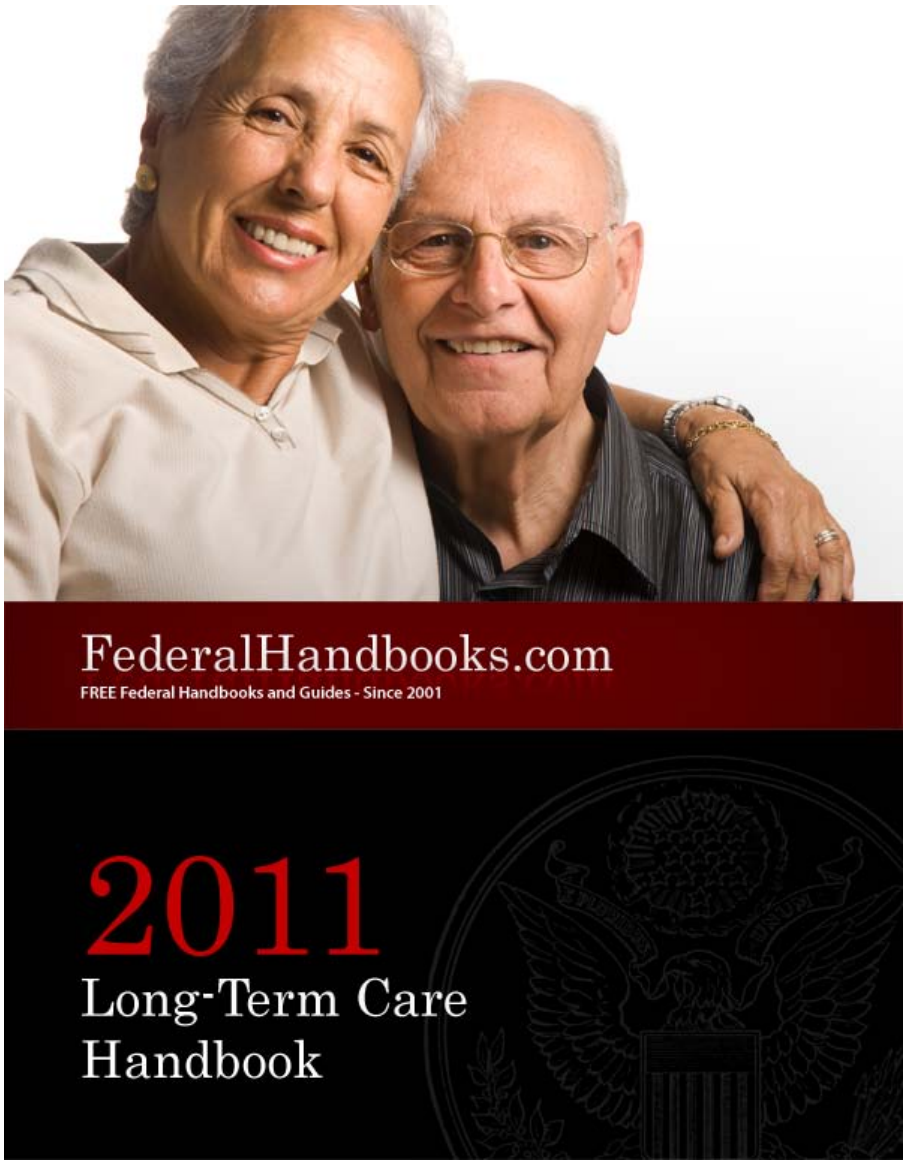

2011 Long-Term Care Planning Handbook

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1

Overview

This handbook is designed to help you – the Federal employee or retiree – understand long-term care and long-term care insurance so that you can make an informed decision about whether you need to purchase this type of insurance, and if so, the factors you should consider when buying a policy.

The handbook is divided into two sections. The first section explains long-term care and long-term care insurance generally – who needs it, how it differs from Medicare, Medicaid and other programs, and the various elements available in most long-term care insurance plans. The second section provides a general overview of the Federal Long-Term Care Insurance Program (FLTCIP), which is available for purchase by those in the "Federal family," and is being administered by the U.S. Office of Personnel Management (OPM).

Defining "Long-Term Care"
Long-term care is the kind of care that you would need to help you perform daily activities if you had a chronic illness or disability. It also includes the kind of care you would need if you had a severe cognitive problem like Alzheimer's disease. It is help with eating, bathing and dressing, transferring from a bed to a chair, toileting, continence, and so forth. Long-term care can also include assistance with such tasks as shopping, transportation, housecleaning, or preparing meals. This type of care isn't received in a hospital and isn't intended to cure you. It is not acute care. It is chronic care that you might need for the rest of your life. It can be received in your own home, at a nursing home, or in another Long-Term care facility. Long-Term care insurance is insurance that helps you pay for Long-Term care services, such as home care or care in a nursing home or assisted living facility.

Many people do not think they will need Long-Term care insurance because they are healthy. However, the odds are that you will need Long-Term care at some point in your life, and you may need it sooner than you think. About 40% of people needing Long-Term care are adults ages 18-64. They may have had an accident, a stroke, developed multiple sclerosis, or some other illness.

Approximately 70% of those Americans who live to the age of retirement will need Long-Term care services at some point in their lives. By 2020, 12 million older Americans will need long-term care. Moreover, the longer you live, the higher the odds that you will need Long-Term care eventually. While more than half of those going into a nursing home will have stays of fewer than ninety days, those who remain in nursing homes will stay an average of 2 ½ to 3 years. This is particularly true for women, who tend to live longer than men, and who consequently often develop chronic disorders that require Long-Term care.

Health Insurance and Long-Term Care
The problem with long-term care is that it can be quite expensive. It can easily exhaust your savings, which is one reason you might decide to buy Long-Term care insurance. It is important for you to know that most health plans do not cover Long-Term care. While health insurance plans generally cover hospital stays and doctors' bill, they often provide limited or no benefits for nursing home care or home health care. And while they may cover some of the skilled medical services you may need when you can't care for yourself after an illness or injury, this is usually for a limited period and only as long as you are showing improvement. Health plans, including the Federal Employees Health Benefits Program (FEHBP) and TRICARE, typically do not cover ongoing chronic care such as an extended stay in an assisted living facility, or a continuing need for a home health aide to help you in and out of bed.

Medicare and Long-Term Care
Medicare typically does not cover Long-Term care. Medicare is a Federal health insurance program for people who are age 65 or older, some people with disabilities under age 65, people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant), and people with Lou Gehrig's disease (ALS, amyotrophic lateral sclerosis). Medicare will cover the first 100 days of care in a nursing home if: (1) you are receiving skilled care, and (2) you have a qualifying hospital stay of at least 3 days and enter the nursing home within 30 days of that hospital discharge. There

are also some deductibles and copayments (meaning you have to pay part of the cost). Medicare also covers limited home visits for skilled care.

It's very important to realize a few things about Long-Term care versus Medicare's coverage:

1. Most Long-Term care is not skilled care;
2. Most Long-Term care does not take place in a nursing home;
3. Most nursing home stays do not immediately follow a hospital stay;
4. Most people who require care in their home usually need more or different types of care than Medicare covers; and
5. Most people won't start Medicare coverage until age 65.

Therefore, don't expect that Medicare will cover your Long-Term care needs.

Finally, while the Centers for Medicare and Medicaid Services recently made a decision to no longer exclude persons with Alzheimer's disease from accessing Medicare-covered services due to their diagnosis alone, be aware that Medicare still only covers skilled care under certain conditions for a limited period of time. All the restrictions on receiving nursing home care or home care, including a prior hospital stay and need for skilled care, as well as required deductibles and copayments, still apply. Alzheimer's disease is a chronic illness. Persons with this illness typically require non-skilled, custodial care for long periods of time. This type of care is still not covered under Medicare, but the change in Medicare's policy has left many with the impression that it might be.

Medicaid and Long-Term Care

Many people also believe that Medicaid will cover their Long-Term care needs. However, Medicaid (called "Medi-Cal" in California) is a state-based program supplemented by Federal funds that acts as a safety net to provide health services to the poor and impoverished. Medicaid covers Long-Term care services and might cover you if you meet your state's poverty criteria and receive care that meets your state's guidelines. Usually this means expending all but $2,000 of your assets and savings (except for perhaps your house and your car). It also means receiving care from a limited number of state-approved caregivers (mostly institutions like nursing homes) that are willing to accept Medicaid payments. People that you wouldn't consider poor sometimes qualify for Medicaid by "playing the game" and "beating the system," usually with legal help. States usually react with more rules.

If you don't have much in the way of assets and income, Medicaid is probably your best bet for Long-Term care. If you can afford Long-Term care insurance, want to control the type and location of care that you receive, and aren't interested in - or don't want to count on – "beating the system," you should consider purchasing Long-Term care insurance.

Long-Term Care Costs Can Be Staggering

Not only will many individuals and families face prolonged long term care, in-home care and nursing home costs continue to rise. According to the 2010 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs national averages for long term care costs are as follows:

- Monthly base rate (room and board, two meals per day, house keeping and personal care assistance) for assisted living care is $3,293 or $39,516 annually, a 5.2% increase from 2009.
- Daily rate for a private room in a nursing home is $229, or $83,585 annually, a 4.6% increase over the 2009 rate.
- Daily rate for a semi-private room in a nursing home is $205, or $74,825 annually, a 3.5% increase over the 2009 rate.
- Hourly rate for home health aides is $21, unchanged from 2009.

These costs vary significantly by region, and thus it is critical to know the costs where the individual will receive care. For example, the average cost for a private room in a nursing home is much higher in the Northeast ($381 per day, or

$139,065 annually, in New York City) than in the Midwest (only $174 per day, or $63,510 annually, in Chicago) or the West ($238 per day, or $86,870 annually, in Los Angeles).

Plan For Aging; www.plan-for-aging.com
*source

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Long-Term Care By The Veteran's Administration
The Department of Veterans Affairs (VA) health system makes certain Long-Term care services available to veterans based on a priority ranking system, with highest priority given to those with severe service-related disabilities. VA-funded Long-Term care may be worth investigating, especially for veterans with service-related disabilities and/or low incomes and assets. Keep in mind, however, that in addition to the priority ranking system, the availability of Long-Term care services from the VA may be subject to funding limitations and may vary by geographic area.

What Long-Term Care Costs
The cost of long-term care depends on where you live and the kind of care you receive. There are generally three kinds of long-term care: nursing home care, assisted living facility care, and in-home care. Nursing home care is the most intensive kind of care, and usually costs the most. Assisted living facility care is for people who don't need nursing home care, but who are unable to remain in their own homes. Home health care is the least expensive kind of care, and is generally for those who can still function well on their own as long as they have some assistance from a home care worker.

Nursing Home Care
You might want to consider using your savings to cover the cost of your long-term care needs. Unfortunately, even the most well laid out plan is subject to unexpected challenges. In 2009, the national average cost of a semi-private room in a nursing home was $66,795 annually. With an average stay of 2.4 years, that's more than $165,000 per average stay.

Major metropolitan areas can be expensive for nursing home costs. An average nursing home in the New York City metropolitan area costs $124,100 annually; Washington, D.C. costs $96,360; Hawaii costs $87,235; the Boston metropolitan area costs $100,740; New Jersey costs $92,345; and the Philadelphia metropolitan area costs $82,855.

The U.S. Department of Labor says that the cost of nursing home care will likely rise dramatically over the next thirty years, reaching $190,000 per year. By 2030, the average nursing home stay is expected to cost about $495,560.

Assisted Living Facilities
"Assisted living facilities" (which can also be called "Assisted Care Communities" or "Domiciliary Care") are a fairly new form of residential care intended for people who do not require skilled nursing care, but who cannot live on their own safely because they need assistance with their daily activities, such as bathing, dressing, or taking their medications. These types of facilities often bridge the gap between living at home and moving to a nursing home.

Assisted living facilities cover a wide range of possibilities, from group homes in which residents share rooms to luxurious private apartments. While services vary widely, a typical package may include a 24-hour on-call staff to help residents with bathing, toileting, dressing, and so forth; a call button in each unit for emergencies; help with managing medications; laundry and housekeeping services; meal service in a dining hall; and recreational and social activities. Residents who develop health conditions that require closer monitoring may need to move from an assisted living facility to a nursing home.

The cost for assisted living facilities typically runs from approximately $1,300 - $3,200 or more per month. The cost of a facility will depend on its geographic location, the housing environment, and the extent of services provided. Some

assisted living facilities offer Alzheimer's care, but others do not. Care for someone with Alzheimer's disease is more expensive, and typically ranges from $2,800 to $3,800 per month for a shared suite.
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Home Care
Home care is another option for those who are unable to live at home completely independently. Home care can be an attractive option for those people who are able to function relatively well on their own, but who may need visits several times each week from a home care nurse, nurse's aide, or home worker who can help with chores and other needs. People who require lengthy, daily visits may find it more cost-effective to move to an assisted living facility.

The average annual cost for at-home Long-Term care is currently approximately $20,000. Depending on the number of visits you need and your geographic location, that cost can be substantially higher. By the year 2030, it is estimated that the cost for at-home care will rise to about $68,000 annually.

Paying For Long-Term Care
The bottom line is that many of us are going to need Long-Term care at some point, and health insurance, Medicare, and Medicaid are most likely not going to pick up the tab. This means that there are generally three options for paying the cost of Long-Term care – either "self-insuring," which means saving enough so that you can pay for your Long-Term care needs out of your own assets and savings, relying on family members to provide care, or purchasing a Long-Term care insurance policy.

If you are interested in "self-insuring," know that you are going to need to set aside a very large "nest egg" to provide for your Long-Term care needs, as well as your normal retirement expenses. If you are married, be sure to consider the possibility that you or your spouse may eventually need Long-Term care services in a facility, while the other remains at home. Therefore, you need to have enough saved to cover both the cost of a nursing home or assisted living facility and the cost of maintaining your home.

If you are interested in exploring this as an option, you must consult with a financial planning expert – preferably one who specializes in retirement planning - to determine whether you have (or can generate) sufficient savings and assets to self-insure. Considering the fact that Long-Term care is already fairly expensive, and that these costs are rising, self-insuring is probably not going to be a viable alternative for most people.

Of course, the advantage to self-insuring is that you won't have to pay the cost of Long-Term care insurance premiums. The downside is that you may require Long-Term care services sooner than you expect and before you are able to generate sufficient savings to pay for your care out-of-pocket. Another problem is that you may run out of money to cover your Long-Term care and other retirement needs. Finally, you may exhaust your estate so that you have little to leave to your heirs.

Some people believe they don't need Long-Term care insurance because they plan to rely on their family members to provide this care when the time comes. Unfortunately, this expectation is not always practical. Family members may not have the necessary training to provide such care, particularly if skilled nursing care is needed. Additionally, work schedules or their own ill health may interfere with their ability to provide such care over a lengthy period. There is also the possibility that the anticipated caregiver may die unexpectedly, leaving you too old or ill to qualify for an affordable Long-Term care policy. Relying on family members to provide Long-Term care may seem like a good solution in theory, but may not be the best plan in reality. In any event, if you intend to rely on family members to provide you with Long-Term care, you need to sit down with them and have a frank talk about your expectations and plans. You don't want to be in a situation where you forego purchasing Long-Term care insurance only to discover that your expected caregiver(s) are unwilling or unable to provide you with the necessary care.

The third option is to purchase Long-Term care insurance. The two primary reasons for purchasing Long-Term care insurance are: (1) so you can rest assured that you will receive the necessary care if you develop a chronic illness or

disability, and (2) to protect your savings and assets for your own needs, your spouse's needs, if any, and/or for your heirs.

Be aware that there are a wide variety of Long-Term care insurance plans available, so if you decide to buy Long-Term care insurance, you need to spend some time looking for the best plan for you and your budget. Here are just a few general rules to keep in mind:

1. As with any other major purchase, shop around before you buy long-term care insurance. When evaluating different long-term care insurance plans, be sure you are making an "apples to apples" comparison. You need to understand each of the elements contained in the various plans, and how they compare to one another before you choose a particular plan.
2. Make sure that you can afford the premiums for life. It makes no sense to purchase long-term care insurance that you cannot afford after you retire. You do not want to have to drop the coverage just as you approach the time when you may need it most. There is usually enough flexibility in the various Long-Term care insurance plans so that you can structure a plan that will cover your most vital Long-Term care needs while keeping your premiums affordable. For instance, you can often customize your inflation protection or change the length of your waiting period before your benefits begin paying out in order to keep your premium lower, if need be.
3. If you decide to purchase the insurance, be sure you buy from a reputable company that has been in business for a significant period of time and has a good track record. You don't want to buy long-term care insurance from a company that may go out of business just when you need the benefits.
4. If you decide you want long-term care insurance, apply for the insurance while you are still healthy. As with any insurance product, you are not going to qualify for coverage if you need the benefits at the time you apply, or if it is apparent that you will need them shortly thereafter.
5. Lastly, be completely honest and forthright when answering questions about your health. If you lie on your application – or omit pertinent information about your health – the company can deny you benefits and cancel your coverage.

2

Elements of a Long-Term Care Insurance Plan

After consulting with your financial advisor, if you decide you should purchase long-term care insurance, you need to become familiar with all of the different elements that typically make up a Long-Term care insurance plan. This chapter describes each of those elements, so that you can make an informed decision about which kind of plan is best for you.

Here are some terms you need to know when choosing a Long-Term care insurance plan:

- Daily Benefit Amount
- Benefit Period
- Inflation Option
- Elimination Period
- Nonforfeiture Benefit
- Home Health Care
- Alternative Plan for Care
- Spousal Discount
- Gatekeepers, Qualifiers, or Triggering Events
- Premium
- Group versus Individual Plan
- Guaranteed Renewable

Daily Benefit Amount

The daily benefit amount is the amount of money that your long-term care insurance plan will pay for eligible care each day. Generally, when choosing a policy, you will have a choice of daily benefit amounts. They can go up to more than $240 per day for nursing home care, and up to $150 or more a day for home health care. Remember that the higher the daily benefit amount, the higher the cost of the insurance premium.

As explained in the last chapter, the national monthly average for nursing home care is now $5,566. This translates into approximately $185 per day ($5,566 divided by 30 days). But remember, this figure is a national average. The cost of nursing home varies widely, depending on your geographic area. Therefore, you need to research the cost of nursing home care in the area in which you plan to use those benefits.

Once you know the cost of nursing home care and home health care in the area in which you plan to use those benefits, you then need to decide how much of those costs you want your Long-Term care insurance policy to cover. For example, if the cost of nursing home care in your area is $155 per day and you want your Long-Term care insurance to cover 100 percent of your costs, then you would need to purchase a policy with a daily benefit amount of $155 or more. Alternatively, you could purchase a policy with a lower daily benefit amount, and plan to make up the difference using your savings.

Again, before choosing the daily benefit amount for your policy, you need to do some research to find out the daily cost for nursing home care and home health care in the area in which you plan to use those benefits. Some areas are much more expensive than others. If you anticipate using your Long-Term care benefits in an area with a high cost of living, then you'll probably want to choose a higher daily benefit amount. A policy with a daily benefit amount of $150 may not cover your costs in a place such as New York City but may be more than enough if you plan to retire in Utah.

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Benefit Period

The benefit period is the length of time your Long-Term care insurance will pay benefits. Some plans may pay benefits for just a few years, while others offer a lifetime benefit. Choosing a lifetime benefit is the ideal option. However, the longer the benefit period, the higher the premium cost. Bearing in mind that the average nursing home stay is just under three years, you should probably choose a benefit period of at least four years. But remember – this is a bare minimum. If you can afford it, you would be much better off choosing a longer benefit period in case you have a lengthy nursing home stay.

Inflation Protection

The cost of Long-Term care is rising. On average, nursing home care now costs $66,795 annually. But the Labor Department estimates that over the next thirty years, that figure is expected to rise nearly four times – to $190,000 per year. That means that while a daily benefit amount of $150 may well cover 100 percent of your nursing home care today, it may only cover 20-25 percent of your nursing home costs 30 years from now, leaving you to pay the difference out of pocket. That's why inflation protection is such an important part of Long-Term care insurance. As the cost of Long-Term care rises, you want to make sure that your daily benefit amount rises too. Inflation protection in a Long-Term care insurance policy is simply a provision that increases your daily benefit amount – or gives you the option to increase your daily benefit amount – to help keep pace with the rising cost of Long-Term care. Therefore, when pricing your policy – or when comparing policies – pay close attention to the kind of inflation protection included in the plan.

The most common kind of inflation protection automatically increases your daily benefit amount by a certain percentage each year. Many plans offer an annual increase of 5 percent each year. You are usually given a choice of whether you want 5 percent simple interest or 5 percent compounded interest. Be aware that the compound interest option will give you more inflation protection than the simple interest option will. (See the table below entitled, "Comparison of Simple versus Compound Interest.") While both will increase your daily benefit amount to help you keep pace with inflation, the compound interest option will result in a higher daily benefit amount over time. Naturally, this means that the compound interest option is going to be more expensive than the simple interest option. Choose the compound interest option if you can afford it. If you can't, choose the simple interest option. Some policies will also permit you to purchase additional insurance in the future – but at your current age rate - so that you can increase your daily benefit amount at a later time. Others will let you purchase additional insurance in the future, but will base the cost on your age at the time you purchase the extra insurance.

Whichever kind of inflation protection you choose, pay attention to whether the policy imposes a cap on the growth of your inflation protection. Some policies will cap growth either through an age limitation or by a particular amount.

If money is no object, the ideal policy would have the compound interest inflation protection with no cap on age or amount. If you can't afford to do that, then choose simple interest or opt for the ability to purchase additional insurance in the future.

If you are over the age of seventy when buying Long-Term care insurance, you may be better off purchasing a policy with a higher daily benefit amount and no inflation protection. If nursing home costs in your area are $93 per day, for example, it may make more sense economically to purchase a policy with a daily benefit amount of $150 and no inflation protection, rather than purchasing a policy with a daily benefit amount of $100 and inflation protection. The extra $50 in the daily benefit amount ($150 versus $100) may be sufficient to cover your inflation protection needs, since presumably you will use the benefits sooner rather than later. Proceed with caution if you choose this strategy – and be sure to consult with your financial advisor and Long-Term care agent before going this route. And remember - this is not a good strategy for those under the age of 70! Those under 70 may not use their Long-Term care benefits for many years, and no matter how large of a daily benefit amount you choose now, chances are that it won't be nearly large enough to protect you against inflation decades later. Those under 70 must have some kind of inflation protection as part of their policies.

The bottom line is that inflation protection is one of the most important elements of a Long-Term care insurance policy. However, you must be able to afford the premium for the rest of your life. Whichever kind of inflation protection you choose, make sure you can continue to pay the premium.

Comparison of Simple versus Compound Interest			
Year	**$100 Daily Benefit Amount**	**5% Simple Interest**	**5% Compound Interest**
1	$100	$100	$100
2	$100	$105	$105
3	$100	$110	$110
4	$100	$115	$116
5	$100	$120	$122
6	$100	$125	$128
7	$100	$130	$134
8	$100	$135	$141
9	$100	$140	$148
10	$100	$145	$155
11	$100	$150	$163
12	$100	$155	$171
13	$100	$160	$180
14	$100	$165	$189
15	$100	$170	$198
16	$100	$175	$208
17	$100	$180	$218
18	$100	$185	$229
19	$100	$190	$240
20	$100	$195	$252
21	$100	$200	$265
22	$100	$205	$278
23	$100	$210	$292
24	$100	$215	$307
25	$100	$220	$322
26	$100	$225	$338
27	$100	$230	$355
28	$100	$235	$373
29	$100	$240	$392
30	$100	$245	$412

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Elimination Period

The elimination period is the period of time for which you need Long-Term care but you do not receive paid benefits. It is something akin to a car insurance deductible. During the elimination period, you must cover the entire cost of your Long-Term care out of your own pocket. When purchasing a Long-Term care insurance plan, you typically get to choose how long you want the elimination period to be. They are generally between zero and ninety days. The longer the elimination period, the lower the premium cost.

It works like this. Say you have a Long-Term care policy with an elimination period of ninety days. The cost of the nursing home you enter is $127 per day, and your stay lasts six months. Under the policy, you would be responsible for paying $11,430 for the stay – that's the daily cost of the nursing home ($127) times the elimination period of 90 days. After ninety days, the Long-Term care policy would kick in, and assuming the daily benefit amount is $127 or more, you would no longer have to pay for your stay.

Thus, the rule is the shorter the elimination period, the better. The ideal policy would have a zero-day elimination period. Be sure to compare the premium cost of a shorter elimination period and a longer elimination period. If the cost of the shorter elimination period is not significantly higher, choose the shorter period.

One final note on elimination periods

Be sure to ask whether the elimination period applies to each stay, or if you need to satisfy it only once. If you have to go in and out of a nursing home or other Long-Term care facility several times, you want a policy that requires you to satisfy the elimination period only once.

Nonforfeiture Benefit

A nonforfeiture benefit is a provision in the policy that says that if you do not use your Long-Term care benefits after a certain amount of time, a portion of your premiums will be returned to you or your heirs. Some people like this benefit because they feel that it protects them from "wasting" their money on Long-Term care insurance. If they don't end up using the Long-Term care benefits, they get some of their money back. Be careful, though. Policies with nonforfeiture benefits can cost substantially more than those without a nonforfeiture benefit. Rather than paying the extra money for the nonforfeiture benefit, you are probably better off saving that money and investing it. Consult with your financial advisor to see what is best for you.

Home Health Care

"Home health care" – or "home care" – is a Long-Term care benefit that covers the cost of visits to your home by a home health care worker, licensed therapist, chore worker, or homemaker. Care can range from visits by a health care worker to someone who cooks meals, does chores like grocery shopping, or helps with bathing or other needs.

Since the vast majority of people would rather receive care in their own homes rather than move to an assisted living facility or a nursing home, you should check to see if the Long-Term care policy you're considering includes this benefit, and how much coverage it provides. Home health care tends to be less expensive than care provided in a nursing home, so most Long-Term care insurance will pay a daily benefit of 50-80 percent of your skilled nursing care coverage for this type of benefit.

You should do some checking to determine how much home care costs in the area where you will likely be receiving benefits. A good rule of thumb is to get a policy that covers a minimum of two years' (or 730) worth of visits.

Alternative Plan for Care

Long-Term care insurance companies often permit you some flexibility in deciding where you will receive care – at home, in an adult day care center, an assisted living facility, a nursing home, or elsewhere. This provision allows you to choose where to receive care as long as you, the insurance company, and your health care provider are all in agreement. It is often a good provision to have in a policy because it gives you additional options for your care.

Spousal Discount

Couples purchasing Long-Term care insurance from the same company can often get a 10 to 15 percent discount on their premiums. Be sure to ask about any spousal discount when shopping for a Long-Term care insurance policy. You may still get the spousal discount even if you and your spouse purchase policies at different times from the same company, so be sure to ask.

Gatekeepers, Qualifiers, or Triggering Events

In order for your Long-Term care policy to start paying benefits, you must satisfy certain requirements. These requirements are frequently called "gatekeepers," "qualifiers," or "triggering events." Some of the most common are:

- Activities of Daily Living (ADLs). The usual ADLs are bathing, feeding, dressing, transferring (which means moving into or out of a bed, chair, or wheelchair), continence, and using the toilet. Many policies require that you not be able to perform two of the six ADLs in order for benefits to begin.
- Cognitive Impairment. You have a mental impairment, such as Alzheimer's disease, that prevents you from caring for yourself without supervision
- Medical Necessity. A doctor certifies that you need the care and makes a request for the care.

Find out what kind of triggering events your policy requires. As a general rule, a policy that allows you to begin receiving benefits when you satisfy any one of the three triggering events described above is best. Be sure to get a copy of the actual policy(ies) you are considering so you can see exactly what the triggering events are and how they are defined by that particular company. Long-Term care insurance companies often vary in how they define triggering events.

Premium

The premium is the amount of money you pay for your Long-Term care insurance policy. The premium will depend on the kind of coverage you choose, your age and health status, and the insurance company you select.

Usually you will be able to choose whether you want to pay your premiums annually, semi-annually, quarterly, or monthly. Before you choose a payment term, do a few quick calculations to make sure you will not pay more if you opt to pay semi-annually, quarterly, or monthly. Since insurance companies usually prefer that you pay annually, some will charge you extra if you pay any other way.

Group versus Individual Plan

It is important for you to know whether you are planning to purchase a group or an individual Long-Term care policy. Many people assume that purchasing a group plan will always be the better deal, but this isn't necessarily the case. Both group plans and individual plans have their advantages and disadvantages, so once again, you need to do your homework to be sure you purchase the best plan for you.

One advantage of an individual plan is that the contract (the insurance policy) is between you (the policyholder) and the insurance company. When you purchase the policy, you and the insurance company agree to particular benefits and requirements at a certain price. Because you are the policyholder, the insurance company cannot make any changes to the policy unless you consent.

In a group plan, however, you are not the policyholder. Rather, the contract is between the insurance company and some third party – usually your employer or an association to which you belong. You are covered under the plan as an "insured" and are listed on a certificate of insurance, but the policyholder is your employer, association, or some other entity. This means that the policyholder – your employer or association - and the insurance company can modify or even cancel the policy without your consent. One other potential problem with group plans is that they typically allow for little flexibility in coverage. Under a group plan, you may have to make due with lengthier elimination periods or less inflation protection than you would prefer.

The point is, if you have the opportunity to purchase a group plan, don't just buy it without shopping around. You still need to do your homework - you may find that you can get better coverage for a lower cost with an individual plan. And if the group plan ends up being the better buy, you can rest easy knowing you got the best deal available.

Guaranteed Renewable

A policy that is "guaranteed renewable" means that as long as you pay your premiums within the specified time frame, you will be insured for life. This is a must in any Long-Term care insurance policy you purchase, particularly if it is a group plan. You want a plan that is guaranteed renewable each year for life.

Tips on Choosing a Long-Term Care Insurance Plan

Choosing An Insurance Company

One of the most important decisions you will make when shopping for a Long-Term care insurance plan will be choosing an insurance company. Before you buy any policy, make sure you are working with a reputable company. You are going to spend thousands of dollars to purchase Long-Term care insurance, so do a little digging to make sure you are working with a company that is financially sound. You may not need to start collecting benefits for many years, so you want to make sure the insurance company that sold you your policy is still going to be in business when you need those benefits.

A good rule of thumb is to look for a company that has been providing Long-Term care insurance – and paying claims – for several years. Also, look for a company that has received a good financial rating from two or more of the independent rating services. Some independent rating services are:

- A.M. Best
- Standard & Poor's
- Moody's
- Duff & Phelps

For A.M. Best, you want a company with a rating of "A++". For Standard & Poor's and Duff & Phelps, look for a rating of "AA" or better. For Moody's, look for a rating of "Aa" or better.

The independent ratings services often provide ratings of insurance companies on their websites. The web site addresses for the four independent rating services mentioned above are:

A.M. Best	http://www.ambest.com
Standard & Poor's	http://www.standardandpoors.com
Moody's	http://www.moodys.com
Duff & Phelps	http://www.duffllc.com

Again, always compare several insurance companies, their benefits, limitations, exclusions, and premiums before you purchase a policy. Work only with an agent who answers all of your questions completely, and who makes you feel comfortable. Don't work with an agent who tries to pressure you into buying a policy quickly, or engages in other "hard sell" tactics.

Be sure to ask the agent for an "Outline of Coverage," which highlights the main features of the plan. This document should be provided to you upon your request, without you having to fill out an application or provide any personal information. If the agent or company gives you any trouble about providing you with this document, keep looking. You don't want to buy a policy from them.

Once you collect the "Outline of Coverage" for all of the plans you're interested in, compare the benefits, limitations on coverage, premiums, and any exclusions to see which is best for you.

Choosing a Plan

In addition to the standard elements of a plan covered in the previous chapter, check the policies you are considering to see how they stack up against each other on the following points.

1. Does the policy require a hospital stay before you can begin receiving benefits? The vast majority of policies these days don't, but be sure the ones you are considering don't have this as a precondition.

2. Does the policy cover home care, as well as care in a nursing home or other facility? You don't want to be forced to move to a nursing home or other facility in order to receive care.

3. Does the policy cover both adult day care and "personal care" (sometimes called "custodial care")? You probably want a policy that covers both these kinds of care.

4. Does the policy require that home health care be provided by someone from a certified home health care agency or a professional health care worker in order to be covered? Generally, you don't want this kind of limitation in your policy.

5. Ideally, you want a policy that does not exclude preexisting conditions at all. If you can't get that, then you want a policy that excludes preexisting conditions for no longer than six months.

6. The policy should allow you a "grace period" so that you do not have to pay premiums while you are collecting benefits. Once you are on your feet again (have left the nursing home, for instance, and are no longer collecting benefits), you begin paying premiums again.

7. The policy should require you to satisfy the elimination period just one time. If you have an elimination period of 30 days, for example, and enter a nursing home, you pick up the tab for the first thirty days, during the elimination period. After the 30-day elimination period ends, your Long-Term care insurance benefits kick in, and the insurance company pays for the nursing home care. If you then leave the nursing home, but have to return for a second stay, you don't want to have to satisfy the 30-day elimination period again. You want a policy that requires you to satisfy the elimination period only once, with the insurance company picking up the entire tab if you have to reenter the nursing home (or receive another kind of care) multiple times.

8. Under the policy your premiums should not increase unless the increase is an across-the-board increase for all the insured in a particular area or group.

9. The policy must be "guaranteed renewable," which means that as long as you pay your premiums, you will be covered.

10. Check to see if the policy you are considering qualifies as a tax-deductible policy. You want a policy that is tax-deductible.

11. Look for a "restoration of benefits" feature, if you buy a policy that does not have a lifetime benefit. A restoration of benefits feature allows the full benefit period to be restored if you recover and do not use any benefits for a particular period of time. For example, say you have a policy with a six-year benefit period. You enter a nursing home, your Long-Term care insurance kicks in, and the insurance company pays for your nursing home care for a year, which would normally leave you with five years remaining on your benefit period. After a year, you recover, leave the nursing home, and do not draw on any of your Long-Term care benefits for two years. The restoration of benefits feature would require the insurance company to restore your original full benefit period – six years – since you did not draw on your Long-Term care benefits for that two-year period after leaving the nursing home. Some companies offer policies that will restore your full benefits if you do not use any benefits for a certain period – often 180 days. (Of course, if you purchase a policy with a lifetime benefit, this is not a concern, since your benefits will never run out.)

12. Make sure the policy provides you with a "free look" period. This means that you are given a certain period of time to cancel the policy and get all of your money refunded if you decide you don't want the policy after purchasing it.

13. The policy should have a grace period for paying the premiums. This means that the policy should stay in effect even if you are a little late in paying your premium. This is crucial. You don't want the policy to be cancelled just because you forgot to pay a premium on time.

14. The policy should have a provision that allows you to designate some third party – a family member or your attorney, for instance – to receive notification from the insurance company if you fail to pay a premium. This is a good way to protect yourself from having your coverage dropped in the event you start becoming incapable of managing your own affairs. The designated third party can make sure the payments get made so you maintain your Long-Term care insurance coverage.

Purchasing Your Policy

Some final advice before you purchase a Long-Term care insurance policy:

1. Be sure you understand all aspects of the written policy before you purchase it. If you don't understand a particular paragraph, make your insurance agent explain it to you to your satisfaction. We say "written policy" because that is what you are actually purchasing. Don't rely on what the agent told you orally – what's important is what is in the written policy. Ideally, there should be no difference between what you were told and what is in the written policy – but read the policy carefully to be sure.

2. Consult with your financial planner and other professional advisors before you purchase the insurance to make sure you will be able to afford the premiums for life, and that you are buying a policy that fits your particular needs.

3. Be completely honest and forthright when answering medical questions. We've said it before, but it's important, so we're saying it again. If you lie on your medical questionnaire and the insurance company finds out about it, they can deny you benefits and cancel your coverage.

4. Never pay your agent in cash. Only make payments by check, and write out the check to the insurance company, not to the agent.

5. Keep a copy of your policy in a safe place, such as a safe deposit box. You want to be able to refer to it if you have any questions or disputes about coverage.

4

The Federal Long-Term Care Insurance Program

The Federal Long-Term Care Insurance Program (FLTCIP) provides Long-Term care insurance to help pay for the cost of care when you need help with activities you perform every day, or you have a severe cognitive impairment, such as Alzheimer's. Over 20 million members of the Federal Family are eligible for the insurance offered through the FLTCIP. This includes Federal and Postal employees and annuitants, active and retired members of the uniformed services and qualified relatives, their qualified relatives, and a few other eligible groups.

In December 2001, OPM contracted with John Hancock and MetLife to provide the insurance. They formed a company called Long-Term Care Partners, LLC to administer the FLTCIP. Below the FLTCIP is explained in detail, including who is eligible to apply, and what benefit options you can select.

Long-Term care insurance provided under the FLTCIP provides you reimbursement for the costs of care when you are unable to perform at least two Activities of Daily Living for an expected period of at least 90 days, or when you need constant supervision due to a severe cognitive impairment, which is defined as the deterioration or loss of intellectual capacity that requires substantial supervision by another person. The FLTCIP will provide reimbursement based on the benefit options and amounts you are approved for.

Eligibility

The Long-Term Care Security Act of 2000 specifies who is eligible to apply for the FLTCIP. Those in the "Federal Family" who are eligible include Federal and Postal employees and annuitants, members and retired members of the uniformed services, their qualified relatives, and a few other eligible groups.

In addition to being eligible to apply for the FLTCIP, you will also have to answer questions about your health on the underwriting application. Depending upon those answers, and perhaps a review of your medical records and/or an interview with a nurse, you may or may not be eligible to enroll in the FLTCIP.

The following groups are included in the Federal Family (please note that you must be at least 18 years old when you submit your application):

Employees

- Most Federal and U.S. Postal Service employees
- Active members of the Uniformed Services who are on active duty or full-time National Guard duty for more than 30 days
- Active Members of the Selected Reserves (Members of the individual Ready Reserve are NOT eligible to apply)
- Navy Personnel Command (BUPERS) NAF employees
- Employees of the Tennessee Valley Authority
- D.C. Government employees who were first employed by the D.C. Government before October 1, 1987
- Employees of the D.C. Courts

For Federal and Postal employees, in general if you are in a position that conveys eligibility for Federal Employees Health Benefits (FEHB) coverage, you are eligible for this program (whether enrolled in FEHB or not - the key is ELIGIBILITY).

Annuitants

- Federal and USPS annuitants, including survivor and deferred annuitants
- Retired members of the Uniformed Services who are entitled to retired or retainer pay
- Compensationers (individuals receiving compensation from the Department of Labor who are separated from the Federal service)
- Retired "grey" reservists
- Navy Personnel Command (BUPERS) NAF employees
- Separated employees with title to a deferred annuity, even if they are not yet receiving that annuity
- Former Federal and USPS employees who separated from service with title to a deferred annuity
- Retired employees of the Tennessee Valley Authority
- Retired D.C. Government employees who were first employed by the D.C. Government before October 1, 1987
- Retired employees of the D.C. Courts
- Surviving spouses. To be considered eligible to apply for this insurance, surviving spouses must be receiving a Federal survivor annuity. They must be a surviving spouse of a deceased person in one of the following groups:
    - Federal and Postal employees or annuitants
    - D.C. Government employees or annuitants who were first employed by the D.C. Government before October 1, 1987, or
    - D.C. Courts employees or annuitants.
- Surviving spouses of deceased active or retired members of the uniformed services who are receiving a Federal survivor annuity. However, they are considered eligible as qualified relatives, rather than as annuitants.

Qualified Relatives

- Current Spouses of employees and annuitants (including surviving spouses of members and retired members of the uniformed services who are receiving a survivor annuity).
- Adult children (at least 18 years old, including natural children, adopted children and stepchildren) of living employees and annuitants. Foster children are not eligible.
- Parents, parents-in-law, and stepparents of living employees (but those of annuitants are not eligible).

People who fall into one of those groups are eligible to apply for the insurance. Whether someone's application will be approved and he/she will be enrolled in the insurance will depend on the results of the medical underwriting. Not everyone who applies for this insurance will be approved for it.

Types of Plans

Four Pre-Packaged Plans
The FLTCIP has four pre-packaged plans. The Facilities 100 plan covers care in nursing homes, assisted living and hospice facilities and respite services provided in a facility. The Comprehensive 100, 150 and 150+ plans cover everything in the Facilities 100 plan, plus home care, adult day care, respite services at home and home hospice care.

Alternatively, you may wish to customize your own plan by mixing and matching the available benefit options. Here is a detailed list of the benefits included in the pre-packaged plans:

Facilities 100 Package. This package includes the following:

- Covered Services:
    - Nursing Homes

  - Assisted Living Facilities
  - Hospice Facilities
  - Respite Services (in a facility)
- Daily Benefit Amount (DBA): $100
- Benefit Period: 3 years
- Maximum Lifetime Benefit: $109,500
- Waiting Period: 90 days
- Inflation Protection: A choice of the automatic compound inflation option or the future purchase option

Comprehensive 100 Package. This package includes the following:

- EVERYTHING in the Facilities 100 Plan, PLUS:
  - Home Care (formal and informal)
  - Adult Day Care
  - Hospice Care at home
  - Respite Services at home
- Daily Benefit Amount (DBA): $100
- Benefit Period: 3 years
- Maximum Lifetime Benefit: $109,500
- Waiting Period: 90 days
- Inflation Protection: A choice of the automatic compound inflation option or the future purchase option

Comprehensive 150 Package. This package includes the following:

- EVERYTHING in the Facilities 100 Plan, PLUS:
  - Home Care (formal and informal)
  - Adult Day Care
  - Hospice Care at home
  - Respite Services at home
- Daily Benefit Amount (DBA): $150
- Benefit Period: 5 years
- Maximum Lifetime Benefit: $273,750
- Waiting Period: 90 days
- Inflation Protection: A choice of the automatic compound inflation option or the future purchase option

Comprehensive 150+ Package. This package includes the following:

- EVERYTHING in the Facilities 100 Plan, PLUS:
  - Home Care (formal and informal)
  - Adult Day Care
  - Hospice Care at home
  - Respite Services at home
- Daily Benefit Amount (DBA): $150
- Unlimited Benefit Period
- Maximum Lifetime Benefit: unlimited
- Waiting Period: 90 days
- Inflation Protection: A choice of the automatic compound inflation option or the future purchase option

Verified on 12/06/2010

Facilities-Only vs. Comprehensive

Whether you choose one of the four pre-packaged plans or customize your own plan, one of the first decisions you will need to make is the type of plan that meets your needs. The two coverage options under the FLTCIP are a Facilities-Only plan or a Comprehensive plan.
A Facilities-Only plan includes services that you would receive while in a Nursing Home, Assisted Living Facility, or inpatient Hospice facility. It also covers respite services in these facilities. It does not cover home care. A Comprehensive plan includes everything in a Facilities-Only plan PLUS home care (formal and informal), adult day care, hospice care at home and respite services at home.

If you're looking for only catastrophic coverage, you may want to consider a Facilities-Only plan. You may also want to consider a Facilities-Only plan if you live alone, do not have a large support network, or do not see yourself using home care.

A Facilities-Only plan is less expensive than a Comprehensive plan. However, some of the features built into a Comprehensive plan, such as coverage for informal care and adult day care, can provide you with a great deal of flexibility. If you think you might prefer to receive care at home rather than (or at least before) care in a facility, you may want to consider a Comprehensive plan.

Daily Benefit Amount

Another option you will need to consider is your Daily Benefit Amount (DBA). Your DBA is the maximum amount the FLTCIP will pay for services you receive in any single day. Choices for your daily benefit amount range from $50 to $300 in increments of $25. The Program will reimburse care in a nursing home, assisted living facility, hospice care (whether in a facility or at home), and respite services (whether in a facility or at home, up to 100% of your DBA, limited to 30 times your DBA per calendar year).

Keep in mind, however, that a Facilities-Only plan does not cover hospice or respite services at home. Home care and adult day care costs, which are covered under a Comprehensive plan only, are reimbursed up to 75% of your DBA.

When selecting your DBA, it is important to consider the average daily cost of home care or facility care in the area where you think you might receive services. The amount you select for your DBA will affect the cost of your plan. A higher DBA will have a higher premium.

Weekly Benefit Amount

If you choose a Comprehensive plan, you will also need to choose whether you want to have your benefits reimbursed on a weekly basis (7 times your daily benefit amount) for greater flexibility. The weekly benefit amount is not available with a Facilities-Only plan. Premiums for weekly reimbursement are an average of 6% higher than premiums for daily reimbursement. However, the greater flexibility may be worth the cost. Here's an example of how this works:

This example assumes that you receive home care 2 days during the week and that you have a DBA of $100. On day 1, the cost of your home care is $75 and on day 2, the cost of your home care is $125 because you also received physical therapy that day. Remember that home care is reimbursed up to 75% of your DBA, so in this example it would be reimbursed up to $75 per day. So with daily reimbursement, day 1 costs will be covered in full and $75 of day 2 costs will be covered. You will have to pay $50 out-of-pocket for the cost that was not covered on day 2 ($125 – $75). If you chose weekly reimbursement for your plan, your home care costs would be covered in full. That's because the weekly benefit with a $100 DBA is $700 (7 x DBA), so home care would be reimbursed up to 75% of that ($525), and the total cost of care is only $200 ($75 + $125).

Benefit Period

Another option you will need to select is your Benefit Period. The Benefit Period is the length of time your insurance will last if you receive care every day at a cost equal to or more than your DBA. If your care costs less than your DBA, or you do not receive services every day, your insurance will last longer than your benefit period.
The FLTCIP provides you with a choice of three Benefit Periods – 3 years, 5 years, and unlimited. An unlimited Benefit Period means exactly that – your benefits are unlimited and will not run out, subject to the daily or weekly restrictions.

Your benefit period is used as a multiplier, along with your DBA, to determine your maximum lifetime benefit.

Maximum Lifetime Benefit

The maximum lifetime benefit is the total dollar amount your plan could pay for covered services. You may also see this referred to as a "pool of money." If you select an unlimited benefit period, there is no "maximum lifetime benefit" – it is unlimited.

Your Benefit Period multiplied by your DBA equals your maximum lifetime benefit:

Using a daily benefit amount of $100 and a benefit period of 3 years: $100 x 1,095 days (365 x 3) = $109,500

Your maximum lifetime benefit would be $109,500. This is the total amount this plan would reimburse you for Long-Term care services. Every dollar paid for your benefits reduces your maximum lifetime benefit. When your maximum lifetime benefit is gone, your insurance coverage ends.

Waiting Period
Next, you will need to choose a waiting period. The waiting period is the number of days during which you must be eligible for benefits and receiving covered services before your benefits start. It works like a deductible in health insurance. You only have to satisfy the waiting period once in your lifetime. Days applied toward satisfying the waiting period need not be consecutive, nor associated with the same episode of care. The days will be added together until the waiting period is satisfied. When you apply for coverage, you select the length of your waiting period - the standard is 90 days, but you may choose 30 days instead, at an additional cost.

The FLTCIP does not pay benefits during your waiting period. However, the waiting period does not apply to hospice care, respite care, and caregiver training. Because there is no waiting period for hospice care, respite care, and caregiver training, these covered services do not count toward meeting your waiting period.

Inflation Protection
You also need to consider how your benefits will stay current with the rising costs of care. To help make sure that your benefits keep pace with inflation, the FLTCIP provides you with two inflation protection options: an Automatic Compound Inflation (ACI) Option and a Future Purchase Option (FPO).

Automatic Compound Inflation Option
With this option, your Daily Benefit Amount (DBA) and the remaining portion of your maximum lifetime benefit will automatically increase by 5% every year with no corresponding increase in your premium. And the benefit increases continue even if you are eligible for benefits. While the initial premium is higher with this option, you won't have to think about the cost of having to buy additional coverage or worry about whether your coverage (especially after you retire) will keep pace with inflation. Your benefits increase year after year, while your premium remains level.

Future Purchase Option
This allows you to buy additional coverage every two years at an extra cost. The increase offered in your Daily Benefit Amount and the remaining portion of your maximum lifetime benefit is based on increases in the Consumer Price

Index for Medical Care. With the Future Purchase Option, you can assess the costs of care in the future and make a decision to upgrade when you can afford to. Each time you buy additional coverage, your premium will increase. The premium for the additional coverage will be based on your age and premium rate at the time the increase takes effect.

Every two years you will receive your Future Purchase Option notification provided you are not eligible for benefits and have not declined three Future Purchase notifications in the past. A unique feature of the FLTCIP is your ability to switch to the Automatic Compound Inflation Option, for an additional premium, without proof of good health when you receive your Future Purchase notification as long as you are not eligible for benefits and have not declined three Future Purchase notifications in the past.

Types of Care Covered

Facilities-Only Option
The following services are covered under the Facilities-Only Option:

Nursing Home and Assisted Living Facility Care:
On any day you are in a Nursing Home or Assisted Living Facility, including those specializing in the care of persons with Alzheimer's disease, the FLTCIP will pay for:

- room and board accommodations; and
- nursing care by a formal caregiver; and
- drugs, incontinence supplies, dietary supplements, personal medical equipment and laundry services.

Inpatient Hospice Facility Care:
On any day you are in a Hospice facility, the FLTCIP will pay for:

- room and board accommodations; and
- hospice care; and
- drugs, incontinence supplies, dietary supplements, personal medical equipment and laundry services.

The waiting period does not apply to care in a Hospice facility. Care in a Hospice facility does not count toward meeting your waiting period.

Respite Services in a Facility
Respite Services provided in a Nursing Home, Assisted Living Facility or Hospice facility will be paid for. Respite Services are limited to 30 times your daily benefit amount per calendar year.

Comprehensive Option
The Comprehensive Option includes all services covered under the Facilities-Only Option plus the following additional covered services:

Home Care
Includes care provided at home by a nurse, home health aide, homemaker, or therapist. The FLTCIP also covers informal care provided by friends, family members and other non-licensed caregivers who did not normally live in your home at the time you became eligible for benefits. Informal care provided by family members is covered up to 365 days in a lifetime.

Formal Care at Home
A Comprehensive plan will pay for services provided to you by a Formal Caregiver at home.

Informal Care
A Comprehensive plan will pay for services provided by an Informal Caregiver if the services are:

- provided to you at home or at a location other than a Nursing Home, Hospice facility or Assisted Living Facility (such as the home of a friend or relative); and
- approved by an FLTCIP care coordinator as part of your written Plan of Care; and
- provided by a person who did not normally live in your home at the time you became eligible for benefits. (Note: The FLTCIP will pay for Informal Caregiver services provided by a person who began living in your home after you became eligible for benefits).

Benefits for Informal Caregivers who are Family Members are limited to 365 days in your lifetime.

Adult Day Care Center
A Comprehensive plan also pays for services provided under an adult day care program at an Adult Day Care Center.

Hospice Care at Home
In addition to hospice care in a facility, a Comprehensive plan will also pay for Hospice Care provided to you at home. The waiting period does not apply to Hospice Care at home. Hospice Care at home does not count toward meeting your waiting period.

Respite Services at Home
Includes care provided in a Nursing Home, Assisted Living Facility or Hospice Facility; by a Formal or Informal Caregiver at home; or at an Adult Day Care Center. Benefits for Respite Services (in a facility or at home) are limited to an amount equal to 30 times your Daily Benefit Amount per calendar year. The waiting period does not apply to Respite Services. Respite Services do not count toward meeting your waiting period.

Verified on 12/06/2010

Limits on Reimbursement For Covered Services
The FLTCIP provides reimbursement for actual charges you incur for covered services *up to* the following percentages:

Covered Services Under Both the Comprehensive Option and the Facilities-Only Option	**Daily Reimbursement Up To**
Nursing home, assisted living facility, or hospice facility	100% of your daily benefit amount
Bed reservations	100% of your daily benefit amount - benefits limited to 30 days per calendar year
Caregiver training	100% of your daily benefit amount - benefits limited to 7 x your daily benefit amount in your lifetime
Respite services	100% of your daily benefit amount - benefits limited to 30 x your daily benefit amount per calendar year

Additional Covered Services Under the Comprehensive Option	**Daily Reimbursement Up To**
Formal caregiver services	75% of your daily benefit amount
Informal caregiver services	75% of your daily benefit amount - benefits for informal caregiver

	services provided by family members who did not normally live in your home at the time you became eligible for benefits are limited to 365 days in your lifetime
Hospice care at home	100% of your daily benefit amount
Adult day care center	75% of your daily benefit amount

If you select the Comprehensive Option, you may choose to have benefits for covered services determined on a weekly instead of a daily basis. The weekly benefit amount is equal to 7 times your daily benefit amount. If you choose the weekly benefit amount, the FLTCIP provides reimbursement for actual charges you incur for covered services **up to** the following percentages:

Covered Services Under the Comprehensive Option (Weekly Benefit Amount)	**Daily Reimbursement Up To**
Nursing home, assisted living facility or hospice facility	100% of your weekly benefit amount
Formal caregiver services	75% of your weekly benefit amount
Informal caregiver services	75% of your weekly benefit amount - benefits for informal caregiver services provided by family members who did not normally live in your home at the time you became eligible for benefits are limited to 365 days in your lifetime
Hospice care at home	100% of your weekly benefit amount
Adult day care center	75% of your weekly benefit amount
Bed reservations	100% of your weekly benefit amount - benefits limited to 30 days per calendar year
Caregiver training	100% of your weekly benefit amount - benefits limited to 7 x your daily benefit amount in your lifetime
Respite services	100% of your weekly benefit amount - benefits limited to 30 x your daily benefit amount per calendar year

Verified on 12/06/2010

Waiver of Premium

You will not have to pay premiums if you are eligible for benefits and have satisfied your waiting period. Premiums are also waived if you are eligible for benefits and receiving hospice care, even though no waiting period applies to hospice care. If you satisfy the requirements for waiver of premium on the first day of a month, the waiver will take effect on that date. Otherwise, the waiver will take effect on the first day of the following month. If, at a later date, you are no longer eligible for benefits (e.g., you recover) and wish to maintain your coverage, you will have to resume paying premiums.

Portability

Your coverage under the FLTCIP is portable. This means that once you enroll in the program, you will remain enrolled as long as you pay the premiums. It doesn't matter if you leave Federal service, divorce your Federal spouse, or otherwise lose your affiliation to the Federal Family.

Bed Reservations

If you are in a Nursing Home, Assisted Living facility, or Hospice facility and you leave that facility, the FLTCIP will pay for actual charges you incur to hold a space to enable you to return to that facility. The FLTCIP will not pay for

more than the benefit that it would pay if you had been in the facility on those days. Benefits for bed reservations are limited to 30 days per calendar year.

Alternate Plan of Care
In certain circumstances, the FLTCIP care coordinators can authorize benefits for services that are not specifically covered under the Federal Program. For example, if you have a Comprehensive plan, the Program might cover making your home wheelchair-accessible, which could be a good alternative to other Program services.

Care Coordination
The FLTCIP care coordinators are registered nurses. They will work with you to help you through the benefit eligibility process and help you identify the Long-Term care providers and services to meet your needs.

Your care coordinator can arrange for discounted services, monitor the care you're receiving, and assist with altering your plan of care as your needs change. Unlike most Long-Term care insurance programs, the FLTCIP also provides care coordination services to qualified relatives of enrollees. This can be invaluable in helping reduce the stress that you can experience when a relative needs Long-Term care.

International Benefits
Because the FLTCIP is designed exclusively for the Federal Family, it provides benefits for covered services outside the United States and its territories and possessions ("the United States"). These international services are covered up to 80% of the benefit limits, not to exceed 80% of your maximum lifetime benefit. The remaining 20% will be available for covered services if you return to the United States and continue to need Long-Term care.

If you have an unlimited benefit period, your benefit period will be limited to 10 years for covered services you receive outside the United States. For such services, your maximum lifetime benefit will be equal to 3,650 days (10 years) x 80% of your daily benefit amount. Your maximum lifetime benefit for covered services you receive in the United States will remain unlimited.

The coordination of benefits provision does not apply to the international benefits.

Caregiver Training
The FLTCIP will pay for the training of a family member or any other informal caregiver to care for you. Benefits for caregiver training are limited to an amount equal to 7 times your daily benefit amount in your lifetime. There is no waiting period for caregiver training.

Service Package
If as a result of the underwriting process you are declined coverage, you will be offered the Service Package option. The Service Package is a non-insurance option that provides access to care coordination and discounts. This option is available for a membership fee of $59.00 per year for a single person or married couple. Anyone eligible for the Service Package will automatically receive more information from LTC Partners about this option.

Alternative Insurance Plan
The alternative insurance plan is available to anyone who answered yes to any of questions 4-7 in part B (and no to all of questions 1-3) of the abbreviated underwriting application. This plan is also available to spouses eligible to use the abbreviated underwriting application who answered yes to questions 8 or 9 in part B of the application, no to all of questions 1-3, and were declined for standard coverage. This is a nursing home only plan that provides a weekly benefit, a 2-year benefit period (104 weeks) and a 180-day waiting period. Anyone who applies for insurance under the Federal Program and is eligible for the Alternative Insurance Plan will automatically receive more information about this option. Verified on 12/06/2010 (http://www.ltcfeds.com)

Original Effective Date

Your original effective date is the date that your coverage is scheduled to go into effect. However, it may not become effective on that date. Employees and members of the uniformed services must be actively at work on that date, otherwise coverage will not become effective on that date. In addition, your coverage may not become effective if you leave your eligible group before that date.

If you apply and your application is approved, you'll receive a Schedule of Benefits that will list an Original Effective Date. Your Original Effective Date will be the first day of the month following approval of your application.

You are responsible for letting LTC Partners know if your health changes from the time you completed your application until your original effective date. If so, and if that change in health is such that you would now answer one or more questions differently on the application, you have a duty to inform LTC Partners. LTC Partners will then determine if you are still approved for coverage. If you do not inform LTC Partners of this change in health, then LTC Partners may have the right to deny a claim for benefits or rescind coverage.

Premiums

The amount of your premium is based on the coverage options you are approved for and your age. Your premiums will not change because you get older or your health changes after your coverage becomes effective.

You can use the Premium Calculator at www.ltcfeds.com to find out the premiums for your age and the benefit options you choose. The calculator will allow you to model up to four options and compare the benefits and costs of each on the same screen.

Premiums are due and payable on the first day of the month in which they are due. You must pay premiums in U.S. currency.

Billing Options

The FLTCIP offers three options for paying your Long-Term care insurance premiums – Automatic Bank Withdrawal, Payroll/Annuity Deduction, and Direct Bill. You may also pay the premiums for any of your qualified relatives who apply and are approved for coverage, even if you don't apply or you apply and are denied coverage.

Automatic Bank Withdrawal

If you choose this option, you will need to complete a Billing Change Form. The deduction will be processed automatically from your checking or savings account on the third business day of every month. You will need to provide details about your account on your application. For checking account deductions, you will have to provide a voided check. For savings account deductions, you will have to provide a savings deposit slip. You will also have to sign a written authorization so that the deductions can begin.

Payroll / Annuity Deductions

This service is available to most employees and annuitants, and members and retired members of the uniformed services. Your premium deduction will begin on the first day of the first pay or annuity period that begins on or after your effective date of coverage.

Direct Bill

If you select the Direct Bill option, you will receive a bill to your designated mailing address during the month before your premium is due. You may designate an alternate billing address if you would like.

You can change your method of payment at any time and for any reason by submitting a Billing Change Form.
To obtain a Billing Change Form you can call 1-800- LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557). You will need to complete, sign and mail the form to the address provided on the form.
Verified on 12/06/2010 (http://www.ltcfeds.com)

Grace Period

There is a 30-day grace period for payment of your premium. This means that your premium payment must be received by the 30th day after the date it is due. If your premium is not received by the end of this grace period, you will be sent a written notice of termination of your coverage by first class mail. You will have 35 days from the date of the termination letter to pay your premium; otherwise your coverage will end.

To help protect you from an unintended lapse of your coverage, you have the option of designating a person to receive a copy of any notice of termination that is sent to you. The person that you designate will not be responsible for your premium payment. If you elect this feature (either on your application or anytime when your coverage is effective), you must notify LTC Partners in writing if you want to change your designation.

Coordination of Benefits

The FLTCIP includes a provision for Coordination of Benefits (COB). This COB provision follows the guidelines set by the National Association of Insurance Commissioners (NAIC).

In determining the amount of benefits LTC Partners will pay, this COB provision allows LTC Partners to look at other plans that might pay benefits for Long-Term care services that you receive. The other plans LTC Partners will look at include government programs (other than Medicaid), group medical benefits, and other employer-sponsored Long-Term care insurance. LTC Partners will not look at individual insurance policies or association group insurance policies. This COB feature does not apply to international benefits.

Tax Qualified

According to Federal law, tax-qualified Long-Term care insurance programs are treated like other medical insurance for Federal income tax purposes. For example, benefits you receive cannot be taxed as income for Federal tax purposes and you may be able to deduct a portion of your premiums from your taxable income.

The FLTCIP, by law, is designed to be a tax qualified Long-Term care insurance coverage under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. That means that you have the same Federal income tax advantages afforded to all such tax-qualified plans. Subject to specified dollar limits that vary depending on your age, you may be able to include your premium in your itemized deductions on your Federal income tax return, if your total medical expenses, including the allowable portion of your premium, exceed 7½ % of your adjusted gross income. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly.

These amounts will increase annually based upon the Consumer Price Index for Medical Care. Many states also offer tax incentives for their residents who purchase Long-Term care insurance. For more information on state specific tax incentives, visit the OPM website at www.opm.gov/insure/ltc or consult your tax advisor.

Outline of Coverage

The Outline of Coverage is an informational booklet that provides a brief description of the most important features of coverage available under the FLTCIP. Items included in the Outline are Benefits Provided, Eligibility, Exclusions and Limitations, and Inflation Protection. Since all insurers are required to issue an outline of coverage, you can use these to compare different plans. Note that the Outline of Coverage is not a contract; the contractual provisions that relate to you are contained in your Benefit Booklet and Schedule of Benefits that you will receive if your application for coverage is approved. You can review a copy of the FLTCIP's Benefit Booklet and Schedule of Benefits Sample by going to www.ltcfeds.com.

Exclusions

The FLTCIP does not cover:

1. illness, treatment or medical condition arising out of :
    a. your participation in a felony, riot or insurrection
    b. your attempted suicide, while sane or insane;
    c. injuries you intentionally inflict on yourself;

2. care or treatment for alcoholism or drug addiction;
3. care or treatment provided to you in a government facility, including a Department of Defense or Department of Veterans Affairs facility, unless otherwise required by law;
4. care you receive while in a hospital, except in a unit specifically designated as a nursing home or hospice facility;
5. any service or supply to the extent that the expenses are reimbursable by Medicare, or would be so reimbursable except for the application of a deductible, coinsurance or co-payment amount (this exclusion will not apply in those instances where Medicare is determined to be the secondary payor under applicable law);
6. services or supplies for which you are not obligated to pay in the absence of insurance; or
7. services provided by another person who normally lived in your home at the time you became eligible for benefits.

Unlike most Long-Term care insurance policies available, FLTCIP coverage does NOT contain a War exclusion. Your coverage may be reduced if a war or act of war (declared or undeclared) is determined to be a Catastrophic Event under the Catastrophic Coverage Limitation. As a result, benefits may be payable under the FLTCIP for conditions due to war or acts of war, declared or undeclared, or service in the armed forces or auxiliary units. Verified on 12/06/2010 (http://www.ltcfeds.com)

Benefit Eligibility

You will be eligible for benefits when a licensed health care practitioner certifies and LTC Partners agrees that either:

- you are unable to perform at least two of the six Activities of Daily Living (ADLs) without substantial assistance for a period expected to last at least 90 days. Activities of Daily Living are eating, bathing, dressing, transferring, toileting, and continence; or
- you require substantial supervision to protect yourself due to a severe cognitive impairment, such as Alzheimer's disease.

Benefits can begin after the waiting period that you choose, if the covered services are part of an approved "plan of care" developed by a licensed health care practitioner of your choice and approved by LTC Partners.

Claims

To initiate a claim, you or your representative must submit written proof of your claim to LTC Partners no later than 12 months from the date you incurred charges for covered services. If you or your representative do not submit proof of claim within this time limit, benefits may be denied unless you can show that it was not reasonably possible for you to submit proof of claim within the time limit, and you or your representative submitted proof of claim as soon as reasonably possible. When you make a claim, make sure you have available:

- Your Social Security number
- The names and telephone numbers of your physician and other health care providers
- Medical insurance information, including your insurer's name and telephone number, if applicable

Verified on 12/06/2010 (http://www.ltcfeds.com)

Claims Determination

LTC Partners will send you written notice of its claim determination no later than 10 business days after it receives all the information it needs.

If your claim is denied, in whole or in part, the notice will provide the reason(s) for the denial. You or your representative may request a review of a denial by sending a written request to LTC Partners no later than 60 days after the date of the denial. No later than 60 days after the date LTC Partners receives your request, it will send you written notice of its decision. If the initial denial is upheld on review, you may request an appeal.

Appeals

If you choose to appeal the eligibility for benefits or claim decision, you must send a written request to LTC Partners, with any additional information that you wish to be considered, no later than 60 days after the date of LTC Partners' review decision. Your appeal will be reviewed by an appeals committee composed of: one or more representatives of John Hancock Life Insurance Company, one or more representatives of Metropolitan Life Insurance Company, and other person(s) if mutually agreed upon by OPM and LTC Partners.

The appeals committee will provide you with written notice of its final decision no later than 60 days after the date your written request for appeal was received. If the appeals committee upholds the denial and that denial is eligible for appeal to an independent third party (as explained below), the written notice will let you know how to request such an appeal.

Independent Third Party

If the appeals committee upholds a denial of your eligibility for benefits or your claim due to its evaluation of your medical condition/functional capacity, such as your ability to perform Activities of Daily Living or your cognitive status, you may request an appeal of that decision to an independent third party mutually agreed to by OPM and LTC Partners. You must make this request in writing no later than 60 days after the date of the notice informing you of the appeals committee's decision.

The independent third party will provide you with written notice of its final decision no later than 60 days after LTC Partners receives your request for appeal to the independent third party. The decision of the independent third party is final and binding.

The following is an example of when a denial by the appeals committee will be eligible for appeal to an independent third party: the appeals committee upholds a denial of your eligibility for benefits because its review indicates that you can perform 5 out of 6 Activities of Daily Living.

The following is an example of when a denial by the appeals committee will not be eligible for appeal to an independent third party: the appeals committee upholds a denial of your claim for benefits for nursing home services because you exhausted your Maximum Lifetime Benefit.

Exhaustion of the Appeals Process

Once you have exhausted this appeals process, you may seek judicial review of a final denial of eligibility for benefits or a claim. Please see the Limits on Legal Actions subsection of the General Provisions section of the Benefit Booklet for more information.

Payment of Benefits

All benefits for the FLTCIP will be paid in United States currency. These benefits will be paid directly to you unless you have completed an assignment of benefits. You may not assign benefits to any provider outside the United States, its territories and possessions. If you have a Comprehensive plan, LTC Partners will determine, at its sole discretion, whether to honor assignments to informal caregivers. You may not assign benefits prior to a claim.

Benefit Changes

You may request an increase (upgrade) or decrease (downgrade) in your coverage by writing to LTC Partners or calling them at 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557). In order to receive approval of a request for an increase, you must provide, at your expense, evidence of your good health that is satisfactory to LTC Partners. You do not have to provide evidence of your good health for a decrease. The amount of an increase or decrease will be subject to Federal Program options available at the time of your request.

Continuation of Coverage

If the group policy under the FLTCIP ends, OPM intends to continue your insurance coverage by replacing the existing group policy with another one that will:

- be effective on the day after the group policy ends;
- provide coverage that is substantially the same as that provided by the group policy; and
- calculate your premium based on the same issue age(s) as under the group policy.

In the unlikely event that the group policy ends and there is no replacement policy as described above, LTC Partners will continue your coverage.

Reinstatement of Coverage

If your coverage ends because you did not pay your premium when due, your coverage will be reinstated as of the date it ended if, within 6 months of the date your coverage ended, you or your representative:

- submits evidence satisfactory to LTC Partners that you suffered a cognitive impairment or loss of functional capacity before the expiration of the 30-day grace period for payment of your premium (the standard of proof LTC Partners will require will be no more restrictive than the requirements to establish eligibility for benefits); and
- submit all past due premiums.

If your coverage ends because you canceled it or did not pay your premium when due, your coverage will be reinstated as of the date it ended, if within 12 months of the date coverage ended you:

- request reinstatement; and
- submit, at your expense, evidence of your good health that is satisfactory to LTC Partners; and
- submit all past due premiums.

If your coverage is reinstated, your premium will be based on your age as if your coverage had continued without interruption.