SHIIP

SENIOR HEALTH INSURANCE INFORMATION PROGRAM

LONG-TERM CARE INSURANCE INFORMATION GUIDE FOR LOUISIANA

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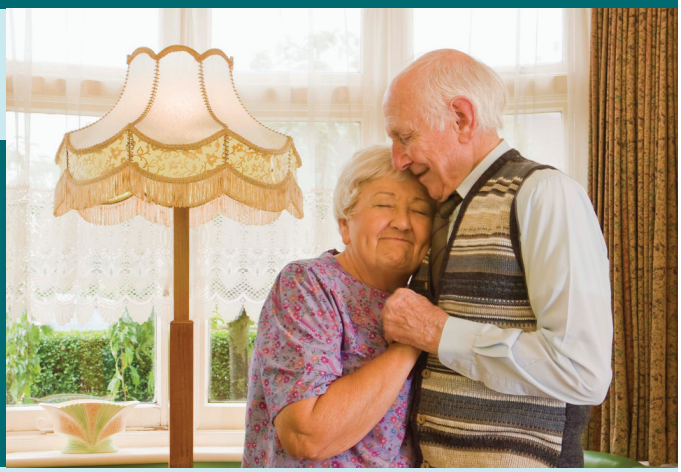

Senior Health Insurance Information Program | James J. Donelon, Commissioner

Long-Term Care Insurance

This guide contains information for individuals shopping for long-term care insurance. The Louisiana Department of Insurance, SHIIP Division, has prepared this publication to assist you in your understanding of long-term care insurance.

Given the tremendous changes in long-term care insurance policy design within the last few years (for instance, elimination of prior hospitalization requirements, expansion of available benefits and coverage of additional sites), buyers today are clearly receiving more benefits for their premium dollars. We want to publicly express appreciation to the many companies and their representatives for providing information for this guide.

Long-term care insurance is a complex product, with many variations among companies. Properly comparing any two policies is a challenge. Complicating the process even further, many companies offer more than one comprehensive plan or offer riders that effectively convert a basic comprehensive plan into an integrated plan. Compiling information from many companies, no matter how careful the data compilation, is still a process that produces inconsistencies and possible errors in the data displayed. Please keep this in mind when you draw your own conclusions from this guide.

If you need personal assistance and counseling, the Senior Health Insurance Information Program (SHIIP) counseling staff can help you understand and sort out problems with:

- Medicare
- Medicare supplement insurance
- Medicare health plans
- Medicaid
- Long-term care insurance
- Other health insurance options

SHIIP also utilizes volunteer counselors who are trained by the SHIIP staff and have completed a required 20-hour, 3 to 4 day, mini-course covering Medicare, Medicare supplement insurance, Medicare health plans, Medicaid, long-term care insurance, and other health insurance options. **If you would like to visit with a trained counselor or are interested in becoming one, please contact SHIIP at 1-800-259-5300, Option 2.**

This booklet is intended as a guide only. Once you have selected a company, you should consult with the insurance company or its representative to determine policy specifics and review the options that are available with the company. If a company you are checking on is not listed you may call SHIIP to help you obtain its phone number.

Consumer brochures explaining other insurance policies are available from:

Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214
www.ldi.la.gov

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1. WHAT IS LONG-TERM CARE?

Long-term care involves a wide variety of services for people with a long physical illness, a disability, or a cognitive disorder (such as Alzheimer's Disease). Long-term care includes many different services that help people with chronic conditions overcome limitations that keep them from being independent. Long-term care helps you maintain a level of functioning, as opposed to improving or correcting a medical condition. Long-term care services include, but are not limited to, help with activities of daily living, home health care, respite care, adult day care, nursing home care and assisted living care. If an individual has a physical illness or disability, they will often need hands-on help with their activities of daily living (ADLs). These ADLs are usually referred to as: bathing, continence, dressing, eating, toileting and transferring (see page 12 for further explanations). If someone has a cognitive impairment they will usually need supervision, protection, or verbal reminders to do their everyday activities. The way long-term care services are provided will continue to change. However, skilled care and personal care are still the terms most often used to describe long-term care and the type or level of care you may need.

SKILLED CARE

People usually need skilled care for medical conditions that require care by medical personnel, such as registered nurses or professional therapists. This care is usually provided 24 hours per day, is ordered by a physician, and follows a treatment plan.

Note: Medicare and Medicaid have their own definition of skilled nursing care. They do not necessarily match the definitions found in long-term care policies.

PERSONAL CARE

This is also called custodial care. It helps you perform activities of daily living, such as bathing, continence, dressing, eating, toileting and transferring. Personal care is less involved than skilled care and may be provided in many different settings.

2. HOW MUCH DOES LONG-TERM CARE COST?

Long-term care includes a broad range of health and support services that people need as they age or if they are disabled. The majority of these services are personal care, or assistance with activities of daily living that many families are able to provide all, or some of, free. But, as care and support needs increase, paid care is usually needed to supplement family provided services and supports, provide respite to family caregivers, or to pay for more extensive services in a facility, such as a nursing home or assisted living, when individuals can no longer be cared for in their homes.

There are variations in costs based on the type and amount of care you need, the provider you use and where you live. Home health and home care services, provided in two-to-four-hour blocks of time referred to as "visits," are generally more expensive in the evening, or on weekends or holidays. Long-term care can be expensive. The average costs in Louisiana for 2012 were:

- $141/day for a semi-private room in a nursing home
- $155/day for a private room in a nursing home
- $3,100/month for care in an Assisted Living Facility (for a one-bedroom unit)
- $15/hour for a Certified Home Health Aide
- $15/hour for a Homemaker services

(Source: 2012 Cost of Care Survey, Genworth Financial, April, 2012)

3. HOW WOULD YOU PAY FOR LONG-TERM CARE SERVICES?

Long-term care services are usually paid for by one or more of the following methods:

INDIVIDUAL OUT-OF-POCKET

Individuals and their families pay less than one-third of all nursing home costs out of their own funds. Generally, the money is obtained from savings, investments or by selling their assets, such as land or their home, to help pay for long-term care.

MEDICAID

Medicaid pays for more than half of all nursing home care. Medicaid may also pay for some home and community-based services. To qualify, you must meet federal poverty guidelines for income and assets. You may have to "spend down" or use up most of your assets before Medicaid is able to help. Many people begin paying for nursing home care out of their own funds and then spend down their financial resources until they are eligible for Medicaid. Medicaid will then pay part or all of their nursing home expenses.

MEDICARE

Medicare will cover the cost of some skilled care in an approved nursing home or in your own home, but only in certain situations. Medicare's benefit in a skilled nursing facility (SNF) covers up to 100 days of care if you meet Medicare requirements. Medicare's coverage for home health care is based on set requirements for skilled medical services in your home for the treatment of an illness or injury. Medicare does not pay for personal care (custodial care); however, it will be covered if you're also getting skilled nursing care or therapy and the care is related to the treatment of your illness or injury. You should not rely on Medicare to pay for your long-term care needs.

MEDICARE SUPPLEMENTS

Medicare supplement plans help fill the gaps in Medicare's coverage. These plans do not cover long-term care expenses. However, Medicare supplement plans (D, G, I and J) pay up to $1600 per year for people recovering at home from an illness, injury, or surgery. The benefit will pay for short-term, at-home help with activities of daily living.

LONG-TERM CARE INSURANCE

Long-term care insurance is designed to help pay for an individual's long-term care expenses. Depending on the plan you choose, it may pay part or all of your care. This guide will help you decide if you need a long-term care insurance policy to help you pay for your long-term care services. If you decide to purchase one, this guide will provide information to select the one that will best fit your needs.

4. WHO MAY NEED LONG-TERM CARE SERVICES?

Your need for long-term care may begin gradually as you find that you need more and more help with your activities of daily living, such as bathing or dressing. On the other hand, you may suddenly need long-term care after an illness, such as a stroke or heart attack. If you do need care, you may need nursing home or home health care for only a short time, or for months, years or for the rest of your life. Although it is difficult to predict if and when you may need care, the following studies may help you evaluate your need.

- One national study projected that 43% of people who turned age 65 in 1990 will go to a nursing home sometime in their life. This study reported that among people living to age 65, 1 in 3 would spend three months or more in a nursing home. About 1 in 4 will spend one year or more and 1 in 11 will spend five years or more in a nursing home. This study shows that 2 out of 3 people will either never go to a nursing home or will spend less than three months in one. Based on these projections, it is much more likely that you will need home health care than nursing home care.

- Women are more likely to need nursing home care than men are. The same study indicates that 13% of women will spend five or more years in a nursing home. Only 4% of men will be in a nursing home five or more years.

- As you grow older, your risk of needing nursing home care also goes up.

5. DO YOU NEED LONG-TERM CARE INSURANCE TO PAY FOR SERVICES?

Long–term care insurance policies are becoming more popular and more widely used by individuals to pay for their long-term care expenses. With the passage of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 (see page 7, Section VI for a further explanation), it is anticipated that even more individuals will choose long-term care insurance policies to help cover their long-term care needs. People buy long-term care insurance for a variety of reasons. These reasons include:

- To avoid spending assets for long-term care
- To make sure there are choices regarding the types and quality of care received
- To protect family members from having to pay for care
- To decrease the chances of going on Medicaid

However, long-term care insurance can be expensive, and is not appropriate for everyone. Whether or not you should buy a policy will depend on your age, health status, overall retirement objectives and income.

AGE

The age that individuals buy long-term care insurance can vary, although most people consider purchasing this product in the middle age and early retirement years. Generally, it is better to buy a policy when you are younger. The annual premium is less and you will pay less total premium in the long run. In addition, if you delay, you run the risk of becoming uninsurable because of an accident or illness.

HEALTH

If you already have existing health problems that are likely to result in the need for long-term care (for example Alzheimer's disease or Parkinson's disease), you will probably not be able to buy a policy. Insurance companies have medical under-writing standards to keep the cost of long-term care insurance affordable. Without these standards, most people would not buy coverage until they need Long-term care services.

RETIREMENT OBJECTIVES

One reason for purchasing long-term care insurance is to protect a nest egg for your spouse or for your children or grandchildren. It is important to look at your objectives for your retirement years to determine if it is important to protect your assets.

CAN YOU AFFORD LONG-TERM CARE INSURANCE?

Insurance companies are required to design and utilize certain standards, known as "Suitability Standards." The purpose of these standards is to determine whether or not the purchase or replacement of long-term care insurance is appropriate for the applicant. This process involves a questionnaire known as a "Personal Worksheet" which reviews a person's income and assets. You are not required to complete this questionnaire, but usually it is in your best interest to accurately complete the information requested.

Long-term care insurance is not for everyone. For some, it is affordable and well worth the cost. For others, it is too costly, or the policy they can afford doesn't offer enough benefits to make it worthwhile. You should not buy a long-term care policy if the only way you can afford to pay for it is by not paying other important bills. It is a good idea to discuss this with a family member. If you buy a policy you should plan on paying premiums for the rest of your life, or until you need to use the benefits.

Some professionals suggest that people consider the purchase of long-term care insurance if they:

- **Own assets of at least $75,000 (excluding home and automobile)**
- **Have annual retirement of at least $25,000-$35,000. This amount may be high or low depending upon costs where you live**
- **Can pay the premium without adversely affecting their lifestyle**
- **Can absorb possible future increases in premium**

It is important to remember that each situation is unique, and that the suggested income and asset minimums should not be treated as absolutes.

People who can afford these services receive help in the setting of their choice. Buyers of comprehensive long-term care insurance gain access to a wide array of services that help them age in place (their home), or receive skilled care in a nursing home as required. Policies typically cover home health aides and homemakers, and the cost of assisted living. Private insurance may also pay for respite care or home modifications. Some policies offer training for family caregivers, while others allow policyholders to pay family caregivers.

New evidence shows that more than 70 percent of policyholders now receiving benefits find that their long-term care insurance policy pays all of the costs of services they need. These benefits are reducing the burden on family caregivers, especially adult children. About two in three caregivers report that having Long-term care insurance benefits available has reduced their level of stress.

6. WHAT IS A FEDERALLY TAX QUALIFIED LONG-TERM CARE INSURANCE CONTRACT?

A federally tax-qualified long-term care insurance contract is a contract that provides certain federal income tax advantages. These qualified contracts were created by the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you are paying a premium for a qualified long-term care contract, you may deduct part or the entire premium you pay for the policy outright. Additionally, the premium can be added to your other deductible medical expenses. If this total amount exceeds 7.5% of your gross income, you can claim a deduction for any amount exceeding 7.5% of your gross income on your federal tax return.

The maximum amount you can add to your other deductible medical expenses is based on your age at the end of each tax year. Benefits you receive from a qualified long-term care insurance contract are generally not taxable as income.

Benefits you receive from a policy that is not federally tax-qualified could be taxable as income. The tax-qualified policy form is clearly becoming the predominant choice in the marketplace. When HIPAA was first passed in 1996, there was a fairly even split between the purchase of non-qualified and tax-qualified policies. Now, more than four out of every five policies sold are tax-qualified. In the last several years, many companies have chosen to offer only the tax-qualified option.

Policies purchased before January 1, 1997:

- HIPAA "grandfathered" these older policies to be considered "federally tax-qualified," although they may not have all of the provisions of the new policies.
- The same income tax treatment applies to the grandfathered policies.
- You should carefully examine the advantages and disadvantages of trading the grandfathered policy for a new one. In most cases, it will be to your advantage to keep your old policy.

Policies sold after January 1, 1997, that are intended to be considered tax-qualified for favorable income tax treatment must meet certain federal standards. In order to be a qualified long-term care policy:

- It must provide coverage only for qualified long-term care services
- It must be guaranteed renewable, generally cannot provide a cash surrender value, and must include a number of consumer protections

Qualified long-term care services are the most common services provided by long-term care providers. These services must be required by chronically ill individuals, and must be given according to a plan of care prescribed by a licensed health care practitioner. A person is considered to be chronically ill if they are expected to be unable to do at least two of five (or six) activities of daily living without substantial help from another person for at least 90 days. Another way you may be considered chronically ill is if you need substantial supervision to protect your health and safety because you have a cognitive impairment. If you have a policy that was issued to you before January 1,1997, these terms do not apply. Some

life insurance policies may provide qualified long-term care benefits. The amounts that you pay out-of-pocket for that portion of the life insurance policy may be the same as a qualified long-term care policy. The benefits that you receive from a life insurance policy for long-term care are also treated the same as if they came from a qualified long-term care policy. You also must be considered to be chronically ill to get qualified long-term care services paid for from a life insurance policy.

NOTE: Tax-Qualified plans may not be right for everyone. Since only 29 percent of taxpayers actually itemize their deductions, the tax savings on premiums may not be of benefit to you if you do not itemize. In addition, qualified plans may have more restrictive benefit triggers. However, the benefits you receive under a tax-qualified plan will not be taxable. Currently, until further regulations are received from the Treasury Department it is unclear whether the benefits on a non tax-qualified plan will be taxable. Many companies no longer sell non tax-qualified policies. Check with your personal tax advisor for further information.

7. HOW CAN YOU BUY LONG-TERM CARE INSURANCE?

Private insurance companies sell long-term care insurance policies. You can purchase this coverage through:

- Your insurance agent (producer)
- The mail
- A group policy of an employer
- Membership in an association
- A life insurance policy

Insurance companies must be licensed in Louisiana to sell long-term care insurance in Louisiana. If you decide to purchase a policy, please contact the Louisiana Department of Insurance to determine if the company you are considering is licensed in Louisiana and in good standing with the Department. To receive information on licensed companies, call toll-free, 1-800-259-5300 and ask for the Financial Solvency Division.

8. HOW DO POLICIES WORK?

Long-term care insurance policies are not standardized like Medicare supplement plans. Instead, companies are selling policies that combine a variety of benefits and coverage in different ways.

Every policy is different. Long-term care insurance was "invented" about 30 years ago. Companies are still experimenting, looking for the best way to design their plans. Policies may also be complicated. Since there are so few standards for these new policies, every company must be careful to define its terms, benefits, and exclusions in the policy. Companies must deliver to a prospective buyer an "Outline of Coverage" which helps to explain these terms. You should be thorough when you shop for long-term care coverage. It is not easy to compare one policy with another. You could be comparing "apples with oranges." Louisiana SHIIP provides counseling and assistance in reviewing long-term care policies. Call 1-800-259-5300 or (225)342-5301 for assistance.

A. WHAT SERVICES ARE COVERED?

If you buy a long-term care insurance policy, you should understand how it covers the many types of long-term care services you might use. Some policies cover only stays in nursing homes. Others cover only care in your home. Still others cover both nursing home and home health care. Many policies also include coverage for adult day care centers, assisted living centers or other community facilities.

Some long-term care policies will only pay for care in licensed nursing facilities. Most policies sold today will pay for any long-term care you need in a licensed facility, not just certain types of care. You must, of course, meet the other eligibility requirements of the policy. These are explained later in this publication.

Home health care coverage also varies. Some policies pay benefits only for skilled nursing care performed in your home by registered nurses, licensed practical nurses, and occupational, speech, and/or physical therapists. Other policies offer broader home care coverage; for instance, the services of home health aides employed by licensed home care agencies. These policies generally will not pay benefits to family members who perform care in the home. Check the policy for specifics. In most cases, you should purchase a comprehensive policy.

B. WHERE ARE SERVICES COVERED?

In reviewing long-term care insurance, it is not enough to know what services are covered. You should also know where services are covered. If you are not in the right type of facility, the insurance company can refuse to pay. New kinds of facilities may be developed in the future and it is important to know whether your policy will cover them. Some policies provide for care in any state-licensed facility, while others tend to limit the kinds of facilities where you can receive care.

Some policies list by name the types of facilities where you will not be covered, like homes for the aged and rest homes. Some explicitly define the types of facilities they will cover. Some will say the facility must care for a certain number of patients or require a certain kind of nursing supervision. You should check these policy requirements very carefully.

C. HOW ARE BENEFITS PAID?

Insurance companies usually pay benefits in one of two ways: the expense-incurred method or the indemnity method.

Expense-Incurred

The insurance company pays either you or the provider for the actual expense up to the daily limits in your policy. The company will pay benefits to you only for services covered in your policy. Most policies bought today pay benefits using this method.

Indemnity Method

The benefit is a set dollar amount. Once the company decides that you are eligible for benefits, it will pay benefits directly to you, not the provider. The policy spells out the amount the company will pay.

D. WHAT IS NOT COVERED?

EXCLUSIONS AND LIMITATIONS

Generally, insurance companies do not pay benefits if services are needed for:

- Mental and nervous disorders or disease, other than Alzheimer's disease
- Alcoholism and drug addiction
- Illness caused by an act of war
- Treatment already paid for by the government
- Attempted suicide or intentionally self-inflicted injuries

NOTE: In Louisiana, companies cannot exclude coverage for Alzheimer's disease.

E. HOW MUCH COVERAGE WILL YOU HAVE?

A policy or certificate may state the amount of coverage in one of several different ways. Be sure you understand how much coverage you will have and how it will cover the types of long-term care services you will receive. Your policy may pay different amounts for different types of long-term care services, such as a lesser amount for the home health care than for the nursing home benefit. In determining coverage amounts, you should understand the following terms that are found in policies to describe the amount of your coverage:

Maximum Benefit Limits

Most policies will limit the total benefits they will pay over the term of the policy. Words like "total lifetime benefit," or "total plan benefit" are often used to describe the maximum policy benefit limit. Companies also offer policies with unlimited lifetime benefits. When shopping for coverage, be sure to check the maximum amount of coverage that you will have. Which is better-a longer or shorter benefit period? Most nursing home stays are short (three months or less) but illnesses that go on for several years could mean very expensive stays. You will have to decide if you want protection for very long stays. Policies with longer benefit periods will cost more.

Daily / Monthly Benefit Amount

A policy may pay benefits on a daily, weekly, monthly or other basis. For example, in an expense-incurred plan, a policy might pay a daily nursing home benefit of up to $120 per day. A policy might pay a weekly home care benefit of up to $350 per week. Some policies will pay for single events, such as installing a home medical alert system. Often, insurance companies let you choose a periodic benefit amount (usually $50 to $250 a day or $1,500 to $7,500 a month) for care in a nursing home. If your policy covers home health care, the benefit is usually some percentage (50% to 100%) of the benefit for nursing home care. It helps to know how much the facilities in your area charge for their care.

F. WHEN ARE YOU ELIGIBLE FOR BENEFITS (BENEFIT TRIGGERS)?

"Benefit triggers" is the term a company usually uses to describe the way it decides when to pay benefits. This is an important part of a Long-term care policy. Look at it carefully as you shop. It is usually described in the policy and outline of coverage under a section called "Eligibility for the Payment of Benefits" or simply "Eligibility of Benefits." Different policies may have very different benefit triggers. Some policies use more than one way to pay benefits. Some states require certain benefit triggers. In addition, some benefit triggers may be different for home health care coverage than for nursing home care. The following are benefit triggers.

Activities of Daily Living

The inability to do Activities of Daily Living or ADLs is the most common way insurance companies decide when you are eligible for benefits. The ADLs most companies use are bathing, continence, dressing, eating, toileting, and transferring. Typically, a policy pays benefits when you cannot do a certain number of the ADLs, such as two or three of the six. The following are some definitions of the ADLs, although they may vary:

a) Bathing- washing yourself either by sponge bath, in a tub, or in the shower; getting into or out of the shower or bath

b) Continence- maintaining control of bowel and bladder function or performing personal hygiene associated with a catheter or colostomy bag

c) Dressing- putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs

d) Eating- feeding yourself by getting food into your body from a receptacle (plate, cup or table) or by using a feeding tube or intravenous tube

e) Toileting- getting to and from, on and off the toilet; performing associated personal hygiene

f) Transferring- moving in and out of a chair, bed or wheelchair

If you are considering buying a policy that pays benefits when you cannot do certain ADLs, be sure you understand what that means. Some policies spell out very clearly what it means to be unable to feed or bathe yourself. Some say that you must have someone actually help you do the activities. That is known as "hands-on" assistance. It is more limiting than a policy that requires someone provide "stand-by" assistance. The more clearly a policy describes its requirements, the less confusion you or your family will have when you need to file a claim. It is important to know that the six ADLs have been developed through years of research. This research has also shown that bathing is usually the first ADL that a person cannot perform. Qualifying for benefits from a policy that uses five ADLs may be hard if bathing is not one of them.

NOTE: For tax-qualified plans under HIPAA, you are expected to be unable, without substantial help from another person, to do at least two of five (or six) ADLs for at least 90 days. This definition is used for this benefit trigger.

Cognitive Impairment

Many policies also pay or provide benefits for "cognitive impairment" or mental incapacity. The policy usually pays benefits if you can't pass certain tests or other assessments of your mental function. Coverage of cognitive impairment is especially important if you have Alzheimer's disease. If the inability to do ADLs is the only benefit trigger in your policy, it may not pay benefits if you have Alzheimer's disease but can still do most of the ADLs on your own. However, if your policy also uses a test of your mental ability as a benefit trigger, it is more likely to pay benefits

if you have Alzheimer's. Louisiana law requires that all policies sold in Louisiana have Alzheimer's disease as a benefit trigger. In addition, all tax-qualified policies must cover cognitive impairment.

NOTE: For tax-qualified plans, your benefit trigger requires that you must need substantial supervision to protect your health and safety because you have a cognitive impairment.

Doctor Certification of Medical Necessity

Some policies will pay benefits if your doctor orders or certifies that the care is medically necessary. If you need personal care in a nursing home but are not sick or injured, a policy that requires medical necessity may not pay benefits.

Prior Hospitalization

Some policies sold several years ago required a prior hospital stay of at least three days before paying benefits. This requirement may make it harder for you to qualify for the benefits provided by your policy. In Louisiana, companies can no longer require a prior hospital stay before paying benefits.

G. WHEN DO BENEFITS BEGIN?

Elimination Period

Your long-term care benefits may not begin the first day you enter a nursing home or begin using home care. Most policies have an elimination period (sometimes called a deductible or a waiting period). With an elimination period, benefits begin 20, 30, 60, 90, or 100 days after you start using long-term care. Some policies have zero elimination periods, but these tend to cost more. The elimination periods may also be shorter for home health care benefits. The number of days you wait will depend on the number of elimination days you select at the time of purchase. Of course, during the elimination period, you will have to cover the cost of nursing care yourself.

In choosing an elimination period, you will want to weigh the trade-off between paying a higher premium for a policy that covers you soon after entering a nursing home, and paying out of your own pocket for the first days of eligible coverage. If your stay is short and you have a policy with a long elimination period, you may receive no benefits from your policy. On the other hand, if you can afford to cover a short stay, a longer elimination period might be in order. A longer period would protect you if you have a prolonged nursing home stay, and also would help keep the cost of your insurance down.

You may also want to think about how your policy pays if there is a repeat nursing home stay. Most policies currently being sold only require the elimination period to be satisfied once during the lifetime of the policy. Keep in mind that repeat nursing home stays do not occur very often, but it is good to review this when comparing policies.

H. WHAT HAPPENS WHEN LONG-TERM CARE COSTS RISE (INFLATION PROTECTION)?

Inflation protection can be one of the most important additions you can make to a long-term care policy. However, some people hesitate to purchase inflation protection since it adds significantly to the cost of the policy. Unless your policy provides for a way to increase your daily benefit, years from now you may find yourself owning a policy whose benefit has not kept pace with the increasing costs of nursing home services. A nursing home that costs $100 today will cost $265 in 20 years, assuming an inflation rate of 5% a year. Obviously, the younger you are when you buy coverage, the more important it is for you to add inflation protection to your policy. You can usually buy inflation protection in two ways. The first regularly increases your benefits each year. The second lets you choose to increase your benefits regularly, such as every three years, at the price the company is currently charging. Be sure you understand the implications of accepting or rejecting an opportunity to increase the inflation protection benefits of your policy. There are also two types of increases made available, simple and compound. Under both, benefits are increased by a fixed percentage, such as 5%, but over time, these differ based on how the interest is calculated. These are explained as follows:

Simple

The dollar amount of the increase added to the benefit is the same every year. Example: On a $100 per day policy that increases by 5% simple interest will provide $200 per day in 20 years.

Compounded

The benefits increase by an increasing dollar amount from one year to the next. Example: On a $100 per day policy that increases at 5% compounded interest will provide $265 per day in 20 years.

NOTE: Louisiana law requires companies to offer the option to purchase inflation protection coverage at a rate not less than 5% compounded on an annual basis. This option is in addition to any other inflation protection options the company offers. You will have the opportunity to decide if you wish to purchase this. However, if you decline, you will be asked to sign a statement saying you do not want inflation protection. Be sure you understand what you are signing. See page 20, Section XIX for more about inflation.

I. OTHER POLICY OPTIONS TO CONSIDER WHEN PURCHASING COVERAGE

You will be able to select from a number of other options or policy features. Each option may add to the cost of your policy, but will enhance your coverage. However, many of these options will not cost extra, but are included in the base price. Be sure to ask which features will increase the cost of your coverage. The most common benefits are: assisted living facility, home health care, hospice care, respite care, alternate care services, case management services, restoration of benefits, medical equipment coverage, spousal discounts, survivorship benefits, bed reservation reimbursement, third party notice and waiver of premium. Some of these options are described in the following pages.

Third Party Notice

It is required that this benefit be offered in Louisiana. Third party notice allows you to name someone that the insurance company would contact if your coverage were about to end due to non-payment of premium. You can pick a relative, friend or a professional contact. After the company contacts the person you choose, he or she will have a set period of time to notify you to pay the premium or, if prior arrangements have

been made between you and the person you chose as your contact, that person can pay the overdue premium. This is especially important for people who develop a cognitive impairment. You can sign a waiver if you do not want to name a person, although this is a recommended feature.

Waiver of Premium

Waiver of premium allows you to stop paying your premium once you enter into a nursing home and the company has started to pay benefits. Waiver of premium may begin when the company makes its first payment or it can be a set period of time such as 90 days. The requirements may be different when receiving home health care benefits.

Non-forfeiture Benefits

Non-forfeiture guarantees you will receive something (such as limited benefits or return of premium) if you cancel the policy or the company cancels because your payments stop. Nonforfeiture pays you back some value for the money you have paid into the policy.

Since long-term care insurance is term insurance, you have the protection only for as long as you pay the premium. long-term care is not a savings or investment. It does not matter how much money you have paid, or how long you've had the policy, Long-term care disappears when your payments stop. Loss of coverage will occur unless you are already receiving benefits under an eligible waiver of premium or the policy has a non-forfeiture provision. In Louisiana, companies are required to offer you the option of a non-forfeiture benefit. In the event you decline the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates. Make sure you understand how much the additional non-forfeiture benefit option will add to the cost before determining if you want this additional option.

Premium Refund at Death

The premium refund at death benefit refunds to your estate any premiums you paid minus any benefits the company paid on your behalf. You must have paid premiums for a certain number of years to receive these benefits. Some policies pay death benefits only if the policyholder dies before a certain age, usually 65 or 70. Death benefits also add to the cost of a policy.

Bed Reservation

If you have to leave the nursing home and go to the hospital, the bed reservation benefit will make sure you have a nursing home bed if you return within a short period of time.

Restoration of Benefits

Some policies restore the benefits that you have used. An example of such a scenario would be: You have a four-year policy and after three years of care in a nursing home, you find you no longer need that level of care and return home. If, after a period of time (more than six months), you return to the nursing home, then your benefits are restored and the policy is good for another four years. This is unlikely to occur but can be very beneficial if it did.

9. WILL YOUR HEALTH AFFECT YOUR ABILITY TO PURCHASE A POLICY?

Companies that sell long-term care insurance underwrite their coverage. Underwriting means that they look at your health before they issue you a policy. Some companies do what is known as short-form underwriting. On the application, they may ask questions to find out if you have been recently hospitalized or are confined to a wheelchair. Most companies conduct more extensive underwriting. They may examine your current medical records and ask for a statement about your health from your doctor. These companies, however, may be more selective about whom they will insure when having certain conditions that are likely to land you in a nursing home in the near future. Parkinson's disease, for example, probably will disqualify you for coverage. No matter what kind of underwriting a company uses, it is very important to answer all health questions truthfully. If a company later learns you have omitted health information, and the company relied on the misstatement to grant coverage, it can cancel your policy and return the premiums you have paid. Companies can usually cancel your coverage within two years after you buy the policy.

Most companies will issue a policy to people who have relatively minor health problems, and will cover those conditions immediately if they are disclosed on the application. Please refer to the following section regarding pre-existing conditions.

10. WHAT HAPPENS IF YOU HAVE PRE-EXISITING CONDITIONS?

Insurance companies may have pre-existing condition limitations in their contracts. Pre-existing conditions are generally defined as a condition for which you sought advice or treatment, or had symptoms within a certain period of time before the policy went into effect. Most companies look at your health status, as explained before, and they may review your past history. This may be important to you if you have a pre-existing condition. A company that learns you did not tell them about a pre-existing condition on your application might not pay for treatment related to the condition and might even cancel your coverage. While some companies have pre-existing condition limitations in their contracts, most do not have them if the condition is disclosed on the application. In Louisiana, the maximum period for a pre-existing condition is six months.

11. CAN YOU RENEW YOUR COVERAGE?

When buying a long-term care policy you must consider not only whether you can afford to pay the premium now, but also whether you will be able to continue to pay the premiums in the future. Premiums on these policies are not guaranteed. When a policy is "guaranteed renewable", it means that the company guarantees that it will offer you the opportunity to renew the policy and continue the coverage; it does not mean that you are guaranteed the opportunity of renewing at the same premium. Premiums may rise over time as companies begin to experience a greater payout in claims. All individual policies sold in Louisiana must be at least guaranteed renewable.

12. WHAT DO POLICIES COST?

A long-term care insurance policy can be expensive. You will need to be sure you can pay the premium for it and still afford your other health insurance coverage. It is not unusual for a couple aged 65 to spend around $7,500 for all of their health insurance coverage. The annual premium for a long-term care policy with good inflation protection can run about $2,000 for someone age 65.

Premiums will be lower for those who are younger and more for those who are older. If you buy a policy at age 75, the premium will generally be two and one half times greater than if you had bought the policy at age 65. It could be six times higher than if you bought it at age 55. Inflation protection can add 25 to 100 percent to the premium depending on your age at purchase. Non-forfeiture benefits can also add significantly to the cost of your policy. Consider how much income you have and how much you can afford to spend on a long-term care policy now. Try to project what your income is likely to be in the future, what your living expenses will be, and how much you can pay for long-term care premiums. If you do not expect your income to increase, it may not be wise to purchase a policy now with a premium that is at the upper limit of what you think you can afford.

13. IF YOU ALREADY OWN A POLICY, SHOULD YOU SWITCH PLANS OR UPGRADE EXISTING COVERAGE?

Before you buy a new policy, make sure it is better than the one you already have. If your agent (producer) has switched companies and wants you to switch to, carefully consider any changes. In addition, you will need to consider your health, to ascertain whether you can qualify for a new policy. Updating your coverage may be right for you, if for example, your existing policy required a prior hospital stay or did not pay benefits for Alzheimer's disease. These are now illegal exclusions in contracts sold today. If you decide to switch, make sure your new application is accepted before canceling the old policy. If you cancel a policy in the middle of its term, some companies will not return any premiums you have paid.

14. REPLACING AN OLD Long-term care POLICY

Shop before you swap. If you purchased a long-term care policy several years ago, listed below are some good reasons to shop for a newer policy:

- Policies sold today include such benefits as home health care and adult day care, which may not be in an older policy.
- If your present policy had no inflation protection, the benefit level may have fallen behind the increase in health care costs.
- Older policies included some limitations, which are not allowed in policies sold today. For example, many older policies do not pay for long-term care unless you spent at least three days in a hospital before going into a nursing home. Additionally, some older policies may have offered coverage for only a skilled or intermediate level of care. Many individuals enter at a custodial level.
- Premiums for a new policy with higher benefits might actually be lower than premiums on your old policy. That is because people who purchased at the same time as you are now filing claims, which could force the company to increase its rates to cover the expenses.

Will you be able to swap? If you are no longer in good health, there is probably no point in shopping for a new policy. You will probably be unable to find a company willing to sell you a policy. Since most companies charge premiums based on your age when you buy, you may also discover that you have passed the age when you can afford to swap.

It may however, be appropriate to switch policies if you have an old policy with requirements for a prior hospital stay or for prior levels of care, and you are now in good health and can qualify for another policy. For example, if you purchased a good policy when you were younger, you might ask if the insurance carrier can enhance the policy by adding inflation protection. It might be cheaper to keep the policy you have and improve it rather than buy a new one.

15. LONG-TERM CARE INSURANCE SHOPPING TIPS

DO:

Do your homework. Get a realistic idea of what you need and how much you can afford to pay for it.

Shop around. There are many long-term policies with big differences in price and benefits.

Read the outline of coverage very carefully.

Ask questions about everything you do not understand.

Ask your lawyer, a friend, or a relative to review the policy to see what you may have missed.

Ask a trusted friend to join you when an agent visits your home.

DON'T:

Don't buy on the first sales visit.

Don't sign a blank application.

Don't pay in cash.

Don't write checks payable to the producer (agent). Always make checks payable to the insurance company.

Don't buy until you are sure you understand exactly what you are getting.

Don't buy unless you are sure you can afford to make the payments every year. Keep in mind that premiums may increase in future years.

16. POINTS TO KEEP IN MIND AS YOU SHOP

Check with several companies and producers. It is wise to contact more than one company (and agent) before buying. Be sure to compare benefits as well as the types of facilities in which you have to use in order to receive coverage. Additionally, compare the limitations of coverage, the exclusions and, of course, the premiums (policies that provide identical coverage and benefits may not necessarily cost the same). The comparison form on pages 24 and 25 is provided for your convenience in comparing policies.

Take your time and compare outlines of coverage. Louisiana requires the agent to leave an outline of coverage at the time the agent initially contacts you. If the agent does not give you an outline or tells you he or she will provide it later, do not deal with that agent. If the agent gives answers that are vague or differ from information in the company literature, or if you have doubts about the policy, tell the agent you will get back to him or her later. Do not hesitate to call or write to the company and ask questions. Beware of an agent who claims the policy can be offered only once. Some companies may sell their policies through the mail, bypassing agents entirely. If you decide to buy a policy through the mail, contact the company if you do not understand how the policy works.

Discuss the policy with a friend or relative. You may also contact the Louisiana Insurance Department's Senior Health Insurance Information Program (SHIIP) at (225) 342-5301 or toll free 1-800-259-5300.

Do not be misled by advertising

Celebrities who endorse policies are professional actors and are paid to advertise. They are not insurance experts. Neither Medicare nor any other federal agency endorses or sells long-term care policies. Be skeptical of any advertising that suggests the federal government is involved with this type of insurance.

Do not buy multiple policies

It is not necessary to purchase several policies to get enough coverage. One good policy is enough.

Application and health questions

Do not be misled by an agent who says your medical history is not important. Disclosing your medical history on the application is very important. If your answers to health questions are wrong or incomplete, the company might sell you a policy but refuse to pay your claims and can even cancel your policy.

- Make sure your answers are complete and accurate.
- If an agent fills out the application, check it carefully before you sign it.

Be sure to get the name, address and telephone number of the agent and the company. Obtain a local or toll-free number (if the company has one).

If you do not receive your policy within 60 days, contact the company or agent. When you receive your policy, keep it in a convenient place where you can find it and tell a trusted friend or relative where it is. Also, be sure to read the policy within the 30-day "free look" period to be sure you have purchased the benefits you wanted.

Read the policy again and make sure it provides the coverage you want. Check the application you signed. It becomes part of the policy. If the application is not filled out correctly, notify the insurance company promptly.

Check to determine whether or not your policy is considered to be a tax-qualified plan. Be sure you understand the differences between tax-qualified plans and those that are not tax-qualified. It may also be a good idea to check with your financial advisor for further information.

Third Party Notification

Louisiana requires that all insureds have an opportunity to name a third party who will be notified in the event the company is no longer getting premium payments. Third party notification helps make sure that policyholders will not be canceled if they become ill and forget to send in their payments.

Check on the financial stability of the company you are considering.

It is important to make sure the company is licensed in Louisiana. In addition, several private companies or rating agencies conduct financial analyses of insurance companies and rate them. These ratings carry no guarantee of accuracy but can provide you with information on how some analysts view the financial health of particular insurance companies. Different agencies use different rating scales, so be sure to find out how the agency labels its highest ratings as well as the ratings for the companies you are considering. Ratings from some agencies are available at most public libraries, or you can call the agencies directly at the numbers below. **(Note that there will be an extra charge on your telephone bill for calls to a "900" number.)**

Best Company
(900) 555-BEST or (800) 424-BEST or at www.ambest.com

DeMotech, Inc.
(614) 761-8602

Duff & Phelps, Inc.
(312) 368-3157 or at www.dcreco.com

Fitch Investors Service
(212) 908-0500 or at www.fitchbaca.com

Moody's Investors Service
(212) 553-0377 or at www.moodys.com

Standard & Poor's
(212) 208-1527 or at www.ratings.standardpoor.com

Weiss Research, Inc
(800) 289-9222 or at www.weissinc.com

Additionally, the Financial Division of the Louisiana Department of Insurance keeps information and filings on each company and can let you know if a company is licensed and in good standing with the Department. You may contact the **Financial Solvency Division at 1-800-259-5300.**

17. REVIEWING A POLICY DURING THE "FREE LOOK" PERIOD

If you decide you do not want the policy after you purchase it, you can cancel, return the policy and get your money back if you notify the company within a certain number of days after the policy is delivered. This is called the "free look" period. Louisiana allows policyholders to cancel within 30 days for any reason. If you want to cancel, do the following:

- Keep the envelope the policy was mailed in, or insist your agent give you a signed delivery receipt when he or she hands you the policy.
- If you decide to return the policy, send it to the insurance company along with a brief letter requesting that the policy be canceled and your premium refunded.
- Send both the policy and letter by certified mail and obtain a mailing receipt.
- Keep a copy of all correspondence.
- The refund process usually takes 4 to 6 weeks.

18. POLICIES FROM YOUR EMPLOYER

Your employer may offer long-term care insurance as an additional benefit. The coverage provided by these employer-group policies is similar to what you could buy from an agent. Companies providing long-term care insurance usually give their employees a choice of benefit periods, maximum payments and elimination periods.

Group policies may offer non-forfeiture benefits and inflation protection. Some even allow employees to keep their coverage after they leave their employer. Group policies do this by offering continuation of coverage or conversion options.

Many employers also allow employees to buy coverage for their parents, which could be an advantage. Typically, employees' parents must pass the company's medical screening to qualify for coverage; employees usually do not have to pass any medical requirements. If your child's company offers such coverage, be sure to consider it carefully. It may offer advantages you will not find if you try to buy a policy on your own.

19. MORE ABOUT INFLATION

Today, people are living longer and enjoying better health than they did just a few years ago. Medical scientists are unlocking the mysteries of the human body at a faster pace, going beyond the science of vaccines and antibiotics, and entering the world of cell reproduction, genetic engineering and organ replacement. The future of pharmaceuticals is in developing drugs that prevent or delay disease, rather than just treat the disease. According to U.S. Census Bureau estimates, there were nearly 70,000 centenarians living in the United States in 2000. People over 85 are the fastest growing segments of the U.S. population. Even though many people will live in good health into advanced years, with advanced age comes chronic illness, and people near the end of life need more care. Many people who are living longer lives do so disabled. The role of inflation protection is more critical as the chances of our living to 90 to 100 increase. Although a person's current life expectancy is less than 90 to 100; you should insure for the unusual, not the normal. A long-term care policy should stand the test of time. Over time, the cost of care can inflate to double or triple what might be needed today. Some agents (producers) recommend purchasing a larger daily benefit rather than inflation protection. A possible problem with this approach is that you are over insured when there is less likelihood of needing the benefits and under insured when the likelihood is much greater.

20. GLOSSARY

Activities of Daily Living (ADLs)
Everyday functions and activities individuals usually do without help. ADL functions include bathing, continence, dressing, eating, toileting, and transferring. Many policies use the inability to do a certain number of ADLs (such as 2 of 6) to decide when to pay benefits.

Adult Day Care
Care during the day for adults, usually at senior or community centers.

Alzheimer's Disease
A progressive, degenerative form of dementia that causes severe intellectual deterioration.

Assisted Living Facility
A residential living arrangement that provides individualized personal care and health services for people who require assistance with activities of daily living.

Benefit Triggers
A term used by insurance companies to describe when to pay benefits.

Care Management Services
A service in which a professional, typically a nurse or social worker, may arrange, monitor, or coordinate long-term care service.

Chronic Illness
An illness with one or more of the following characteristics: permanency, residual disability, causes disability, requires rehabilitation training, or requires a long period of supervision, observation, or care.

Cognitive Impairment
A deficiency in a person's short-or long-term memory; orientation as to person, place and time; deductive or abstract reasoning, or judgment as it relates to safety awareness.

Community-Based Services
Services designed to help older people stay independent and in their own homes.

Copayment or Coinsurance
A cost-sharing arrangement under which the insurance company insures only part of the potential loss, and the policy owners pay the other part.

Custodial Care (Personal Care)
Care to help individuals meet personal needs such as bathing, dressing and eating. Care may be provided by someone without professional training.

Daily Benefit
The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

Dementia
Deterioration of intellectual faculties due to a disorder of the brain.

Durable Power of Attorney for Health Care
A written document allowing an individual (the principal), when competent, to authorize one or more individuals (the agents) to make decisions about medical treatment and care in the event of incapacity of the principal.

Elimination Period
A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments. The longer the elimination period in a policy, the lower the premium.

Guaranteed Renewable
When a policy cannot be canceled and must be renewed upon expiration unless benefits have been exhausted. The company cannot change the coverage or refuse to renew the coverage for other than nonpayment of premiums (including health conditions and/or marital or employment status).

Health Insurance Portability and Accountability Act (HIPAA)
Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.

Home Health Care
Services for occupational, physical, respiratory, speech therapy, or nursing care. Also, included are medical, social worker, home health aide, and homemaker services.

Homemaker Services
Household services performed by someone other than yourself because you are unable to perform them.

Inflation Protection Benefit Rider
This inflation protection benefit can help keep pace with inflation and increased expenses. Policy benefits may be adequate now but not later. This can be simple or compounded and increase automatically either unlimited, lifetime, or until policy terminates. Most insurers offer a rate of at least 5%/annum.

Lapse
Termination of a policy when a renewal premium is not paid.

Long-term care Insurance
An insurance policy designed to provide coverage for long-term care expenses that are not covered by general insurance plans or by government programs.

Medicaid
A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

Medicare
A federal entitlement program providing hospital and medical insurance to people aged 65 or older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited.

Medicare Supplement Insurance
A private insurance policy that covers many of the gaps in Medicare coverage.

Non-forfeiture Benefits
A policy feature that returns at least part of the premiums to you if you cancel your policy or let it lapse.

Pre-existing Condition
Illnesses or disabilities for which you were treated or advised within a certain time period before applying for a health or life insurance policy.

Respite Care
Offers help for a few hours or several days to relieve family caregivers.

Rider
Addition to an insurance policy that changes the provisions of the policy.

Substantial Assistance
Means hands-on or stand-by help required to do ADLs.

Substantial Supervision
The presence of a person directing and watching over another person who has a cognitive impairment.

Tax-Qualified Long-term care Insurance Policy
A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

Third Party Notice
A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment. This can be a relative, friend, or professional such as a lawyer or accountant.

Underwriting
The process of examining, accepting, or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each.

Waiver of Premium
A provision in an insurance policy that relieves the insured of paying the premiums while receiving benefits.

21. DEFINITIONS OF BEST'S RATINGS AND NOT RATED CATEGORIES (NR)

For the latest rating, access www.ambest.com

SECURE BEST'S RATINGS

A++ and A+ (Superior)

Assigned to companies which have, on balance, superior balance sheet strength, operating performance and business profile when compared to the standards established by the A.M. Best Company. These companies, in A. M. Best's opinion, have a very strong ability to meet their ongoing obligations to policyholders.

A and A- (Excellent)

Assigned to companies which have, on balance, excellent balance sheet strength, operating performance and business profile when compared to the standards established by the A.M. Best Company. These companies, in A. M. Best's opinion, have a strong ability to meet their ongoing obligations to policyholders.

B++ and B+ (Very Good)

Assigned to companies which have, on balance, very good balance sheet strength, operating performance and business profile when compared to the standards established by the A.M. Best Company. These companies, in A. M. Best's opinion, have a good ability to meet their ongoing obligations to policyholders.

VULNERABLE BEST'S RATINGS

B and B- (Fair)

Assigned to companies which have, on balance, fair balance sheet strength, operating performance and business profile when compared to the standards established by the A.M. Best Company. These companies, in A. M. Best's opinion, have an ability to meet their current obligations to policyholders, but their financial strength is vulnerable to adverse changes in underwriting and economic conditions.

C++ and C+ (Marginal)

Assigned to companies which have, on balance, marginal balance sheet strength, operating performance and business profile when compared to the standards established by the A.M. Best Company. These companies, in A. M. Best's opinion, have an ability to meet their current obligations to policyholders, but their financial strength is vulnerable to adverse changes in underwriting and economic conditions.

C and C- (Weak)

Assigned to companies which have, on balance, weak balance sheet strength, operating performance and business profile when compared to the standards established by the A.M. Best Company. These companies, in A. M. Best's opinion, have an ability to meet their current obligations to policyholders, but their financial strength is very vulnerable to adverse changes in underwriting and economic conditions.

D (Poor)

Assigned to companies which have, on balance, poor balance sheet strength, operating performance and business profile when compared to the standards established by the A.M. Best Company. These companies, in A. M. Best's opinion, may not have an ability to meet their current obligations to policyholders and their financial strength is extremely vulnerable to adverse changes in underwriting and economic conditions.

"Rating Modifiers and Affiliation Codes" explained on next page.

E (Under Regulatory Supervision)

Assigned to companies and (possibly their subsidiaries/affiliates) that have been placed by an insurance regulatory authority under a significant form of supervision, control or restraint, whereby they are no longer allowed to conduct normal ongoing insurance operations. This would include conservatorship or rehabilitation, but does not include liquidation. It may also be assigned to companies issued cease and desist orders by regulators outside their home state or country.

F (In Liquidation)

Assigned to companies which have been placed under an order of liquidation by a court of law or whose owners have voluntarily agreed to liquidate the company.

NOT RATED CATEGORIES (NR)

NR-1 (Insufficient Data)

Assigned predominantly to small companies for which A.M. Best does not have sufficient financial information required to assign a rating opinion. The information contained in these limited reports is obtained from several sources, which include the individual companies and the National Association of Insurance Commissioners (NAIC). The data received from the NAIC, in some cases, is prior to the completion of their cross checking and validation process.

NR-2 (Insufficient Size and/or Operating Experience)

Assigned to companies that do not meet A.M. Best's minimum size and/or operating experience requirements.

NR-3 (Rating Procedure Inapplicable)

Assigned to companies that are not rated by A.M. Best, because the normal rating procedures do not apply due to their unique or unusual business features.

NR-4 (Company Request)

Assigned to companies that request that their rating not be published.

NR-5 (Not Formally Followed)

Assigned to companies that are not formally evaluated for the purposes of assigning a rating opinion.

Rating Modifiers and Affiliation Codes

Under Review (u) Rating Modifiers are assigned to Best's Ratings and Financial Performance Ratings to identify companies whose rating opinions are Under Review and may be subject to near-term change. Qualified (q) Rating Modifiers may be assigned to Health Maintenance Organizations (HMO's) and Canadian insurers that do not subscribe to our interactive rating process. Best's Qualified Ratings are therefore based primarily on a quantitative analysis of a company's balance sheet strength and operating performance. Best's Public Data (pd) Rating Modifiers may be assigned to UK and other European insurers that do not subscribe to our interactive rating process. Best's Public Data Ratings reflect both qualitative and quantitative analysis using publicly available data and other public information. Syndicate (s) Rating Modifiers are assigned to syndicates operating at Lloyd's. Affiliation Codes are based on a Group (g), Pooling (p) or Reinsurance (r) affiliation with other insurers.

Rating Modifiers	Affiliation Codes
u - Under Review	g - Group
q - Qualified	p - Pooled
s - Syndicate	r - Reinsured
pd - Public Data	

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