairment in the following areas:

- The insured's short term or long-term memory,
- The insured's orientation as to
 1. Person (who the insured is),
 2. Place (where the insured is),
 3. Time (day, date, and year), and
- The insured's deductive or abstract reasoning.

CONTINENCE

An **activity of daily living**. The ability to control urinary and/or bowel function with a proper degree of hygiene.

COORDINATION OF BENEFITS

The practice of offsetting or paying benefits only after any other insurance or government agency has made payment. Most policies will coordinate with Medicare and workers' compensation to avoid double-payment for the same service. Most policies do not coordinate with other LTCI policies unless written by the same carrier. (Note that under Medicaid, LTCI benefits are considered a form of income available to offset Medicaid's responsibility.)

COINSURANCE

Also called co-payment is a percentage of the cost of care that the policyholder must pay on every expense. A typical **coinsurance** rate is 20% meaning that, for every dollar spent on care, the policy will only reimburse \$0.80.

CUSTODIAL CARE

Helps with ADLs or **cognitive impairment**. It is given by people without medical training, but who may have training as an "aide." Custodial care may involve preparation of meals, help with managing medicines, and other routine activities as well. Custodial care can be given in nursing homes, assisted living facilities, adult day centers, or at home.

Most LTCI policies pay for custodial care in an approved facility and at the insured's home.

DAILY BENEFIT AMOUNT

Also called the benefit level. May be expressed as a daily or a monthly amount. This is the maximum amount a policy will pay for a day (or month) of care. The daily benefit may be higher for nursing home care than for home care and is often limited to the amount charged for the care.

DEDUCTIBLE

An amount not paid by insurance, usually specified as a dollar amount. It is the amount the insured pays out of pocket before the insurer begins payment of an insurance claim.

For LTCI insurance, the deductible is usually the number of days of care the insured pays for before the insurer begins paying (see **elimination period**).

ELIMINATION PERIOD

This is the policy's "deductible." It is usually expressed as a number of days, but some older policies set a total dollar amount that must be spent before benefits begin. It is the time between when the insured meets a benefit trigger and begins receiving care and when the policy begins paying benefits. Typical options include 20, 60, 90 or 100 days. It may be as long as 180 or 365 days.

The shorter the elimination period, the sooner the policy begins paying benefits and typically the more expensive the policy. The period may be different for nursing home care and home care. Newer policies generally only require the **elimination period** to be satisfied once; older policies may require a new period for separate periods of care.

EXPENSE INCURRED METHOD

Also known as reimbursement. Once there's an expense for an eligible service, the insurer pays benefits either to the insured or his or her provider. The coverage typically pays either the amount of the expense or the policy's dollar limit, whichever is less. Most policies sold today use the reimbursement expense incurred method.

EXCLUSIONS

All policies specify certain situations in which they will not pay benefits. These usually include care:

- required by war or act of war
- for intentionally self-inflicted injury
- paid by the government (other than Medicaid)
- for which no charge is made in the absence of insurance
- due to alcoholism or drug addiction

Other exclusions frequently used are for care:

- received outside of the United States
- provided by a family member.

GRACE PERIOD

This refers to how many days after the insured's premium remains unpaid that the policy will remain in effect. The standard grace period is 31 days. This means that the insured has 31 days after the premium due date to make the payment without any lapse of coverage.

GUARANTEED RENEWABLE

The insurance company cannot cancel the insured's policy for any reason except for not paying the premiums. The policy provisions also can not be changed by the company. If a policy is guaranteed renewable, it states this explicitly, usually on a coverage page.

All LTC policies issued since 1993 are now guaranteed renewable. If not, the company is not obligated to continue insuring the insured.

Guaranteed renewable does not mean that the premiums are guaranteed. Premiums can increase. It is the coverage that is guaranteed as long as premiums are paid on time.

HANDS ON ASSISTANCE

This is the physical assistance of another person, without which the disabled individual would be unable to perform an ADL.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 went into effect on January 1, 1997. HIPAA established specific federal requirements that a long-term care insurance policy must meet to be "tax qualified." Tax qualified policies' benefits are generally received income tax free and premiums may be deducted as medical expense. All policies issued before 1/1/1997 were grandfathered and are considered tax qualified. Policies issued after 1/1/1997 must explicitly state on the coverage page if it is tax qualified or not.

HOME HEALTH AIDE

A health worker employed by a home health agency or working as an individual, who provides help at home with **activities of daily living**, cognitive impairment and, in some cases, homemaker or companion services.

HOME HEALTH CARE

This is care provided by an agency or individual and can include services provided by a nurse, home health aide, nutritionist, or occupational, speech, respiratory, or physical therapist. It does not usually cover services provided by members of the insured's family, special companions, or homemakers.

Home health care is not covered by all insurance companies. When it is offered, the services may be covered as part of the long-term care policy, an option or rider available with the policy, or a separate policy.

INDEMNITY

An indemnity benefit is a fixed amount paid when care is received, regardless of the cost of care.

A policy with a \$100 daily indemnity benefit will pay \$100 for each day any covered care is received no matter what the actual charges are. "Daily" or "professional" indemnity benefits require that some paid "professional" care be received.

See also **cash benefit**.

INFLATION PROTECTION

Because long-term care costs can be expected to rise in the future, policies provide protection or benefit increase options that increase the maximum daily benefit and the total lifetime benefit each year.

Usually the buyer can choose between simple and compound increases. Simple increases add the same dollar amount to the daily benefit each year, typically 3-5% of the original benefit.

Compound inflation protection increases the benefit by a percentage of the current benefit, again 3-5%. Because price inflation is a compound effect, compound protection is more likely to keep up with the cost of care in the long run.

Guaranteed purchase options allow the insured to increase the benefit in future years for an additional premium. Often the option expires if it is not accepted in two or three successive years.

Capped increases may also be offered, such as compound inflation with a two-times cap. This means that increases stop when the benefit reaches twice the original benefit. Alternatively, increases may stop after 10 years, 20 years, or some other defined period.

IN-FORCE COVERAGE

A policy that is active / has not lapsed.

INFORMAL CARE

Care provided by family or friends. Some LTCI policies provide limited benefits for informal care. Whether benefits are available may depend on the relationship of the caregiver to the insured, and on whether the caregiver lives with the insured. Some policies will pay a one-time expense for an informal caregiver to receive training to more safely and effectively take care of the insured.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

These are activities such as using a telephone, shopping, traveling outside the home, taking medications, managing money, preparing meals, doing housekeeping and laundry. Persons unable to perform one or more of these without assistance are said to have an IADL limitation.

These limitations may be early warnings of disability requiring long-term care, and evidence of IADL limitations may be used in the underwriting process to deny insurance to an applicant.

IADL assistance does not qualify a person for benefit to begin, but once eligible (based on ADL or **cognitive impairment**) most policies will pay for IADL services. These are usually called “homemaker services.”

LIFETIME LIMIT

Most insurance companies set a limit on the amount of benefits that a policy will pay, unless it is an “unlimited” policy. These limits are set in terms of either years or dollars, but not both.

MEDICAL NECESSITY

A benefit trigger on older policies. This is usually defined as care provided in accord with “accepted standards of medical practice” which is required by the insured’s condition, is specified by a “plan of care” written by a doctor or other health professional, and which is not solely for the convenience of the insured or care provider.

Some insurers accept the insured’s doctor’s statement that care is medically necessary, while others may review the claim and make their own decision as to whether the care is medically necessary.

See also **benefit triggers**.

MENTAL/NERVOUS DISORDER

Refers to a mental or emotional disease or disorder of any kind that does not have an organic origin.

Both Alzheimer’s disease and most other forms of dementia are considered organic in origin; since 1993 all insurance companies cover these and it should say clearly that “Alzheimer’s disease, senile dementia and other organic brain disorders” are covered by the policy.

Many insurance policies will not cover “non-organic” mental and nervous disorders and disorders due to alcohol or drug related problems.

See the **policy’s exclusions**.

OUTLINE OF COVERAGE

This is a marketing outline with very basic, mandated disclosures about the policy. It is not an acceptable claim evaluation tool.

PER DIEM

A daily **indemnity** benefit.

PHYSICAL IMPAIRMENT

Loss of (or need for help with) functional **activities of daily living**.

POOL OF MONEY

This usually refers to an insurance policy’s maximum benefit that can be used for any combination of home/community care and facility care, up to a specified maximum dollar amount.

PRE-EXISTING CONDITION

Any illness or disorder for which the insured received treatment during a specified period of time – typically 6 to 12 months - before the policy became effective. These conditions are then not covered for a defined period of time after the effective date – typically also 6 to 12 months. Policies that require medical underwriting do not impose a pre-ex limit.

PRIOR HOSPITALIZATION

Early LTC policies would only pay for nursing home care if the insured had just been hospitalized, and they would only pay for home care if the insured had been hospitalized or in a nursing home recently.

If you start to use your LTCI benefits, most policies waive, or forgive your premiums, but read the policy information carefully to see if there are any restrictions or exceptions such as during the elimination period or for home care.

REIMBURSEMENT

The standard way that most policies pay for long-term care. The insured or a care provider submits a claim for the charges for care delivered, and the claim is paid up to the daily or monthly maximum specified in the policy.

A policy might pay “usual and customary charges” for care services rather than actual charges. In this case reimbursement is likely to be lower than actual charges incurred.

See also **indemnity and cash benefit**.

REINSTATEMENT

If an insured lets his or her policy lapse by not paying premiums, and later decides to reactivate it, the insurer may allow him or her to do so or may refuse. If allowed to reinstate the policy, he or she may have to reapply with a new medical review.

RESPIRE CARE

This is care provided by a paid caregiver as a replacement to care the insured usually receives at home from a relative or friend. Respite care is provided to give relief to the person who normally cares for the insured without charge at home.

RESTORATION OF BENEFITS

A policy may reinstate benefits the insured has used, after he or she has not needed care for a prescribed period, usually 180 days. Example: an insured with a 3-year policy received benefits for 1 year, and then needed no care for 6 months. The policy then “gives back” the year, and the insured again has 3 years of coverage to use.

Restoration of benefits may apply to facility care only, may be included in the base policy, or may be an optional rider. In some cases only a percentage of the benefit amount used is restored.

SHARED BENEFITS

A newer feature. Some policies provide a benefit that can be drawn upon by either of two spouses, if both spouses hold equal policies. The benefit is triggered when one spouse uses all of the benefits under his/her plan while the other spouse's plan has benefits remaining. This benefit is offered as an optional rider, or in some cases as a joint policy covering both spouses.

This benefit may also be available to unmarried domestic partners, depending on the insurer.

STANDBY ASSISTANCE

The presence of another person within arm's reach of the individual that is necessary to prevent injury while the individual is performing an ADL. It is sometimes referred to as supervisory assistance.

An example is being ready to catch an individual who may fall getting into or out of a bath or shower.

TAX QUALIFIED POLICIES

Long-term care policies that meet certain standards in federal law and offer certain federal tax advantages.

See also *HIPAA*.

TOILETING

One of the *activities of daily living* used to determine the need for long-term care. Toileting is the activity of using a toilet to relieve bowels or bladder, including getting to and from as well as on and off the toilet, and with a reasonable degree of hygiene.

See also *activities of daily living*.

TRANSFERRING

One of the *activities of daily living* used to determine the need for long-term care. Transferring is the activity of getting into and out of bed or a chair.

See also *activities of daily living*.

WAIVER OF PREMIUM

A provision that the insured will not have to pay premiums after a prescribed number of days while receiving care. The waiting period for waiver of premium is often 90 days, but the insurer can start counting days with the day the insured first receives care or the day the insured first receives benefits, which could be longer.

For instance, if an insured has a 90-day waiver of premium that begins with payment of benefits and a 60-day elimination period before benefits are paid, then he or she must receive care for 150 days before the premium is waived.

Also, a policy may have different waiver of premium rules for nursing home care and home care, or may waive the premium only for nursing home care.

WRITTEN PLAN OF CARE

The written plan of care is a document that describes the client's possible future impairments and care needs. The written plan of care outlines how those needs will be met and who will provide the services. It is required for all claims to be paid.