

LONG-TERM CARE INSURANCE: HOW DOES IT WORK?

- What determines if you're entitled to benefits?
- Who determines if you're entitled to benefits?
- When will benefits start?
- The mechanics of filing a claim

Whether you've had a long-term care insurance (LTCI) policy for years or you're thinking of buying one, it's critical to understand exactly what set of conditions will trigger coverage. This information is the bread and butter of any LTCI policy. In addition, you should know how to file a claim, preferably before you're on the verge of needing care.

What determines if you're entitled to benefits?

LTCI policies differ on how benefits are triggered, so it's crucial to examine your individual policy. Here are some typical ways you can become eligible for benefits:

- You're unable to perform a certain number of activities of daily living (ADLs) without assistance, such as eating, bathing, dressing, continence, toileting (moving on and off the toilet), and transferring (moving in and out of bed). Look in your policy to see what ADLs are included, the number you must be unable to perform, and how your policy defines "unable to perform" for each ADL, as criteria can vary from one company to another (e.g., does the definition require someone to physically assist with the activity or simply to supervise the activity?).
- Your doctor has ordered specific care.
- Your care is medically necessary.
- Your mental or cognitive function is impaired.
- You've had a prior hospitalization of at least three days (this is rare with newer policies).

An LTCI policy may contain one or more of these provisions. The more specific the language in the provision, the less room for disagreements about coverage.

Who determines if you're entitled to benefits?

Just as important as what triggers benefits is the question of who decides if you've triggered them. These gatekeepers are an integral part of any LTCI policy—after all, they're the ones whom insurance companies rely on before paying out claims. In some cases, a policy may have more than one gatekeeper.

The best policies let you qualify for benefits if your own doctor orders specific care, rather than require that you be examined by an insurance company physician. Similarly, it's insurance companies that define performance criteria for ADLs, as well as create and administer tests to see if you satisfy the mental impairment threshold. Make sure you know who the ultimate decision maker is under your policy.

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When will benefits start?

Most LTCI policies have a waiting period, commonly known as an elimination period, before you can start receiving benefits after you're judged medically eligible. Common waiting periods are 20, 30, 60, 90, or 100 days. During any waiting period, you're responsible for paying for your care, whether it's in a nursing home, an assisted-living facility, or in your home.

Some LTCI policies have no waiting period—you can start receiving benefits on the first day you need care. However, this type of policy is more expensive than a policy with a waiting period. Generally speaking, the longer the waiting period, the less expensive the policy.

Keep in mind that the calculation of the waiting period can vary from company to company. Some companies may count the days cumulatively (e.g., adding up the total number of days you spend in a nursing home, even with gaps), while others may count the days consecutively (e.g., adding the total number of days you spend in a nursing home without interruption). Also, some companies require only one waiting period for the life of the policy, while others require a waiting period every time you apply for benefits (unless you become eligible for benefits again within a certain period of time, such as six months or a year, in which case only one waiting period will need to be satisfied).

The mechanics of filing a claim

Ideally, you should know how to file a claim before you actually need benefits—you don't want to lose coverage on a technicality. Typically, filing a claim means submitting a written notice to the insurance company, along with a proof-of-loss form (supplied by the insurance company) and relevant medical records.

Most policies require you to give written notice of a claim within a specific time after needing care (e.g., 30 or 60 days). In addition, you may need to verify your condition in writing every 30 to 90 days. The company may also require you to submit to an independent medical evaluation by a physician of its choosing to verify your claim.

Follow the instructions in your policy carefully. If you don't, your insurance company can deny you benefits, in which case your only recourse will be to make a complaint with your state insurance department or file a lawsuit (and most companies limit the period of time in which you can file a lawsuit). Don't let all those premium payments go to waste—take the time now to understand the claims-filing process for your policy.

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Final Page - Disclaimer

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