The Connecticut PARTNERSHIP FOR LONG-TERM CARE™

Policy Comparisons

Comparisons of Connecticut Partnership Long-Term Care Insurance Policies

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Connecticut Partnership for Long-Term Care
Office of Policy and Management
State of Connecticut

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How To Use This Report

This report is intended to provide basic information about the required features of Connecticut Partnership for Long-Term Care Insurance policies, and how the other features vary. **This report reflects the company's most recently approved Partnership policy. It does not compare or discuss all features of every policy.** ***In addition, this report reflects the various options available from the company, which sometimes includes multiple Partnership policies.*** Before you purchase a long-term care insurance policy, it is essential that you request and review a sample policy completely, compare it with other policies, and have all of your questions answered to your satisfaction by the insurance company, insurance agent, or by calling the Partnership's Consumer Information Service toll-free number in Connecticut **1-800-547-3443** (outside of Connecticut call 1-860-418-6318).

This report will not recommend a particular policy or insurance company. Nor will it recommend the appropriate premium you should pay based upon your income or assets. Instead, this report will assist you in determining whether long-term care insurance is appropriate for you, and if so, what considerations you should take into account in choosing the best policy for you. By following the steps below, you will become an informed consumer of long-term care insurance. Choosing a policy will be an involved process that is worth the time you invest. Always remember that you, not the state, your agent, nor a volunteer must make these decisions.

The following steps will help guide your decision-making process.

1. **Review "A Shopper's Guide To Long-Term Care Insurance",** which is available from insurance agents. The "Shopper's Guide" reviews what to look for in a policy and how to find good advice.
2. **Choose benefits** and features that meet your needs.
3. **Compare policies** using this report and by talking to agents who can provide you with the policies that meet your needs.
4. **Review total cost** of premiums, deductibles and co-payments (see Page 19).
5. **Choose a policy** that meets your needs (adequate asset protection, and appropriate benefits) at an acceptable cost.

This report reflects Partnership policies and the regulations for those policies in place on January 1, 2026. Contact your insurance agent for the most up-to-date policy information. Please note that the Partnership policies must meet stricter regulations than non-Partnership policies. This report will be updated periodically as features change, as new policies are approved, and as new regulations are passed. The information contained in this report has been taken from the policies themselves by the Connecticut Partnership for Long-Term Care staff and has been reviewed by representatives from the insurance company.

Publications - Free publications are available by calling the Partnership's Consumer Information Service at **1-800-547-3443** (toll-free in Connecticut – outside of Connecticut call 1-860-418-6318). Please note that each of these publications is contained in the Partnership's "Consumer Packet." The Partnership publications include:

- **"Planning Today for a Secure Tomorrow"-** *Description of long-term care, the Partnership, and appropriate candidates for the Partnership*
- **"Frequently Asked Questions" -** *Frequently asked questions about long-term care insurance and the Partnership program*
- **"Cost of Long-Term Care in Connecticut" –** *Provides private pay costs for nursing facility and home and community-based care in Connecticut.*

Website - You can also visit the Partnership's website at www.ctpartnership.org for additional information and to download the publications noted above.

Questions - Staff are available to answer your questions on the Partnership, and on Medicaid Asset Protection. Please call **1-800-547-3443** (toll-free in Connecticut – outside of Connecticut call 1-860-418-6318).

STAFF DO NOT SELL INSURANCE NOR DO THEY RECOMMEND ONE POLICY OVER ANOTHER.

Each Partnership policy must include the following features, which are not required of other long-term care insurance policies:

- Must offer the option to purchase a wide array of home and community-based benefits including, but not limited to, skilled nursing care, adult day health care, home health aide, homemaker services, respite care and occupational, physical, respiratory and speech therapies.
- Must provide, as part of a home care benefit, care management services designed to: make an individualized assessment, develop a coordinated plan of care, and monitor the policyholder's health and services provided. ***Care management services are not meant to restrict or limit benefits.*** Home and Community-based services must follow a Plan of Care that has been approved by an Access Agency (an approved care management company) in order for the services to count towards Medicaid asset protection.
- Must cover, as part of the nursing facility benefit, the variety of facility charges (e.g., room & board, therapies, nursing, laundry, etc.), up to the benefit amount purchased. *Please note the average cost for a semi-private nursing home room in Connecticut is $526 per day.*
- Must provide for inflation protection at a minimum rate of at least 3.0% compounded annually. This protection will be both automatic and for as long as the policy is active. Inflation protection can also be provided by paying benefits on a percentage of the average cost for private payers. When offered, persons age 65 and over can waive the lifetime maximum inflation protection, but the daily benefits must continue to inflate.
- At a minimum, provide daily benefit rates for Nursing Facility and Home and Community-Based benefits as follows:

Minimum Daily Benefit Rates		
Year of Application	Nursing Facility	Home and Community Based
2026	$344.00	$172.00
2027	$354.00	$177.00

For each additional year both minimum benefit rates will rise by at least 3.0% over the previous year, rounded down to the nearest dollar.

- Must offer the policyholder, in the event they are about to drop their policy, the option to switch their coverage to a shorter benefit period than originally purchased. The new lower premiums for the shorter benefit period must be based on the age of the policyholder when they bought their original policy. This offer need only be made once.
- Only Partnership policies provide Medicaid Asset Protection. This allows you to protect $1 in assets for every $1 paid in benefits. You must be a CT resident at two points in time to receive Medicaid Asset Protection: 1) when you buy your Partnership policy, and 2) when you need Medicaid to pay for your long-term care services. If you need long-term care services while in another state, your insurance will pay for services and those payments can count towards Medicaid Asset Protection when you apply to CT's Medicaid program or another state's Medicaid program that CT has a reciprocal agreement with. (Please call 1-800-547-3443 for information on reciprocal agreements with other State Medicaid programs.)
- Special "Partnership Certification" training is required for all agents before they can discuss, present or sell CT Partnership-approved policies.
- Must provide quarterly Asset Protection reports and any Service Summary reports to both the policyholder and the CT Partnership Office.
- Must display the Partnership logo, (see front cover), on each Application, Outline of Coverage, Policy, and marketing materials.

Each Partnership policy must include the following features, which are required of <u>all</u> long-term care insurance policies:

- Must guarantee that the policy is renewed until the policyholder dies, benefits are exhausted, or premiums are not paid in a timely manner.
- Upon the death of the policyholder with an active policy, refund any portion of any premium paid that applies to the period after death.
- Must allow you to identify someone to receive a notice if your policy were about to lapse (due to late payments).
- If a long-term care policy replaces another long-term care policy, the replacing insurer must waive any time periods for pre-existing conditions and probationary periods to the extent that similar time periods have already been satisfied under the original policy.
- Cannot exclude coverage for Alzheimer's Disease type conditions once a policy has been issued.
- Cannot require that you enter a hospital prior to receiving nursing facility benefits; or enter a nursing facility or hospital prior to receiving home care benefits.
- Cannot offer an "Elimination Period" (also called a deductible or waiting period) greater than one hundred (100) days.
- Must allow the consumer thirty (30) days to review the policy within which time the policy can be canceled by the consumer and any premiums paid will be refunded. This feature is referred to as the "Free Look Period."
- Must include a Contingent Nonforfeiture benefit which will provide a paid-up benefit if the policyholder's rate increases by a certain percentage. Must also offer, as an option, an additional type of nonforfeiture benefit.
- Must waive the payment of future premiums after benefits have been paid for a nursing facility stay of no more than ninety (90) consecutive days, until benefits are no longer being paid. Also, must waive the payment of future premiums after benefits have been paid for home and community-based care for a reasonable period.

Each policy may include some or all of the following restrictions, which are also allowed in <u>all</u> long-term care insurance policies:

- Claims **may be denied** due to material misrepresentation or fraud.
- Claims **may be denied** for pre-existing conditions during the six-month period after the effective date of the policy. The conditions are only those for which medical advice was given by, treatment was recommended by, or treatment was received from a physician within six months before the policy was issued.
- Claims **may be denied** when losses are caused by War; Mental disease or disorder without demonstrable organic disease; Suicide; Intentional self-inflicted injury; or Alcoholism or drug addiction.
- Claims **may be denied** when care or treatment is given at: Government institutions; Hospitals; or, with some companies, outside the U.S.

Required Company and Agent Practices

- Agents must have reasonable grounds for believing that the recommendation to purchase any long-term care insurance is suitable for the applicant based upon health and financial circumstances.

- Agents are prohibited from using high-pressure sales tactics.

- All advertising materials must identify the insurance company, agency or agent, and it must be clear that the purpose of the advertising materials is to solicit the purchase of insurance.

- At the time of application, every applicant must receive the following materials:
    1. Outline of Coverage
    2. Graphic comparison of the difference between increasing benefits vs. level benefits
    3. Long-Term Care Insurance Shopper's Guide – published by the National Association of Insurance Commissioners (NAIC)
    4. If eligible for Medicare, a copy of "Guide to Health Insurance for People with Medicare," when requested.

☆ In addition to the above bullet, agents are required to give every applicant for a Partnership-approved policy the following:
    1. Written statement on Mandatory Inflation Protection
    2. The publication "Before You Buy" – published by the State of Connecticut
    3. The toll-free consumer information phone number – answered by the Connecticut Partnership staff.

☆ This is required of Partnership-approved policies only.

Common Company Practices Which Are Not Required

- The "Coordination With Other Benefits" provision allows benefits from other insurance policies to be used to supplement the benefits of the Partnership policy, thus potentially stretching the time for overall coverage. Other types of insurance include:

  1. Medicare
  2. Medicare Supplement or Medigap
  3. Health Insurance
  4. Other Long-Term Care policies

  The specifics of the "Coordination With Other Benefits" provision vary amongst the policies. Check the policies carefully and ask your agent how this provision can affect the payment of benefits.

- Generally, companies will review an applicant's medical history to consider if the policy will be issued. Indications of certain chronic health problem(s) will most likely result in the company not issuing you the policy. This is called *"medical underwriting"*. However, each company uses different ways to define chronic health problems. Therefore, while one company might not accept you for coverage, another company might be willing to issue you a policy. Policies sold through a group or employer may not use medical underwriting or may ask only a few medical questions for *eligible persons* (such as an active employee*)* but will screen others who are able to purchase through the group, such as retirees and family members of active employees.

☎ Staff are Available to Assist You 1-800-547-3443
(toll-free in Connecticut – outside of Connecticut call 1-860-418-6318)

The Health Insurance Portability and Accountability Act of 1996 (the Act) states that "Tax Qualified" long-term care insurance will be treated in the same manner that health and accident insurance is treated under the Federal Income Tax Code.

This means that:

- Benefits paid by a "Tax Qualified" long-term care insurance policy will not be counted as taxable income to the policyholder; and
- Premiums paid by an individual for "Tax Qualified" long-term care insurance can be counted as an unreimbursed medical expense for those itemizing their deductions for Federal income tax purposes. (See chart below for some limitations); and
- Premiums paid by an employer for their employee's "Tax Qualified" long-term care insurance can be deducted in the same manner as a health insurance deduction.

These provisions only apply to what the Act defines as "Qualified Long-Term Care Insurance Contracts". A "Tax Qualified" policy is:

- Any long-term care insurance policy ***issued prior to January 1, 1997***. These policies are grandfathered under the Act and are considered "Qualified". Therefore, policies issued by December 31, 1996 are considered "Tax Qualified" for purposes of the Act.
- Policies ***issued after January 1, 1997*** must meet a set of standards described in the Act in order to be "Tax Qualified" policies. **Therefore, as of January 1, 1997, any long-term care policy wishing to be considered "Tax Qualified" for Federal tax purposes will need to meet all the standards listed in the Act.**

The Act provides the following schedule for how much of the premiums paid for a "Tax Qualified" policy can be applied as an unreimbursed medical expense for Federal income tax purposes for calendar year 2026. Individuals can use their actual premium amount up to the limitation noted in the chart.

Attained Age Before the Close of the Tax Year	Tax Limitation on Premiums* Calendar Year 2026
40 or less	$ 500
41 – 50	$ 930
51 – 60	$1,860
61 – 70	$4,960
71 and older	$6,200

* The Tax Limitation on Premium amounts will be increased each year by an amount equal to the adjustment of the medical care cost component of the Consumer Price Index, (as measured in August of the preceding calendar year), and rounded to the nearest $10. The above figures are for calendar year 2026.

Please note the deduction under the Act ***is not a straight tax deduction***. Individuals who have purchased a "Tax Qualified" long-term care insurance policy can count an amount of their premiums, *up to the amount noted in the chart above*, as an unreimbursed medical expense when they itemize their deductions. Therefore, in order to benefit from the tax deduction, an individual must:

- ✓ Itemize their deductions (use Schedule A); and
- ✓ Have an amount of unreimbursed medical expenses that ***exceeds*** 7.5% percent of their Adjusted Gross Income (AGI).

The amount an individual can then use for a deduction is the amount that exceeds the 7.5% percent figure.

FOR EXAMPLE: A 61-year-old single woman who has a Federal tax rate of 24%, has unreimbursed medical expenses equal to 7.5% of her AGI before counting her long-term care premium of $4,960. Under the Act, she can count all of her $4,960 long-term care premium as unreimbursed medical expenses and, therefore, she has $4,960 in excess of the 7.5% of her AGI. At her tax rate, she will be able to save $1,190 in taxes because of her long-term care insurance together with her other unreimbursed medical expenses. *[Note: If her unreimbursed medical expenses, including the* $4,960 *allowed for long-term care premiums, were equal to or less than 7.5% of her AGI, there would be* ***no*** *tax deduction.]*

Additional Comments:

- All of the Partnership policies described in this report have been approved by the Connecticut Department of Insurance as ***intended*** to be ***"Tax Qualified***." The Department of Insurance does not have the authority to approve the plans as "Tax Qualified;" therefore, it is the responsibility of the insurance company to develop their plan in order to meet the criteria to be "Tax Qualified."
- The standards noted in the Act are modeled mostly after the National Association of Insurance Commissioners' (NAIC) Model Long-Term Care Regulation and Act as of January 1993. For specific information on the standards, contact either your insurance company or the Connecticut Partnership office.
- **You should discuss the tax implications of purchasing long-term care insurance with your accountant or tax advisor.**

In addition to the "Required Policy Features" listed in Section 2, the Connecticut Partnership for Long-Term Care has developed "Standards of Excellence" intended to improve on the already high standards required by regulation. The following list indicates which "Standards" the participating company has met. A check ✓ indicates the standard is included in the policy contract.

Policy Features	**Bankers Life**
Provide paid-up options (e.g., 10 year, 20 year).	
Provide discounts for domestic partners.	✓
Offer persons age 65 and over the option of only inflating their daily, weekly, or monthly coverages.	
Use or Offer Weekly or Monthly limits for home & community-based benefits.	✓
Offer shorter term coverage (i.e. 1 and/or 2 years)	✓

Policy Features	**Bankers Life**
Lifetime Maximum Benefit	
Initial Amount of Coverage or Potential Medicaid Asset Protection. (Years of Coverage)	$127,750 - $438,000 (1, 2, 3, yrs)
Amount of Coverage for Shared Benefit between Spouses	$127,750 - $438,00 ***(In addition to the Initial Amount of Coverage listed above.)***
Premiums	
How long do you have to pay premiums until you need care and premiums are waived (see below)?*	Lifetime
When are Premiums waived for Home & Comm. Based services?	After Elimination Period ◈
When are Premiums waived for Nursing Facility services?	After Elimination Period

◈ Three days will be counted for each day of care received.

* Some insurers offer riders that allow premiums to be waived for one spouse while the other spouse is receiving benefits or riders where the premiums may be waived after one spouse dies. Please contact the insurer or your agent for more details.

Policy Features	Bankers Life
Inflation Protection	
Automatic Increase in Daily Benefit	5% Comp. Annually
Automatic Increase in Lifetime Benefit.	5% Comp. Annually
Benefit Amounts*	
Nursing Facility	$350 –$400 per day
Home & Community Based (HC)	$5,250 – $12,000 per month
Assisted Living	50% or 100% of Nursing Facility Daily Benefit Amount
Maximum Annual Respite Care Benefit in a Nursing Facility (NF)	21 days @ HC benefit
Maximum Annual Respite Care Benefit at Home or in the Community (HC)	21 days @ HC benefit

* The minimum daily benefits are adjusted annually. See page 3 for minimum daily benefits.

Policy Features	**Bankers Life**
Elimination Periods (EP) *Days*	
Nursing Facility (NF)	0, 15, 30, 60, 90
Home & Community Based (H&C), and/or Adult Day Care	Integrated with NF period
In order for a day to count towards the E.P., do covered services need to be received?	Yes ♣
E.P. is met by counting "service" or "calendar" days	Service Days♣
Once the E.P. has been met, do you have to meet it again?	No
Nonforfeiture Options *	
At Time of Lapse	Reduced Paid Up, Contingent & Return of Premium

* Reduced Paid Up - receive reduced benefits without having to continue paying premiums.
Contingent – receive reduced benefits without having to continue paying premiums as a result of premium increases above specified limits.
Return of Premium – some or all of previously paid premiums will be returned upon lapse of the policy or the death of the policyholder – various options are available depending on the insurance company.

♣ Three days will be counted for each day of care received for Home and Community Based Care.

❁ An optional 0-Day Elimination Period is available for Home and Community Based Care.

Policy Features	**Bankers Life**
Insured Event *What triggers benefits?*	
Functional Impairment	
Degree of *Assistance* or *Supervision* required with Activities of Daily Living (ADLs) *(Tax Qualified Plans require certification that the impairment is expected to last at least 90 days.)*	Substantial assistance from another individual for at least 90 days❁
Number of ADLs checked below that will trigger insurance benefits	2 - All benefits
Bathing♥	✓
Dressing♥	✓
Eating ♥	✓
Toileting♥	✓
Transferring♥	✓
Continence♥	✓
Cognitive Impairment	
Degree of *Supervision* required, failure of *Standardized Tests* (Failure), or exhibiting *Behavioral Problems* (Behavior)	Substantial supervision for "Failure" or "Failure with Behavior"

❁ "Substantial assistance" includes hands-on or standby assistance.

♥ When a person needs the level of assistance or supervision needed with two or more of the Activities of Daily Living (ADLs) checked above, the policy's insured event has been met.

Policy Features	Bankers Life
Home Care Offerings	
Are Nursing Facility only plans available in addition to comprehensive plans (home care included)?	Comprehensive and NF only
Do Initial Assessment fees reduce Lifetime Benefits?	No
Do other Case Management costs reduce Lifetime Benefits?	No
Restoration of Benefits	
If care is no longer needed for 180 consecutive days, will Lifetime Benefit be restored?	Yes, with optional rider
Pre-Existing Conditions	
When are pre-existing conditions **admitted** or **not admitted** ☹ on the application covered?	Covered Immediately
Mental & Nervous Disorders	
After you have been approved for the insurance which mental or nervous disorders will be covered.	All Mental or Nervous Disorders including Organic Diseases ↯

☹ Intentional errors or omissions can lead to an invalid policy. It is in your best interest to admit to all health conditions at the time of application.
↯ Organic Diseases include, Alzheimer's & Parkinson's Diseases, and Senile Dementia, which must be covered by ALL policies.

Policy Features	Bankers Life
Selected Services Provided♥	
Nursing Facility (NF) Services	✓
Skilled Nursing Care	✓
Physical, Occupational, and Speech Therapy	✓
Respiratory Therapy	✓
Home Health Aide and Homemaker Services	✓
Adult Day Health Care	✓
Care Management Services	✓
Alternative Plan of Care *	✓
Assisted Living: Room & Board	✓
Assisted Living: Services	✓
Chore Services	✓
Emergency Response System	✓
Hospice Care	✓
Home Delivered Meals	✓
Informal Caregiver Training	✓
Medical Equipment - Durable	✓
NF Bed Hold / Reservation	✓
Nutritionist / Dietitian	✓
Respite Care	✓

♥ Benefits paid for any service (home & community-based services must be part of a Plan of Care) will earn Medicaid Asset Protection.
* Allows policyholder to possibly receive services not specifically listed in the policy, subject to the insurance company's approval.

How to Evaluate Discounts -- Do not choose a policy just based upon its discount!
Once you have chosen the policies that include the features that meet your long-term care needs, then you are ready to compare premiums and investigate discounts. Discounts vary depending on the type of discount and the insurance company.

PLEASE NOTE, A POLICY THAT INCLUDES THE FEATURES YOU NEED BUT HAS NO DISCOUNT MAY STILL BE MORE AFFORDABLE THAN A POLICY WITH A LARGE DISCOUNT.

Policy Features	**Bankers Life**
Discounts Offered	
Household, Spousal or Partner Discounts ♣	Yes
Buy through a "group" ♦	Yes
Purchase Options	
Married couple or partners can: share 1 policy, share extra policy, or share one another's policy	Yes, share extra policy
International Coverage	
Where benefits are payable:	Worldwide
Limitations	Lifetime maximum = to 30 times Nursing Facility Care Maximum Daily Benefit
Age at Time of Purchase	
Full Benefits for individuals	18 - 84
Full Benefits for "groups" ♦	18 - 84
Reduced Benefits	Full Benefits Offered

♦ "Group" offerings may offer premium discounts and are commonly offered through employers to their employees, retirees, and their families (spouses, parents, in-laws, grandparents and sometimes adult children and their spouses), even though the insurance is an "individual" policy. Other types of groups and associations can also arrange for discounts. However, the arrangements vary by insurance company.

♣ A "Yes" indicates the company has a least one of these types of discounts but not necessarily all 3.

The cost of long-term care insurance, expressed in premiums paid to an insurance company, is one of the most important factors in deciding whether, and from which company, to purchase long-term care insurance. It is also one of the most complex. The policies vary greatly, making comparisons of premiums more like comparing apples and oranges. What follows are the factors (or features) that will affect the premium.

Factors that Affect Premiums:

1. **Age**	Age is the single **most important factor**. Insurance companies price their policies according to the age of the applicant with the older your age, the more expensive the premium. Therefore, it is advantageous to start the planning process at as young an age as possible. As you reach your sixties, an upcoming birthday can have a significant impact if you wait to purchase a policy.
2. **Elimination Period**	The longer the elimination period (i.e., 90 days instead of 30 days) the less expensive the premium.
3. **Daily & Lifetime Benefit**	The greater the benefit purchased the higher the premium, (weekly or monthly benefits are also available at a higher premium).
4. **Benefits purchased**	The type of services covered can impact the premium, (i.e., a comprehensive plan that covers both home care and nursing facility care will cost more than a nursing facility only plan).
5. **Riders or Options**	Additional features, such as a non-forfeiture benefit, will increase the premium.
6. **Spousal or Partner Discounts**	Most companies will provide for some discount if both spouses purchase a policy from the same company. Other companies offer a discount if two adults are living together even if only one person purchases a policy.
7. **Group Discounts**	Purchasing a policy through a group offering such as through your employer or an association may decrease the premium. Check to see if your, or any family member's, employer offers such a benefit to their employees and retirees. (See previous page.)
8. **Paid Up Options**	Premiums can also be paid up within a specific period (e.g., 10 or 20 years) of time, in which case the annual premium for the specified period is higher than the annual premium would be if it was paid for the lifetime of the policyholder or until they need care.
9. **Health Factors**	Some companies offer lower premiums for applicants in very good health and higher premiums for applicants with particular health conditions.

Premiums will remain the same for your lifetime unless the insurance company gets state approval to change premiums for an entire "class" of policyholders. **An individual policyholder cannot be singled out for a premium increase.**

CONSUMER TIPS ON PREMIUMS

- Buy at a young age - while you are healthy and the premiums are more affordable.
- Know what you are buying - a low cost plan may mean that you will pay a high deductible and/or co-payment.
- Most policies are not directly comparable with other policies due to the wide range of benefits available. Therefore,

PLEASE SHOP AROUND! COMPARE PREMIUMS, BENEFITS, DEDUCTIBLES AND CO-PAYMENTS!

If you decide that purchasing a long-term care insurance policy is an affordable option for you, then you must choose how much insurance to buy. Several factors, in addition to the premium charged for the insurance, should be considered. If you just compare premiums, many of the future costs associated with the need for long-term care services can be overlooked. These factors include:

- **Deductible or Elimination Period;**
- **Amount of Coverage; and,**
- **Actual Costs of Care.**

An example of each factor will illustrate its importance on what your costs may be if you do need long-term care services in the future.

Deductible or Elimination Period:

As with most insurance, the higher the deductible the lower the premium. As the policyholder, you are responsible for paying the cost of your care during the deductible period; (the period of time before your insurance policy begins to pay). This cost may be covered by other insurance, such as Medicare, or you may have to pay for the care out of your pocket. Therefore, while a higher deductible may reduce your premium, your future out-of-pocket costs may be higher.

Amount of Coverage and **Actual Costs of Care:**

It will be helpful, when deciding how much insurance to purchase, to examine what level of assets you wish to protect through a Partnership policy. If the answer were $200,000, then you would be looking to purchase $200,000 worth of coverage. The next decision is what amount you want the policy to pay on a daily basis. If you choose $344 per day of long-term care coverage the policy would pay benefits for approximately 1 ⅔ years. However, if you choose $526 per day the policy would pay benefits for approximately 1 year and 1 month.

The amount you choose the policy to pay on a daily basis will affect your co-payment costs -- the difference between the actual cost of care and what the insurance will pay. Using the average cost of $526 per day for nursing facility care, the policy that pays $344 per day will require a $182 per day co-payment; the policy paying $526 per day will **not** require a co-payment.

Of the two examples described above, the policy that pays $344 per day for approximately 1 ⅔ years of coverage will generally have lower premiums. However, as the example illustrates, the tradeoff of a lower premium could be higher co-payments. The key factors will be what the actual cost of care is and what amount of income you can spend for co-payments. Therefore, when deciding how much insurance to purchase it is important to determine what the average cost of care is in your area.

A helpful guide in deciding how much, and whether, to purchase a Partnership policy, is that your **income plus your insurance benefits should be equal to or greater than the cost of your care.** If it is not, then you will need to use some of your assets to pay for your care, which may include some of the assets you hope to protect.

* Some policies pay the charges up to the average private pay rate for each service received which may not be the same amount each day.

Insurance Company	Website Address
Bankers Life and Casualty Company *Individual Policy - sold to individuals*	www.bankerslife.com

Your comments are welcome. Please direct inquiries and comments to:

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