Section I
Long-term care insurance

What is long-term care?

The term long-term care describes a wide range of services intended to provide for the health, personal care and social needs of chronically ill. Long-term care may become necessary as a result of prolonged illness, injury leading to disability or aging.

1. Long-term care can range from simple help with daily activities at home (e.g., bathing and dressing) to highly skilled nursing care. It can be provided in a variety of settings.

2. We usually think of long-term care as being in a nursing home—and nursing home care is a significant part of long-term care. Besides a nursing home, long-term care may be provided in:

- Assisted living facilities
- Basic care facilities
- Home health care
- Home and community based services
- Adult day care
- Adult family homes
- Programs for all inclusive care for the elderly (PACE)
- Personal care

Who will need long-term care?

Not all individuals will need long-term care.

1. There are a number of factors that are likely to influence whether or not an individual will need nursing home care.

A. **Women** are more likely to need nursing home care. Women live longer, making them more likely to develop chronic health problems and more likely to live alone.

B. Elderly **widows and widowers** are five times more likely to enter a nursing home than their married counterparts.

C. Family and individual **health history** plays an important role in determining future risk of needing long-term care.

1. **Circulatory disease** is the primary diagnosis at admission.
2. Many nursing home residents have some level of **cognitive impairment** or senility.

2. Traditionally, long-term care has been provided informally by spouses, family, friends and neighbors. Reliance on family for long-term care is becoming more difficult because:

A. Women have traditionally provided most of the informal long-term care for family members and an increasing number of women now work outside the home.

B. Families are more geographically scattered and family size is smaller.

C. Spouses and children of persons needing long-term care (age 85+) are themselves older and less able to provide care and support.

3. The need for long-term care will grow in the years ahead because people are living longer. Interestingly, the older you are, the longer your life expectancy.

4. **Most nursing home stays are short, e.g., recuperation from an acute condition (heart attack or broken hip) before returning home.** These shorter stays have been encouraged by the way Medicare pays for hospital care. (Remember, Medicare pays hospitals a flat rate for a particular condition, regardless of how long the patient is in the hospital. This encourages hospitals to discharge patients as early as possible, often to nursing homes.)

A. National statistics indicate that the risk for needing nursing home care is 43 percent. (*Long-Term Care Insurance, Baby Boom or Bust?* Conning & Co., 1999. B.C. Spillman and J. Lubitz, 2002.
B. The average length of stay in a nursing home in North Dakota is one year.
C. The number of persons with more than one nursing home stay is significant. **Nearly half of all persons discharged from a nursing home will re-enter at some point in their life.**

Cost and financing of long-term care

Not many older adults can afford long-term care costs for very long.

1. The average cost of a year in a nursing home in North Dakota is about $5,948 per month or $195.55 per day in 2010. (Daily rates may vary depending on level of care required.)

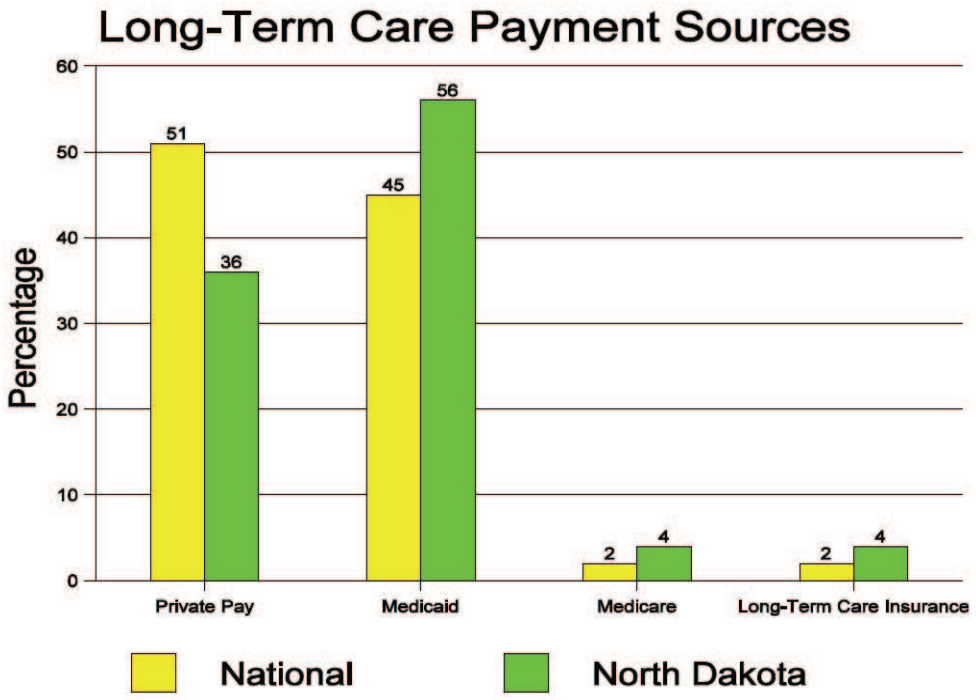
2. Medical inflation is generally double compared to regular inflation and has averaged eight percent over the last five years. At that rate, a nursing home costing $130 per day today would cost $606 per day in 20 years.

3. Medicare pays four percent of nursing home bills in North Dakota.

4. Medicare supplement insurance and employer health insurance seldom pay anything toward nursing home care, unless it is a Medicare-approved stay in a skilled nursing facility (again, this coverage is very limited).

5. Private long-term care (nursing home) insurance paid less than two percent of nursing home expenses nationally in 1987. In North Dakota, as of 1995, about four percent of nursing home expenses were paid by long-term care insurance.

The chart on the next page illustrates the sources of payment for long-term care nationally and in North Dakota.



Medicare and long-term care

Many people mistakenly believe that Medicare covers long-term care. Actually, Medicare pays only a very small percentage of all nursing home costs. **Medicare is not designed to cover the bulk of long-term care expenses.**

1. Medicare pays **only for skilled nursing care following an approved hospital stay** provided the patient meets other stringent criteria. Medicare does not pay for basic or custodial care which is what most people entering a nursing home need.

2. Even if the patient qualifies, Medicare Part A pays only 20 days in full and 80 more days partially (2010—$137.50/day).

3. **Medicare should be considered as little or no help for long-term care needs.**

Medicaid

Medicaid is the government program which pays the bulk of nursing home costs and some home and community-based services. It is the federal/state/local medical assistance program designed to financially subsidize individuals who cannot afford the cost of the nursing home.

Individuals must meet certain medical and financial criteria to qualify. Eligibility requirements vary from state to state. For case specific information, contact the nearest Social Services office.

Private long-term care insurance

Private long-term care insurance is designed specifically to cover nursing home care and other long-term care services; however, most do not pay these costs in full. Long-term care insurance policies have evolved considerably over the last 10 years. **There is no standardization and policies vary widely. There is no open enrollment or other guarantee of coverage.**

Long-term care insurance is generally defined as any policy or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred or indemnity basis, provided in a setting other than an acute care unit of a hospital.

A. **Life insurance policies which accelerate the death benefit specifically for one or more qualifying events are not considered long-term care insurance policies**. Terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement are common qualifying events. The policy provisions usually provide the option of a lump-sum payment for those benefits and neither the benefits or the eligibility for the benefits is conditioned upon the receipt of long-term care.

B. Long-term care insurance is meant to provide coverage for the most catastrophic expense. In long term care, this expense is **room and board and nursing care in nursing homes**. This insurance may not cover all of an individual's long-term care expenses, such as doctor visits, therapy, personal care supplies and prescriptions. (Some of these, e.g., doctor visits and therapy, may be covered by Medicare.)

C. Types of long-term care insurance policies sold are **nursing home care only, home health care and community-based care only, or a combination of both**. (Community-based care includes adult day care, respite care, etc.)

Who should buy long-term care insurance?

Many people will need some type of long-term care service in their lifetime. However, not everyone should purchase long-term care insurance.

1. Anyone considering the purchase of long-term care insurance should ask themselves a number of questions and evaluate their specific circumstances carefully before making a decision.

2. People asking the question, "Do I need a long-term care insurance policy?" must evaluate their financial, emotional and lifestyle preferences and needs. The following issues/areas should be considered:

• Consider a plan if, by about age 55, you have a chronic medical condition that you and your doctor believe eventually could require nursing home care.

• Consider a plan if your assets are between $200,000 and $1.5 million, and you must protect them for a spouse or relatives. It is important to establish the importance of buying a plan if your net worth is less than $200,000.

Medicaid may pick up the bills after you exhaust your funds and decrease your assets. Spouses may be allowed to keep some assets and their own income up to specified limit, and may also remain in the family home.

• Skip buying a plan if you cannot afford the premiums for the necessary coverage. Remember, premiums may increase.

• Look for a strong insurer from which to buy a policy. Check online ratings from www.moodys.com, www.standardandpoors.com or www.weissratings.com.

• Buy a flexible plan. Choose a policy requiring that a person be unable to perform no more than two activities of daily living (ADLs).

• A good policy will cover care not only in nursing homes but also in assisted living facilities.

• Make sure the policy will cover future costs; call several nursing homes in the area where you are likely to be living and make sure that the benefit amount will cover their charges.

North Dakota laws and rules

North Dakota statutes and regulations include some consumer protections for purchasers of long-term care policies.

1. **Prior hospitalization** as a condition of eligibility for benefits is prohibited for policies issued after July 1, 1990.

2. Policies sold today cannot require higher levels of care before they pay at lower levels. Example: If a policy states it will pay for **both** skilled care and intermediate care, it **cannot** require the policyholder to receive skilled care **before** paying for intermediate care. Some older policies may still require a higher level of care before they pay at lower levels. **This does not mean every policy covers every level of care.**

3. **Six months is the maximum** allowed for a waiting period on pre-existing conditions. Preexisting conditions are those for which you have sought or received medical advice or treatment within the last six months.

4. Long-term care insurance policies must be at least **guaranteed renewable**. This means they cannot be cancelled unless the premium is not paid.

5. Long-term care insurance **premiums are level**. This means the premium cannot increase as one's age increases. However, if a company can demonstrate their need for additional premium dollars to cover claims being paid, North Dakota law requires that an increase be approved. Such an increase would apply to everyone with the same policy form number.

6. The **option** to purchase an **inflation protection feature** must be offered to each applicant at the time of purchase. Inflation protection provides an automatic benefit increase each year (generally five percent a year for the first 10 years) in order to protect against the rising costs of long-term care insurance.

7. Coverage for **Alzheimer's disease** and other conditions of organic origin **may not be excluded** by a long-term care insurance policy.

8. Beginning July 1, 1994, prospective purchasers of long-term care insurance must receive a CMS **Long-Term Care Insurance Shopper's Guide** prior to presentation of an application or enrollment form if agent solicited or in connection with the application or enrollment form if direct response. **Notice of the availability of the SHIC program is also required to be provided.**

9. The policyholder has a **30-day free-look period**. Within 30 days of its delivery or the effective date of the policy, whichever is later, the policy may be returned for a full premium refund if the buyer is not satisfied for any reason.

10. Group long-term care policies must include a provision to provide covered individuals with an option to continue or convert their coverage when coverage under the group policy is about to terminate. This option is available to those who have been insured under the group policy for a minimum of six months. The individual does not have to prove insurability for the new coverage.

11. When dealing with clients 65 or older, agents are required to have reasonable grounds at the time of sale for believing that the recommendation is suitable for the consumer and shall make reasonable inquiries to determine suitability. Considerations include:

A. Income and assets
B. Client's need for insurance
C. Current insurance vs. suggested insurance

12. To protect older policyholders from unintentional lapse, companies must offer clients the opportunity to designate a third party to whom notice will be sent 30 days after a premium is due and unpaid. If a person chooses not to designate a third party, they must sign a waiver.

A. If the insurer is provided with proof of cognitive impairment or loss of functional capacity and if a request is made within five months after termination of the policy and if past due premiums are paid, the policy may be reinstated.

Consumer choices in long-term care products

Long-term care products are not standardized like Medicare supplement plans. Therefore, consumers have many choices to make and each will affect the price of the product. This section provides an overview of long-term care policy features.

1. Long-term Care Partnership—offers Medicaid asset protection to consumers who buy long term care insurance policies,

2. **Indemnity v. expense policies**

A. Long-term care insurance is usually the **indemnity** type, meaning that it pays a fixed amount for each day care is received. Example: An $80/day benefit means the policy would pay $80 each day of care, regardless of the actual cost of care.
B. An **expense** policy pays the actual daily charge up to a maximum daily benefit. Example: An $80/day benefit means the policy will pay the actual charge up to a maximum of $80/day. If the actual charge is $75/day, the policy pays $75/day. If the actual charge is $90/day, the policy pays $80/day.
C. Daily benefits vary. The higher the daily benefit, the more costly the premium.

3. **Benefit period and maximum benefits**
   A. The person purchasing the policy chooses the term or duration of coverage. Most plans are purchased for a specific period of time, for example, one, three or five years. **The longer the benefit period, the more costly the premium.**
   B. Some policies may provide for more than one benefit period. A benefit period is generally defined as the time for which payments for benefits of an insurance policy are available. In long-term care policies, if a benefit period limits the number of **consecutive** days for which coverage is paid, the insured could exhaust his/her benefits before reaching the policy's maximum benefit.
   C. Some policies define maximum benefits in terms of time, usually a set number of days.
   D. Some policies define maximum benefits in dollars. This means benefits will be paid up to a maximum dollar amount for services covered.

4. **Elimination period**
   A. This term applies to the number of days the individual must be in a nursing home before the long-term care insurance product will begin paying its benefits. T**he elimination period is the same as a deductible and must be met before the plan will pay.**
   B. Most plans offer a choice of elimination or waiting periods. A common choice is 90 days. **The shorter the elimination period, the higher the cost of the premium.**
   C. If an individual requires more than one stay in a nursing home, some policies may waive additional elimination periods after the individual has met the initial one.

Read the policy!

5. **Inflation adjustment**
   A. Due to inflation, a policy that pays $50 per day will not be worth $50 per day in 10 years. In North Dakota, companies offering long-term care insurance are required to offer an **inflation protection option.** Inflation protection provides an automatic benefit increase each year (generally five percent a year for the first 10 years) in order to protect against the rising costs of long-term care.
   B. Other companies may offer the policyholder the right to purchase more daily benefits in later years without regard to changes in the health of the individual.
   C. Inflation adjustments can be helpful but will cause the premiums to be higher. Frequently, if an inflation option is not exercised the first time it is available, it will not be available again.

General notes on long-term care

There are other features and issues that should be understood when considering purchase of long-term care insurance.

1. **Underwriting and health questions**
   A. **Underwriting** is one of the ways companies try to control levels of risk. Most companies ask detailed health questions before deciding to insure the applicant. Some require a medical history or physical examination. They are especially sensitive to such risks as heart problems, leukemia, rheumatoid arthritis, Alzheimer's, Parkinson's and those people already bedridden or with mental or physical disorders. The companies would rather decline your business than assume a bad risk.

1. Applicants should make sure their health questionnaire is complete and accurate.
    - Fill it out yourself.
    - Review it thoroughly if someone else fills it out.
    - Answer all questions completely and honestly.

B. **Preexisting condition**. Health questions on the application assist companies in determining whether a person has any preexisting conditions. Policies usually will not pay benefits arising from a preexisting condition for a specified amount of time (waiting period) after the effective date of the policy. Generally, a **preexisting condition is defined as any condition for which you have sought or received medical advice or treatment within the past six months**. Six months is also the maximum a company can impose as a preexisting condition waiting period for long-term care insurance.

2. **Renewability of policy and premium**

A. All long-term care policies are **guaranteed renewable** for life. Guaranteed renewable means the insurance **company cannot cancel** the policy as long as the premium is paid on time.

3. **Waiver of premiums**

A. Most companies have a **waiver of premium** feature. After an insured enters the nursing home or facility and benefits are paid for a specified number of days, no further premiums will be due while the confinement continues. Premiums resume if the patient leaves the nursing home before policy benefits are exhausted.

B. The typical waiver of premium feature takes effect after 90 days of a covered stay. Counting for the premium waiver **usually** starts after the elimination period is completed.

4. **Services covered**

A. Long-term care policies may pay for skilled, intermediate or custodial care in a nursing home, home health care and other home and communitybased services (adult day care, respite care). **Each policy may define these terms differently.** It is important to understand these definitions because **benefits will be provided only if the care received is covered under the policy.**

B. Policies generally pay for care only in facilities or by providers that are, at a minimum, licensed by the state. **Check the definitions section of the policy to find the specific facility/provider standards required in order to receive benefits.**

C. Licensed assisted living facilities. Any facility that holds itself out as an assisted living facility must be licensed by the Department of Human Services. Licensing does not guarantee that a long term care policy will cover stays in an assisted living facility. As stated above, **benefits will be provided only if the care received meets policy requirements.**

5. **Benefit trigger/insured event**

A. A **benefit trigger** is the **event or condition that must be present for the policy to begin paying benefits.** The same benefit triggers in a policy must be met to access all of the levels of care. Terms typically used in policies to describe when benefits are triggered are:
    - Activities of daily living (ADLs)
    - Cognitive impairment
    - Medically necessary or injury or sickness

B. **Medically necessary** and **injury or sickness** are both subject to the insurance company's and the insured's doctor's interpretations. If a person needed custodial care in a nursing home due to inabilities of old age (forgetfulness, frailty, etc.), a policy using medically necessary or injury and sickness as benefit triggers might not pay benefits.

C. **Activities of daily living** (ADLs) usually include some or all of the following: bathing, dressing, feeding, transferring, mobility, toileting and/or continence.

1. This benefit trigger means the insured must need help with a certain number of ADLs before the policy begins paying benefits. Two out of five ADLs are the most common requirement.
   Example: Bathing is usually the first ADL skill an elderly person loses. A "two of five" ADL requirement without bathing may be just as restrictive as a "three of six" ADL requirement that includes bathing.
2. The policy may use words such as hands on, continual one to one, supervisory, stand by, reminding-directional, substantial help from another person, or any combination of these to define deficiencies or need of assistance. A requirement of "hands-on" assistance is more restrictive than a requirement of stand-by assistance.

D. **Cognitive impairment** relates to the mental ability to safely care for oneself. This is an important inclusion because many persons with Alzheimer's disease may need long-term care even though they may not be deficient in any ADLs. Such a person may be able to dress, feed, and bath herself without hands-on assistance, and yet not be able to care for herself safely due to wandering and forgetfulness.

E. It is also important to know who is the **certifier of the benefit trigger**. When the policyholder believes he/she needs long-term care, who should be contacted? Who will determine whether the benefit trigger has been met and whether the policy will begin paying benefits? Is it a doctor, a case worker or a representative of the company? This answer should be found in the benefits section of the policy.

6. **Typical exclusions** found in policies include:
   - Alcoholism and drug addiction
   - Preexisting conditions or diseases
   - Mental or nervous disorders, except Alzheimer's or related degenerative and dementing illnesses
   - Conditions caused by suicide, attempted suicide or intentionally self-inflicted injury
   - Services provided by a member of immediate family
   - Services already paid for by government (except Medicaid), workers compensation or motor vehicle no-fault law

7. **Cost of long-term care insurance**

A. **Two of the principal factors** companies use to determine the amount of **premium** the individual will pay are:
   - Age
   - Amount of benefits (daily and maximum)

B. The younger the individual is when the policy is purchased, the less expensive the premium.
   1. Example: A 25-year-old may buy a certain policy for $8 per month, while that same policy for a 75-year-old may cost $250-$350 per month.
   2. Premium cost is determined by age at the time the policy is issued and does not increase **due to age** as the policyholder grows older.

C. Length of the benefit payment and daily benefit amounts have a significant effect on the premium.

D. Benefits, such as home health care coverage, inflation protection and nonforfeiture benefits may also increase the premium.

E. The insurance agent can quote a price only after the applicant has selected his/her options and features.

Other potential features of long-term care plans

As long-term care policies have evolved, the options available for purchase have increased.

1. Some policies cover medications, X-rays and physical exams during a nursing home stay. Some policies cover such services as hospice, some ambulance charges, adult day care and homemaker services. Please keep in mind benefit triggers must be met to access other types of care.

2. Some policies offer **nonforfeiture benefits**. Should a person choose to cancel the coverage or if coverage lapses because s/he forgot or could not pay the premium, nonforfeiture benefits would return part of the investment in the policy.

3. Some policies offer a **paid-up premium feature**.

4. **Return of premium** is an option of some policies.

5. Some insurance companies contract for the services of a case manager to assess an individual's need for care, devise a treatment plan and monitor the care that is given.

6. **Most of the extras offered in a policy will raise the premium.**

Tax-qualified long-term care insurance policies

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a category of long-term care insurance policies called tax qualified plans. **Policies must meet certain federal standards in order to be considered tax qualified plans**.

1. Qualified plans must use specific eligibility standards.
    A. The insured must be certified by a licensed health care professional to be chronically ill and have a plan of care (must be recertified annually).

2. To be considered chronically ill, a person must meet one of two standards:
    A. S/he is expected to be unable, without substantial help from another person, to do at least two of five (or six) activities of daily living (ADLs) for at least 90 days.

NOTE: ADLs are bathing, dressing, toileting, transferring, eating and continence. States may allow companies to choose which five ADLs to include or can require companies to use all six. In **North Dakota**, companies may use five or six ADLs but bathing must be one.

    B. A person must need substantial supervision to protect their health and safety because of a cognitive impairment.

3. **Benefits received from a tax-qualified long-term care policy are generally not taxable as income.**

4. Benefits received from a policy that is not a tax-qualified long-term care policy **may** be taxable as income (Treasury Department has yet to issue regulations).

5. Individuals with tax-qualified long-term care plans may be able to deduct all or part of the premium.
    A. The long-term care premium can be added to other deductible medical expenses.
    B. These policies can be a tax deduction. A range of 25 percent of the premiums paid to a maximum of $100 can be a deduction.

Tips for buying insurance

Here are some issues people should review and consider before purchasing a long-term care insurance policy.

1. Determine the motivation and/or need for long-term care by asking certain questions.
    A. Do I have enough income to pay my own way without insurance?
    B. Is there any reason to preserve my assets for heirs or are there no heirs?
    C. Would I prefer to make a long-term care decision now rather than to leave such decisions for my family?
    D. Do I have enough income to pay a portion of the nursing home costs and then rely on a small long-term care policy for the remainder, i.e., a $50 per day policy?

2. Once the reason for long-term care insurance is ascertained, then it is important to carefully select features which are appropriate for you. Consider the following issues:
    A. Do not buy a $100 per day policy if you only need $50 per day.
    B. Remember that **long-term care costs** increase yearly and premium costs may increase as well.
    C. The premium is more reasonable if you purchase a policy at a younger age.
    D. Medical necessity may be important. Most people enter a facility at the custodial level first which is essentially nonmedical.
    E. Consider your very long-term care goals. Most people who enter a skilled facility, for instance, eventually go home.

3. Many people over 65 cannot afford long-term care insurance because of their fixed and limited incomes. If purchasing such insurance strains the budget, other options should be considered.

4. Dealings with insurance agents:
    A. Do not submit to high pressure tactics.
    B. Do not rely on the information orally submitted by the agent. Read the policy yourself.
    C. If you are dissatisfied, take advantage of the 30-day free-look period and return your policy to the company, not to the agent.
    D. Always pay by check (not cash). Make checks payable to the insurance company, not the agent.
    E. Compare several polices before buying and READ THE SMALL PRINT.
    F. Write down the agent's name, address and telephone number.
    G. Be sure the insurance company's product is approved for sale in your state and check the company rating (measure of financial stability).
    H. Inquire if any administrative action has been taken against the company.
    I. Request information on the premium history (have there been rate increases; if so, how much and how often).

Duplicate coverage and policy replacement

There is no federal or state prohibition against the purchase of more than one long term care insurance policy as there is with Medicare supplements; however, it may not be advisable to own more than one. There is an increased cost to the policyholder because each policy carries its own administrative costs. Understanding and keeping track of more than one policy may be burdensome. Before purchasing an additional policy, it may be advisable to consider increasing the coverage on the first policy.

There are situations when it is reasonable to have more than one policy. A case in point might be when an older policy has coverage limits that can be supplemented by a newer policy. An example might be if the first policy requires a three-day hospital stay, a clause no longer permitted in long term care insurance policies.

Replacing a policy, especially with a different company, brings important factors into consideration. **Under certain circumstances the new policy may place preexisting conditions clauses on some coverages for six months**. Or it may exclude coverage altogether for certain medical conditions. In addition, most premiums are based on recovering generally high initial costs of issuing a policy.

If replacement is being considered because the premium on the existing policy has become too high, the owner should ask the existing company if reductions in policy benefits would reduce the premium. This cost could then be compared to the cost of a new policy from another company.

Because of the seriousness of duplicating coverage and policy replacement, the Insurance Department places specific requirements on insurance companies and agents. Among them are questions that must be in the application designed to determine if the applicant has another long term care policy or certificate in force and/or whether it is to replace another policy or certificate currently in force. The questions include asking if the applicant is on Medicaid, the name of the insurance company/companies that issued the other policy/policies, and if the new policy will replace any other coverage. Agents must also list other health insurance policies they have sold to the applicant. If replacement is involved, the agent must furnish a notice that addresses these issues. The applicant must date and sign the notice.

Long-term care review

1. Besides a nursing home, where else may long-term care be provided? List three.

a.
b.
c.

2. Name three factors which increase the risk of needing nursing home care.

3. Why does Medicare rarely pay for nursing home care?

4. What government program covers the bulk of nursing home costs?

5. In North Dakota, a long-term care insurance policy must cover all levels of long-term care. T _____ F _____

6. Alzheimer's disease may not be excluded once the policy becomes effective. T _____ F _____

7. The longer the benefit period on a long-term care policy, the more expensive the premium. T _____ F _____

8. What is meant by inflation protection?

9. Define the following terms:

Indemnity policy

Expense policy

Elimination period

Waiver of premium

Benefit trigger

10. Name three common benefit triggers.

11. For a long-term care policy to be a "tax-qualified" plan, it must use specific federal eligibility standards.
T _____ F _____

12. Benefits received from a tax-qualified plan are generally not _____.

13. Before purchasing an additional long-term care policy, what should a beneficiary do first?

Word match

A. Cognitive impairment
B. Pre-existing condition
C. Medicaid
D. Inflation protection
E. Guaranteed renewable
F. Free look
G. Indemnity policy
H. Expense policy
I. Elimination period
J. Benefit trigger

____ A policy with a built in daily benefit increase to defray the increasing costs of LTC expenses.

____ Any condition for which you have sought or received medical advice or treatment within the last six months.

____ Works the same as a deductible as the beneficiary has to pay so many days before the plan will start to pay.

____ A health insurance policy that cannot be cancelled unless the premium is not paid.

____ A 30 day period of time where a policy can be returned for a full premium refund if the buyer is not satisfied.

____ An event or condition that must be present for the policy to begin paying benefits; an example of this is how many activities of daily living (ADL's) are affected may be a trigger.

____ A government program that pays the bulk of nursing home costs and some home and community based services.

____ A policy that pays the actual daily charge up to a maximum daily benefit.

____ Many nursing home residents have this diagnosis; the diagnosis means the beneficiary does not have the mental ability to take care of oneself.

____ A policy that pays a fixed amount for each day care is received.