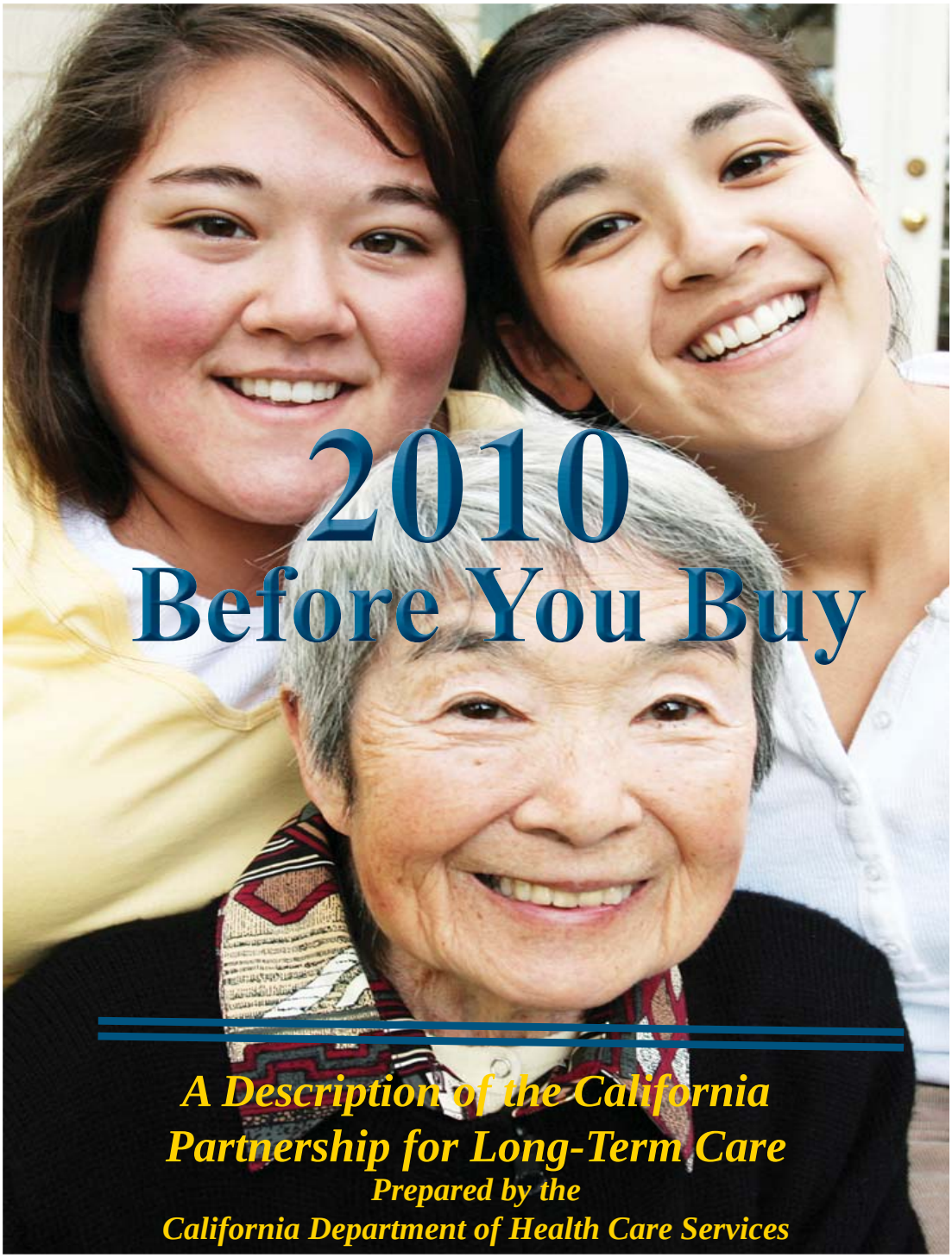
CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE



2010 Before You Buy

A Description of the California Partnership for Long-Term Care

Prepared by the California Department of Health Care Services

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Only long-term care insurance policies bearing any of the California Partnership for Long-Term Care logos (shown above) are approved by the State of California, Department of Health Care Services, California Partnership for Long-Term Care.

Insurance companies may sell several different long-term care insurance policies. But only policies bearing any of the three Partnership logos shown above and the following statement boldly displayed on the first page of the outline of coverage qualify for a Medi-Cal asset disregard. This statement reads:

"THE BENEFITS PAYABLE BY THIS POLICY/CERTIFICATE QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE."

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Please take your time and read this brochure carefully. If any information is unclear, please contact the California Department of Aging, Health Insurance Counseling and Advocacy Program (HICAP) 1-800-434-0222. HICAP can also provide you with a copy of "Taking Care of Tomorrow: A Consumer's Guide to Long-Term Care," which contains a checklist of terms and options you should examine in evaluating long-term care insurance.

Before You Buy …

A description of the California Partnership for Long-Term Care, a program of the Department of Health Care Services

The California Partnership for Long-Term Care (LTC) is an alliance between the State of California's Medi-Cal Program, private long-term care insurance companies, and you–Californians interested in planning for your own, or a loved one's, potential long-term care needs.

You have probably read other materials about the California Partnership for LTC and about specific LTC insurance policies approved by the California Partnership. Should you decide to purchase a Partnership-approved LTC insurance policy, you will receive documents from your Insurer, detailing all of the provisions of your insurance policy.

This booklet from the California Department of Health Care Services will inform you about Medi-Cal's role in the California Partnership. It will explain in detail the special Medi-Cal asset protection feature unique to Partnership-approved LTC insurance policies. It will also discuss:

- How the Partnership asset protection is determined and documented;
- When and how you could transition from your private LTC insurance coverage to Medi-Cal;
- What requirements you would need to meet for Medi-Cal eligibility; and
- What services you would be entitled to once you were eligible for Medi-Cal.

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Unique Features of Partnership Policies

The California Partnership for Long-Term Care has four special features to help you plan to meet your long-term care needs.

1 Insurance policies sold under the Partnership are required to meet stringent insurance standards. Many of these standards are more strict than those applied to long-term care policies not participating in the Partnership.

2 Policies sold under the CA Partnership allow you to protect assets equal to what your Partnership policy paid for long-term care services in addition to the amount Medi-Cal would normally allow. These protected assets will be disregarded if you apply for the Medi-Cal program.

3 With a Partnership policy, you may elect to buy insurance equal to the amount of assets you want to protect to achieve lifetime protection against the costs of long-term care. This will make purchasing insurance coverage more affordable for many.

4 Impartial consumer information and assistance from the California Department of Aging's HICAP are available to assist you in evaluating whether a Partnership policy is right for you. Just call 1-800-434-0222.

Additional Standards for Partnership Policies

All long-term care policies sold in California must meet certain consumer standards established by state law. All Partnership policies include many additional standards. Among those standards are the following provisions:

- All Partnership-approved policies use the same set of criteria to determine eligibility for benefits. These criteria are based on the inability to perform activities of daily living and/or cognitive limitation;

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- The Department of Health Care Services has established minimum daily benefits for these policies to guarantee you receive meaningful coverage;

- Mandatory automatic inflation protection is included to help assure that your coverage will keep pace with the expected increases in the cost of care;

- Waiver of premium for all days your policy pays for care in a Residential Care Facility or a Nursing Facility;

- Provisions are included to keep your coverage affordable after you purchase a policy. Among these requirements are limits on any future rate increases; and

- Requirement that Residential Care Facility coverage be included.

Other Important Provisions

Residency Requirements

The California Partnership for LTC is designed to help California residents pay for long-term care needs. Residency must be established at two points:

- In most cases, you *must* be a California resident to buy a Partnership approved long-term care policy; and

- You *must* be a California resident when you apply for Medi-Cal and take advantage of your accumulated Partnership asset protection.

Should you need long-term care services while you are in another state, your policy will pay for your needed care and these insurance payments will count toward your Partnership asset protection. However, the Partnership asset protection is only recognized by the CA Medi-Cal program. You would need to return to California to apply for Medi-Cal and take advantage of your Partnership asset protection.

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Eligibility for Benefits Under Your Partnership Policy

All Partnership policies use the same criteria to determine eligibility for benefits. This is called the "insured event". Eligibility does not automatically occur because you have a heart attack or break a hip. To meet the insured event two types of criteria are used:

- The need for substantial human assistance or constant supervision in performing normal Activities of Daily Living, called ADLs (which include bathing, dressing, eating, transferring to/from a bed or chair, getting to and using the toilet as well as maintaining continence); *or*

- Severe cognitive impairment such as Alzheimer's Disease or other types of dementia that limit cognitive abilities.

As a Partnership policyholder, you (or a family member) should contact your insurance company *immediately* if you believe you meet your policy's insured event. If you enter a hospital or nursing home, inform the admissions staff that you have long-term care insurance.

Care Management

All Partnership policies include a built-in care management benefit. It is important to understand what role a care manager will have in your care. A care manager is a health care professional or a social worker who is employed by a care management agency that provides assessment, care coordination, and monitoring. She or he will work with you to assess your circumstances, determine the specific services you need, develop a plan of care to address your needs and, if you desire, coordinate and monitor services to insure you are cared for appropriately.

The care management agencies your Insurer contracts with, and that agency's individual care managers, are all required to meet specific standards established by the California Partnership for LTC.

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What Does Medi-Cal Asset Protection Mean?

Medi-Cal asset protection is an essential feature of long-term care insurance policies participating in the California Partnership for Long-Term Care. Asset protection is a right extended to you by California law when you use the benefits of a Partnership policy/certificate. This right allows you to protect one dollar of your assets for every dollar a Partnership policy pays out in benefits, in the event you later apply for Medi-Cal benefits or other qualifying public long-term care benefits.

The amount of this asset protection at any time is equal to the sum of all benefit payments made for your care by this policy. Should you later apply for Medi-Cal or for other qualifying public long-term care benefits, you will not be required to expend your protected assets before becoming eligible. Your protected assets will also be exempt from any claim the State of California may have against your estate to recover the cost of State-paid long-term care or medical services provided to you.

The Partnership guarantees a dollar's worth of asset protection for each dollar your insurance pays out for long-term care services. This permanent asset protection is over and above the asset amounts Medi-Cal normally exempts. *(See Appendices A and B for the Medi-Cal Property and Asset Limits.)*

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You may need some services that are not covered by your insurance plan. You will have to pay directly out of your income or assets for any needed services that are not included in your insurance benefits. These out-of-pocket payments will not be included in calculating the Partnership asset disregard you are entitled to when applying for Medi-Cal. (See Appendix C for more details).

Do All Insurance Benefits Qualify for the Asset Disregard?

All of the services covered in your Partnership Long-Term Care policy will count toward your Partnership asset disregard. When you begin receiving benefits, your Insurer will send you a quarterly "Medi-Cal Property Exemption Report" that documents the insurance benefits paid out, the amount of asset protection earned during that quarter, and the cumulative asset protection you have received. It is your responsibility to check the accuracy of these quarterly statements and report any errors to your Insurer.

If you exhaust your insurance benefits or you cancel your policy, your Insurer will automatically provide you with a Service Summary statement documenting the total amount of Partnership asset protection you are entitled to. You should keep this statement with your other important insurance documents. Should you apply for Medi-Cal, you will be required to submit this Service Summary statement to your county welfare office (usually the County Department of Social Services) to verify the additional Medi-Cal asset disregard you are entitled to.

When To Apply for Medi-Cal

You may apply for Medi-Cal when the asset protection you have accumulated from your Partnership insurance pay outs (as indicated in your quarterly "Medi-Cal Property Exemption Report") comes close to the current amount of your personal assets. Remember, the Partnership asset protection is over and above the asset amounts Medi-Cal normally exempts.

Medi-Cal eligibility is not automatic. You must apply for Medi-Cal to become eligible for public assistance. To become eligible for Medi-Cal, you must:

- Be aged, blind, or disabled;
- Be a citizen or have satisfactory immigration status; and
- Meet the Medi-Cal property and asset requirements.

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SHARE OF COST is the amount you may have to pay each month toward the cost of your health and long-term care, before Medi-Cal will begin paying. Your share of cost may change when your monthly income changes. You only pay a share of cost in a month when you actually get health or LTC services (See Appendix B for more details).

Once your eligibility has been determined, you may be required to pay, from your income, a monthly "share of cost" for your care.

Once accepted by Medi-Cal, you are eligible for all services that Medi-Cal covers. Medi-Cal services may be different than those you received under your private long-term care insurance. For example, Medi-Cal has no limits on the number of days covered, if they are medically necessary. **However, Medi-Cal will not pay for your stay in a Residential Care Facility.** Medi-Cal will pay for some nursing services in the home, including services in a Residential Care Facility, if that is where you live, and if you are temporarily or permanently unable to leave your home. For example, if you are recently discharged from a hospital, Medi-Cal will pay for follow-up care which can be provided in your home.

How to Apply for Medi-Cal

In applying for Medi-Cal, you must give your *Service Summary* report from your Insurer to your county welfare office. The *Service Summary* will list the Medi-Cal approved benefits your Insurer has paid. This will verify the value of assets, over and above those normally exempted, that Medi-Cal will allow you to keep. It generally takes two months to process a Medi-Cal application, although that processing time varies from county to county.

Insurance Records/Release of Information

The California Department of Health Care Services requires all insurers to maintain detailed records on the individuals who participate in the Partnership. These statistics will be collected to evaluate whether the Partnership is a cost-effective long-term care program. Insurers are required to document the long-term care benefits that have been paid out on your behalf to verify your claim for asset protection. Participating insurance companies must also meet certain Medi-Cal auditing requirements detailed in the Partnership insurance regulations.

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To meet these requirements, if you purchase a Partnership policy, your insurance company will ask you to sign an agreement that allows them to release information about you to the Department of Health Care Services. You will also be asked to provide general information on your income and assets. This information will only be used to help evaluate the effectiveness of the Partnership. This information will be held strictly confidential.

Consider Carefully…

Remember, long-term care insurance is not a substitute for Medicare, Medicare Supplemental Insurance (Medigap) or Major Medical Insurance. They all cover specifically different kinds of needs.

DO NOT CANCEL ANY CURRENT INSURANCE YOU MAY HAVE UNLESS YOU ARE SURE IT IS IN YOUR BEST INTEREST TO DO SO.

Review your circumstances with a knowledgeable and unbiased person if you are confused. If you doubt whether you have enough assets to protect, or enough resources to pay for a long-term care policy, DO NOT BUY A POLICY. There are other options you should consider.

The Department of Aging's HICAP volunteers can answer specific questions you may have about the Partnership, help you understand the differences between the policies you are reviewing, or discuss other financing options for you to consider.

Call 1-800-434-0222 to request counseling assistance or to receive the Department of Aging's "Taking Care of Tomorrow: A Consumer's Guide to Long-Term Care."

BE AN INFORMED CONSUMER

The California Partnership for Long-Term Care, the State of California and the Department of Health Care Services do not endorse any Partnership company long-term care insurance policy over another.

This publication is for education and consumer information only.

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Appendices

APPENDIX A — Medi-Cal Property and Asset Limitations

There are property/asset limits for the Medi-Cal program. If your property/assets are over the Medi-Cal property limit, you will not get Medi-Cal unless you lower them according to the program rules.

The county looks at how much you and your family have each month. If your property/assets are below the limit at any time during that month, you will get Medi-Cal, if otherwise eligible. If you have more than the limit for a whole month, you will be discontinued until you are once again below the limits.

The home you live in, furnishings, personal items, and one motor vehicle are not counted.

A single person is allowed to keep $2,000 in property/assets, the limit is higher if you are married or have a family.

For more information, please ask your county welfare office (usually the Department of Social Services) for a form called "Medi-Cal General Property Limitations for all Medi-Cal Applicants" (MC Information Notice 007).

APPENDIX B — Medi-Cal Property and Asset Limitations for Married Couples When One Spouse is in a Nursing Home

If one spouse (husband or wife) goes into a nursing home, and the other spouse is still at home, the spouse at home may keep up to $109,560 while the institutionalized spouse may keep $2,000 (this is the amount allowed in 2010; the amount is adjusted by the annual increase of the Consumer Price Index).

In 2010, the spouse at home may keep all of the couple's income he/she receives in his/her own name. If this amount is under $2,739 per month, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse's income up to at least $2,739 per month. This is referred to as the at-home spouse's "monthly maintenance needs allowance." (This amount is also adjusted annually by the cost of living increase.)

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The at-home spouse may retain additional income or assets through a "fair hearing," or by court order. The spouse in the nursing home is permitted to keep $35 a month for personal needs.

APPENDIX C — Medi-Cal Share of Cost

If you are on Medi-Cal, you may need to use some portion of your monthly income from Social Security, a pension, etc. to pay for your health and long-term care expenses. Your income will probably not be enough to pay the entire bill, so Medi-Cal will pay the rest of your nursing home bill or any other medical expenses you may have.

You will be allowed to keep a certain amount of your income each month. In 2010, you may keep the following "Maintenance of Need" amount:

- If you are living in the community, an individual may keep $600*, a married couple $934*; or

- If you are in a nursing home, an individual may keep $35 for personal needs. If he or she has a spouse at home, the at-home spouse may keep all of the couple's income he/she receives in his/her name. If this amount is under $2,739 per month, a monthly allocation may be made from the institutionalized spouse to the at-home spouse to bring the at-home spouse's income up to at least $2,739 per month.

In determining your share of cost, Medi-Cal will calculate the applicant's/institutionalized spouse's total monthly income. This figure is your net income. The county will subtract the allocation to the at-home spouse, if applicable. Then the "Maintenance of Need" amount is subtracted from your net income. The remaining amount is your monthly share of cost—the amount you would have to spend on medical or long-term care before Medi-Cal begins payment.

For more detailed information on how the Medi-Cal share-of-cost is calculated, contact your county Department of Social or Human Services (also known as the county welfare office).

*There may be other adjustments allowed based on individual circumstances.

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The Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) provides consumer information and counseling on health and long-term care insurance issues. For printed materials, help with a question you may have, or an appointment with a trained volunteer counselor, just call 1-800-434-0222.

THE MISSION OF THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

The mission of the California Partnership for Long-Term Care is to increase the number of middle income Californians who have quality long-term care insurance coverage that prevents or delays their dependence on Medi-Cal.

The California Partnership for Long-Term Care is a program of the California Department of Health Care Services.

CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

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Visit the Partnership's web site at **www.dhs.ca.gov/cpltc.**

To get free brochures about the Partnership call **1-800-CARE-445.**

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