



GE Financial

**Classic SelectSM
& Privileged ChoiceSM**
Long Term Care Insurance Plans

Answers to Frequently Asked Questions

Q&A Guide



Questions & Answers For Privileged Choice and Classic Select

This Q & A does not apply to coverage in California where final product approval is pending.

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PART I – PRIVILEGED CHOICE AND CLASSIC SELECT PRODUCTS OVERVIEW

Privileged Choice and Classic Select are comprehensive, tax qualified plans that provide substantial coverage for Long Term Care services in a nursing home, assisted care facility, at home and in the community. Privileged Choice is a robust, all-inclusive plan, while Classic Select is a multi-featured plan that makes many of the Privileged Choice features available on an optional basis. They replace the GE Long Term Care Choice, Privileged Care Custom and Privileged Care Facility products. The following table shows improvements made with these new products.

	CHOICE[®]	PRIVILEGED CHOICESM	CLASSIC SELECTSM
BENEFIT PERIODS (BP'S)/ BENEFIT MAXIMUMS	<u>INDIVIDUAL PLANS</u> 2, 3, 4, 6 Years & Lifetime <u>SHARED BENEFIT PLANS</u> 3, 4, 6, 8 and 12 Years	<u>INDIVIDUAL PLANS</u> 2, 3, 4, 5, 6, 8, 10 Yrs & Lifetime <u>SHARED BENEFIT PLANS</u> 4, 6, 8, 10, 12, 16 and 20 Years	<u>INDIVIDUAL PLANS</u> 2, 3, 4, 5, 6, 8, 10 Yrs & Lifetime <u>SHARED BENEFIT PLANS</u> 4, 6, 8, 10, 12, 16 and 20 Years
DAILY/MONTHLY MAXIMUMS	\$30 - \$250 Daily <i>(\$30 - \$150 for 80-84, on all BP's except Lifetime)</i>	\$1,500 - \$12,000 Monthly <i>(Not available over age 79)</i> Purchased in \$100 increments	\$50 - \$400 Daily <i>(Not available over age 79)</i> Purchased in \$5 increments
ELIMINATION PERIODS	50 or 100 Days For Facility Benefits Only	30, 90, 180 days For Facility Benefits Only	30, 90, 180 or 365 days Facility & Home Care Benefits
0-DAY HC EP	Included in the Base Plan	Included in the Base Plan	Added Cost Option
FACILITY BENEFIT	Pays Expenses up to the Daily Maximum	Pays Expenses up to the Monthly Maximum	Pays Expenses up to the Daily Maximum Added Cost Option Monthly Maximum (all benefits)
COVERED FACILITIES	Licensed Nursing Homes, assisted care or Alzheimer's facilities with 5 residents that meet stated criteria. Pays up to the Daily Maximum.	Licensed Nursing Homes; Assisted Care Facilities with at least 10 residents that are either: Licensed; Certified; or meet stated criteria. Pays up to Monthly Maximum.	Licensed Nursing Homes; Assisted Care Facilities with at least 10 residents that are either: Licensed; Certified; or meet stated criteria. Pays up to the Daily Maximum.
BED RESERVATION	50 days per year	60 days per year	30 days per year
HOME CARE BENEFIT	Pays Prevailing expenses up to the Monthly Maximum	Pays expenses incurred up to the Monthly Maximum	Pays expenses incurred up to the Daily Maximum
EQUIPMENT	50 X Daily Maximum (Lifetime)	2 X Monthly Maximum /Lifetime	50 X Daily Maximum/Lifetime
CAREGIVER TRNG	5 X Daily Maximum (Lifetime)	20% of Monthly Maximum /Lifetime	5 X Daily Maximum/Lifetime
RESPIRE CARE	21 days per year	30 days per year	21 days per year
COMPOUND INFLATION	No Claims Offset	No Claims Offset	Calculation offset by claims payments
SHARED BENEFIT PLAN	Single Owner No Right to Sever	Joint Owners Split/Conversion available upon Divorce/Separation	Joint Owners Split/Conversion available upon Divorce/Separation
SURVIVORSHIP BENEFIT (10 YEARS WITH NO CLAIMS)	Included in the Base Plan	Included in the Base Plan Added Cost Option of 7 Years with No Claims Restrictions	Added Cost Options for 7 or 10 Year Survivorship Benefit
INTERNATIONAL COVERAGE	Not Available	Included In the Base Plan	Not Available
EATING ADL	Eating definition includes Tube & Intravenous Feeding	Eating definition excludes Tube & Intravenous Feeding	Eating definition excludes Tube & Intravenous Feeding
OTHER COVERAGE WITH US	Provides no coordination of benefits	Coordinates benefits with future coverage with Us	Coordinates benefits with future coverage with Us
LIMITED PAY	10 Year or To Age 65	10 Year or To Age 65	10 Year or To Age 65
COUPLES DISCOUNT	25% each – both must apply	25% both apply - One Issued 40% if Both Policies Issued	25% both apply - One Issued 40% if Both Policies Issued
PREFERRED HEALTH DISCOUNT	10%	20% <i>(10% when combined with Couples Discount)</i>	20% <i>(10% when combined with Couples Discount)</i>

PART II – GENERAL HIGHLIGHTS

The Increased Choices and How Coverage Has Changed

1. *Why are both the Privileged ChoiceSM and Classic SelectSM products replacing prior GE Long Term Care products?*

We wanted to provide greater choice. Privileged Choice continues our line of premier, all-inclusive comprehensive products. Classic Select offers a more affordable, but less robust base plan alternative that can be enhanced and tailored to fit individual needs. For those wishing facility coverage with minimal home care, a 50% Home Care alternative is available with Classic Select.

NOTE: These products replace the GE Long Term Care Choice, Privileged Care Custom and Privileged Care Facility products.

2. *How do these plans improve upon the benefits from the GE Long Term Care Choice product?*

Some of the more notable improvements include:

- 40% Couples Discount when both are issued policies; 50% discount for each who also has a Preferred Health Discount.
- 20% Preferred Health Discount is available to healthy applicants (10% when combined with Couples Discount)
- Elimination Period Choices are 30, 90, 180 and 365 days (365 Days - Classic Select only; available in most but not all states) instead of 50 or 100 days.
- More Benefit Period/Lifetime Maximum choices.
- Higher daily/monthly issue limits.
- Coverage for Assisted Care Facilities that are licensed, certified, or meet stated contract requirements.
- Prevailing Expense limitations removed.
- International Coverage in the Privileged Choice product (this coverage is not available with Classic Select).
- 7-Year Survivorship optional rider that applies after 7 years of concurrent coverage regardless of claims.
- Limited Pay options of “10 Year” or “To Age 65” available in most (but not all) states.
- Improved Shared Coverage provisions with joint ownership and conversion option on divorce/final separation.
- Addition of an “Other Coverage With Us” provision that provides coordination of benefits between Privileged Choice, Classic Select and future products. (Not applicable in all States.)

Plan Comparisons

3. *What are the differences between Privileged Choice and Classic Select?*

Privileged Choice has higher coverage limits and more standard features as shown below:

<u>Benefit/Feature</u>	<u>Privileged Choice Limits</u>	<u>Classic Select Limits</u>
Shared Coverage Available	Yes	Yes
Privileged Care Coordination (PCC)	Includes Advantages	Advantages not standard
Home Care	Monthly Maximum/No Elimination Period	Daily Maximum/Elimination Period
Respite Care	Up to Monthly Maximum per year	21 days per year
Caregiver Training	20% of Monthly Maximum per Lifetime	5 times Daily Maximum per Lifetime
Equipment	2 times Monthly Maximum per Lifetime	50 times Daily Maximum per Lifetime
Nursing Home/Assisted Care Facility	Monthly Maximum per calendar month	Daily Maximum per day
Bed Reservation	60 days per year	30 days per year
Alternative Care	Included	Included
Waiver of Premium	With PCC advantages	Only after Elimination Period
10 Year Survivorship Benefit	Included (most states)	Added Cost Rider
International Coverage	75% of Monthly Maximum per month; Lesser of 48 Months or exhaust policy maximum	Not Available
Compound Inflation	No Claims Offset	Claims Offset in calculations
Added Cost Optional Riders	Restoration, Nonforfeiture 7 year Survivorship	Restoration, Nonforfeiture, 7 or 10 year Survivorship Monthly Benefits Waiver of Home Care Elimination Period
Lower Cost Option		365-Day Elimination Period

4. **How do the premiums compare between Privileged Choice and Classic Select?**

The actual difference varies slightly by issue age. Privileged Choice costs approximately 17% more than Classic Select, without any Riders. For Classic Select, the 10 Year Survivorship Rider costs an added 9%, the Monthly Benefits Rider adds 6%, and the Waiver of Home Care Elimination Period Rider adds 9%. If all 3 Riders are purchased the Classic Select premium is increased by 24% (9% + 6% + 9%). As a general rule of thumb, if the client desires 2 of these 3 Riders then Privileged Choice is probably the best choice. Additionally, International Coverage is not available on Classic Select, and Privileged Choice provides a higher “personal benefit account” than Classic Select when Compound Inflation is chosen. The Classic Select 365-Day Elimination Period is priced 30% lower than its 90-Day Elimination Period.

5. **My client wants a lower cost, facility-only policy. What can I use to meet those needs?**

Consider Classic Select, which is now available with a 50% Home Care Benefit. Since it is intended to provide a lower cost alternative, please note that the 0-Day Home Care Elimination Period and Monthly Maximum Riders are not available with this option. In addition, the 365-Day Elimination Period with Classic Select is a lower-cost alternative.

PART II - PREMIUMS AND DISCOUNTS

Couples Discount

6. **How are the Couples and Preferred Health Discounts calculated?**

To determine the discounted premium, the following multipliers are used:

	<u>Both People in a Couple Apply*</u>	
	<u>One Issued</u>	<u>Both Issued Separate Policies</u>
Preferred Health Discount only:	10%	10% each qualifying policy
Couples Discount only:	25%	40% each policy
Both Preferred Health and Couples Discount:	35%	50% each Preferred Health policy

***Note:** For Shared Coverage a 40% Couples Discount is built into the rates. A 10% Preferred Health Discount is available to each qualifying applicant. *For individual applicants, a 20% Preferred Health Discount is available.*

7. **Must the two applicants be married to qualify for the Couples Discount?**

Except where prohibited by State Regulations, they can either be: (a) married, or (b) in a “committed relationship” and submit a completed “Requirements to Access Special (Couple) Benefits” form with their application(s). A committed relationship is consistent with the following description:

Two people living together for at least three years in a committed relationship as partners or family members sharing basic living expenses, and who:

- Are not married to each other, or to anyone else; and
- If related, must belong to the same generation of the same family (e.g. brothers, sisters, cousins).

8. **Is proof of marriage required to be eligible for the Couples Discount?**

No. However, the company reserves the right to seek back premium if there is a misrepresentation on the application regarding marriage or a committed relationship.

9. **a. To be eligible for the 40% Couples Discount, must both applicants be issued policies?**

Yes, they must both be issued policies. In the event both applicants pass the Insurability Profile (a “no” response to questions in the Insurability Profile on the application) at the time their applications are taken, but one applicant is declined for other reasons, the approved applicant will still receive a 25% Couples Discount (this can increase to 35% if he or she qualifies for the Preferred Health Discount).

***Note:** This 40% Couples Discount is incorporated in the Shared Coverage rates.

b. If a couple applies and submits premium based on the anticipated 40% Couples Discount, what happens to the premium if one of them is declined?

The approved person will be issued a policy with a 25% Couples Discount. The submitted monies from the declined individual’s portion will be applied to the issued policy to make-up the additional 15% of premium required. The remainder of the premium is refunded in the form of a check sent to the agent along with the issued policy.

10. **What if one applicant cannot pass the Insurability Profile at the time of application? Can the insurable applicant still receive the Couples Discount?**

No. As stated above, both applicants must pass the Insurability Profile on the applications for any Couples Discount to apply.

11. **How does the Couples Discount work in a situation in which the first applicant applies for and is issued a policy today, but the second applicant does not apply until a later date?**

A 40% Couples Discount will be given to the second applicant when he or she is issued a Privileged Choice or Classic Select policy. The first applicant will also get a discount if the application for the second applicant is received within 12 months of the effective date of the first applicant’s policy. The discount on the first policy will take effect as of that policy’s effective date, and will be the 40% Couples Discount if that policy is also a Privileged Choice or Classic Select contract (only 25% for Choice and 20% for Privileged Care Custom and Privileged Care Facility).

12. *If a couple has individual policies, each with a Couples Discount, and one dies, does the survivor retain the Couples Discount?*

Yes.

Preferred Health Discount

(See also Section IX)

13. *Is it possible that an individual could answer “No” on the Preferred Health questions on the application (thus qualifying for Preferred Health) but still not receive the Preferred Health Discount?*

Yes. The company reserves the right to adjust premium if the applicant’s medical history is found to be inconsistent with the answers to the questions on the application.

14. *Must the Preferred Health Discount be calculated at the time of application? Who is responsible for determining eligibility for the discount and applying it to the premium?*

The applicant must answer the Preferred Health questions at the time of application. It is the agent’s responsibility to determine if the applicant is eligible for the Preferred Health Discount and include it in the premium calculation.

15. *If an individual has talked to his or her physician about a history noted in the Preferred Health questions in the Insurability and Medical Profiles on the application, (such as Osteoporosis prevention or the likelihood of developing Emphysema after having smoked as a young adult) without having an actual diagnosis or treatment, would this individual be excluded from the Preferred Health Discount?*

It is not our current intention to exclude individuals in the above or comparable scenarios. Only those who carry a diagnosis of one of the listed conditions are ineligible for the discount.

16. *The application asks about an individual’s smoking history within the past three years. If someone has an occasional cigar around the holidays, or something to that effect, is that individual considered ineligible for the Preferred Health Discount?*

Yes, even the occasional use of tobacco will make the applicant ineligible for the Preferred Health Discount.

17. *What happens if a couple elects to purchase Shared Coverage and only one applicant is eligible for the Preferred Health Discount?*

Since premium for the Shared Coverage plan is calculated by adding the rates for each applicant, it is possible that only one person could be eligible for the Preferred Health Discount. Please refer to your rate guide for a calculation example.

Modal Premium Disclosure

18. *Why do these policies have a Modal Premium Disclosure section?*

This section is intended to address our concerns that some individuals may not realize that it costs more out-of-pocket to pay premiums more frequently than annually. Highlighting this fact along with disclosing our Modal Premium factors is just one more way we provide full disclosure to our Insureds.

PART III – SPECIFIC BENEFITS AND FEATURES

19. *Have the Benefit Eligibility requirements changed?*

Not really, however we have liberalized the “Eating” ADL so that a person who needs to be fed intravenously or by feeding tube could be considered as having an Eating ADL deficiency.

20. *What has been done to change the Home Care Benefit?*

There is a more specific listing of the types of services that are covered. In addition to covering Nurse and Therapist services, Adult Day Care and Hospice Care, we cover the following services that will enable the Insured to stay independent and at home.

- **Home Health Aide and Personal Care Attendant Services:** This is assistance with simple health care tasks, personal hygiene, managing medications, and help in performing Activities of Daily Living.
- **Homemaker Services:** This is assistance with one or more of the following tasks: meal planning and preparation; doing laundry; and light house cleaning (such as: vacuuming, dry mopping, dishwashing, cleaning the kitchen or bath, and changing soiled bedding).
- **Chore Services:** This is assistance with the following light work activities: minor household repairs related to safety at home (such as to handrails and safety rails, stairs, or floors); taking out the garbage; and simple cleaning tasks to remove unsafe debris or dirt in the home. Chore Services do not include any type of residential upkeep, construction, renovation or routine home preservation (such as painting); lawn or yard care; snow removal; vehicle or equipment maintenance; or similar tasks.

Providers of these services do not need to be affiliated with a home health care agency; but cannot be someone who normally resides in the Insured’s home. Coverage for these services applies when the Insured resides someplace other than in a Covered Facility.

21. How does the Elimination Period differ between Privileged Choice and Classic Select?

Privileged Choice, like the prior Choice product, has no elimination Period for Home Care, and when a Privileged Care Coordinator is used, days for which Home Care Benefits are received count towards satisfying the Elimination Period for the Nursing Home and Assisted Care Facility Benefits.

Classic Select, like the plans of many other insurers, applies the Elimination Period to the Nursing Home, Assisted Care Facility, and Home Care Benefits. In addition, a less-costly 365-Day Elimination Period is also available on Classic Select plans.

22. Is it possible to have 1st Day Home Care with Classic Select?

Yes, when the Waiver of Home Care Elimination Period Rider (not available with a 365-Day Elimination Period) is purchased the Elimination Period applies only to the Nursing Home and Assisted Care Facility Benefits and not to Home Care Benefits. Additionally, when a Privileged Care Coordinator is used, the days for which Home Care Benefits are received count toward satisfying the Elimination Period.

23. How have the facility benefits changed?

We now have separate Nursing Home and Assisted Care Facility Benefits each paying up to the applicable daily or monthly maximum. Under these Benefits, Nursing Homes are facilities that are licensed to provide nursing care; and Assisted Care Facilities must provide ADL or cognitive assistance and supervision to at least 10 residents either:

- Under a license, certificate or substantially similar permit and oversight from the Federal or State government; or
- In accordance with applicable laws and continuously meet staffing and service requirements stated in the policy.

24. What coverage is provided by the International Coverage Benefit that is included in Privileged Choice contracts?

This is a limited benefit that covers Out-of-Country Nursing Home stays for up to 75% of the Monthly Maximum for up to 48 months or until the policy maximum is exhausted, whichever occurs first. This Benefit is in lieu of all other Benefits, does not include Privileged Care Coordination Services and Waiver of Premium, and requires the Insured, at his or her own expense, to provide us with satisfactory proof that all criteria for payment of this Benefit have been met.

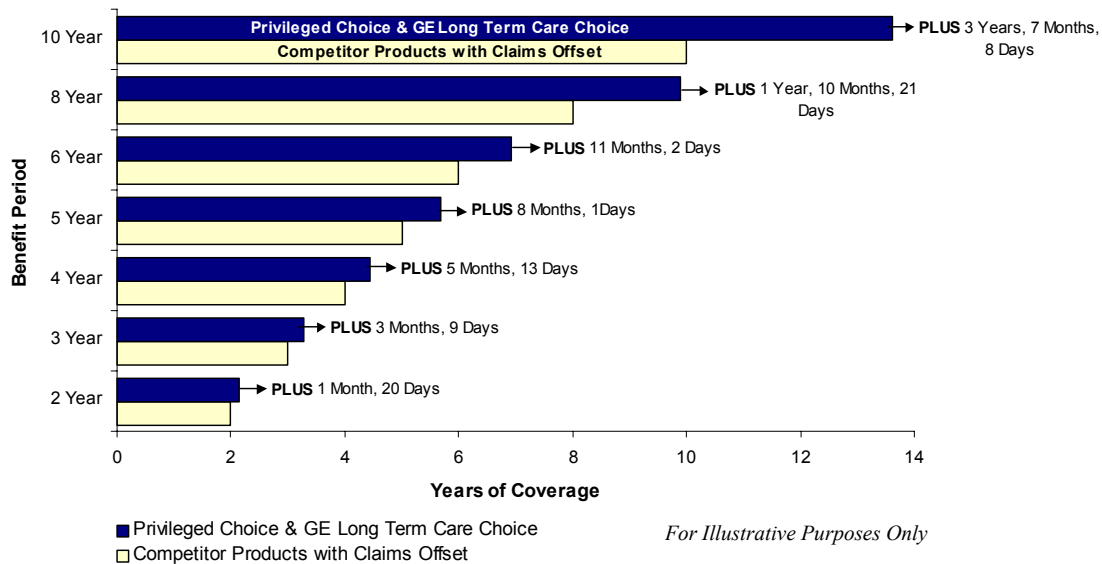
Inflation Protection/Benefit Increase Options

25. How do the Inflation Protection/Benefit Increase Options differ between these products?

- Equal/Simple Benefit Increases under both products are as they have been in prior products – they annually increase the maximum amounts by 5% of the original amounts (without taking claims payments into consideration – no “Claims Offset”).
- For Privileged Choice the Compound Increases are also like they have been in prior products – they annually increase the previously inflated Monthly and Lifetime Maximum amounts by 5% (without taking claims payments into consideration – no “Claims Offset”).
- For Classic Select annual Compound Increases of 5% are applied to the Daily Maximum and the remaining Lifetime Maximum (after it has been reduced by claim payments made over the last year). This “Claims Offset” calculation is like the method used by many other insurers.

26. Explain more about how the Compound Inflation Protection differs between these 2 products?

Because Privileged Choice increases are not affected by benefit payments, a larger pool of money is available when claims are paid. The graph below shows how this works when a person has each of the following Benefit Period plans and immediately goes on claim for the full daily maximum. (For illustrative purposes we are using plans that pay daily benefits.)



This example assumes 100% of the monthly maximum benefit is paid continuously until all benefits exhausted

Privileged Care Coordination Services

27. *What do Privileged Care Coordination Services provide?*

They give the Insured a resource to help find needed health care services. The national vendors we use help provide assessment and care coordination services for claimants covered under our Long Term Care Insurance policies. These vendors specialize in providing health care assessments and care coordination services in the long term care marketplace. These services include assistance in negotiating rates with care providers chosen by the Insured and help with completing the initial claim forms required to get benefits under the policy.

28. *Do Privileged Care Coordinators act as “gatekeepers?”*

No. Privileged Care Coordinators are trained to provide objective, clinical recommendations. They are not involved in any claim eligibility determinations. Care coordination is designed expressly to help an Insured identify the services needed during a stressful period. They provide options to help the Insured remain safe, comfortable and independent at home. An Insured is never told what provider must be used; rather the Insured is given a list of local, quality caregivers from which to choose. In addition, an Insured can always choose to get care from providers other than those recommended by a Privileged Care Coordinator.

29. *How does Privileged Care Coordination help Insureds?*

Privileged Care Coordination helps our Insureds in several ways:

- By providing guidance and assistance during a stressful time.
- By helping to ensure that they get the care they need to remain safely at home.
- By providing feedback on the appropriate costs for care and services; and assistance in negotiating the best value for the Insured’s benefit dollars.
- By helping to maximize the Insured’s potential for recovery and increased independence.
- By providing on-going quality checks of the care being received.

30. *Are there any other advantages to using a Privileged Care Coordinator?*

Yes, the cost of these services does not count against the Lifetime Maximum. In addition for Privileged Choice, when Home Care is provided under a Privileged Care Coordinator’s Plan of Care, the Elimination Period for Nursing Home and Assisted Care Facilities is reduced by one day for each day for which Home Care Benefits are paid; and the Waiver of Premium applies. For Classic Select, an optional Rider with these advantages is available for an additional cost.

Survivorship Benefits

31. *What Survivorship Benefits are available?*

Two Survivorship Benefits are available.

- The 10-Year Survivorship Benefit requires that no claim be paid or payable for either person during the first 10 years of concurrent coverage. This Benefit is standard in Privileged Choice in all approved states except Florida and Washington where it is not available. The 10-Year Survivorship Benefit is available as an optional rider at an added cost with Classic Select in all approved States except Florida, Oregon and Washington where it is not available.
- The 7-Year Survivorship Benefit is available at an added cost with both Privileged Choice and Classic Select. It applies if death occurs after 7 years of concurrent coverage, even if claims have been paid during those 7 years.

32. *How do the Survivorship Benefits work?*

If both members of a couple have long term care policies with similar Survivorship Benefits in force continuously (original or replacement policies) for the required time period, and one member of the couple dies, the surviving member’s policy will be fully paid up. As stated above, the 10 year version requires that no claim be payable during the first 10 years of concurrent coverage; however, the 7 year Survivorship Benefit does not require claims-free coverage.

33. *If a couple has long term care policies with similar 10-Year Survivorship Benefits for ten years without a claim, and one member has a claim and receives benefit payments in the 11th year and then dies while still insured – does the surviving member have a paid up policy?*

Yes. Since there was not a claim in the first ten years of concurrent coverage, the surviving partner will have all future premiums waived.

34. *A couple has long term care policies with similar 10-Year Survivorship Benefits and one of them uses benefits after his or her policy has been in force for one year, then 10 years pass without further claims on either policy. The person who used the benefits dies in the policy’s 12th year. Does the survivor have a paid up policy?*

No, since a claim was paid within the first ten years of concurrent coverage.

35. *A couple has long term care policies with similar 7-Year Survivorship Benefits and one of them uses benefits after his or her policy has been in force for one year, then 7 years pass without further claims on either policy. The person who used the benefits dies in the policy’s 9th year. Does the survivor have a paid up policy?*

Yes, since claims payments are not a factor in determining whether the 7-Year Survivorship Benefit applies.

36. *What happens if one member of a couple has the 10-Year Survivorship Benefit and the other has the 7-Year Survivorship Benefit?*

We will not knowingly sell different Survivorship Benefits to a couple, however, if a couple has existing policies with different versions of the Benefit, we will apply the 10-Year Survivorship Benefit provisions to determine whether premiums are waived for the survivor's policy.

Waiver of Premium

37. *If an Insured becomes confined in a Nursing Home or Assisted Care Facility, when does the Waiver of Premium go into effect?*

The Waiver of Premium goes into effect on the first day of the coverage month that begins while an Insured is receiving continuing benefits, after the Elimination Period has been satisfied and facility benefits have become payable.

38. *If an Insured uses Privileged Care Coordination Services in conjunction with the Home Care Benefit, when does the Waiver of Premium go into effect?*

- For Privileged Choice policies, it goes into effect on the first day of the coverage month after Home Care Benefits become payable in accordance with the Privileged Care Coordinator's Plan of Care.
- For Classic Select product, it goes into effect on the first day of the coverage month after the Elimination Period has been satisfied. If the optional Waiver of Home Care Elimination Period Rider is purchased, Waiver of Premium can begin on the first day of the coverage month after Home Care Benefits become payable in accordance with the Privileged Care Coordinator's Plan of Care.

39. *If an Insured chooses not to use the Privileged Care Coordination Services in conjunction with the Home Care Benefit, when does the Waiver of Premium go into effect?*

- For Privileged Choice policies and Classic Select policies with the optional Waiver of Home Care Elimination Period Rider, the Waiver of Premium will go into effect after satisfaction of a qualifying period equal to the number of days in the Elimination Period. The qualifying period can be satisfied by: (a) days used to satisfy the Elimination Period (that applies only to the Nursing Home and Assisted Care Facility Benefits), or (b) days for which Home Care benefits are received, or (c) a combination of (a) and (b).
- For Classic Select policies, it goes into effect on the first day of the coverage month after the Elimination Period (that applies to the Nursing Home, Assisted Care Facility and Home Care Benefits) has been satisfied.

Restoration of Benefits Rider

40. *How does the Restoration of Benefits Rider work?*

If the Insured uses benefits from the policy, and then goes a period of 180 consecutive days without being benefit eligible, we will not count those prior benefit payments against the Lifetime Maximum that would have applied if no benefits had been paid.

41. *How much does the Restoration of Benefits Rider add to the premium?*

It increases the overall cost of a policy between 6% and 10% depending upon the Benefit Multiplier that applies.

42. *Under the Restoration of Benefits Rider, is there a limit to how many times benefits can be restored during the policy's lifetime?*

No, except the Restoration will not apply if the policy is in force under a Nonforfeiture Benefit.

43. *How does the Restoration of Benefits Rider work for Shared Coverage?*

If either Insured uses benefits, and then both go a period of 180 consecutive days without being benefit eligible, we will not count those prior benefit payments against the Lifetime Maximum. If a person dies before his or her benefits have been restored, they will not be restored for use by the survivor.

The "Other Coverage With Us" Provision

44. *What is the "Other Coverage With Us" provision?*

This provision provides coordination of benefits between Privileged Choice, Classic Select and future products.

45. *How does this benefit our clients?*

Because the policies are coordinated, any benefits that are not used under one of the policies (because we limit combined coverage to the actual expense incurred) will be available for future claims.

46. *How does this affect benefits payable under older contracts and policies with other insurers?*

We will not coordinate with older contracts that do not have a similar provision, nor will we coordinate with coverage provided by other insurers.

Optional Nonforfeiture Benefit Rider

47. How does the optional Nonforfeiture Benefit Rider work?

If the policy should lapse after it has been in force for at least three years, coverage will continue automatically with a reduced Lifetime Maximum. The policy will then be in a paid-up status with no further premium payments required. The amount of the reduced Lifetime Maximum would be the greater of:

- The maximum benefit amount payable for one month (30 days) at the time of lapse; or
- 100% of the sum of all premiums paid for the policy and any attached riders, including premium paid prior to any change in benefits.

48. Approximately how much is premium increased by adding the Nonforfeiture Benefit Rider?

It varies based on issue age. It is 30% for issue ages 65 and younger. For older issue ages, it decreases by 1% per issue age year until it levels off at 14% for issue age 79 (e.g. 25% at age 70 and 20% at age 75).

49. With Shared Coverage, is the nonforfeiture amount determined the same way?

Yes.

Contingent Nonforfeiture Benefit

50. How does the Contingent Nonforfeiture Benefit work?

This benefit becomes available if a “substantial” cumulative increase has been made in the premium charged for the policy. We use the NAIC standards adopted by many states to determine whether or not a cumulative increase is substantial. If it is determined that we have increased rates by a substantial cumulative amount, under this benefit we will make the following offers available:

- Offer to reduce policy benefits to a level that will not require an increase in current premiums;
- Offer to convert coverage to a paid-up status with a shortened benefit period. The same benefits, Elimination Period and daily/monthly Payment Maximum will apply. Only the Lifetime Maximum will be reduced. In addition, if there is a default or lapse in an Insured’s policy within 120 days of the premium increase, the policy will automatically be converted to this paid-up status

The Contingent Nonforfeiture Benefit has the same shortened benefit periods as the optional Nonforfeiture Benefit.

PART IV – THE SHARED COVERAGE PROVISIONS

Payment Maximums with Shared Coverage

51. If both members of a couple are on claim and the policy’s payment maximum is \$100 a day or \$3,000 a month, will the policy reimburse up to the \$100 a day or \$3,000 a month limit for each per person?

Yes, the only maximum that is shared is the Lifetime Maximum; all other limits apply separately to each individual and it is possible for both to be getting benefits at the same time.

52. Under the Equipment Benefit, does the Lifetime Maximum apply to each member of a couple?

Yes.

53. Under the Respite Care Benefit, does the per year maximum apply to each member of a couple?

Yes.

54. Under the Caregiver Training Benefit, does the Lifetime Maximum apply to each member of a couple?

Yes.

55. If Shared Coverage has the Restoration of Benefits Rider, and one person dies after being on claim, are benefits paid on that person’s behalf restored for the surviving person after 180 days?

No, the Restoration will only restore that portion of the Lifetime Maximum that was used by the survivor and not previously restored.

56. With Shared Coverage, is the full premium for the policy waived if just one member in a couple qualifies for the Waiver of Premium?

Yes, joint Waiver of Premium is a feature built into Shared Coverage.

Elimination Period with Shared Coverage

57. Must each member of a couple satisfy their own Elimination Period prior to that person receiving benefits?

Yes.

Policyholder vs. Insured

58. What is meant by the “Policyholder” and the “Insured”? What is the difference between the two?

Unlike our earlier Shared Coverage plans, each Insured has equal rights and they must jointly participate in requesting coverage changes and policy cancellation. The role of the Policyholder is to be the recipient of bills and correspondence and to make routine administrative decisions. Designating the Policyholder is the Insured Couple’s decision.

59. When we bill or correspond on Shared Coverage, will we list both applicants?

When we issue contracts or correspond, both applicants will be listed. Billing statements will note the Policyholder only. All communications will be sent to the Policyholder’s address of record.

60. Can either applicant pay the premium for a Shared Coverage policy?

Yes. We’ll take money from anyone other than the agent. Tax limits on premium deductions may dictate which Insured should pay what amount of premium.

61. How will ProDATA (our automated application/policy status information line) differentiate the Primary from the Secondary Applicant?

If the message is specific to either person, ProDATA will differentiate between the two. If the message applies to both, ProDATA will simply state the message.

Declination of One Member of a Couple Applying for Shared Coverage

62. What happens if one applicant is declined and the other is accepted? Is there a contingent selection at the time of sale?

The approved applicant will be issued an individual policy using the Contingent Benefit Selections indicated on the application. If the applicant who was declined truthfully answered “no” to questions in the Insurability Profile on the application, the approved applicant will qualify for the 25% Couples discount. A letter will accompany the policy explaining the decision, and how premiums have been adjusted. The decline letter and any premium refund will be sent with the policy that is mailed to the agent of record to return to the applicant.

Death of Spouse under Shared Coverage

63. What are the options available upon the death of one Insured in a Shared Coverage contract?

Without underwriting, the surviving member of a couple may do one of the following:

- Keep the contract as is. Premium payments will become 125% of the survivor’s portion of the total premium as reflected on the Schedule page. The change in premium will take effect on the next billing due date. There is no refund of premium (unless required by law and stated in the policy); or
- Keep the contract but decrease premiums by reducing the Lifetime Maximum or a periodic (daily or monthly) maximum, or by increasing the Elimination Period. (Client must submit a signed written request or Coverage Change Request Form to exercise this option.); or
- *With full underwriting*, the survivor may convert to any of our individual policies with increased benefits, at attained age rates and current contract effective date. Discounts will be based on current health and eligibility for couples discount.

64. If an Insured dies after Shared Coverage has been in force for at least ten years and no claim is payable for the first ten years for either Insured, (or 7 years if the 7 Year Survivorship option was purchased), so that the surviving Insured would have a paid up contract, would replacing the policy with an individual contract generally be in that person’s best interest?

No.

Divorce/Final Separation under a Shared Coverage contract

65. What is the effect on Shared Coverage if the Insureds divorce or agree to a final separation (including dissolution of a committed relationship)?

Both Insureds are still covered under the contract. Neither a divorce nor final separation automatically changes the contract; however, we will make changes to the contract upon request of both Insureds. All rights are joint in the Shared Coverage contract. For any and all Shared Coverage contract claims, benefits are payable to the Insured having the claim.

66. In the event of divorce or final separation, who would be responsible for paying the premiums?

The issue is more likely who will be billed, not who is responsible for paying the premium. The premium notice would still be sent only to the Policyholder unless we are directed otherwise. We would accept premiums from either party. In this instance they may want to change the lapse notice designee to the Insured who is not receiving the premium notice.

67. Upon divorce or final separation, could Shared Coverage be split into two individual plans?

Yes, but only if both request the conversion, provided neither is eligible for benefit payments and no Waiver of Premium or Nonforfeiture Benefit is in effect.

68. ***What benefits will be provided when Shared Coverage is converted upon divorce or final separation??***
The policies will be exact duplicates of the original policy, except they will each have only one Insured. They will retain the original Effective Date and have an original Lifetime Maximum equal to ½ that of the Shared Coverage policy.
69. ***What Lifetime Maximum will be available under the converted policies when benefits had been paid under the Shared Coverage policy?***
One-half the total amount of all benefits paid for both Insureds (and not restored by any Restoration of Benefits Rider) will be deemed to have been paid as benefits under each Insured's converted policy.
70. ***How will a person know what benefits have been charged against his or her converted policy?***
Each converted policy will include an attached statement of: (a) the current Lifetime Maximum (reflecting any Benefit Increases and other changes to the original Lifetime Maximum); (b) any benefit payments deemed paid under the converted policy; and (c) the amount of unused benefits available as of the date of conversion.
71. ***How will premium for a converted policy be calculated?***
Premiums for each converted policy will be based on the Insured's original issue age and original Rate Classification under the Shared Coverage policy. Combined premiums for both policies will equal the premium for the Shared Coverage, but each Insured will become responsible for his or her share of the premium.
72. ***Can a couple opt for conversion when there is no divorce or final separation?***
No.
73. ***What happens if the Policyholder cancels a Shared Coverage contract?***
The Policyholder alone cannot cancel a Shared Coverage contract - both Insureds must sign any request to terminate coverage. Both people can then apply for individual contracts at their current ages. The new contracts will be subject to underwriting approval and be given current effective dates.
74. ***What happens if the Policyholder requests that his or her portion or the portion for the other Insured on a Shared Coverage contract be cancelled?***
The request will be denied. Because these are joint policies, unless there is a divorce or final separation, only the entire policy can be cancelled for both Insureds, partial termination is not allowed.
75. ***What happens if a Shared Coverage contract Insured also has an individual policy contract in addition to the Shared Coverage contract, and makes a claim? Which policy pays?***
Benefit payments will be coordinated if both policies have an "Other Coverage With Us" provision. Otherwise, we will pay benefits due under each contract as long as benefit eligibility requirements are satisfied under each contract.
Note: If at the time of underwriting an application for Shared Coverage, the combined periodic (daily or monthly) maximum for the Shared Coverage contract and the existing individual contract exceeds our issue limits, the Shared Coverage contract maximum will be reduced to the maximum allowable and any contract issued will have the reduced amount.
76. ***How would the effective date be determined if one Shared Coverage applicant is approved and issued an individual contract, but the other applicant is declined and then considered at a later date?***
If the declined applicant is reconsidered and approved for coverage within 60 days of the approved applicant's policy effective date, that same effective date will be assigned to the new Shared policy. If this occurs 61 or more days later, then the effective date will be based on the Underwriter's approval date of the reconsidered applicant.
In the first scenario (within 60 days), the applicant may not want to be issued a policy with the effective date of the original policy, as they may owe back premium. They can request to be given the Underwriter approval date instead.

PART V – THE CONDITIONAL INSURANCE AGREEMENT

77. ***What is the Conditional Insurance Agreement (CIA)?***
The CIA does the following:
- Guarantees that changes in health status of the applicant after the application date will NOT be considered during our underwriting process.
 - Guarantees full policy benefits back to the application date to applicants who are approved and issued coverage.
 - Provides temporary limited benefit insurance of up to \$10,000 (not available in some states) if the applicant becomes benefit eligible during the underwriting period and qualified for CIA but is eventually declined.
78. ***Does the Elimination Period apply to the temporary limited benefit insurance of up to \$10,000 under the CIA?***
Yes, the same Elimination Period and all other benefits, features, exclusion and limitations as defined in the policy for which application was made would apply under the CIA.

79. How does a person qualify for the CIA?

The CIA is given at the time of application to an applicant who satisfies the following requirements and conditions:

- The person has not requested an effective date that is later than the Application Date.
- All questions on the application in the Insurability Profile section are answered “No”.
- The answers in the application accurately indicate that:
 - Within the past 5 years the applicant has NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: brain disorders, convulsions, seizures, fainting spells, black outs, mental illness, or paralysis; and
 - Within the past 3 years the applicant has NOT: been medically advised to have surgery that has not been performed; received home health care; or been medically advised to enter or been confined to a nursing home, assisted care facility or other long term care facility.
 - No material misrepresentation or material misstatement was made in the application.

80. What kind of mental illness will disqualify an applicant for the CIA?

Any chronic or recurring condition such as depression, manic depression (bi-polar disorder), or schizophrenia would very likely make the applicant INELIGIBLE for insurance coverage. Conditions such as "situational depression", anxiety, or emotional instability may NOT typically disqualify an applicant from coverage.

81. If an applicant qualifies for the CIA, what must he/she do in order to get it?

If an applicant qualifies for the CIA based on the criteria outlined above, the applicant must:

- Submit an initial modal premium (minimum of 3 months premium) with the application (where allowed by law)
- Leave the section on the application “Request for an effective date later than the date of application” blank – DO NOT SIGN

82. Why would an applicant want the CIA?

Most applicants should want CIA because it guarantees the most complete coverage as of the earliest possible date (Application Date) while eliminating the concern of a change in health status post application.

83. If the applicant wants the CIA, but accidentally signed the opt-out or did not provide at least 3 months of premium (where allowed by law), is there any way the applicant can still get it?

No. No exceptions will be made, so please make every effort to ensure that your applicant does not sign the opt-out and provides the required amount of premium if he/she wants the CIA.

84. Are there any circumstances under which the CIA is not available?

There are a few exceptions. Specifically, the CIA does not include temporary insurance in Connecticut, Maryland and Texas. It also is not available with list billed policies.

85. In a Shared Coverage policy, can one applicant elect the CIA and the other opt-out?

No. If 2 applicants who qualify for the CIA want a Shared Coverage policy, then both must either elect CIA or opt-out. One cannot elect and get the CIA if the other does not. If only one of the two applicants qualifies and he/she wants the CIA, please submit two individual applications in order to satisfy their desires.

86. Does the CIA affect the 30-day free look period?

Absolutely not. The policyholder still has the right to review the policy and return it for a full refund within 30 days after he/she receives it.

87. Assume a husband and wife take out a Shared Coverage policy, get the CIA, and are eventually approved. After the policy is issued they exercise their 30-day free look period and decide to return the policy. Is their money refunded to them in full?

Yes, they would receive a full refund.

88. Will Policyholders still have the right to increase benefits without underwriting up to 60 days after the policy is issued?

Only Policyholders who have not had a significant health change since they submitted the application will have a 60-day window to make changes without going through underwriting. Those Policyholders who have had a significant health change after signing the application will not be allowed to increase their policy coverage.

89. Does our competition offer the CIA?

Nearly all of our competitors offer some kind of conditional receipt. However, most of them do not combine it with a temporary limited benefit insurance feature like ours, so that differentiates our CIA from most of the competition.

90. ***Assume an agent takes an application for someone who is age 73 who wants the CIA. Two days after the application is submitted, the client has a stroke and is unable to complete any health interview the company would normally require. What is done then?***
 As part of our normal underwriting process, our underwriters use the results of a health interview to aid in the assessment of the applicant's health status as of the application date. However, in scenarios where the health interview cannot be performed, each case will be judged based on its particular facts and circumstances, and a decision will be made based on the best information available to our underwriting staff. The stroke would not be considered in our underwriting decision. In any event, the applicant would have the CIA's limited benefits available.
91. ***Does the CIA require additional premium?***
 No, the CIA does not require any additional premium. However, in order to be eligible for the CIA, the applicant must submit the initial modal premium with the application (3 month minimum) and meet the eligibility requirements for the CIA (as described above).
92. ***With Shared Coverage, does each applicant have a maximum benefit limit of \$10,000 under the CIA?***
 Yes, assuming each satisfies the eligibility requirements and conditions of the CIA.
93. ***If CIA is selected at the time of application and sufficient premium is submitted, can the effective date ever be changed to a more current date?***
 No, the effective date cannot be changed. CIA policies are underwritten based on the medical history prior to the date of application. As such, any incident that occurs after the application date, that may otherwise have disqualified them for coverage, is not included in the review of medical history. In addition, they would have been covered from the application date had they needed to file a claim and, as such, are required to pay premium for that period of time.
94. ***If a couple applies for two individual policies and both select CIA and submit the required premium, but one does not get issued as a CIA due to a keying error, what is the effective date of the policy?***
 We must honor the policyholder's request/intent based on their application to receive CIA and we must correct the effective date to be the same as the application date. Had they filed a claim we would have been required to honor it.
95. ***If a couple did not sign the opt-out for CIA on their application but also did not submit the required premium, can we go back and give them CIA after issue?***
 No. Because they did not submit the required premium, they did not meet the CIA requirements. There can be no exceptions to this requirement.

PART VI – SUITABILITY OF PURCHASE

96. ***What are the Suitability of Purchase requirements?***
 In the sale of Long Term Care Insurance policies agents are required to determine whether the purchase is appropriate for the needs of the applicant.
97. ***What factors go into making that determination?***
- The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.
 - The applicant's goals or needs with respect to long term care and the advantages and disadvantages of insurance to meet those goals or needs.
 - The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.
 - The values, benefits and costs of Privileged Choice and Classic Select when assessed against the applicants goals or needs.
98. ***Are there any guidelines?***
 In general, a sale is NOT suitable if:
- The applicant has less than \$10,000 in annual income, or less than \$20,000 in assets to protect, unless premium is being paid by a family member or other outside source
 - The applicant is eligible or about to become eligible for Medicaid.
 - The applicant's only source of income is Social Security or supplemental security income.
 - The applicant otherwise has limited assets and can't afford to pay the premium over the life of the policy.
 - The Applicant purchases the Classic Select policy with 2 or more riders (while this may be appropriate, agents should generally consider the Privileged Choice policy.)

PART VII – ADMINISTRATIVE QUESTIONS

This information covers procedures currently in place. These procedures are subject to change.

99. ***Will there be a new Policy Prefix for these contracts?***
 Yes, the prefix will be AAA.

Application Processing for Couples

100. Will the processing of spousal applications differ from the way they are being handled to date?

No. All couples that apply together will still be processed together. We will hold each applicant's file until there is a final underwriting decision on BOTH files, and then they will both be processed and issued together with the same effective date; one issued and the other declined; or both declined.

101. If a couple applies for individual policies at the same time will both policies be mailed together?

Yes. Both individual policies will be mailed together in the same policy envelope. If the couple applied for *Shared Coverage*, then only one policy is mailed.

Conversions From Existing Plans

102. What are the rules for converting from existing coverage?

You must submit a new application for a replacement policy. Because of the many differences in plan design and product features, like-for-like exchanges are not practical. This would also apply for applications that are in process.

PART VIII – COMMISSION QUESTIONS

Replacements

103. How will I be able to identify a replacement policy on my commission statement?

By an identifier "letter" placed after the policy number. This identifies that the policy has been replaced or is the replacing policy and therefore commission protection rules will apply.

104. What is the impact to my commissions when I replace an old GE policy with one of these new products?

There is no change in the way we pay commissions:

- We pay first year commissions on any increase in premiums.
- We will continue to protect commissions of the original agent on that plan and his or her hierarchy.
- We will pay renewal commissions on any other premiums.

NOTE: There will be instances where a conversion replacement may result in a lower premium and therefore affect commissions. See the Sales Compensation Plan of your agent contract for full details.

Some states allow renewal commissions only for replacements (regardless of conversion time) even on first year premiums.

PART IX – CHOICE II ENHANCEMENTS

20% Preferred Health Discount

105. Why did you make this change to the Preferred Health Discount?

We now believe that individual applicants being approved with a Preferred Health Discount have a risk profile that closely approximates that of a person with a companion in the home to provide a support system.

106. How does this apply to people who are currently insured?

The new discount is applicable to business with an application date of April 26, 2004 and later in states that approve the enhancements prior to that date. (States that approve the discount at a later date will have separate effective dates which will be communicated at the time the new features are launched). Any existing applicants or policyholders wishing to apply for the new discount must submit a new application and go through underwriting at their attained age.

107. How does this apply to pending applications or recently issued policies?

We cannot offer the new Preferred Health Discount prior to receiving a state's approval, and will not offer it on applications dated prior to April 26, 2004. Any existing policyholders or pending applicants wishing to apply for the new discount must submit a new application and go through underwriting at their attained age. There can be no exceptions made. Representatives should carefully consider whether submitting a new application provides additional benefit to the applicant.

108. What if a couple applies together, but one of them turns out to be an invalid applicant? What premium/discount would apply to the remaining partner?

In the event that one member of a couple applying together is not a valid applicant (that is, they could not truthfully answer the knock-out questions with a "no" answer), then the remaining applicant will be treated as an individual applicant. This applicant will not be eligible for a Couples Discount, but may be able to qualify for a 20% Preferred Health Discount.

109. *What if only one member of an applying couple qualifies for preferred health status?*

A couple applying together is eligible for a Couples Discount: 40% to each of them if they are both issued a policy; 25% to one of them if only one is issued a policy. Our Preferred Health Discount is 10% when combined with a Couples Discount and 20% when not combined with the Couples Discount. So, in the event that any member of a couple qualifies for Preferred Health Status, that individual would receive a 10% Preferred Health Discount.

- If both are issued an Individual policy: The Preferred health-qualified Insured would receive a total cumulative discount of 50%, and the other Insured would receive the 40% Couples Discount.
- If both are issued a Shared policy: A 40% Couples Discount is built-in to the rates for Shared policies. In addition, the person who qualifies for Preferred Health status receives an additional 10% Preferred Health Discount
- If one is issued with Preferred Health status and one is declined: The person who is issued a policy would receive a cumulative total discount of 35%.

110. *If an individual applies for Classic Select or Privileged Choice and receives the 20% Preferred Health Discount, and then his or her spouse applies and is approved for coverage within 12 months of the effective date of the first policy, what discounts will apply to each of them?*

The first applicant was eligible for the 20% Preferred Health Discount. When the spouse subsequently applies and is issued a policy, they are now both eligible for a Couples Discount. Because the Preferred Health Discount is limited when combined with a Couples Discount, the first policyholder will only receive an additional 30% discount, bringing it to a combined total discount of 50%. The second applicant will receive a 40% Couples Discount and a 10% Preferred Health Discount (if qualified), up to a combined total discount of 50%.

365-Day Elimination Period

111. *How much lower is the premium for the 365-Day Elimination period on Classic Select?*

Premiums are 30% less than those for the 90-Day Elimination Period.

112. *Why can't I buy the Waiver of Home Health Care Elimination Period rider with the 365-Day Elimination Period on Classic Select?*

The intent of the 365-Day Elimination Period is to provide a substantial reduction in premium, by requiring the policyholder to cover the first 365 Service Days (Days of Covered Care). Adding the Waiver of Home Health Care Elimination Period rider is counter to that philosophy and would not result in a meaningful premium reduction.

113. *Does the purchase of the 365-Day Elimination Period mean that my client will pay for their first year of care?*

Elimination Periods apply to Service Days, which are "Days of Covered Care." The purchase of a 365-Day Elimination Period is an agreement by the Policyholder to pay for the first 365 Days of Covered Care.

Example: If Mr. Smith has a stroke, triggers 2 or more ADLs and goes into a Covered Facility, then each day of that confinement will count against the Elimination Period and be considered a service day, and he will be benefit eligible 1 year after his admittance, provided that he is in the facility each and every day. In other words, Mr. Smith must pay for his own care in the facility for one full year before his policy will begin to reimburse for services.

In the same situation, if Mr. Smith receives care at home 4 days per week, he will not be benefit eligible until at least 91.25 weeks (365 days ÷ 4 days per week = 91.25 weeks) after his first covered expense. In this case, Mr. Smith must pay for his own care for 91.25 weeks before his policy will begin to reimburse for services.

114. *Will there be any benefits available to my client during the 365-Day Elimination Period?*

Yes. The Elimination Period specifically applies to home and facility care benefits. So, Privileged Care Coordination, Respite Care, Caregiver Training and the Equipment Benefit may be available during the Elimination Period. Because the Alternate Plan of Care is intended to be an alternative to benefits otherwise payable by the policy, it is not available during the Elimination Period, nor is Waiver of Premium. A Plan of Care is still required for access to any benefits.