

Frequently Asked Questions About Long-Term Care LTC04I

Underwriting

1. **Question:** If the applicant's state of residence is different from the state in which the application is written, do producers need to be licensed in the state of residence for applicant?

Answer: No. The producer must be licensed in the state where the application is written but is not required to have a license in the applicant's residence state. The point of sale materials, including the application, must be approved for the insured's residence state.

2. **Question:** For employer paid and employee paid business, should the producer collect money with application?

Answer: No. PRD applications and Employer list billed applications are submitted without premium (NCWA).

3. **Question:** Is there a stipulated waiting period after an application is declined before the applicant can reapply?

Answer: Refer to the underwriting guide for specific conditions and waiting periods. The application also contains timeframes for waiting after prior care, denial, etc.

4. **Question:** Will we offer a spouse discount on a delayed second application?

Answer: Both applicants must apply at the same time in order to receive the 30 percent discount. If one policy is already in-force without a discount and the other spouse's application comes in later, both receive a 15 percent discount.

5. **Question:** Where do I overnight applications?

Answer: Use for the address below for overnights:

Long-Term Care Service Office
7805 Hudson Rd
Suite 180
Woodbury MN 55125

6. **Question:** Is the 30-day look back provision to save age automatic? Do we back date the application and charge the extra (up to 30 days) premium?

Answer: Yes, the save age feature is automatic. No, we do not back date the coverage effective date and charge extra premium.

7. **Question:** Can the home health care benefit period or daily benefit amount exceed the confined care/assisted living benefit period or daily benefit amount on the LTC II plan issued with two separate maximum benefit amounts?

Answer: No, the home health care benefit period or daily benefit amount must be equal to or less than those amounts chosen for the confined care/assisted living facility. Also, the home health care daily benefit amount cannot be less than fifty percent of the nursing home daily benefit amount. However, the elimination period for the home health care benefits can be lower than that chosen for confined care/assisted living facility benefits.

8. **Question:** Can the 30% spousal discount be applied if one spouse purchases the LTCI and the other purchases the LTCII?

Answer: Yes, we will honor the discount when the two plans are "mixed" as long as they are applied for and issued together and properly cross-referenced.

9. **Question:** Is the Enrollment Form (by Employee) – M24625 required for payroll deduction?

Answer: No, The Enrollment Form M24625 is no longer required.

10. **Question:** Is height and weight a required field on the new LTC proposal software?

Answer: No. The prompt on the proposal screen to enter height and weight is a new feature added to assist you in determining eligibility for coverage. If you choose not to complete this information, leave the height and weight information at the default settings (which is Standard height and weight) so that the system will not generate a warning message.

11. **Question:** If both spouses are issued long-term care coverage, can the Spouse Benefit be added to their policies?

Answer: No, the Spouse Benefit is not available if both spouses apply for and are issued coverage.

12. **Question:** Under the 30-day look back to save age, does the proposal software automatically look back and calculate rates based on the younger age?

Answer: No. The proposal software does not automatically check back 30 days for a birthday. Therefore, the producer needs to enter the younger age if a birthday took place within 30 days of the application date. To "save age", if the applicant's date of birth is within 30 days of the application date, rates will be based on the younger age, as long as the application is received within 30 days of the application date.

13. **Question:** When is LTC Employer Questionnaire (Form MC31959) required?

Answer: If a new employer group, the employer must complete the LTC New Employer Questionnaire and submit it, with three applications, in the special envelope provided by the Home Office to the Long-Term Care Service Office so the group is set up correctly and receives the appropriate discounts.

14. **Question:** Can the unlimited benefit period be offered to insureds that are rated Class I or Class II?

Answer: No. The unlimited benefit period is not available to Class I and Class II risks, and the elimination period must be at least 90 days.

15. **Question:** When the Agreements section of the long-term care application is completed, under what circumstance does the applicant need to initial the rejection of Compound Inflation Protection option?

Answer: If the applicant declines to accept the 5% Compound **Lifetime** Inflation Protection option, then the applicant must initial the statement, "I reject the 5% Compound Inflation Protection option". Even when the **Twenty Year** 5% Compound Inflation Option is selected, this section must still be initialed.

16. **Question:** Should the producer show a preferred rate on the application if the applicant meets the criteria found in the Underwriting Guide?

Answer: No. The underwriter will obtain the necessary information to determine if the applicant meets the preferred criteria. Some of this information will be obtained through the telephone or face-to-face interview. Once the underwriting determines the applicant qualifies, the premium will be reduced by 15 percent.

17. **Question:** If an owner of a C Corporation and spouse apply for long-term care through their business, do they receive the 10 percent employer paid premium discount?

Answer: No. A three-application minimum is required to qualify for the 10 percent employer sponsored discount. If less than three applications are involved, submit the applications as normal individual coverage to be handled in the usual manner.

18. **Question:** In order to qualify for the Spouse Benefit, must the spouse have applied for and been declined coverage of his/her own?

Answer: No. The spouse does not have to be uninsurable to qualify for the spouse benefit. The spouse benefit can be added to the other spouse's application without having to meet any special criteria. No underwriting is involved. In some cases, for example, the spouse may decide not to apply for his/her own coverage and choose to have a Spouse Benefit instead.

Product

1. **Question:** What is the policy maximum benefit limit for Home Modification benefits approved by the Care Coordinator?

Answer: The lifetime maximum benefit amount for Home Modifications is 60 times the home health care daily benefit amount.

2. **Question:** Does any special maximum apply to the Informal Caregiver Benefit?

Answer: The Informal Caregiver Benefit is paid at a rate of 25 percent of the home health care maximum daily benefit amount for each day care is provided. A few states, such as Missouri, have a state special 365-day benefit period limit.

3. **Question:** Under the International Travel Benefit, must an applicant meet the elimination period and 90-day certification requirement on a tax-qualified plan to receive this benefit?

Answer: Yes. The elimination period and the 90-day certification for tax-qualified coverage apply to the International Travel Benefit.

4. **Question:** Under Alternate Plan of Care, Durable Medical Equipment and Home Modification features, do the benefits paid come out of the maximum lifetime benefit amount?

Answer: Yes, the benefits paid for these features do reduce the maximum lifetime benefit.

5. **Question:** Can the Return of Premium at Death option be sold on both TQ and NTQ policies under LTCII?

Answer: Yes, in states where this benefit is approved, it can be added to TQ and NTQ policies.

6. **Question:** When the Return of Premium at Death benefit is added to a policy where the premiums are being paid as part of an executive carve out plan by the employer, who receives the refund at death of the employee?

Answer: The policyowner in this situation is the employee. Coverage is completely portable. The employer pays the premium but has no rights under the policy. The employee designates the beneficiary and the refund goes to the employee's beneficiary at time of death.

7. **Question:** When does the Spouse Benefit terminate?

Answer: The Spouse Benefit terminates upon death of the spouse or divorce.

8. **Question:** To be eligible for restoration of benefits, must the insured be fully recovered and in good health?

Answer: Our policy requires the insured to: 1) perform all activities of daily living; 2) not require substantial supervision due to a cognitive impairment, and; 3) not require or have been advised to receive covered services and not receive services that would have otherwise been covered. Our restoration of benefits provision does not require the insured to be fully recovered and in good health - this is a competitive advantage.

9. **Question:** Does the new LTCI and LTCII product pay benefits when Medicare pays?

Answer: The only time this policy will pay benefits in addition to Medicare is when the Nursing Home/Assisted Living Facility Indemnity Option is selected. The Indemnity option states: "Benefits under this provision will be paid whether or not payments are made for the same day(s) by Medicare . . ." If the policy is paying benefits on a reimbursement basis, benefits are not payable if services are covered by Medicare.

10. **Question:** If an employer purchases a long-term care plan with return of premium at death benefits for a key employee, is the refund taxable at time of death of the employee?

Answer: Return of premium benefits are includible in income to the extent that the employer took a deduction or exclusion for the payment of the premium.

11. **Question:** Does the informal caregiver need to be registered with a home health agency in order for the policy to pay benefits?

Answer: No. The policy states, "If you meet the Eligibility for the Payment of Benefits requirements and Informal Caregiver Benefits for Homemaker Services Benefits are recommended by the Care Coordinator in a written Plan of Care, we will pay a daily benefit for care you receive from an informal Caregiver who does not normally reside with you and who is providing you with Maintenance or Personal Care Services." The daily benefit is equal to 25 percent of the Home Health Care Maximum Daily Benefit.

12. **Question:** Must a certified home health aide be employed by a licensed home health care agency in order for the policy to pay benefits for this service?

Answer: No. The home health aide can be an independent provider not affiliated with a home health care agency. The independent provider must be licensed or certified in the state where the care will be provided; if licensing or certification is required for the services provided. If the state does not require licensing or certification, approval of benefits would be based on our determination that the individual has the proper training and experience. The education of the home health aide must include training in safely assisting persons with activities of daily living.

13. **Question:** Do the policy provisions regarding expenses incurred utilize Reasonable and Customary language?

Answer: No. Although our normal course of business involves detection of abuse or evaluation of excessive charges, the policy does not include any Reasonable and Customary language.

14. **Question:** If the Home Health Care Waiver of Elimination Period is added to the one maximum benefit plan, do the days when benefits are payable for home health care count toward the elimination period for confined care?

Answer: Under the Home Health Care Waiver of Elimination Period, Home Health Care benefit days do not count toward the elimination period for confined care (except where required by state regulations, such as in Connecticut).

15. **Question:** How is the home health care elimination period satisfied?

Answer: Each day on which the insured remains chronically ill, or meets the Qualifying for Benefits criteria and incurs Covered Expenses, or receives Covered Services will count toward the Elimination Period.

16. **Question:** Do we offer a nursing home only policy?

Answer: No. We offered nursing home only until February of 2003 – the product was withdrawn at that time because claims experience is not as favorable under nursing home only coverage compared to comprehensive coverage. If we were to market this type of plan, the rates would need to be adjusted for anti-selection - the increase in rates would make the premium comparable to a comprehensive plan, which includes some home health care benefits - making nursing home only unattractive.

Therefore, we do not have plans to offer stand alone nursing home coverage. The new one pool of dollars product can be used for all types of LTC services - benefits come out of one bucket of money. This money can also be used entirely for nursing home only - the plan is very flexible as far as type of services that are covered.

Claims

1. **Question:** Can limited payment policies be placed on waiver of premium status when the insured goes on claim? If the limited pay premiums have not been completed, do waived premiums count toward completing the limited pay period?

Answer: Yes. If the insured goes on claim while paying premiums, the premiums are waived once the elimination period has ended. The time during which premiums are waived count toward the limited pay period. For example, under a 10-year limited pay policy, if the insured goes on claim during year five and remains on waiver of premium for five years, once the waiver period ends, no further premium is due.

2. **Question:** If you are on Claim and your benefits are being waived, is the Guaranteed Purchase Option still being offered to you?

Answer: No, if you are receiving benefits, the Guaranteed Purchase Option offer will not be made available to you. This is different handling than our current LTA and NHA plan.

3. **Question:** Are expenses incurred to utilize the Patient Advocacy benefit, and does this benefit reduce the policy's lifetime maximum benefit amount?

Answer: No. Patient Advocacy is a part of the care coordination provision and does not result in any expense to the insured nor does it reduced the policy lifetime maximum.

4. **Question:** Does the nursing home ambulance benefit only apply if the insured is already on claim and receiving benefits?

Answer: Yes. The insured must already be on claim and receiving covered services in order to be eligible for the nursing home ambulance benefit.

5. **Question:** Does the elimination period apply to Durable Medical Equipment, Medical Alert System, Home Modifications and Caregiver Training?

Answer: No. The elimination period does not apply to these benefits.

6. **Question:** In order to receive benefits, can a home health aide be a family member?

Answer: The policy will not pay for a family member to provide Care as an Independent Provider or to provide Nursing Services. It would allow a family member to be the Home Health Aide as long as he or she is a regular employee of an organization that is providing the treatment, service or care and the organization receives payment for the treatment, service or care and he or she receives no compensation other than the normal compensation for employees in his or her job category. Homemaker Services that are recommended by the Care Coordinator in a written plan of care can be provided by a family member that does not normally reside in the home.

7. **Question:** Can the person providing homemaker type services under the informal caregiver provision reside with the insured?

Answer: No. In order for the informal caregiver to be eligible to provide covered services, this person cannot be residing with the insured when the need arises for care. This person can move in with the insured once insured meets the eligibility for benefits criteria.

8. **Question:** If an insured is on claim, can this person switch from non-tax qualified coverage to tax-qualified coverage?

Answer: Yes. The insured can switch to tax qualified coverage while on claim. New rates will be based on the original issue age. Keep in mind that:

- If the insured is on waiver of premium, waiver would continue after the switch as long as the insured remains benefit eligible.

- If the claim is a result of the medical necessity trigger, this trigger does not apply to tax-qualified coverage and could jeopardize the claim.

9. **Question:** If a client takes an ambulance to the hospital, stays a few days and comes back via ambulance, is that considered one or two trips?

Answer: A trip from the nursing home to the hospital and back is considered one round-trip, so the round-trip maximum (2 x Nursing Home daily benefit) applies. The annual maximum is 4 x Nursing Home daily benefit and so the insured is entitled to two round-trips per year.

10. **Question:** Can there be more than one modification to the home, so long as the first one didn't exceed 60x the daily benefit?

Answer: Yes, there can be more than one home modification as long as the total amount of expense (lifetime) doesn't exceed 60 x the home health care daily benefit amount. A written plan of care and care coordination is necessary.

11. **Question:** When an insured is receiving benefits for adult day care, what criteria must be met to qualify for waiver of premium?

Answer: Adult day care services qualify for waiver of premium. An eight service day minimum per month is required to be eligible for and remain on waiver of premium.

12. **Question:** Can a child who currently does not live in the house come home and move in with the parent to be the caregiver under the informal caregiver benefit?

Answer: Yes. If the child does not currently live with the insured but wants to provide care under the informal caregiver benefit, then that person can move in with the insured to provide the care. Please note: The eligibility for payment of benefits provision must be met and a Care Coordinator must recommend an informal caregiver in a written plan of care.

Administration

1. **Question:** If the simple or compound inflation protection benefit is dropped post issue, what happens to the policy maximum benefit?

Answer: If the inflation benefit is dropped post issue, the maximum daily benefit and the policy maximum lifetime benefit amounts remain at the current level and the premium is changed to the appropriate amount based on the original issue age of the insured.

2. **Question:** When an employee receives the Employee Paid (PRD) 10 percent discount and the employee is no longer with the employer, is the discount taken away?

Answer: No. The discount is never removed. This applies to employer paid and association marketing discounts as well.

3. **Question:** If the spouse survivorship benefit is exercised and the policy is placed on paid-up status, do Guaranteed Purchase Option offers continue?

Answer: Yes, The GPO option states, "If You have the Spouse Waiver of Premium and Survivorship Benefit, and premiums are being waived due to the Survivorship Benefit, **you still must pay an additional premium for the additional increases under this Guaranteed Purchase Option.** Premiums for the additional increases will be based on the current premium rate table in effect and your attained age on the date of the purchase."

4. **Question:** When the waiver of premium is applied to a policy, is any unearned premium returned to the insured?

Answer: HIPAA regulations will not allow the return of unearned premium. Therefore, unearned premium is used to advance the policy paid to date when the insured goes off of waiver of premium.

September 20, 2004