



CONSUMER PARTICIPATION AGREEMENT
2/2/100 DOLLAR FOR DOLLAR PLAN
NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE

PURPOSE

The New York State Partnership for Long-Term Care (“the Partnership”) is authorized by New York State Social Services Law Section 367-f, as amended by Chapter 659 of the Laws of 1997 and Chapter 58 of the Laws of 2004. Its purpose is to help New York State residents plan long-term care financing. The Partnership operates under the direction of the New York State Department of Health in consultation with the New York State Department of Insurance and the New York State Office for the Aging.

Under the Partnership, persons who purchase Partnership policies/certificates (“Participating Consumers”), and who use a certain amount of benefits under these policies/certificates, can apply for Medicaid Extended Coverage. Medicaid Extended Coverage means that all or a partial amount of the Participating Consumer’s resources will be disregarded in determining eligibility for Medicaid, and that such amount of “protected resources” will not be subject to Medicaid liens and recoveries. Section C below provides a more complete description of Medicaid Extended Coverage as it pertains to the type of Partnership policy/certificate you are purchasing.

The standards for Partnership policies/certificates are found in New York State Department of Insurance Regulation 144 (11 NYCRR 39). All Partnership-approved tax-qualified policies/certificates issued by Participating Insurers on and after January 1, 1997 shall comply with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and shall comply with all applicable requirements stipulated in federal regulations promulgated under the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and shall also meet the standards required under New York State laws and regulations for favorable New York State tax qualification status.

General information about the Partnership is available by calling 1-888-NYS-PLTC (1-888-697-7582) from within New York State, or (518) 474-0662 or (518) 486-9057 from anywhere.

A. DEFINITIONS

1. A **Participating Consumer** is a person who has signed this Agreement and has purchased a Partnership policy/certificate from a Participating Insurer.
2. A **Participating Insurer** is a private insurer which offers a Partnership insurance policy/certificate approved under New York State Department of Insurance Regulation 144 (11 NYCRR 39), and signs the Insurer Participation Agreement.
3. A **Partnership Certified Agent/Broker** is an agent or broker authorized to sell accident and health insurance by the New York State Department of Insurance and who has successfully completed a Partnership-Medicaid specific training course

required by the New York State Department of Health. At least one Partnership Certified Agent/Broker must be directly involved in the marketing and sale of a Partnership policy/certificate, where the involvement of an agent/broker is required.

4. A **Partnership policy/certificate** is long-term care insurance which is sold by a Participating Insurer and which has been approved by the New York State Department of Insurance as meeting the minimum requirements for a Partnership policy/certificate. Under Department of Insurance regulations, approved policies/certificates must display the Partnership logo.
5. A **2/2/100 policy/certificate** is a Partnership policy/certificate that provides a minimum of 24 months of nursing home care coverage or 24 months of home care coverage, or some combination of the two, with a minimum home care daily benefit equal to 100 percent of the minimum nursing home daily benefit, and provides such other minimum coverage as required by New York State Department of Insurance regulations at 11 NYCRR § 39.6.
6. **Resources** (accumulated assets) are property of all kinds, including real property and personal property.
7. **Protected resources** under a 2/2/100 policy/certificate are an amount of resources equal to the total dollar amount of the insurance benefits paid on behalf of the Participating Consumer.
8. **Income** includes payments from any source, received on a one-time or recurring basis, whether earned or unearned. Income from all sources, including income generated by accumulated resources, both protected and unprotected, is counted in determining eligibility for Medicaid Extended Coverage.

B. AGREEMENT CONDITIONS

This Agreement provides information concerning the advantages and responsibilities of participating in the Partnership as a Participating Consumer. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THIS AGREEMENT before choosing to participate in the Partnership. For full details about the Partnership and Medicaid Extended Coverage, please see the Partnership publication entitled *Consumer Booklet: Affordable Financing for Long-Term Care*. To determine the status of an agent/broker as a Partnership Certified Agent/Broker, you can check the Partnership web site (www.nyspltc.org) or call the Partnership program office at (518-474-0662) or (518) 486-9057.

The Partnership follows guidelines of the National Association of Insurance Commissioners Model Act and Regulation regarding the consumer's financial suitability to purchase long-term care insurance. In accordance with the guidelines, the selling Partnership Certified Agent/Broker or Participating Insurer is required to provide you with the "Long Term Care Insurance Personal Worksheet" (from the latest published *A Shopper's Guide to Long-Term Care Insurance*, National Association of Insurance Commissioners) and related information to help you examine whether long-term care insurance is right for you. Signing the Worksheet's

Disclosure Statement acknowledges that you received and reviewed it. You must submit the signed Disclosure Statement with this Agreement and your application to purchase the insurance.

NOTE: If a Partnership Certified Agent/Broker is involved in the application and sale of your Partnership policy/certificate application, he/she must also sign the Personal Worksheet Disclosure Statement. If the policy/certificate application results from a direct mail or other type of non-agent situation, the Disclosure Statement need only be signed by you when submitting it with your application for Partnership insurance coverage.

According to New York State Department of Insurance regulations at 11 NYCRR Section 39.6, the Participating Insurer offering you this 2/2/100 policy/certificate also must offer you a basic 1.5/3/50 dollar for dollar policy/certificate¹ at the same time. By signing this Consumer Participation Agreement, you acknowledge that you are aware of the availability of this alternate coverage.

If you decide to participate in the Partnership, you must sign this Agreement and the original signed Agreement must be returned by your Participating Insurer to the Partnership office within thirty (30) days of the date you sign this Agreement. Please keep a copy of the signed Agreement in a safe place with your other important papers.

C. MEDICAID EXTENDED COVERAGE UNDER 2/2/100 DOLLAR FOR DOLLAR PLANS

1. **Use of minimum amount of benefits.** Before applying for Medicaid Extended Coverage, a Participating Consumer MUST use up the minimum amount of benefits under his or her Partnership policy/certificate. This minimum amount of benefits for a 2/2/100 policy/certificate is 24 months of paid nursing home benefits or its equivalent. For a description of the benefits under a 2/2/100 policy/certificate which are equivalent to nursing home benefits, see ATTACHMENT 1 of this Agreement, "Equivalent Benefits." Before you use up the minimum amount of benefits under your Partnership policy/certificate, your insurance company is required to notify you and recommend that you begin the application process for Medicaid Extended Coverage. You will need this notification letter to apply for Medicaid Extended Coverage.

2. **Medicaid Extended Coverage.** Participating Consumers who purchase a 2/2/100 policy/certificate, and who receive 24 months of paid nursing home benefits (or its equivalent) under the policy/certificate, can apply for Medicaid Extended Coverage. When considering a your application for Medicaid Extended Coverage as a Participating Consumer, the Medicaid program will establish an amount of "protected resources" for you equal to the total dollar amount of the insurance benefits paid on your behalf under the 2/2/100 policy/certificate. In

¹ A 1.5/3/50 dollar for dollar policy/certificate is a Partnership policy/certificate that provides a minimum of 18 months of nursing home care coverage or 36 months of home care coverage, or some combination of the two, with a minimum home care daily benefit equal to 50 percent of the minimum nursing home daily benefit, and provides such other minimum coverage as required by New York State Department of Insurance regulations at 11 NYCRR § 39.4.

determining your Medicaid eligibility, the Medicaid program will not count as available any protected resources retained by you, and will not assess a penalty based on any protected resources you transferred away. In other words, you can retain or transfer away protected resources without jeopardizing Medicaid eligibility. In addition, the Medicaid program will not make any claims to recover correctly paid Medicaid against your protected resources.

NOTE: At the time you apply for Medicaid Extended Coverage, the Medicaid program will look to see if you transferred any resources during the transfer look-back period then in effect. Currently, the look-back period is the 36-month period (or, in the case of trust-related transfers, the 60-month period) prior to applying for Medicaid. Any resources transferred during the applicable look-back period will be counted in establishing the amounts of your protected and unprotected resources.

Otherwise, eligibility for Medicaid will be determined in accordance with the normal rules and regulations governing the Medicaid program, including Section 366 of the Social Services Law. As a Participating Consumer, your income and any unprotected resources will be counted in determining Medicaid eligibility, and you will be required to spend down excess, unprotected resources and contribute income toward the cost of care, in accordance with Medicaid rules and regulations.

3. Transfer of resources. Because the amount of protected resources is not counted in determining eligibility for Medicaid Extended Coverage, Participating Consumers are free to use protected resources in any way, including making gifts or otherwise transferring away ownership of protected resources. This is true even if a protected resource generates income which otherwise would be counted in determining eligibility for Medicaid Extended Coverage. In other words, as a Participating Consumer, you will not lose eligibility for Medicaid Extended Coverage because your income decreases after transferring an income-generating protected resource.

4. New York State residence. Medicaid Extended Coverage is available only through the New York State Medicaid program. Although the benefits payable under a Partnership policy/certificate may be used outside New York State, at the time your eligibility for Medicaid Extended Coverage is determined, you must be a resident of New York State pursuant to the rules and regulations of the Medicaid program. It is permissible for a Participating Consumer to reside outside New York State while receiving benefits under a Partnership policy/certificate, and to reside in New York State when it is time to apply for Medicaid Extended Coverage.

NOTE: If New York State elects to withdraw from the Partnership, all new sales of policies/certificates will be halted. However, the State will continue to honor its obligations under Consumer Participation Agreements in effect at that time, provided that the Participating Consumer maintains his or her in-force Partnership policy/certificate and complies with his or her responsibilities under the Consumer Participation Agreement.

D. BENEFITS UNDER PARTNERSHIP-APPROVED POLICIES/CERTIFICATES

1. **Benefits.** Details about applying for benefits under your Partnership long-term care insurance can be found in the policy/certificate issued by your Participating Insurer.

2. **Benefit Authorization Requests.** All Benefit Authorization Requests (BARs) denied for failure to meet Participating Insurer disability standards under Partnership policies/certificates are subject to the following process:

BENEFIT AUTHORIZATION REQUESTS DENIED FOR FAILURE TO MEET PARTICIPATING INSURER DISABILITY STANDARDS

If your Participating Insurer denies your request to authorize your insurance benefits due to your failure to meet the company's disability standards based on their assessment of you, you may request that the Partnership review your denied BAR. **IF YOU REQUEST SUCH A REVIEW, IT IS YOUR RESPONSIBILITY TO GET AN INDEPENDENT ASSESSMENT** of your condition from a qualified professional. Upon being notified by your insurance company that your BAR has been denied, if you wish to have the Partnership review your denied BAR, you or your representative may obtain information regarding the independent assessment by calling the Partnership program office at (518) 474-0662 or (518) 486-9057, from anywhere, or the New York Medicaid Help Line, 1-800-541-2831, from within New York State, or by writing:

New York State Partnership for Long-Term Care
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

You will be sent an independent assessment packet that will include instructions that must be followed in order for your denied BAR to be reviewed. To ensure a timely review, you should request the independent assessment instructions as soon as possible after being notified by your insurance company that your BAR has been denied.

If the Partnership office determines that the denial may be unwarranted, the Partnership will contact your Participating Insurer to review your situation. If your Participating Insurer and the Partnership office cannot agree on the appropriate outcome, an independent board, the Joint Technical Review Board (JTRB) comprised of State and Participating Insurer representatives (other than your own), will review your denied BAR. If this board finds that, in its opinion, your BAR warrants approval, your Participating Insurer may reverse its denial and approve your BAR, or may reject the independent board's recommendation and continue to deny your BAR.

If your Participating Insurer continues to deny your BAR, you have the option to elect binding arbitration to resolve your disagreement. The Partnership will notify you or your representative of your option to arbitrate your denied BAR, and provide you or your representative with the New York State Partnership for Long-Term Care Rules of Arbitration, as adopted by its governing body, the Evolution Board. These rules describe the procedures for

arbitration under this Agreement. If you elect to arbitrate your denied BAR, it shall be arbitrated by an independent entity approved by the Evolution Board, and the decision rendered by the arbitrator(s) shall be binding on both parties and may be entered as a judgment in any court having jurisdiction thereof.

If you elect to arbitrate, the Participating Insurer will be required to pay all arbitration fees as provided for in the New York State Partnership for Long-Term Care Rules of Arbitration. The arbitration hearing will be conducted and a decision rendered, unless otherwise agreed to by the parties or specified by law, no later than thirty (30) calendar days from the date of closing the hearing. If the arbitrator(s) finds on your behalf, he or she may grant you the cost of the independent assessments necessary for JTRB review and arbitration and payment of the disputed benefits retroactive to the date you were determined by the arbitrator(s) to have been eligible for benefits, after any required elimination period or other policy/certificate provisions have been satisfied. It shall not be within the authority of the arbitrator(s) to award you reimbursement beyond that mentioned above. A decision against you shall absolve the Participating Insurer of any liability or additional cost associated with this proceeding except for the cost of arbitration as noted above.

NOTE: If your BAR is denied for any reason except failure to meet the disability standards of your Participating Insurer, no individual review of the denied BAR is provided through the Partnership. However, your Participating Insurer may have its own appeals process that you can use to seek review of both disability-based and non-disability-based BAR denials. If you are entitled to have the Partnership review a denied, disability-related BAR, you may ask for the Partnership's review at the same time that you are pursuing the Participating Insurer's appeals process. In addition, you may litigate to have a court of law review a non-disability-based BAR denial (or a disability-based BAR denial if you do not elect binding arbitration).

E. YOUR RESPONSIBILITIES AS A PARTICIPATING CONSUMER

To be eligible for Medicaid Extended Coverage under the Partnership:

1. You must maintain your Partnership policy/certificate coverage. At the time you purchase a Partnership policy/certificate, the daily benefit amounts of the policy/certificate must be at least equal to the Partnership's minimum required benefits. In addition, unless you are age 80 or over at the time of your initial purchase of a Partnership policy/certificate and do not choose inflation protection, the daily benefit amounts of the policy/certificate must be at least equal to the Partnership's minimum required benefits throughout the entire benefit period of the policy/certificate.
2. You are responsible for all insurance premiums and co-payments, and for long-term care and other medical expenses not covered by your insurance or by Medicaid Extended Coverage.
3. You must be a resident of New York State when you apply for Medicaid Extended Coverage, under the rules of the Medicaid program.

4. An application for Medicaid Extended Coverage within New York State should be made to your Local Department of Social Services (LDSS); in New York City, to the local office of the Human Resources Administration. The telephone number of the appropriate LDSS office appears in the blue pages of your telephone directory under County Government, Department of Social Services. You or your representative must complete all documents and submit all information and documentation required by the New York State Medicaid program to apply for Medicaid Extended Coverage.
5. In accordance with the rules and regulations of the New York State Medicaid program set forth under 18 NYCRR, if you are otherwise eligible for Medicaid Extended Coverage but your income exceeds the appropriate income standard, and/or you have unprotected resources in excess of the standard Medicaid resource exemption level, you will be eligible for Medicaid Extended Coverage only after incurring medical expenses equal to or greater than your excess income and/or your excess, unprotected resources, or by prepaying your excess income to your LDSS if a prepayment plan is offered.
6. Because there are a small number of nursing homes in New York State which do not accept Medicaid as a payment source, it is important that you select a nursing home which accepts Medicaid so that your continued care, after using up the minimum amount of benefits under your Partnership policy/certificate, can be covered under Medicaid Extended Coverage. If you choose a nursing home which accepts only non-Medicaid residents, it is your responsibility to pay for the continuing cost of your care, if required by the home, or to relocate to a nursing home which accepts Medicaid.
7. In order to receive Medicaid Extended Coverage for assisted living services, you must receive such services in a facility approved to operate an assisted living program by the New York State Department of Health.
8. In order to receive Medicaid Extended Coverage for home care services, you must receive such services from a home health care agency licensed and/or certified by the New York State Department of Health in accordance with a plan of care approved by your LDSS.
9. You will need to meet the citizenship and alien status requirements of the Medicaid program.

F. REQUIRED INFORMATION; CONFIDENTIALITY

The Partnership program office must collect information about you to administer and evaluate the Partnership, review BARs, and verify eligibility for Medicaid Extended Coverage. Therefore, as a Participating Consumer, you must provide certain information about yourself to your Participating Insurer and to the Partnership. You may not enroll in the Partnership as a Participating Consumer and become eligible for Medicaid Extended Coverage unless you consent to supply this information.

To evaluate the overall effectiveness of the Partnership program and its value to all Participating Consumers, the Partnership program office will be conducting a mail survey at some future time. All individually identified information will be held in the strictest confidence and will not be shared with anyone except the Partnership program office at the New York State Department of

Health. As a safeguard to the confidentiality of your personal information, the findings of the planned survey will be reported using aggregate or group data, not individual-level data.

Additionally, you are required to provide the following information in order to enroll in the Partnership program:

Your Name (Please print): _____

Social Security Number: _____ - _____ - _____

Your Insurance Company's Name: _____

Group Policy/Certificate: Yes _____ No _____

Your Address:

Street: _____

City or Town: _____

State: _____

Zip Code: _____

G. GOVERNING LAW

The laws of the State of New York govern this agreement.

ATTACHMENT 1

EQUIVALENT BENEFITS

For purposes of qualifying for Medicaid Extended Coverage, a Participating Consumer must receive at least 24 months of paid nursing home benefits or the equivalent under a 2/2/100 policy/certificate. The following coverage and benefits paid under the Partnership policy/certificate can be substituted as equivalent to nursing home benefits:

1. Residential care facility (for example, assisted living facility or adult care facility), in a ratio of one residential care facility day for one nursing home day;
2. Home care, in a ratio of one home care day for one nursing home day;
3. Respite care, in a ratio of one respite care day for one nursing home day, up to a maximum of 14 days annually;
4. Alternate care in a hospital setting, in a ratio of one alternate care day for one nursing home day;
5. Hospice care, in a ratio of one hospice care day for one nursing home day;
6. Nursing home care reserved bed days, in a ratio of one reserved bed day for one nursing home day, up to a maximum of 20 days annually;
7. Residential care facility reserved bed days, in a ratio of one reserved bed day for one nursing home day, up to a maximum of 20 days annually; and
8. Care management benefits, equal in value to nursing home benefits, up to two days annually.