JAMES K. RUBLE SEMINAR

Ruble Graduate Seminar

Pennsylvania
October 17-18, 2023

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THE NATIONAL ALLIANCE
for Insurance Education & Research

A Letter from William J. Hold, President/CEO

We know that choosing the right professional development programs to strengthen your career can be challenging. There are many options for you to choose from; so how can you be sure that your time, efforts, and money are being invested and not wasted?

By becoming a committed participant of The National Alliance, you can rest assured that you are also making the best educational choice for your career—no matter what step of your learning path you are on.

For the last 50 years, our designations have been regarded throughout the industry as symbols of quality and trust. Our practical insurance and risk management courses are taught by active insurance practitioners, include polices and forms currently used in the field, and guide you through real-world scenarios to give you a deeper understanding of what your clients are facing today. The knowledge and skills you develop in any one of our courses (or designation programs) can be put to use immediately.

You will build long-lasting relationships with your clients, stay ahead of industry trends, emerging risks, and products that are constantly evolving in our dynamic market. You will have access to the industry's latest learning materials and will be the first to hear about new courses. With a learning path customized to fit your needs, you will be better equipped to protect your clients.

Have no doubt that your success is our priority. Whether you are new to your career, or a seasoned professional, you are about to embark on a wonderful professional development journey. Thank you for choosing The National Alliance for Insurance Education & Research as your guide toward a thriving career.

Let's take the first step.

William J. Hold, M.B.A., CRM, CISR
President/CEO

James K. Ruble Seminar

a proud member of The National Alliance for Insurance Education & Research

Section 1

Agency Coverage Standards

Insurance Concepts & Services

Allen Messer, CIC, CPCU

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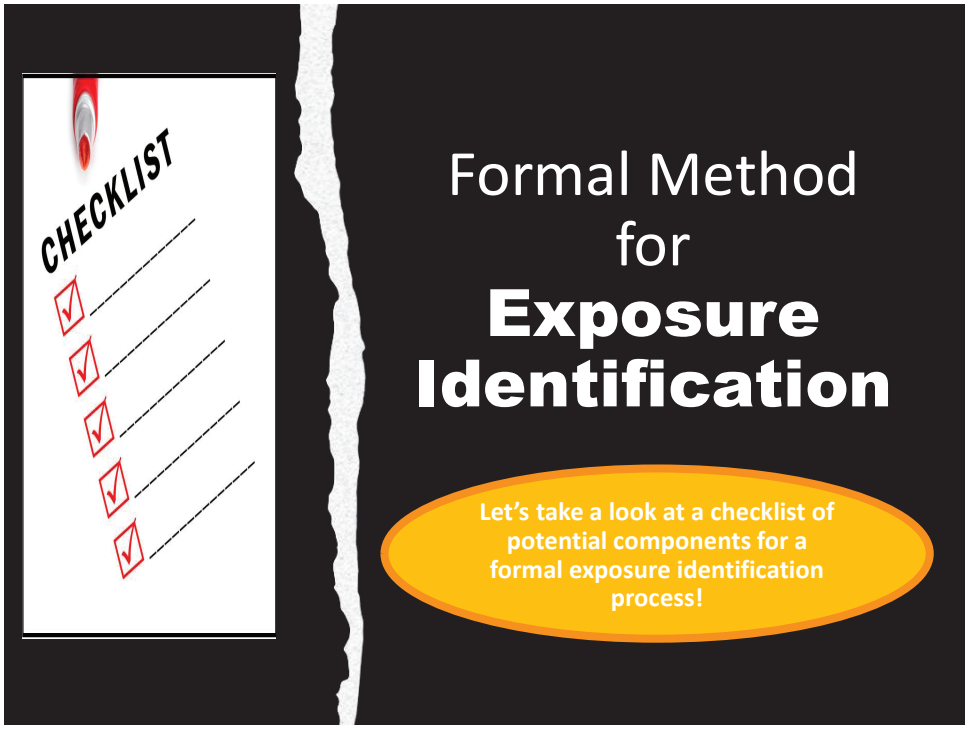
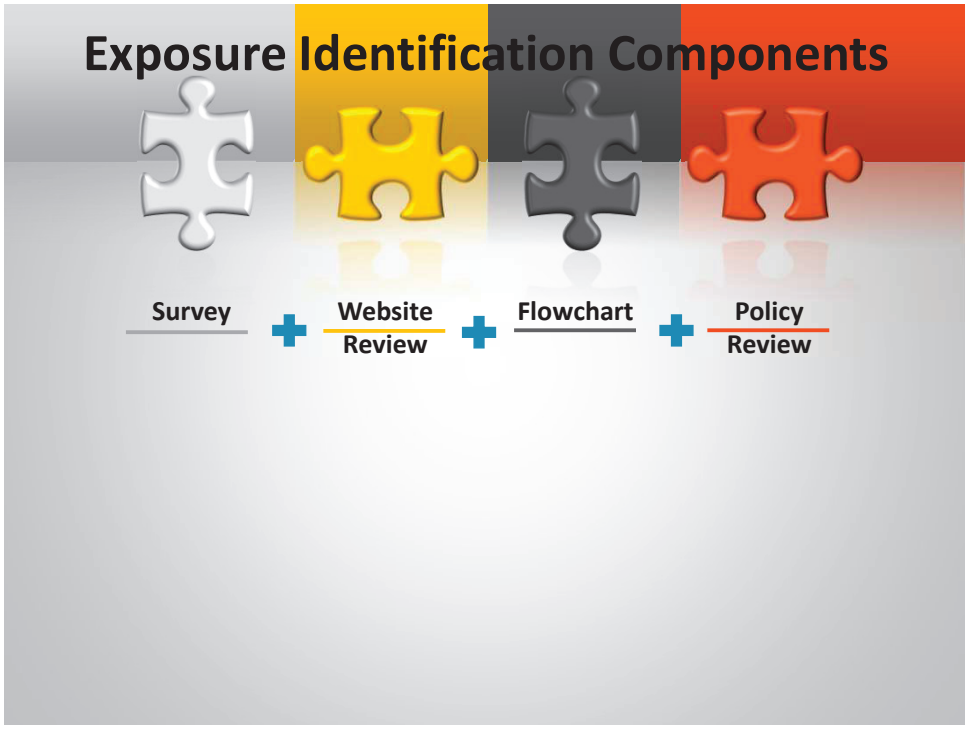
Agency Coverage Standards Introduction

Every agency needs a **formal method** for exposure identification.	**Point 1**
Every agency should establish coverage standards. May need to be modified as exposures/forms change!	**Point 2**
Coverage standards include needed coverages/endorsements and avoided endorsements.	**Point 3**
Every agency should establish procedures that apply to coverages as well, including permitted "*language*".	**Point 4**

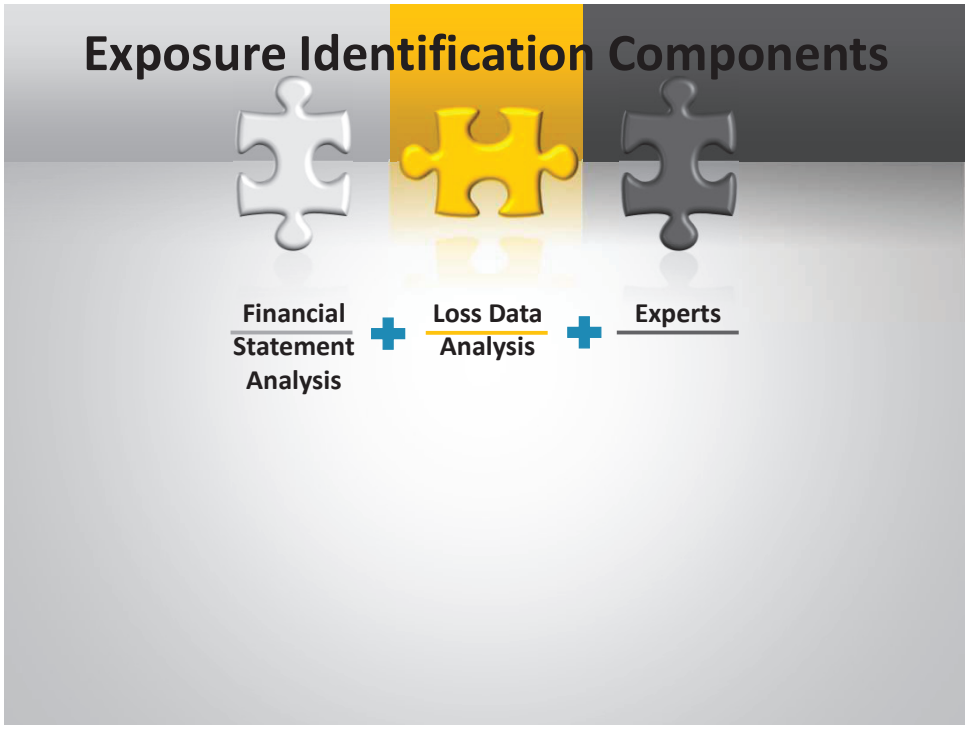
Agency Procedures Standards Examples

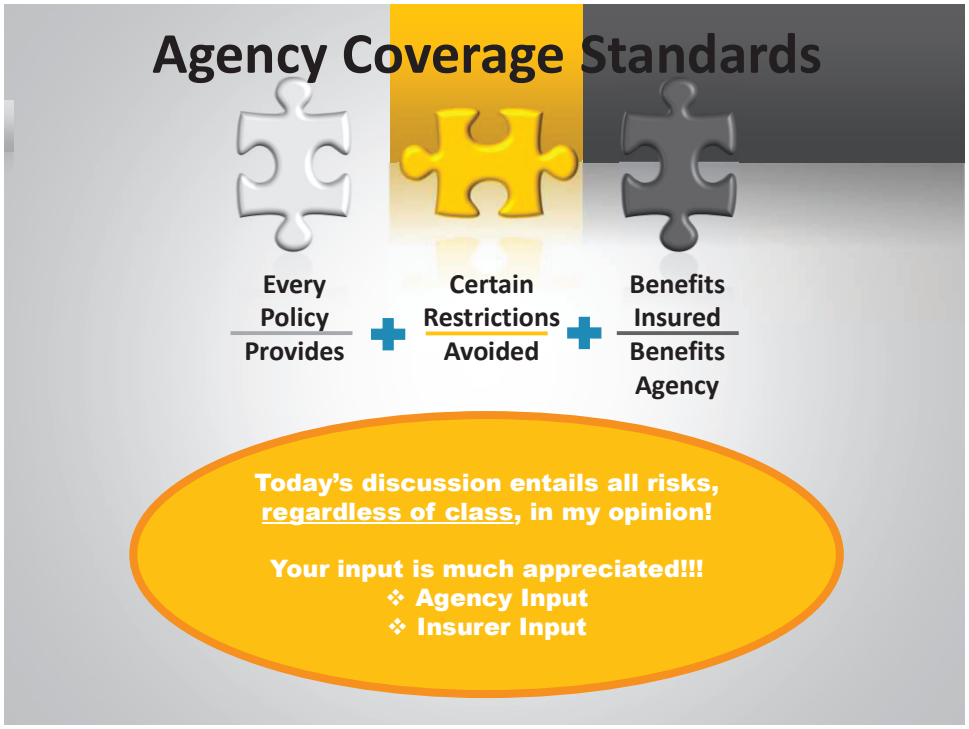
All Certificates of Insurance must follow ACORD Forms Instruction Guide as well as any applicable statutes and/or regulations	**Example 1**
First named insured … letter of authorization	**Example 2**
Verification of insurable interest	**Example 3**
Annual Statement of Values	**Example 4**
Earthquake is a three-endorsement process	**Example 5**
Copies of vehicle registrations	**Example 6**
Letter upon delivery of policies that policies supersede all prior quotations, binders, etc.	**Example 7**

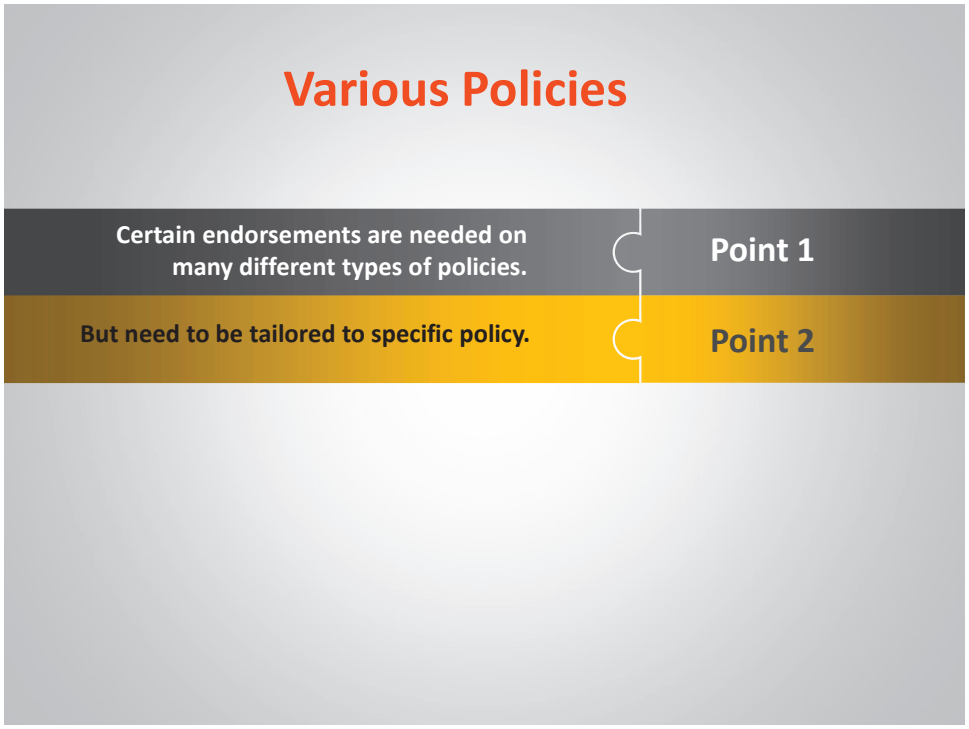

CHECKLIST
Formal Method
for
Exposure
Identification
Let's take a look at a checklist of potential components for a formal exposure identification process!


Exposure Identification Components
Survey
Website Review
Flowchart
Policy Review


Exposure Identification Components
Physical Inspections
Compliance Review
Policies Procedures Review
Contract Review


Exposure Identification Components
Financial Statement Analysis
Loss Data Analysis
Experts


Agency Coverage Standards
Every Policy Provides
Certain Restrictions Avoided
Benefits Insured Benefits Agency
Today's discussion entails all risks, regardless of class, in my opinion!
Your input is much appreciated!!!
❖ Agency Input
❖ Insurer Input


Various Policies
Certain endorsements are needed on many different types of policies.
Point 1
But need to be tailored to specific policy.
Point 2

Various Policies
Common Policy Conditions

Extended Notice Of Cancellation Or Nonrenewal

Section A., Cancellation, of the Common Policy Conditions is deleted and replaced by the following:

A. CANCELLATION OR NONRENEWAL

1. The first Named Insured shown in the Declarations may cancel this policy by mailing or delivering to us advance written notice of cancellation.
2. We may cancel this policy by mailing or delivering to the first Named Insured written notice of cancellation at least:
   - **a.** 10 days before the effective date of cancellation if we cancel for nonpayment of premium; or
   - **b.** 90 days before the effective date of cancellation if we cancel for any other reason.
3. If we decide not to renew this policy, we will mail or deliver to the first Named Insured shown in the Declarations written notice of the nonrenewal not less than 90 days before the expiration date. If we do not give such notice of our intent not to renew prior to expiration, the policy period will be extended for 90 days from the date of notice and existing policy terms, conditions and rates, where not prohibited by law, will remain in effect for that period.
4. We will mail or deliver our notice to the first Named Insured's last mailing address known to us.
5. Notice of cancellation will state the effective date of cancellation. The policy period will end on that date.
6. Notice of nonrenewal will state the effective date of nonrenewal.
7. If this policy is cancelled, we will send the first Named Insured any premium refund due. If we cancel, the refund will be pro rata. If the first Named Insured cancels, the refund will be less than pro rata and will not be less than the minimum premium stated in the declarations. The cancellation will be effective even if we have not made or offered a refund.
8. If notice is mailed, proof of mailing will be sufficient proof of notice.

Various Policies

Knowledge Of Occurrence

Knowledge of an "occurrence," claim, or "suit" by an agent, servant, or “employee” of any named insured; and receipt of any demand, notice, summons, or other legal paper in connection with a claim or "suit" by any agent, servant, or “employee” of any named insured shall not in itself constitute knowledge of the named insured or receipt by the named insured unless an individual in one of the positions listed below shall have such knowledge or shall have received such demand, notice, summons, or legal paper from the agent, servant, or employee.

Scheduled Positions:

_____

_____

Various Policies

Unintentional Failure To Disclose Hazards

It is agreed that failure of the named insured to disclose all hazards existing as of the inception date of the policy shall not prejudice the insured with respect to the coverage afforded by this policy provided such failure or omission was not intentional.

Commercial General Liability Policy

Every business needs a CGL Policy.	Point 1
#1 Commercial Policy for E&O	Point 2

Commercial General Liability Policy

Who Is An Insured Endorsement

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

Bodily Injury To Co-employee Endorsement

It is agreed that Paragraph **2.a.(1)(a)** of **SECTION II - WHO IS AN INSURED** does not apply to the persons or positions shown in the Schedule with respect to "bodily injury" to a co-"employee" while in the course of his or her employment or performing duties related to the conduct of your business, or to your other "volunteer workers" while performing duties related to the conduct of your business.

SCHEDULE

(List Individuals or Positions)

Commercial General Liability Policy

Additional Insured Endorsements

- **CG 20 01 - Primary And Noncontributory – Other Insurance Condition**
  - ❑ **BUT…**This insurance is primary to and will not seek contribution from any other insurance available to an additional insured under your policy provided that: (1) **The additional insured is a Named Insured under such other insurance**; and
- **CG 20 34 - Additional Insured—Lessor Of Leased Equipment—Automatic Status When Required In Lease Agreement With You**

Commercial General Liability Policy

CG 04 37 – Electronic Data Liability

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Loss Of Electronic Data Limit: $ Usually a Sublimit

Modifies definition of property damage as well as Exclusion p. Access Or Disclosure Of Confidential Or Personal Information And Data-related Liability so that damage to data resulting from physical injury to tangible property is provided coverage.

Commercial General Liability Policy

CG 22 74 - Limited Contractual Liability Coverage For Personal And Advertising Injury

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Designated Contract Or Agreement: ALL

Commercial General Liability Policy

CG 24 53 - Waiver Of Transfer Of Rights Of Recovery Against Others To Us (Waiver Of Subrogation)—Automatic

- The following is added to **Paragraph 8. Transfer Of Rights Of Recovery Against Others** To Us of **Section IV – Condition**s:

(requires written contract or agreement – prior to loss)

Commercial General Liability Policy

CG 24 54 - Automatic Insured Status For Newly Acquired Or Formed Limited Liability Companies

Commercial General Liability Policy

CG 25 04 -Designated Location(s) General Aggregate Limit

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Designated Location(s): ALL

Commercial General Liability Policy

CG 25 46 - Designated Location(s) Products-Completed Operations Aggregate Limit

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Designated Location(s): ALL

Commercial General Liability Policy

Contractual Liability Endorsements

- **CG 21 39 – Contractual Liability Limitation**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

The definition of "insured contract" in the Definitions section is replaced by the following:

"Insured contract" means:

- **CG 24 26 – Amendment of Insured Contract Definition**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

The definition of "insured contract" in the Definitions section is replaced by the following:

"Insured contract" means:

Commercial General Liability Policy

CG 21 44 - Limitation Of Coverage To Designated Premises, Project Or Operation – 2017 edition

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Premises:

Project Or Operation:

Commercial General Liability Policy

CG 21 49 – Total Pollution Exclusion Endorsement

- **CG 21 65 - Total Pollution Exclusion With A Building Heating, Cooling And Dehumidifying Equipment Exception And A Hostile Fire Exception**

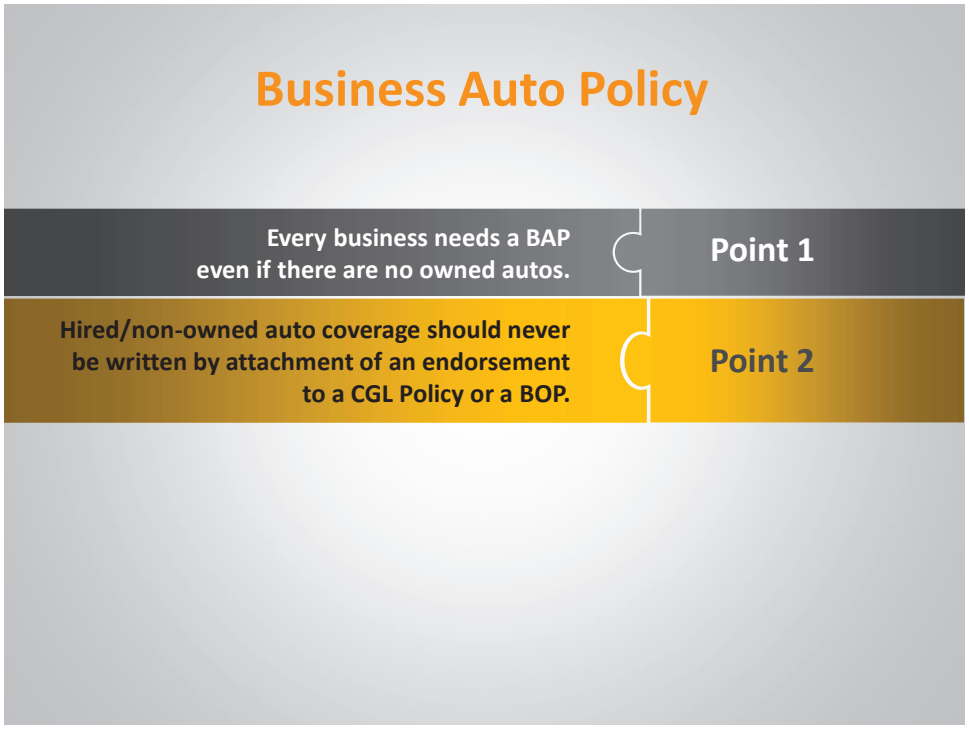
- **CG 21 55 - Total Pollution Exclusion With A Hostile Fire Exception**

Commercial General Liability Policy

CG 21 50 – Amendment Of Liquor Liability Exclusion

- **CG 40 09 – Amendment Of Liquor Liability Exclusion – Limited Exception For Bring Your Own Alcohol**


Commercial General Liability Policy
Every CGL Policy!
Point 1
Agency Coverage Standards
Should also apply per class of business!
Point 2
Endorsements may be needed to further tailor
coverages to exposures.
Point 3


Business Auto Policy
Every business needs a BAP
even if there are no owned autos.
Point 1
Hired/non-owned auto coverage should never
be written by attachment of an endorsement
to a CGL Policy or a BOP.
Point 2

Business Auto Policy

Symbols

- Symbol 1 for Covered Autos Liability
- If Symbol 2 for Covered Autos Liability - add Symbols 8, 9, 10
  - ❑Symbols 2+8+9 DO NOT EQUAL Symbol 1
- If Symbol 7 for Covered Autos Liability - add Symbols 8, 9, 10, 19

❑CA 99 54 – Covered Auto Designation Symbol

Symbol	Description Of Covered Auto Designation Symbols
	For use with the Business Auto Coverage Form
10	=

Business Auto Policy

Additional Insured Endorsements

- CA 04 49 – Primary and Noncontributory – Other Insurance Condition
- CA 04 39 – Volunteer Hired Autos
- CA 20 54 – Employee Hired Autos
- CA 99 33 – Employee As Insureds
- CA 05 24 – Non-ownership Liability Coverage For Volunteers

Business Auto Policy

CA 04 43 - Waiver of Transfer of Rights of Recovery Against Others to Us (Waiver of Subrogation) - Automatic When Required by Written Contract or Agreement

Business Auto Policy

CG 20 56 -Fellow Employee Coverage for Designated Employees/Positions

This endorsement modifies insurance provided under the following:

BUSINESS AUTO COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by the endorsement.

This endorsement changes the policy effective on the inception date of the policy unless another date is indicated below.

Named Insured:

Endorsement Effective Date:

SCHEDULE

Name Of Person(s), Job Title(s) Or Position(s):

The Fellow Employee Exclusion contained under the Covered Autos Liability Coverage does not apply to the "employee(s)", job title(s) or position(s) named or listed in the Schedule

Business Auto Policy

Physical Damage – Aggregate Deductible

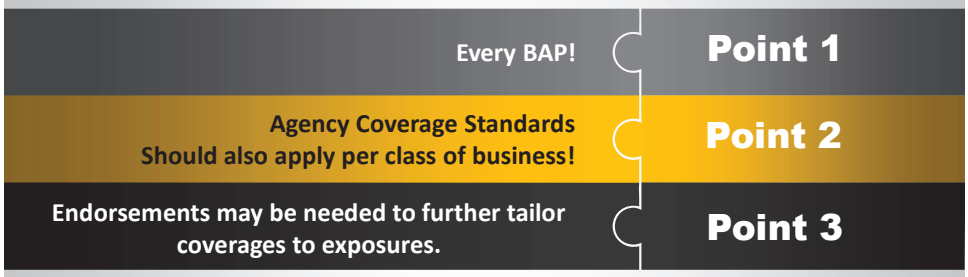
2. Regardless of the number of covered "autos" damaged or stolen, the maximum deductible applicable for all "loss" in any one event caused by:

   a. Theft or mischief or vandalism; or

   b. All perils.

   will be equal to **five times the highest deductible applicable to any one covered "auto"** on the Policy for Comprehensive or Specified Causes of Loss Coverage. The application of the highest deductible use to calculate the maximum deductible will be made regardless of which covered "autos" were damaged or stolen in the "loss".

Business Auto Policy



Workers Compensation And Employers Liability Insurance Policy

Almost every business needs this Policy.	Point 1
Incorporates state law into Policy provisions.	Point 2

Workers Compensation And Employers Liability Insurance Policy

Information Page

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers' Compensation Law of the states listed here:

B. Employers Liability insurance: **Part Two of the policy applies to work in each state listed in Item 3.A.** The limits of our liability under Part Two are:

Bodily Injury by Accident $_____ each accident

Bodily Injury by Disease $_____ policy limit

Bodily Injury by Disease $_____ each employee

C. Other States insurance: Part Three of the policy applies to the states, if any, listed here:

D. This policy includes these endorsements and schedules:

Workers Compensation And Employers Liability Insurance Policy

WC 00 03 01 A – Alternate Employer Endorsement

Schedule

1. **Alternate Employer:** As required by written contract or written agreement.

2. **State of Special or Temporary Employment:** **All states except North Dakota, Ohio, Washington, and Wyoming.**

3. **Contract or Project:** All written contracts and written agreements.

Workers Compensation And Employers Liability Insurance Policy

WC 00 03 11 A - Voluntary Compensation And Employers Liability Coverage Endorsement

Schedule

Employees: all employees not subject to the workers compensation or occupational disease law of any state

State of Employment: all states where legally permissible

Designated Workers Compensation Law: state of operations or state of hire or state where the injury occurs

Workers Compensation And Employers Liability Insurance Policy

WC 00 03 13 - Waiver Of Our Right To Recover From Others Endorsement

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. ~~(This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)~~

This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

Schedule

As required by written contract or written agreement.

Workers Compensation And Employers Liability Insurance Policy

Every Policy every time.	Point 1
Additional endorsements may be required to tailor coverage to exposures.	Point 2

Commercial Umbrella Liability Policy

Every business needs this Policy.	Point 1
Debunk “myth” of “follow form”!	Point 2

Commercial Umbrella Liability Policy

Follow Form??

- Do you show follow form on Certificate of Insurance?
- Are you verifying that all of the terms and conditions modified in the underlying insurance also apply to this coverage as well?
- Are you verifying that all of the endorsements you avoided in the underlying are not being inserted in this coverage?

Commercial Umbrella Liability Policy

Concurrency of Underlying Policies

- **Common inception and expiration dates** of CU Policy with Underlying Policies with aggregates
  - E.g., CGL Policy, Workers Compensation And Employers Liability Insurance Policy, Liquor Liability Policy, etc.
  - Commercial Umbrella Policy *could* include verbiage that permits non-concurrency

Commercial Umbrella Liability Policy

Additional Insureds

- **CU 24 78 – Noncontributory – Other Insurance Condition**
  - ❑ **Does not adequately address order of coverage – may need to modify**
    - ❖ However, if you specifically agree in a written contract or agreement that the insurance provided to any person or organization that qualifies as an insured under this insurance must apply … on a primary and non-contributory basis….
      - ➢ This insurance will apply *before* any "other insurance" that is available to such additional insured which covers that person or organization as a named insured, and *we will not share* with that other insurance

Commercial Umbrella Liability Policy

Additional Insureds

- **Limits Of Insurance**

  With respect to the insurance afforded to these additional insureds, the following is added to Limits Of Insurance:

  If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

  1. Required by the contract or agreement; or
  2. Available under the applicable limits of insurance;

  whichever is less.

  This shall not increase the applicable limits of insurance.

Commercial Umbrella Liability Policy

Aggregate Limits Of Insurance

- **Aggregates follow form**

Limits Of Insurance

1. **The Limit of Insurance shown in the Declarations as EACH OCCURRENCE is the most we will pay for damages arising out of any one occurrence or offense.**

2. **The Limit of Insurance shown in the Declarations as AGGREGATE WHERE APPLICABLE shall apply in the same manner as the aggregate limits shown in the SCHEDULE OF UNDERLYING INSURANCE.**

Commercial Umbrella Liability Policy

Pollution Exclusion

- **Pollution exclusion "follows form"**
  - **E.g., CGL Policy, BAP, Employers Liability Insurance**

Commercial Umbrella Liability Policy

Every Policy every time. — **Point 1**

Additional endorsements may be required to tailor coverage to exposures. — **Point 2**

Commercial Property Policy

Every business needs a CP Policy.	Point 1
Whether it be for property at a fixed location, at a temporary storage location, or in transit.	Point 2

Building And Personal Property Coverage Form

CP 14 60 – Leased Property

This endorsement modifies insurance provided under the following:

BUILDING AND PERSONAL PROPERTY COVERAGE FORM

SCHEDULE

Premises No.	Bldg. No.	Description of Property	Agreed Value (Optional)
		All leased property	**As required by written lease**

Building And Personal Property Coverage Form

CP 04 15 – Debris Removal Additional Insurance

This endorsement modifies insurance provided under the following:

BUILDING AND PERSONAL PROPERTY COVERAGE FORM

SCHEDULE

Premises Number	Building Number	Debris Removal Amount	Additional Premium
		$	$
		$	$

The additional amount of $25,000 for debris removal in the **Debris Removal** Additional Coverages section is replaced by the higher amount shown in the Schedule.

Building And Personal Property Coverage Form

Optional Coverage - Agreed Value

G. Optional Coverages

If shown as applicable in the Declarations, the following Optional Coverages apply separately to each item:

1. Agreed Value

Building And Personal Property Coverage Form

Optional Coverage – Replacement Cost

G. Optional Coverages

If shown as applicable in the Declarations, the following Optional Coverages apply separately to each item:

3. Replacement Cost

Building And Personal Property Coverage Form

CP 04 09 - Increase In Rebuilding Expenses Following Disaster (Additional Expense Coverage On Annual Aggregate Basis)

This endorsement modifies insurance provided under the following:

BUILDING AND PERSONAL PROPERTY COVERAGE FORM

Schedule

Premises Number	Building Number	Additional Expense Coverage Percentage
		%
		%

Building And Personal Property Coverage Form

CP 04 11 – Protective Safeguards

B. The following is added to the Exclusions section of:

Causes Of Loss – Basic Form

Causes Of Loss – Broad Form

Causes Of Loss – Special Form

We will not pay for loss or damage caused by or resulting from fire if, prior to the fire, you failed to comply with any condition set forth in Paragraph **A.**

Types of Protective Safeguards

- "P-1" Automatic Sprinkler System
- "P-2" Automatic Fire Alarm
- "P-3" Security Service
- "P-4" Service Contract
- "P-5" Automated Commercial Cooking Exhaust And Extinguishing System
- "P-9" the protective system described in the Schedule

Building And Personal Property Coverage Form

CP 12 11 - Burglary And Robbery Protective Safeguards

B. The following is added to the **Exclusions** section of the **Causes Of Loss – Special Form**:

Burglary And Robbery Protective Safeguards

We will not pay for loss or damage caused by or resulting from theft if, prior to the theft, you failed to comply with any condition set forth in Paragraph **A.**

Types of Protective Safeguards

- "BR-1" Automatic Burglary Alarm
- "BR-2" Automatic Burglary Alarm
- "BR-3" Security Service
- "BR-4" the protective safeguard described in the Schedule

Causes Of Loss – Special Form

CP 04 05 – Ordinance Or Law Coverage

This endorsement modifies insurance provided under the following:

BUILDING AND PERSONAL PROPERTY COVERAGE FORM

Schedule

Building Number/ Premises Number	Coverage A	Coverage B Limit of Insurance	Coverage C Limit of Insurance	Coverages B And C Combined Limit Of Insurance	
/	☐	$	$	$	*
/	☐	$	$	$	*
Post Loss Ordinance Or Law Option: Yes ☐ No ☐					
*Do **not** enter a Combined Limit of Insurance if individual Limits of Insurance are selected for Coverages **B** and **C**, or if one of these Coverages is not applicable.					

Causes Of Loss - Special Form

CP 10 38 - Discharge From Sewer, Drain Or Sump (Not Flood-Related)

This endorsement modifies insurance provided under the following:

BUILDING AND PERSONAL PROPERTY COVERAGE FORM

Premises Number	Building Number	Discharge Limit (Property Damage)	Discharge Limit (Business Interruption)	Annual Aggregate Limitation Applies
		$	$	[ ]

C. There is no coverage under this endorsement if:

1. The discharge results from an insured's failure to perform routine maintenance or repair necessary to keep a sewer or drain or a sump, sump pump or related equipment free from obstruction and in proper working condition. This limitation does not apply to sudden mechanical breakdown of a sump pump or its related equipment, provided the breakdown is not the result of an insured's negligence; or

2. Sump pump failure is caused by or results from failure of power, unless this policy is endorsed to cover power failure affecting the described premises.

Causes Of Loss – Special Form

CP 04 17 - Utility Services – Direct Damage

This endorsement modifies insurance provided under the following:

BUILDING AND PERSONAL PROPERTY COVERAGE FORM

Schedule

Enter "X" for each applicable property.							
Premises Number	Building Number	Utility Services Limit Of Insurance	Water Supply Property	Communication Supply Property (including overhead transmission lines)	Communication Supply Property (NOT including overhead transmission lines)	Power Supply Property (including overhead transmission lines)	Power Supply Property (NOT including overhead transmission lines)
		$					
Covered Property:							
Covered Causes Of Loss Applicable:							

Causes Of Loss – Special Form

CP 10 36 – Equipment Breakdown Coverage

This endorsement modifies insurance provided under the following:

Causes Of Loss – Special Form

Schedule

Premises Number	**Building Number**	**Higher Sub-limit***	
		Ammonia Contamination	**Hazardous Substance Other Than Ammonia**
		$	$
		$	$
*Leave blank if sub-limit of up to $25,000 applies. If higher sub-limit is shown in the Schedule, the higher sub-limit applies instead.			

Causes Of Loss – Special Form

CP 10 65 – Flood Coverage Endorsement

This endorsement modifies insurance provided under the following:
Commercial Property Coverage Part

- Need to attach CP DS 65 - **Flood Coverage Schedule**
  - **Separate deductible** applies
  - Provides a **no-coinsurance option**
  - Provides the **capability** of an **underlying insurance waiver**
  - Provides an **annual aggregate limit**
  - May be written on a **blanket basis or** a **separate limits** basis

Causes Of Loss – Special Form

CP 10 36 - Limitations On Coverage For Roof Surfacing

This endorsement modifies insurance provided under the following:
Building And Personal Property Coverage Form
Schedule

Premises Number	Building Number	Indicate Applicability (Paragraph A. and/or Paragraph B.)

Business Income (And Extra Expense) Coverage Form

Optional Coverage - Agreed Value

G. Optional Coverages

If shown as applicable in the Declarations, the following Optional Coverages apply separately to each item:

3. Business Income Agreed Value

Business Income (And Extra Expense) Coverage Form

Optional Coverage - Extended Period Of Indemnity

G. Optional Coverages

If shown as applicable in the Declarations, the following Optional Coverages apply separately to each item:

4. Extended Period Of Indemnity

Business Income (And Extra Expense) Coverage Form

CP 15 04 – Discretionary Payroll Expenses

This endorsement modifies insurance provided under the following:
Business Income (And Extra Expense) Coverage Form

Schedule

Job Classifications Or Employees	Maximum Number Of Days For Discretionary Payroll Expense

Business Income (And Extra Expense) Coverage Form

CP 15 31 - Ordinance Or Law – Increased Period Of Restoration

This endorsement modifies insurance provided under the following:
Business Income (And Extra Expense) Coverage Form

Schedule

Described Premises:

Post-Loss Ordinance Or Law Option: Yes ☐ No ☐

Business Income (And Extra Expense) Coverage Form

CP 15 32 – Civil Authority Changes

This endorsement modifies insurance provided under the following:
Business Income (And Extra Expense) Coverage Form

Schedule

Premises Number	Building Number	Schedule Part A Coverage Period (Number Of Days)	Schedule Part B Radius (Number Of Miles)

Business Income (And Extra Expense) Coverage Form

CP 15 45 – Utility Services – Time Element

This endorsement modifies insurance provided under the following:
Business Income (And Extra Expense) Coverage Form

Schedule

Enter "X" for each applicable property.

Premises Number	Building Number	Utility Services Limit Of Insurance	Water Supply Property	Communication Supply Property (including overhead transmission lines)	Communication Supply Property (NOT including overhead transmission lines)	Power Supply Property (including overhead transmission lines)	Power Supply Property (NOT including overhead transmission lines)
		$					
Covered Property:							
Covered Causes Of Loss Applicable:							
Business Income Waiting Period: _____Hours							

Business Income (And Extra Expense) Coverage Form

CP 15 50 – Radio Or Television Antennas – Business Income Or Extra Expense

This endorsement modifies insurance provided under the following:
Causes Of Loss – Special Form

The radio or television antennas **Special Exclusion** does not apply.

Commercial Property Policy

Every Commercial Property Policy!	Point 1
Agency Coverage Standards Should also apply per class of business!	Point 2
Endorsements may be needed to further tailor coverages to exposures.	Point 3

Commercial Crime Policy

Every Commercial Crime Policy!	Point 1
Endorsements may be needed to further tailor coverages to exposures.	Point 2

Commercial Crime Policy

Discovery Form versus Loss Sustained Form

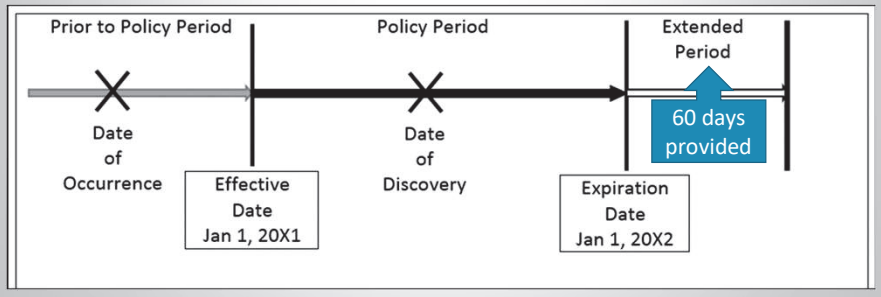
Insuring Agreements

Coverage is provided under the following Insuring Agreements for which a Limit Of Insurance is shown in the Declarations and applies to loss that you sustain resulting directly from an "occurrence" ***taking place at any time*** which is "discovered" ***by you*** during the Policy Period shown in the Declarations or during the period of time provided in the Extended Period To Discover Loss Condition E.1.g.

Coverage is provided under the following Insuring Agreements for which a Limit Of Insurance is shown in the Declarations and applies to loss that you sustain resulting directly from an "occurrence" ***taking place during the Policy Period shown in the Declarations***, except as provided in Condition E.1.k. or E.1.l., which is "discovered" by you during the Policy Period shown in the Declarations or during the period of time provided in the Extended Period To Discover Loss Condition E.1.g.

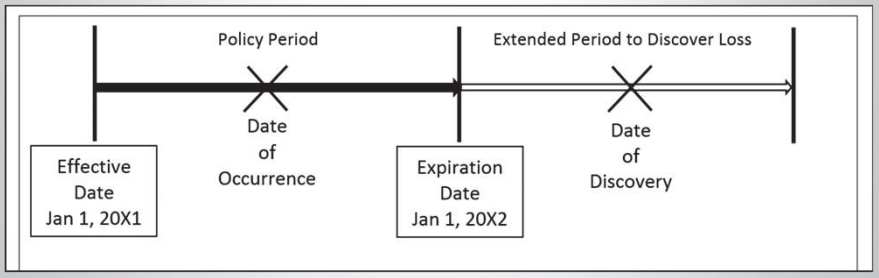
Discovery Form - CR 00 20

- Must be discovered during the policy period or Extended Period To Discover Loss (60 days)
- The **occurrence <u>can take place</u> anytime prior to the expiration/cancellation/nonrenewal date of the policy**



Loss Sustained Form - CR 00 21

- **"Occurrence" <u>must take place during the Policy Period</u>**
- Must be **"discovered" during the Policy Period or within the Extended Period To Discover Loss Condition** (1 year following expiration/cancellation/nonrenewal)



Commercial Crime Policy

CR 20 04 - Change Extended Period To Discover Loss

This endorsement modifies insurance provided under the Discovery Form version of the following:

Commercial Crime Coverage Form

Schedule

Number Of Days:
The Extended Period To Discover Loss Condition is changed by adding to the 60-day period to "discover" loss the number of days shown in the Schedule.
However, this extended period to "discover" loss terminates immediately upon the effective date of any other insurance obtained by you, whether from us or another insurer, replacing in whole or in part the coverage afforded under this insurance, whether or not the other insurance provides coverage for loss sustained prior to its effective date.
With regard to any "employee benefit plans" (covered under the Commercial Crime Coverage Form, Commercial Crime Policy or Employee Theft And Forgery Policy), the one-year period to "discover" loss remains unchanged.

Commercial Crime Policy

CR 20 22 - Include Designated Person Required To Have Knowledge Of Loss (Discovery Form)

This endorsement modifies insurance provided under the Discovery Form version of the following:

Commercial Crime Coverage Form

Schedule

Positon Of Designated Person:

The following definition is added:
"Designated person" means:
(1) Any insurance risk manager;
(2) An "employee" in your Human Resources Department or its equivalent;
(3) Any director, trustee, partner, "member", "official" or "manager";
(4) Any elected, appointed or otherwise titled officer;
(5) The highest ranking "employee" at the "premises" where such "employee" performs the majority of his or her duties; or
(6) Any person in a position shown in the Schedule;
of any Insured.

Commercial Crime Policy

CR 20 25 - Loss Reporting Threshold

This endorsement modifies insurance provided under the Discovery Form version of the following:

Commercial Crime Coverage Form

The **Duties In The Event Of Loss** Condition is replaced by the following: After you "discover" a loss or a situation that may result in loss of or damage to "money", "securities" or "other property", you must:

Commercial Crime Policy

CR 20 26 - Provide Automatic Coverage For Acquired Entities

This endorsement modifies insurance provided under the Discovery Form version of the following:

Commercial Crime Coverage Form

Schedule

Percentage Of Total Assets: **%**

The **Consolidation – Merger Or Acquisition** Condition is replaced by the following:

……

b. For entities you acquire in which you **own greater than 50%** of the voting stock or voting rights, coverage under this coverage form/policy shall automatically become effective on the date of such acquisition with **no additional premium required**, provided: (1) All "**occurrences**" causing or contributing to a loss involving the acquired entity must take place **after** the **effective date** of such **acquisition**; and (2) The **assets** of the acquired entity **do not exceed the percentage shown** in the Schedule **of your total assets** as reflected in your most recent calendar quarter consolidated financial statements immediately preceding the effective date of the coverage form/policy.

Commercial Crime Policy

Insuring Agreements

ISO CRIME COVERAGE PART DECLARATIONS
(COMMERCIAL ENTITIES)

Insuring Agreements	Limit Of Insurance Per Occurrence	Deductible Amount Per Occurrence
1. Employee Theft	$	$
2. Forgery Or Alteration	$	$
3. Inside The Premises – Theft Of Money And Securities	$	$
4. Inside The Premises – Robbery Or Safe Burglary Of Other Property	$	$
5. Outside The Premises	$	$
6. Computer And Funds Transfer Fraud	$	$
7. Money Orders And Counterfeit Money	$	$

Coverage is provided only if an amount is shown opposite an Insuring Agreement.
If the amount is left blank or "Not Covered" is inserted, such Insuring Agreement and any other reference thereto in this Policy are deleted.

Commercial Crime Policy

Insuring Agreements
CR 04 17 - Fraudulent Impersonation

This endorsement modifies insurance provided under the Discovery Form version of the following:

Commercial Crime Coverage Form
Schedule

Check the appropriate box(es):

I. Fraudulent Impersonation Of "Employees" Included: Yes ☐ No ☐
- ☐ A. Verification Is Required For All "Transfer Instructions"
- ☐ B. Verification Is Required For All "Transfer Instructions" In Excess Of $
- ☐ C. Verification Of "Transfer Instructions" Is Not Required

II. Fraudulent Impersonation Of "Customers" And "Vendors" Included: Yes ☐ No ☐
- ☐ A. Verification Is Required For All "Transfer Instructions"
- ☐ B. Verification Is Required For All "Transfer Instructions" In Excess Of $
- ☐ C. Verification Of "Transfer Instructions" Is Not Required

Commercial Crime Policy

Employee Theft Condition

2. Conditions Applicable To Insuring Agreement A.1.

a. Termination As To Any Employee

This Insuring Agreement **terminates** as to any "employee":

(1) As soon as:

(a) You; or

(b) Any of your partners, "members", "managers", officers, directors or trustees not in collusion with the "employee";

learn of "theft" or any other dishonest act committed by the "employee" whether before or after becoming employed by you; or

(2) On the date specified in a notice mailed to the first Named Insured. That date will be at least 30 days after the date of mailing.

We will mail or deliver our notice to the first Named Insured's last mailing address known to us. If notice is mailed, proof of mailing will be sufficient proof of notice.

Commercial Crime Policy

CR 25 40 - Include Expenses Incurred To Establish Amount Of Covered Loss

This endorsement modifies insurance provided under the Discovery Form version of the following:

Commercial Crime Coverage Form

Schedule

☐ **Employee Theft Insuring Agreement**

Costs, Fees Or Other Expenses

Limit Of Insurance	**Covered Loss**
$	**%**

☐ **Computer And Funds Transfer Fraud Insuring Agreement**

Costs, Fees Or Other Expenses

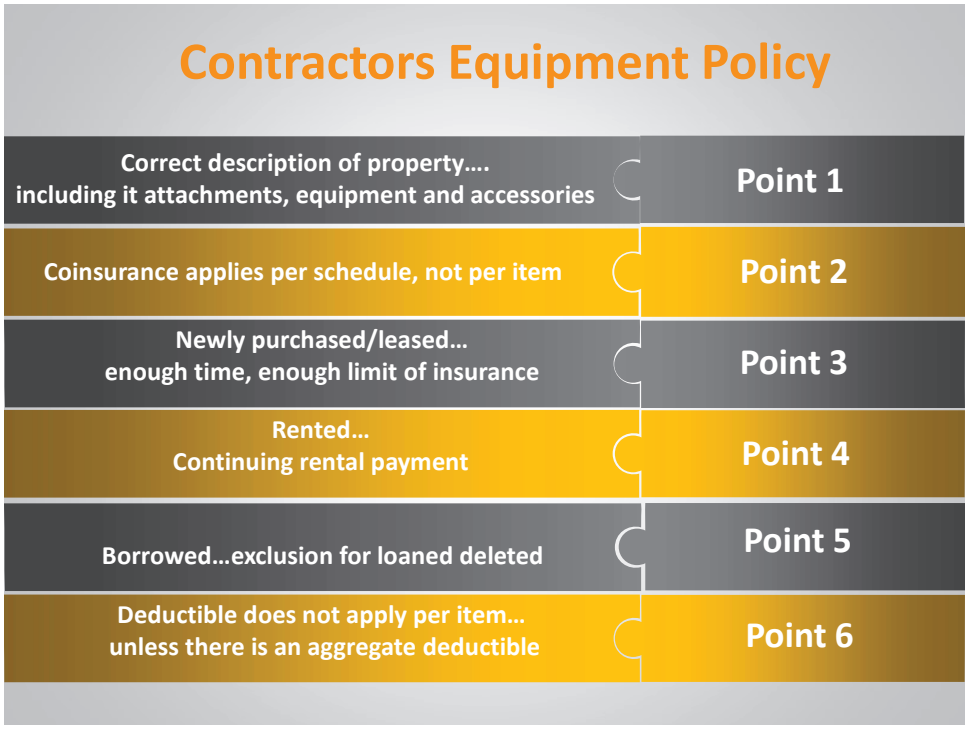
Limit Of Insurance	**Covered Loss**
$	**%**

Commercial Crime Policy

Every Commercial Crime Policy!	Point 1
Endorsements may be needed to further tailor coverages to exposures.	Point 2

Contractors Equipment Policy

Every Contractors Equipment Policy!	Point 1
Endorsements may be needed to further tailor coverages to exposures.	Point 2


Contractors Equipment Policy
Correct description of property….
including it attachments, equipment and accessories
Point 1
Coinsurance applies per schedule, not per item
Point 2
Newly purchased/leased…
enough time, enough limit of insurance
Point 3
Rented…
Continuing rental payment
Point 4
Borrowed…exclusion for loaned deleted
Point 5
Deductible does not apply per item…
unless there is an aggregate deductible
Point 6


Agency Coverage Standards
Conclusion
Every agency needs a formal method for
exposure identification.
Point 1
Every agency should establish coverage standards.
Point 2
Coverage standards include needed
coverages/endorsements and avoided endorsements.
Point 3

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Section 2

Contractual Risk Transfer

CONTRACTUAL RISK TRANSFER

This outline is designed to provide accurate information in regard to the subject matter covered. It is furnished with the understanding that Insurance Concepts & Services and/or Allen Messer are/ is not engaged in rendering legal or accounting services. If legal or accounting advice is required, the services of a competent professional should be sought.

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CONTRACTUAL RISK TRANSFER

08/01/2023

I. Overview

A. Risk management and contractual risk transfer

B. Examples of contractual risk transfer

1. Indemnity provisions
2. Waivers of subrogation
3. Limitation of liability clauses
4. Exculpatory clauses
5. Insurance requirements

C. So, should the insurance professional review contracts for his/her client

1. NOT as an attorney – **for exposure identification** – what has client agreed to do?
2. **OPINION** -no duty to review; review could create errors & omissions exposure
3. **OPINION** -duty to review; failure to review could create errors & omissions exposure
4. To create a **value-added service**
5. If insurance professional reviews, must create a **consistent methodology for review**
6. Client wants to know **how insurance policy provisions "match" contract provisions**

D. Contractual risk transfer as a process itself

1. Knowledge of the law AND knowledge of insurance
2. Effective contract provisions
3. Administration
4. Coordination

II. Indemnity Provisions

A. General comments

1. Most frequently encountered risk transfer device
2. Law (common law and/or statutory law) is not absolute – may or may not be enforceable
3. Indemnity may be implied by action of common law or expressly provided for by contract between (among) parties
4. Indemnity versus contribution

Contribution: A contribution claim is based on the theory that one party has been made to pay a judgment, while only being partly, or *contributorily*, at fault. So, if you remember that contribution and contributory are closely related terms, you are half way there in determining if a certain set of facts requires an action for contribution rather than indemnification.

Example: If two joint tortfeasors are to blame, A being 20% at fault and B being 80% at fault, either can suffer a judgment for the entire amount of damages to the plaintiff under the theory of joint and several liability. If, in the situation illustrated here, B has a final judgment entered against him/her for the entire amount, equity demands that s/he be able to file a contribution action against A for the 20% of the harm that A's negligence caused.

Indemnity: An indemnity claim is based on the theory that one party has a duty to make good any loss, damage or liability incurred by another. For example, this may occur where the one seeking indemnity has only a derivative or vicarious liability for injury or damage caused by the one from whom indemnity is sought.

B. Express indemnity agreements

1. One party (the indemnitor) agrees to indemnify another party (the indemnitee) from liabilities the indemnitee may incur as a result of a business venture; the extent of the obligation is based upon the degree to which the indemnitor assumes responsibility for the negligence of the indemnitee

2. Examples of business ventures affected

   a. Construction contracts

   b. Other service agreements

   c. Leases

   d. Purchase orders

3. Indemnity agreements versus hold harmless agreements

4. Obligation to indemnify is independent of insurance protection purchased by indemnitor, even though indemnitee may often require purchase of contractual liability insurance to support indemnification; in fact, insurance protection afforded indemnitor may fall short of obligation to indemnify

5. Indemnification agreement does not relieve indemnitee of liability; if indemnitor cannot respond, indemnitee will still be required to pay

C. Types of express indemnity agreements (could include responsibility for gross negligence)

1. Limited
   (Indemnitor assumes responsibility for Indemnitee's liability for Indemnitor's own negligence)

2. Intermediate
   (Indemnitor assumes responsibility for Indemnitee's liability for Indemnitor's own negligence AND/OR Indemnitee's liability for Indemnitor's and Indemnitee's joint negligence)

3. Broad
   (Indemnitor assumes responsibility for Indemnitee's liability for Indemnitor's own negligence AND/OR Indemnitee's liability for indemnitor's and Indemnitee's joint negligence AND/OR Indemnitee's liability for Indemnitee's sole negligence)

D. Types of express indemnity agreements – California

In California, hold harmless agreements are identified as Type I, Type II or Type III OR General versus Specific; both California systems focus on the concept of active negligence versus passive negligence

1. The first type of provision is that which provides "expressly and unequivocally" that the indemnitor is to indemnify the indemnitee for, among other things, the negligence of the indemnitee, whether active or passive

    a. Indemnitee is indemnified as the result of sole negligence

    b. Indemnitee is indemnified as the result of concurrent negligence

    c. Indemnitee is indemnified as the result of vicarious responsibility for indemnitor

2. The second type of provision is that which provides that the indemnitor is to indemnify the indemnitee for "any and all claims" (but not specifically mentioning an indemnitee's negligence) and is interpreted (as a general indemnity clause) to only indemnify the indemnitee for the negligence of the indemnitee which is passive

    a. Indemnitee is indemnified as the result of sole passive negligence

    b. Indemnitee is indemnified as the result of concurrent negligence, if indemnitee's negligence is passive

    c. Indemnitee is indemnified as the result of vicarious responsibility for indemnitor

    d. Indemnitee is not indemnified for his own acts of active negligence that solely or contributorily cause indemnitee's liability

3. The third type of provision is that which provides that the indemnitor is to indemnify the indemnitee for the indemnitee's liabilities caused by the indemnitor, but which does not provide that the indemnitor is to indemnify the indemnitee for the indemnitee's liabilities caused by other than the indemnitor

    a. Indemnitee is indemnified as the result of vicarious responsibility for indemnitor

    b. However, any negligence on the part of the indemnitee, either active or passive, will bar indemnification against the indemnitor irrespective of whether the indemnitor may have also been a cause of the indemnitee's liability

Difference between “active” and “passive” negligence is that one is only passively negligent if s/he merely fails to act in fulfillment of duty of care which the law imposes upon her/him, while one is actively negligent if s/he participates in some manner in conduct or omission which caused the injury; for example:

- a contractor who installs scaffolding with inadequate fall protection has been actively negligent
- a contractor who violates the contractor’s contractual obligation to install safety nets has been actively negligently
- a general contractor who fails to discover defective conditions created by others has been passively negligent
- a general contractor who fails to exercise its right to inspect work and specify changes has been passively negligent

4. In 1975, while not specifically rejecting the Type I, Type II, Type III classification system, the court offered an alternative classification system - general versus specific

    a. General hold harmless agreements don’t specifically address the issue of indemnitee negligence; provisions purporting to hold an indemnitee harmless “in any suit at law”, “from all claims for damages to persons”, “from any cause whatsoever” are general clauses; general clauses are broad enough to include sole passive negligence of indemnitee but no active negligence of indemnitee

    b. Specific hold harmless agreements specifically address the issue of indemnitee negligence; if clear and unequivocal language is included, the indemnitor is responsible for the passive or active negligence of the indemnitee, up to and including the sole active negligence of the indemnitee

5. In 1987, the court indicated the true test should be the intent of the parties as expressed in the contract’s hold harmless agreement and not a mechanical test; court permitted the transfer of responsibility for the indemnitee’s active concurrent negligence even though the contractual transfer did not meet the criteria of Type I

E. Additional comments

1. Most begin with a **savings clause** - "to the fullest extent permitted by law"

2. Most include **assumption of defense costs** – "will indemnify, hold harmless and defend"

3. Most are intended to eliminate the attempt by the indemnitor to limit responsibility to statutory requirements or limitations of payment available to indemnitor under common law

F. Treatment of hold harmless agreements by the courts

1. In general

   a. Frequent source of litigation

   b. Rules applicable to all written contracts are used

   c. Case law specific to indemnification agreements has emerged

2. The question of public policy

3. Enforceability

   a. Is the injury or damage within the parameters of the hold harmless clause?

      (1) "Arising out of..." - "but for" causal connection

      (2) Scope of the subject matter - fact sensitive

   b. When does the obligation to indemnify begin and end?

   c. Clear and unequivocal

      (1) Does not necessarily mean the word negligence must be used

      (2) As long as the indemnification agreement clearly and without doubt expresses the intent of the parties, it may be interpreted to include negligent acts of the indemnitee

d. Express negligence rule

(1) Express negligence rule states that if an indemnitee is to be indemnified from his/her own negligence, then that intent is to be in specific terms within the contract; must use the word negligence

(2) Conspicuous test - must be written so that a reasonable person against whom it is to operate ought to have noticed it – e.g., a specific heading

(3) Express negligence test plus conspicuousness test equals fair notice requirement, e.g., Texas

e. Ambiguity interpreted against drafter

f. Contract as a whole

g. Third party beneficiaries

h. May require agreement to be in writing

G. Treatment of hold harmless agreements by the legislature

1. In general

a. Rationale of public policy has been codified

b. May be limited to construction contracts – usually does not apply to all types of contracts

2. Anti-indemnification statutes

a. Varies by jurisdiction

b Ability to “circumvent” anti-indemnification by insurance requirements may/may not exist

H. How does an indemnitee recover? An indemnitee generally must show that:

1. The liability is covered by the contract;
2. That liability existed; and
3. The settlement was reasonable.

I. Additional notes

1. Some indemnification/hold harmless agreements may involve ***personal injury*** (e.g., wrongful detention) as well as bodily injury!
2. Indemnification agreement may include ***punitive damages/exemplary damages*** - If so, can this be negotiated out?

Insurance professional's "**need to know**" about punitive damages:

- ***Three*** questions
  - **Are they recoverable?**
    - **Statutory limitations applicable?**
  - **Are they insurable?**
    - **Directly assessed?**
    - **Vicariously assessed?**
  - **Does the insurance policy cover them?**

III. Waivers Of Subrogation

A. Subrogation – defined

- The principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy. **Black's Law Dictionary - Ninth Edition**

1. Attempts to allocate liability to person / organization responsible for injury or damage

2. Example - insurance company / insured / third party

   a. Insurer's right of subrogation does not depend on any stated provision in the insurance policy
   b. However, insurer must not act as a volunteer
   c. And, insurer has no greater rights against the third party than those of the insured

B. Express waiver - defined

- The voluntary, intentional relinquishment of a known right. **Black's Law Dictionary**

1. Technically, an insured could waive his/her rights against a third party before or after a loss

2. Examples

   a. Owner / contractor

   b. Landlord / tenant

3. Note - the insured does not technically waive subrogation; the insured waives all or part of his/her right to recovery from the third party for injury or damages arising out of the contract, **usually to the extent recoverable by insurance**

C. Subrogation provision in an insurance policy

1. Reminds the insured of the insurer's right of subrogation

2. Outlines if and when the insured may waive his/her rights against a third party

3. Violation of the insurance policy provision may subject the insured to a claim from the insurer for breach of contract

D. WAIVER OF SUBROGATION INVOLVES A PROVISION IN THE CONTRACT AND A PROVISION IN AN INSURANCE POLICY

E. Scope of the waiver

1. Parties to which it applies

- ...shall waive all rights of recovery against Owner and Contractor...
- ...shall waive all rights of recovery against Landlord...
- ...shall waive all rights of recovery against Owner, Contractor, Subcontractor and Sub-subcontractors

May apply to executive officers, employees, etc.

a. Does the waiver provision extend to employees?

(1) Under some jurisdictions, the waiver provision would be required to specifically waive rights against employees in order to apply to employees

(2) In these jurisdictions, if the waiver provision does not specifically waive rights against employees, the insurer would be allowed to subrogate against employees if the employees are the responsible wrongdoers

b. What is meant by a specific term, e.g., subcontractor?

(1) Does the term subcontractor include a supplier?

(2) Language in waiver needs to be precise!

2. Extent to which the waiver applies

- ...to the extent covered by insurance
- ...to the extent covered by insurance applicable to the work

a. Does the waiver provision extend to only the work itself or to injury or damage beyond the work as well, as long as that injury or damage “arises out of” the work?

(1) Will more than likely depend on the verbiage of the waiver

(2) Caution must therefore be exercised, e.g., a renovation project

b. Does the waiver apply to SIRs, deductibles, exclusions, coinsurance penalties, self-insurance, retrospective premium adjustments, etc.?

(1) Are these considered “covered by insurance”?

(2) In my opinion, these items should be specifically addressed in the contract provision!

F. Waiver of subrogation for workers compensation insurance

1. Potential effects

a. Premium for endorsement

b. Potential negative impact on experience modification

c. Potential negative impact on loss sensitive rating plan

d. Potential double recovery by employee

(1) Example

(2) Methods adopted by some states to prevent double recovery

(a) Statutory employer mechanism

(b) Judge may deduct payments received under workers compensation from jury award

(c) Case law

(d) Prohibition of waivers of subrogation

2. Is there really a need?

IV. Limitation Of Liability Provisions

A. In general – a contractual provision by which the parties agree on a maximum amount of damages recoverable or restrict the remedies available

1. Limits liability of the party in whose favor it operates

a. Limits liability to a predetermined amount or type of recovery

b. Method by which an organization can attempt to equalize the imbalance between the potential risk and the compensation (reward) to be received

2. Therefore, risk is transferred to (borne by) the other party to the contract

B. Types

1. Limitation of liability is expressed in a dollar amount

12.2.1 COMPENSATION. Neither the Architect, the Architect's consultants, nor their agents or employees shall be jointly, severally or individually liable to the Owner in excess of the compensation to be paid pursuant to this agreement or of _____ dollars ($_____), whichever is greater, by reason of any act or omission, including breach of contract or negligence not amounting to a willful or intentional wrong.

- *Limits liability for tort and/or contract actions*

12.2.1 INSURANCE. Neither the Architect, the Architect's consultants, nor their agents or employees shall be jointly, severally or individually liable to the Owner in any amount in excess of the currently maintained professional liability insurance coverage carried by the Architect, by reason of any act or omission, including breach of contract or negligence not amounting to a willful or intentional wrong.

- *Limits liability for tort and/or contract actions*

2. Limitation of liability is expressed in the type(s) of damages recoverable / not recoverable

CONSEQUENTIAL DAMAGES. In no event shall Engineer, or its subcontractors of any tier, be liable in contract, tort, strict liability, warranty or otherwise, for any special, indirect, incidental or consequential damages, such as, but not limited to, delay, disruption, loss of product, loss of anticipated profits or revenue, loss of use of the equipment or system, non-operation or increased expense of operation of other equipment or systems, of capital, or cost of purchased or replacement equipment or system, or power.

- *Excludes responsibility for consequential damages*

C. Treatment of limitation of liability clauses by the courts

1. The question of public policy

2. Unequal bargaining power

   a. Parties need to <u>have an opportunity</u> to negotiate

   b. Example

> **1. LIMITATION OF LIABILITY. Neither the Architect, the Architect's consultants, nor their agents or**
> **2. employees shall be jointly, severally or individually liable to the Owner in excess of the**
> **3. compensation to be paid pursuant to this agreement or of _____ dollars ($_____),**
> **4. whichever is greater, by reason of any act or omission, including breach of contract or**
> **5. negligence not amounting to a willful or intentional wrong. In the event the Owner does not**
> **6. wish to limit our liability to this sum, the Architect agrees to waive this limitation of liability**
> **7. upon receiving Owner's written request, and an agreement by Owner to pay additional**
> **8. consideration of five percent (5%) of our total fee or $500, whichever is greater.**

   - *Prima facie evidence of opportunity to negotiate*

3. Is the injury or damage within the parameters of the limitation of liability clause?

   a. Example

> **1. The owner agrees to limit the engineer's liability to owner to the engineer's professional negligent**
> **2. acts, errors or omissions, such that the total aggregate liability of the engineer to the owner shall**
> **3..not exceed Fifty Thousand Dollars ($50,000) or the engineer's total fee for services rendered from**
> **4. this project, whichever is greater.**

      (1) Cause of action is for breach of contract

      (2) Is the injury or damage within the parameters of the limitation of liability clause? **NO**

   b. All types of risks intended to be covered must be specifically addressed, i.e., breach of contract, errors and omissions, bodily injury/personal injury/property damage, consequential damages, etc.

   c. All parties intended to be covered must be specifically addressed, e.g., agents, employees, etc.

4. Ambiguity interpreted against drafter

D. Treatment of limitation of liability clauses by the legislation

1. May permit such clauses

2. May limit such clauses, e.g., for breach of contract actions only

3. May prohibit limitation of liability clauses

V. Exculpatory Clauses

A. Defined

- A contract clause which releases on of the parties form liability for his or her wrongful acts. **Black's Law Dictionary - Ninth Edition**

B. In general

1. Eliminates the liability of the party in whose favor it operates - exonerates from fault the wrongdoer
2. Therefore, risk is transferred (borne) by the other party to the contract

C. Examples

1. Parking agreement

> **This Contract Limits Our Liability. Read It.**
> **The acceptance of the parking ticket constitutes an agreement between the vehicle owner and the garage operator, that the operator is not responsible or liable for loss or damages by reason of fire, theft, collision or any other cause to vehicle or contents, whatsoever, including radar detectors, cellular phones, and sound systems. The vehicle owner and occupants assume full responsibility for any personal injuries that may occur while the vehicle is parked in the parking facility. Employees are not authorized to change the terms of this agreement.**

- *Attempts to exonerate garage operator for damage to vehicle*

2. Construction contract

> **4.7 RISK OF LOSS. Except to the extent covered by the builder's risk insurance, the Subcontractor shall have the sole responsibility for the proper storage and protection of, and assumes all risk of loss of Subcontractor's Work and tools, materials, equipment, supplies, facilities, offices and other property at or off the Project site. Subcontractor agrees not to look to Owner or Contractor for any loss or damage to such items, however caused.**

- *Waives rights for recovery against Owner or Contractor for damage to any of Subcontractor's property*

3. Lease of premises

> **Lessor shall not be liable for any damage to or loss of personal property owned by or in the care, custody or control of Lessee arising from the leaking of the roof or from the bursting, leaking or overflowing of water, sewer or steam pipes, or from heating or plumbing fixtures or from any other cause whatsoever. The Lessee expressly agrees to exonerate the lessor in all such cases.**

- *Exonerates landlord from damage to tenant's personal property*

D. If exculpator purchases property insurance for exposure to loss, exculpatory clause may also act as a waiver of subrogation (insurer can have no greater rights against a responsible party than the insured has against a responsible party – if insured has waived rights of recovery against responsible party, then insurer has no rights of recovery against responsible party)

E. Treatment of exculpatory clauses by the courts

1. The question of public policy

a. Disclaimers may be required to be conspicuous

b. May be against public policy if deemed to be an attempt to free wrongdoer from its own negligence, particularly gross negligence

c. *Potential public policy factors

(1) Contract concerns a business of a type generally thought suitable for public regulation

(2) Party seeking exculpation is engaged in performing a service of great importance to the public, which is often a matter of practical necessity for some members of the public.

(3) The party seeking exculpation holds itself out as one who will perform the service for any member of the public that seeks it or at least any member coming within certain established standards.

(4) As a result of the essential nature of the service, in the economic setting of the transaction, the party invoking exculpation possesses a decisive advantage of bargaining strength against any member of the public who seeks its services.

(5) In exercising superior bargaining power, the party confronts the public with a standard adhesion contract (usually a “take it or leave it” form contract) of exculpation and makes no provision whereby a purchaser may pay additional reasonable fees and obtain protection against the negligence of the party seeking to be exculpated from liability.

(6) As a result of the transaction, the personal property of the purchaser is placed under the control of the seller, subject to the risk of carelessness by the seller or its agents.
*Source - IRMI - Contractual Risk Transfer - 12222 Merit Drive Suite 1660, Dallas, Texas

2. Clear and unequivocal

3. Ambiguity

F. Treatment of exculpatory clause by the legislature

VI. Contractual Risk Transfer Through Insurance Requirements

A. What sort of liability insurance requirements have you encountered?

- Comprehensive General Liability Policy with XCU exclusions removed?
- CGL Policy must be a standard unendorsed CG 00 01 12 07 or equivalent?
- Completed operations coverage for ____ years following completion?
- Comprehensive automobile liability?
- Symbol 1?
- Additional insured under BAP?
- Completed operations for snowplowing operations?
- Public liability?
- Cross- liability endorsement?
- Broad form property damage?
- Combined single limit?
- Borrowed servant endorsement?
- Additional insured - CG 20 10 11 85 edition or its equivalent?
- Primary & non-contributory? Including umbrella? (Horizontal versus vertical exhaustion!)
- $2,000,000 per occurrence requirement for either CGL Policy or BAP?

B. Is non-compliance with insurance requirements material breach of contract? Courts have said yes!

C. Standards for Insurance Requirements

1. Clear and concise – no archaic language!
2. What coverages are to be purchased by each party?
3. Who are to be included as insureds under which policies?
4. What limits of insurance are required?
5. What is expected scope of coverage?
6. How long should coverage be in place?
7. How should other insurance clause address application of two or more policies?
8. What are acceptable deductibles or SIRs?
9. What waivers of subrogation apply?
10. What are acceptable insurance companies?
11. How will evidence of compliance take place?

VII. Insurance Policy Provisions and Contractual Risk Transfer

A. Insurance provisions relating to indemnification agreements

1. General comments

   a. All policy exclusions apply to the contractual liability coverage provided except where the exclusion makes a specific exception for liability assumed under an insured contract

   b. Therefore, the assumption of responsibility for liability may be broader than the coverage provided

   c. A claim against the indemnitee does not always immediately activate coverage under the indemnitor's insurance coverage

   d. But indemnitor's Insuring Agreement may provide him/her coverage for the contractual agreement to pay for BI or PD to others – "becomes legally obligated to pay"

   e. Many times, the indemnification agreement is supplemented by a requirement to be named as an additional insured to act as a safety net for the indemnitee in case the indemnification agreement is unenforceable and, in some instances, to provide immediate defense coverage for the indemnitee

2. Commercial General Liability Coverage Form

2. Exclusions
This insurance does not apply to:
b. Contractual Liability
"Bodily injury" or "property damage" for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages:

(1) That the insured would have in the absence of the contract or agreement; or

(2) Assumed in a contract or agreement that is an "insured contract", provided the "bodily injury" or "property damage" occurs subsequently to the execution of the contract or agreement. Solely for the purposes of liability assumed in an "insured contract", reasonable attorney fees and necessary litigation expenses incurred by or for a party other than an insured are deemed to be damages because of "bodily injury" or "property damage", provided:

(a) Liability to such party for, or for the cost of, that party's defense has also been assumed in the same "insured contract"; and

(b) Such attorney fees and litigation expenses are for defense of that party against a civil or alternative dispute resolution proceeding in which damages to which this insurance applies are alleged;

a. Bodily injury or property damage must occur subsequent to the execution of the contract or agreement

b. Specifically addresses assumption of defense costs

(1) Assumed defense costs will be deemed to be damages because of bodily injury or property damage under certain circumstances

(2) Therefore, assumed defense costs may be within the Limits Of Insurance

(3) On occasion, assumed defense costs may qualify as Supplementary Payments

Supplementary Payments of CGL Policy

2. If we defend an insured against a "suit" and an indemnitee of the insured is also named as a party to the "suit", we will defend that indemnitee if all of the following conditions are met:

a. The "suit" against the indemnitee seeks damages for which the insured has assumed the liability of the indemnitee in a contract or agreement that is an "insured contract";

b. This insurance applies to such liability assumed by the insured;

c. The obligation to defend, or the cost of the defense of, that indemnitee, has also been assumed by the insured in the same "insured contract";

d. The allegations in the "suit" and the information we know about the "occurrence" are such that no conflict appears to exist between the interests of the insured and the interests of the indemnitee;

e. The indemnitee and the insured ask us to conduct and control the defense of that indemnitee against such "suit" and agree that we can assign the same counsel to defend the insured and the indemnitee; and

f. The indemnitee:

(1) Agrees in writing to:

(a) Cooperate with us in the investigation, settlement or defense of the "suit";

(b) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the "suit";

(c) Notify any other insurer whose coverage is available to the indemnitee; and

(d) Cooperate with us with respect to coordinating other applicable insurance available to the indemnitee; and

(2) Provides us with written authorization to:

(a) Obtain records and other information related to the "suit"; and

(b) Conduct and control the defense of the indemnitee in such "suit".

So long as the above conditions are met, attorneys' fees incurred by us in the defense of that indemnitee, necessary litigation expenses incurred by us and necessary litigation expenses incurred by the indemnitee at our request will be paid as Supplementary Payments. Notwithstanding the provisions of Paragraph **2.b.(2)** of Section **I** – Coverage **A** – Bodily Injury And Property Damage Liability, such payments will not be deemed to be damages for "bodily injury" and "property damage" and will not reduce the limits of insurance.

Our obligation to defend an insured's indemnitee and to pay for attorneys' fees and necessary litigation expenses as Supplementary Payments ends when we have used up the applicable limit of insurance in the payment of judgments or settlements or the conditions set forth above, or the terms of the agreement described in Paragraph **f.** above, are no longer met.

(a) Both insured and indemnitee must be named in suit – this has potential that all employee injury claims of indemnitor will not qualify (exclusive remedy of WC)

(b) Allegations in the suit and the information insurer knows about the occurrence are such that no conflict appears to exist between the interests of the insured (indemnitor) and the interests of the Indemnitee

(c) Indemnitee and insured ask insurer to conduct and control the defense of that indemnitee against such "suit" and agree that the insurer can assign the same counsel to defend the insured and the Indemnitee

(d) Indemnitee agrees to specific policy conditions, i.e., cooperation, notice, authorization, etc.

c. Exception for "insured contract" - NO "BLANKET CONTRACTUAL" - key is definition of "insured contract"

9. "Insured contract" means:
a. A contract for a lease of premises. However, that portion of the contract for a lease of premises that indemnifies any person or organization for damage by fire to premises while rented to you or temporarily occupied by you with permission of the owner is not an "insured contract";
b. A sidetrack agreement;
c. An easement or license agreement, except in connection with construction or demolition operations on or within 50 feet of a railroad;
d. An obligation, as required by ordinance, to indemnify a municipality, except in connection with work for a municipality;
e. An elevator maintenance agreement;
f. That part of any other contract or agreement pertaining to your business (including an indemnification of a municipality in connection with work performed for a municipality) under which you assume the tort liability of another party to pay for "bodily injury" or "property damage". Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.

(1) Paragraphs a. - e. equate to "incidental contracts"- watch out for **CG 21 39 – CONTRACTUAL LIABILITY LIMITATION** which eliminates paragraph f. from the definition of insured contract

(2) Exception to paragraph a. may create a need for property insurance

(3) Insurance protection is broad enough to include sole negligence of indemnitee, subject to policy terms and condition

(4) CAUTION: CGL Policy contractual is for bodily injury and property damage only

d. "Insured contract" does not include

> Paragraph **f.** does not include that part of any contract or agreement:
> **(1)** That indemnifies a railroad for "bodily injury" or "property damage" arising out of construction or demolition operations, within 50 feet of any railroad property and affecting any railroad bridge or trestle, tracks, road beds, tunnel, underpass or crossing;
> **(2)** That indemnifies an architect, engineer, or surveyor for injury or damage arising out of:
> **(a)** Preparing, approving or failing to prepare or approve maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or
> **(b)** Giving directions or instructions, or failing to give them, if that is the primary cause of the injury or damage; or
> **(3)** Under which the insured, if an architect, engineer or surveyor, assumes liability for an injury or damage arising out of the insured's rendering or failure to render professional services, including those listed in **(2)** above and supervisory, inspection, architectural or engineering activities.

(1) Need for **Railroad Protective Liability Coverage Form** and **CG 24 17 – CONTRACTUAL LIABILITY RAILROADS** [deletes paragraph (1) above and modifies paragraph c. of definition of "insured contract" on previous page to provide contractual coverage for a designated job site for a scheduled railroad]

(a) Railroad Protective Liability Coverage Form protects the railroad as a named insured, subject to policy terms and conditions

(b) Contractual Liability Railroads endorsement protects the named insured for liability assumed under contract, subject to policy terms and conditions

(c) These options are not mutually exclusive

(2) No contractual liability insurance protection for the assumption of certain professional liabilities

e. CAUTION – RESTRICTIVE ENDORSEMENT – modifies paragraph f.

CG 24 26 AMENDMENT OF INSURED CONTRACT DEFINITION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

Paragraph 9 of the Definitions Section is replaced by the following:

9. "Insured contract" means:

a. A contract for a lease of premises. However, that portion of the contract for a lease of premises that indemnifies any person or organization for damage by fire to premises while rented to you or temporarily occupied by you with permission of the owner is not an "insured contract";

b. A sidetrack agreement;

c. Any easement or license agreement, except in connection with construction or demolition operations on or within 50 feet of a railroad;

d. An obligation, as required by ordinance, to indemnify a municipality, except in connection with work for a municipality;

e. An elevator maintenance agreement;

f. **That part of any other contract or agreement pertaining to your business (including an indemnification of a municipality in connection with work performed for a municipality) under which you assume the tort liability of another party to pay for "bodily injury" or "property damage" to a third person or organization, <u>provided the "bodily injury" or "property damage" is caused, in whole or in part, by you or by those acting on your behalf</u>. *However, such part of a contract or agreement shall only be considered an "insured contract" to the extent your assumption of the tort liability is permitted by law.* Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.**

Paragraph f. does not include that part of any contract or agreement:

(1) That indemnifies a railroad for "bodily injury" or "property damage" arising out of construction or demolition operations, within 50 feet of any railroad property and affecting any railroad bridge or trestle, tracks, road-beds, tunnel, underpass or crossing;

(2) That indemnifies an architect, engineer or surveyor for injury or damage arising out of:

(a) Preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or

(b) Giving directions or instructions, or failing to give them, if that is the primary cause of the injury or damage; or

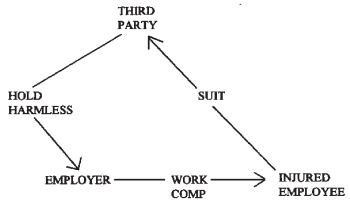
(3) Under which the insured, if an architect, engineer or surveyor, assumes liability for an injury or damage arising out of the insured's rendering or failure to render professional services, including those listed in (2) above and supervisory, inspection, architectural or engineering activities.

- Does not provide for indemnification of the sole negligence of another
- Not suitable for most risks

Caution: may be imbedded in insurer specific coverage form

f. Exceptions to other CGL exclusions for "insured contract"

e. Employer's Liability
"Bodily injury" to:
(1) An "employee" of the insured arising out of and in the course of:
(a) Employment by the insured; or
(b) Performing duties related to the conduct of the insured's business; or
(2) The spouse, child, parent, brother or sister of that "employee" as a consequence of Paragraph **(1)** above.
This exclusion applies whether the insured may be liable as an employer or in any other capacity and to any obligation to share damages with or repay someone else who must pay damages because of the injury.
This exclusion does not apply to liability assumed by the insured under an "insured contract".



g. Aircraft, Auto Or Watercraft
"Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and "loading or unloading".
This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involved the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft that is owned or operated by or rented or loaned to any insured.
This exclusion does not apply to:
(1) A watercraft while ashore on premises you own or rent;
(2) A watercraft you do not own that is:
(a) Less than 26 feet long; and
(b) Not being used to carry persons or property for a charge;
(3) Parking an "auto" on, or on the ways next to, premises you own or rent, provided the "auto" is not owned by or rented or loaned to you or the insured;
(4) Liability assumed under any "insured contract" for the ownership, maintenance or use of aircraft or watercraft; or
(5) "Bodily injury" or "property damage" arising out of:
(a) The operation of machinery or equipment that is attached to, or part of, a land vehicle that would qualify under the definition of "mobile equipment" if it were not subject to a compulsory or financial responsibility law or other motor vehicle insurance law in the state where it is licensed or principally garaged; or
(b) The operation of any of the machinery or equipment listed in Paragraph **f.(2)** or **f.(3)** of the definition of "mobile equipment".

(1) Contractual liability for owned/nonowned aircraft

(2) Contractual liability for owned/nonowned watercraft

g. Personal and advertising injury coverage

2. Exclusions
This insurance does not apply to:
e. Contractual Liability
"Personal and advertising injury" for which the insured has assumed liability in a contract or agreement. This exclusion does not apply to liability for damages that the insured would have in the absence of the contract or agreement.

(1) Exclusion applies to liability assumed in a contract or agreement for personal injury or advertising injury

(2) Contractual liability coverage may not match exposure; many indemnification agreements do not distinguish between bodily injury/property damage AND personal injury

(3) May want to delete exclusion

(4) May want to endorse

LIMITED CONTRACTUAL LIABILITY COVERAGE FOR PERSONAL AND ADVERTISING INJURY - CG 22 74

(a) Assumed defense costs will be deemed to be damages because of personal injury

(b) Assumed defense costs will be within the Limits Of Insurance

(c) On occasion, assumed defense costs may qualify as Supplementary Payments

(5) If either exclusion is deleted or endorsement is attached, will need to consider endorsement to Umbrella Policy or Excess Liability Policy

3. Business Auto Coverage Form

This insurance does not apply to:
2. CONTRACTUAL
Liability assumed under any contract or agreement.
But this exclusion does not apply to liability for damages:
a. Assumed in a contract or agreement that is an "insured contract" provided the "bodily injury" or "property damage" occurs subsequent to the execution of the contract or agreement; or
b. That the "insured" would have in the absence of the contract or agreement.

a. Similar to Commercial General Liability Coverage Form

b. Bodily injury or property damage must occur subsequent to the execution of the contract or agreement

c. Does not specifically address the assumption of defense costs

d. Exception for "insured contract" - NO BLANKET CONTRACTUAL - key is definition of "insured contract"

H. "Insured contract" means:
1. A lease of premises;
2. A sidetrack agreement;
3. Any easement or license agreement, except in connection with construction or demolition operations on or within 50 feet of a railroad;
4. An obligation, as required by ordinance, to indemnify a municipality, except in connection with work for a municipality;
5. That part of any other contract or agreement pertaining to your business (including an indemnification of a municipality in connection with work performed for a municipality) under which you assume the tort liability of another to pay for "bodily injury" or "property damage" to a third party or organization. Tort liability means a liability that would be imposed by law in the absence of any contract or agreement; or
6. That part of any contact or agreement entered into, as part of your business, pertaining to the rental or lease, by you or any of your "employees", of any "auto". However, such contract or agreement shall not be considered an "insured contract" to the extent that it obligates you or any of your "employees" to pay for "property damage" to any "auto" rented or leased by you or any of your "employees".

(1) First four paragraphs equate to "incidental contracts"

(2) Insurance protection is broad enough to include sole negligence of indemnitee, subject to policy terms and condition

(3) Paragraph 6. specifically addresses auto rental agreements

(a) Includes contracts entered into by named insured's employees

(b) Reinforces CCC exclusion of BAP pertaining to physical damage to rental vehicle

(4) Not all indemnification clauses will be considered insured contracts

An "insured contract" does not include that part of any contract or agreement.
a. That indemnifies a railroad for "bodily injury" or "property damage" arising out of construction or demolition operations, within 50 feet of any railroad property and affecting any railroad bridge or trestle, tracks, roadbeds, tunnel, underpass or crossing;
b. That pertains to the loan, lease or rental of an "auto" to you or any of your "employees", if the "auto" is loaned, leased or rented with a driver; or
c. That holds a person or organization engaged in the business of transporting property by "auto" for hire harmless for your use of a covered "auto" over a route or territory that person or organization is authorized to serve by public authority.

(1) Indemnification involving railroad construction operations excluded

- **CA 20 70 – Coverage for Certain Operations in Connection with Railroad**
- May need **Railroad Protective Liability Coverage Form**

(2) Named insured has no control over the operation of the auto rented with driver; owner should bear responsibility

(3) Indemnification of common carrier is excluded

e. Exceptions to other BAP exclusions

This insurance does not apply to:
4. EMPLOYEE INDEMNIFICATION AND EMPLOYER'S LIABILITY
"Bodily injury" to:
a. An "employee" of the "insured" arising out of and in the course of:
(1) Employment by the "insured"; or
(2) Performing the duties related to the conduct of the "insured's" business, or
b. The spouse, child, parent, brother or sister of that "employee" as a consequence of Paragraph **a.** above.
This exclusion applies:
(1) Whether the "insured" may be liable as an employer or in any other capacity; and
(2) To any obligation to share damages with or repay someone else who must pay damages because of the injury.
But this exclusion does not apply to "bodily injury" to domestic "employees" not entitled to workers' compensation benefits or to *liability assumed by the "insured" under an "insured contract"*. For the purposes of the Coverage Form, a domestic "employee" is a person engaged in household or domestic work performed principally in connection with a residence premises.

(1) Similar to CGL Coverage Form exception for insured contract

(2) Injury to an employee could result in a Workers Compensation And Employers Liability Insurance Policy claim AND a Business Auto Policy claim

4. Workers Compensation And Employers Liability Insurance Policy

a. Liability assumed under contract excluded here

b. Covered by exception to exclusions in CGL Policy and BAP

B. Insurance provisions relating to waivers of subrogation / exculpatory clauses

1. General comments

a. Most insurance policies have an express provision addressing the insurer's right of subrogation – Transfer Of Your Rights Of Recovery Against Others To Us

b. These provisions do not expand the insurer's rights of subrogation; the provisions:

(1) Remind the insured that the right of subrogation for the insurer exists

(2) Place restrictions on the insured's right to waive rights of recovery against others

c. An endorsement to the policy for an additional premium charge *may* be necessary to effectuate compliance with the intent of the contracting parties

d. Many insurance policy provisions may allow an insured to simply include waivers of rights of recovery against others in its business contracts and not inform insurers of the waivers; however, it is advisable to discuss, in advance, with the insurer how these waivers will be handled; comments that follow are based on standard ISO & NCCI policy forms

2. Commercial General Liability Coverage Form

SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS
8. Transfer of Rights of Recovery Against Others To Us
If the insured has rights to recover all or part of any payment we have made under this Coverage Part, those rights are transferred to us. The insured must do nothing after loss to impair them. At our request, the insured will bring "suit" or transfer those rights to us and help us enforce them.

a. Inference is that insured is permitted to waive rights of recovery prior to a loss

b. Not permitted after a loss

c. **WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US (WAIVER OF SUBROGATION) CG 24 04** is available to evidence waivers of subrogation where individual person(s) or organization(s) must be specifically scheduled

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US (WAIVER OF SUBROGATION) CG 24 04 12 19
This endorsement modifies insurance provided under the following:
COMMERCIAL GENERAL LIABILITY COVERAGE PART
SCHEDULE
Name of Person(s) or Organization(s): ***SHOULD MIRROR CONTRACT REQUIREMENT***
The following is added to Paragraph **8. Transfer Of Rights Of Recovery Against Others To Us** of **Section IV – Conditions:**
We waive any right of recovery against the person(s) or organization(s) shown in the Schedule above because of payments we make under this Coverage Part. Such waiver by us applies only to the extent that the insured has waived its right of recovery against such person(s) or organization(s) prior to loss. This endorsement applies only to the person(s) or organization(s) shown in the Schedule above.

(1) Attached prior to loss

(2) Applicable to the person(s) or organization(s) shown in the Schedule

(3) Expresses intent of parties to allocate risk

d. **WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US (WAIVER OF SUBROGATION) – AUTOMATIC – CG 24 53 12 19**

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US CG (WAIVER OF SUBROGATION) – AUTOMATIC 24 53 12 19
This endorsement modifies insurance provided under the following:
COMMERCIAL GENERAL LIABILITY COVERAGE PART

The following is added to Paragraph **8. Transfer Of Rights Of Recovery Against Others To Us** of **Section IV – Conditions:**
We waive any right of recovery against any person or organization, because of payments we make under this Coverage Part, to whom the insured has waived its right of recovery in a written contract or agreement. Such waiver by us applies only to the extent that the insured has waived its right of recovery against such person or organization prior to loss.

(1) Attached prior to loss

(2) "Triggered" by written contract or written agreement

(3) Expresses intent of parties to allocate risk

3. Workers Compensation And Employers Liability Insurance Policy

PART ONE
WORKERS COMPENSATION INSURANCE
G. Recovery From Others
We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help enforce them.
PART TWO
EMPLOYERS LIABILITY INSURANCE
H. Recovery from Others
We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

a. Not permitted prior to a loss

b. Not permitted after a loss

c. Approach - **WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT- WC 00 03 13**

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT
We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. *(This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)*
This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

(1) Attached prior to loss

(2) Words in parenthesis are optional with insurer

(a) Suitable for construction contracts

(b) Unfortunately, some insurers have “hardcoded” verbiage into their endorsement, thus may not meet named insured’s needs

(3) Additional premium usually required

(4) No standard NCCI “automatic” endorsement

4. Business Auto Coverage Form

SECTION IV – Business Auto Conditions
5. If any person or organization to or for whom we make payment under this Coverage Form has rights to recover damages from another, those rights are transferred to us. That person or organization must do everything necessary to secure our rights and must do nothing after "accident" or "loss" to impair them.

a. Implied right to waive prior to loss

b. Standard countrywide ISO endorsements available

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US (WAIVER OF SUBROGATION) CA 04 44
This endorsement modifies insurance provided under the following:
BUSINESS AUTO COVERAGE FORM

SCHEDULE

Name(s) of Person(s) or Organization(s):

_____

The **Transfer Of Rights Of Recovery Against Others To Us** Condition does not apply to the person(s) or organization(s) shown in the Schedule, but only to the extent that subrogation is waived prior to the "accident" or the "loss" under a contract with that person or organization.

(1) Attached prior to accident (liability) or loss (physical damage)

(2) Appears to require privity of contract

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US (WAIVER OF SUBROGATION) – AUTOMATIC WHEN REQUIRED BY WRITTEN CONTRACT OR AGREEMENT CA 04 43 11 20
This endorsement modifies insurance provided under the following:
BUSINESS AUTO COVERAGE FORM

The **Transfer Of Rights Of Recovery Against Others To Us** Condition does not apply to any person(s) or organization(s) for whom you are required to waive subrogation with respect to the coverage provided under this Coverage Form, but only to the extent that subrogation is waived:
A. Under a written contract or agreement with such person(s) or organizations(s); and
B. Prior to the "accident" or the "loss".

(1) Attached prior to accident (liability) or loss (physical damage)

(2) Appears to require privity of contract

5. Commercial Property Policy

I. TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US
If any person or organization to or for whom we make payment under this Coverage Part has right to recover damages from another, those rights are transferred to us to the extent of our payment. That person or organization must do everything necessary to secure our rights and must do nothing after loss to impair them. But you may waive your rights against another party in writing:
1. *Prior to a loss* to your Covered Property or Covered Income.
2. *After a loss* to your Covered Property or Covered Income only if, at time of loss, that party is one of the following:
a. Someone insured by this insurance;
b. A business firm:
(1) Owned or controlled by you; or
(2) That owns or controls you; or
c. Your tenant.
This will not restrict your insurance.

a. Permitted prior to a loss

b. Permitted after a loss *(specific parties)*

c. No standard endorsement to evidence waiver of subrogation

d. May not be needed – "Sutton Doctrine"

6. Commercial Inland Marine

Subrogation. You may not waive your rights to recover damages from other responsible parties except as agreed to in writing by us.

Subrogation. If we pay for a loss, we may require the insured to assign to us the right of recovery against others. We will not pay for a loss if the insured impairs this right to recover. The insured's right to recover from others may be waived in writing before a loss occurs.

a. Non-standard policy

b. MUST READ to determine if allowed

c. Endorsement may be required; additional premium payment may be necessary

VIII. Additional Insured Endorsements Added To The Commercial General Liability Coverage Form

A. 2013 edition of many additional insured endorsements added significant language

Sample revised ISO AI wording

> However:
> 1. The insurance afforded to such additional insured only applies to the extent permitted by law; and

1. There are several states that have passed legislation that voids certain indemnification/hold harmless provisions in contracts, primarily construction contracts

   a. Some states indicate that these statutes do not affect contractual risk transfer through the use of requirements to purchase insurance to protect another party

   b. But, statutory limitations also apply to additional insured requirements - in essence, cannot have an additional insured endorsement that "picks up" more insurance protection than that permitted by statute

> 2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

2. Incorporates contract provisions, if any, into the insurance protection available

> With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**
> If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:
> **1.** Required by the contract or agreement; or
> **2.** Available under the applicable limits of insurance;
> whichever is less.
> This endorsement shall not increase the applicable limits of insurance.

3. Adds Limits Of Insurance provision – modified with 12 19 edition

COMMENT - EXCESS/UMBRELLA POLICY NEEDS TO INCORPORATE THESE THREE PROVISIONS AS WELL

B. Additional Insured – Owners, Lessees or Contractors – Scheduled Person or Organization CG 20 10 12 19

A. **Section II - Who Is An Insured** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by:

1. Your acts or omissions; or

2. The acts or omissions of those acting on your behalf.

In the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

However:

1. The insurance afforded to such additional insured only to the extent permitted by law; and

2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusions apply:

This insurance does not apply to "bodily injury" or "property damage" occurring after:

1. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or

2. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

C. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance:

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or

2. Available under the applicable limits of insurance;

whichever is less.

This endorsement shall not increase the applicable limits of insurance.

- Does not require a written contract
- Sometimes insurer will try to “turn into” automatic additional insured endorsement by inserting “AS REQUIRED BY WRITTEN CONTRACT” in Schedule
- Not intended to provide sole negligence coverage
- Does not provide completed operations coverage

C. Additional Insured – Owners, Lessees or Contractors – Completed Operations CG 20 37 12 19

A. Section II - Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury" or "property damage" caused, in whole or in part, by "your work" at the location designated and described in the schedule of this endorsement performed for that additional insured and included in the "products completed operations hazard".

However:

1. The insurance afforded to such additional insured only to the extent permitted by law; and

2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance:

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or

2. Available under the applicable limits of insurance;

whichever is less.

This endorsement shall not increase the applicable limits of insurance.

- Does not require a written contract
- Sometimes insurer will try to “turn into” automatic additional insured endorsement by inserting “AS REQUIRED BY WRITTEN CONTRACT” in Schedule
- Not intended to provide sole negligence coverage
- Does not provide ongoing operations coverage

D. Additional Insured – Managers or Lessors of Premises – CG 20 11 12 19

A. Section II – Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability arising out of the ownership, maintenance or use of that part of the premises leased to you and shown in the Schedule and subject to the following additional exclusions:
This insurance does not apply to:
1. Any "occurrence" which takes place after you cease to be a tenant in that premises.
2. Structural alterations, new construction or demolition operations performed by or on behalf of the person(s) or organization(s) shown in the Schedule.
However:
1. The insurance afforded to such additional insured only applies to the extent permitted by law; and
2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.
B. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance:
If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:
1. Required by the contract or agreement; or
2. Available under the applicable limits of insurance;
whichever is less.
This endorsement shall not increase the applicable limits of insurance.

- TWO part “test” for coverage to apply – creates potential “problem”
- Use preferred verbiage – lease premises as stated in the lease - to eliminate potential for error

E. Additional Insured – Lessor of Leased Equipment CG 20 28 12 19

A. Section II – Who is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage", or "personal and advertising injury" caused, in whole or in part, by your maintenance, operation or use of equipment leased to you by such person(s) or organization(s).

However:

1. The insurance afforded to such additional insured only to the extent permitted by law: and

2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, this insurance does not apply to any "occurrence" which takes place after the equipment lease expires.

C. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance:

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or

2. Available under the applicable limits of insurance;

whichever is less.

This endorsement shall not increase the applicable limits of insurance.

- Does not require a written contract
- Sometimes insurer will try to "turn into" automatic additional insured endorsement by inserting "AS REQUIRED BY WRITTEN CONTRACT" in Schedule
- Does not provide sole negligence coverage

IX. "Automatic" Additional Insured Endorsements For The Commercial General Liability Coverage Form

A. Insureds don't always call

B. Lessens administrative burden

C. But need to read to determine what "triggers" coverage – caution!!!!!

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – AUTOMATIC STATUS WHEN REQUIRED IN A WRITTEN CONSTRUCTION AGREEMENT WITH YOU – CG 20 33 12 19

A. **Section II – Who Is An Insured** is amended to include as an additional insured any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy. Such person or organization is an additional insured only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury", caused, in whole or in part, by:

1. Your acts or omissions: or

2. The acts or omissions of those acting on your behalf;

in the performance of your *ongoing operations* for the additional insured.

However, the insurance afforded to such additional insured:

1. Only applies to the extent permitted by law; and

2. Will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

A person's or organization's status as an additional insured under this endorsement ends when your operations for that additional insured are completed.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusions apply:

1. "Bodily injury', "property damage" or "personal and advertising injury" arising out of the rendering of, or the failure to render, any professional architectural, engineering or surveying services, including:

a. The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specification; or

b. Supervisory, inspection, architectural or engineering activities.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved the rendering of or the failure to render any professional architectural, engineering or surveying services.

2. "Bodily injury" or "property damage" occurring after:

a. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or

b. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

C. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance:

The most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement you have entered into with the additional insured; or

2. Available under the applicable limits of insurance;

whichever is less.

This endorsement shall not increase the applicable limits of insurance.

- Does require a written contract or written agreement
- Does require privity of contract

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – AUTOMATIC STATUS FOR OTHER PARTIES WHEN REQUIRED IN WRITTEN CONSTRUCTION AGREEMENT – CG 20 38 12 19

A. Section II – Who Is An Insured is amended to include as an additional insured:

1. Any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy; and

2. Any other person or organization you are required to add as an additional insured under the contract or agreement described in Paragraph **1.** above.

Such person(s) or organization(s) is an additional insured only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by:

a. Your acts or omissions; or

b. The acts or omissions of those acting on your behalf;

in the performance of your ongoing operations for the additional insured described in Paragraph **1.** or **2.** above.

However, the insurance afforded to such additional insured:

a. Only applies to the extent permitted by law; and

b. Will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

A person's or organization's status as an additional insured under this endorsement ends when your operations for that additional insured are completed.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusions apply:

1. "Bodily injury', "property damage" or "personal and advertising injury" arising out of the rendering of, or the failure to render, any professional architectural, engineering or surveying services, including:

a. The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specification; or

b. Supervisory, inspection, architectural or engineering activities.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved the rendering of or the failure to render any professional architectural, engineering or surveying services.

2. "Bodily injury" or "property damage" occurring after:

a. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or

b. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

C. With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**

The most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement you have entered into with the additional insured; or

2. Available under the applicable Limits of Insurance shown in the Declarations;

whichever is less.

This endorsement shall not increase the applicable Limits of Insurance shown in the Declarations.

- Doe require a written contract or written agreement
- Does not require privity of contract as with CG 20 33

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – AUTOMATIC STATUS WHEN REQUIRED IN WRITTEN CONSTRUCTION AGREEMENT WITH YOU (COMPLETED OPERATIONS) – CG 20 39 12 19

A. Section II – Who Is An Insured is amended to include as an additional insured any person or organization for whom you have performed operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy. Such person or organization is an additional insured only with respect to liability for "bodily injury" or "property damage" caused, in whole or in part, by "your work" performed for that additional insured and included in the "products-completed operations hazard".

However, the insurance afforded to such additional insured:

1. Only applies to the extent permitted by law; and

2. Will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusion applies:

This insurance does not apply to:

"Bodily injury" or "property damage" arising out of the rendering of, or the failure to render, any professional architectural, engineering or surveying services, including:

1. The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or

2. Supervisory, inspection, architectural or engineering activities.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involved the rendering of or the failure to render any professional architectural, engineering or surveying services.

C. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance: The most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement you have entered into with the additional insured; or

2. Available under the applicable limits of insurance;

whichever is less.

This endorsement shall not increase the applicable limits of insurance.

- Does require a written contract or written agreement
- Does require privity of contract

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – AUTOMATIC STATUS WHEN REQUIRED IN WRITTEN CONSTRUCTION AGREEMENT WITH YOU (COMPLETED OPERATIONS) – CG 20 40 12 19

A. Section II – Who Is An Insured is amended to include as an additional insured:

1. Any person or organization for whom you have performed operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy; and

2. Any other person or organization you are required to add as an additional insured under the contract or agreement described in Paragraph **1.** above.

Such person or organization is an additional insured only with respect to liability for "bodily injury" or "property damage" caused, in whole or in part, by "your work" performed for the additional insured described in Paragraph 1. Or 2. above and included in the "products-completed operations hazard". However, the insurance afforded to such additional insured:

1. Only applies to the extent permitted by law; and
2. Will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusion applies:

This insurance does not apply to:

"Bodily injury" or "property damage" arising out of the rendering of, or the failure to render, any professional architectural, engineering or surveying services, including:

1. The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or
2. Supervisory, inspection, architectural or engineering activities.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involved the rendering of or the failure to render any professional architectural, engineering or surveying services.

C. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance: The most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement you have entered into with the additional insured; or
2. Available under the applicable limits of insurance;

whichever is less.

This endorsement shall not increase the applicable limits of insurance.

- Does require a written contract or agreement
- Does not require privity of contract as with CG 20 39

ADDITIONAL INSURED – LESSOR OF LEASED EQUIPMENT – AUTOMATIC STATUS WHEN REQUIRED IN LEASE AGREEMENT WITH YOU - CG 20 34 12 19

A. **Section II - Who Is An Insured** is amended to include as an additional insured any person(s) or organization(s) from whom you lease **equipment when you and such person(s) or organization(s) have agreed in writing in a contract or agreement that such person(s) or organization(s) be added as an additional insured on your policy**. Such person(s) or organization(s) is an insured only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" **caused, in whole or in part**, by your maintenance, operation or use of equipment leased to you by such person(s) or organization(s).
However, the insurance afforded to such additional insured:
1. Only applies to the extent permitted by law; and
2. Will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

A person's or organization's status as an additional insured under this endorsement ends when their contract or agreement with you for such leased equipment ends.

B. With respect to the insurance afforded to these additional insureds, this insurance does not apply to any "occurrence" which takes place after the equipment lease expires.

C. With respect to the insurance afforded to these additional insureds, the following is added to Section III – Limits Of Insurance:
The most we will pay on behalf of the additional insured is the amount of insurance:
1. Required by the contract or agreement; or
2. Available under the applicable Limits of Insurance ~~shown in the Declarations~~;
whichever is less.
This endorsement shall not increase the applicable Limits of Insurance ~~shown in the Declarations~~.

- Does require a written contract or written agreement
- Does require privity of contract

D. Insurer specific form must be perused to determine what triggers coverage and how much coverage is provided

What triggers coverage?
- Contract requirement?
- Written contract requirement - executed?
- AND, shown on certificate of insurance?

What coverage is provided?
- Vicarious liability only
- Vicarious liability and joint negligence
- Vicarious liability, joint negligence, and sole negligence

Are there any specific exclusions applicable?

X. Some Of The Most Common Additional Insured Endorsements Pertaining To Contractual Risk Transfer Added To The Business Auto Coverage Form

- **CA 20 01 - LESSOR - ADDITIONAL INSURED AND LOSS PAYEE**

  Adds the lessor's interest to the named insured's policy for the leased auto described in the endorsement, or a substitute or replacement of that auto. The endorsement also provides loss payee status to the lessor as well as notice of cancellation.

- **CA 20 48 - DESIGNATED INSURED FOR COVERED AUTOS LIABILITY COVERAGE**

  Provides vicarious liability coverage for an individual or organization named in the endorsement provided the person or organization qualifies as an insured under the Who Is An Insured provision.

- **CA 99 16 - HIRED AUTOS SPECIFIED AS COVERED AUTOS YOU OWN**

  Adds the lessor as an additional insured for the auto described in the schedule. The lessor does not have to be named on the endorsement. The described auto is covered as an owned auto. Endorsement does not provide coverage for replacement or substitute autos or notice of cancellation to the lessor.

- **CA 99 47 - EMPLOYEE AS LESSOR**

  Extends coverage for the employee who leases his or her auto to the named insured. The scheduled auto is considered an owned auto.

XI. CONCLUSION

EXHIBITS

INDEMNITY AGREEMENTS OUTSIDE CALIFORNIA - TYPES

EXHIBIT A

HOLD HARMLESS AGREEMENTS

LIMITED FORM	*INTERMEDIATE FORM*	*BROAD FORM*
DEFINED Indemnification of the indemnitee for "situations" arising from the indemnitor's "operations." No assumption for any negligence of the indemnitee except as respects omissions or supervisory acts in connection with "operations" performed by the indemnitor. COMMENT: This type of hold harmless agreement is narrower that the other two types. In order to require indemnification by the indemnitor, a negligent act must be committed by: (a) The indemnitor or the indemnitor's employees; **OR** (b) The indemnitee in the course of a supervisory act or omission thereof in connection with the indemnitor's "operations."	DEFINED: Indemnification of the indemnitee for "situations" arising from the indemnitor's "operations." No assumption for the sole negligence of the indemnitee except as respects omissions or supervisory acts in connection with "operations" performed by the indemnitor. COMMENT: This type of hold harmless agreement is narrower that the Broad Form. In order to require indemnification by the indemnitor, a negligent act must be committed by: (a) The indemnitor or the indemnitor's employees; **OR** (b) The indemnitor or the indemnitor's employees and the indemnitee, jointly; **OR** (c) The indemnitee, in the course of a supervisory act or omission thereof in connection with the indemnitor's "operations."	DEFINED: Indemnification of the indemnitee for "situations" arising from the indemnitor's "operations." Assumption for the joint negligence of the indemnitor and indemnitee, assumption of the sole negligence of the indemnitee. COMMENT: Under this type of hold harmless agreement, it is immaterial whether a negligent act is committed by the indemnitor, indemnitee, or both. In order to require indemnification by the indemnitor, a negligent act must be committed by: (a) The indemnitor or the indemnitor's employees; (b) The indemnitor or the indemnitor's employees and the indemnitee, jointly; **OR** (c) The indemnitee in connection with the indemnitor's "operations."

James K. Ruble Seminar

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Section 3

Cutting Edge Insurance Issues

INSURANCE ISSUES

Presented by:

Steven D. Lyon,

CIC,CRM,CPCU,ARM,AAI,AIS,CRIS,MLIS,AFIS,TRIP

1

Legal Disclaimer

The information provided and statements made in this seminar / panel discussion are for informational purposes and is not intended as legal or other professional advice. Please procure the appropriate legal or other professional advice and services to address your individual circumstances. There is no representation, guaranty or warranty made as to the sufficiency or accuracy of the information provided. Any legal cases discussed or cited, may or may not be enforceable and/or valid in your jurisdiction. The opinions and views expressed by the instructor or panel members do not necessarily reflect the opinions and views of any sponsor.

2

New Formula

PE > PP = ↓ V

(When PE is greater than PP, we wind up below the V)

WHEN POLICY HOLDER EXPECTATIONS
ARE GREATER THAN
POLICY PERFORMANCE
WE WIND UP IN LITIGATION

3

PLAINTIFF

v.

INSURANCE COMPANY / AGENCY

4

Dr. Ronald T. Anderson- Agent's Legal Responsibility

"Our E & O Insurance picks up, where the client's Insurance coverage ends."

5

Overview

- My Objective
  - Make you aware of "emerging" issues
  - I don't have all the answers
  - I don't know or understand the full impact of these new issues
  - There is little, if any, case law yet
  - My job today, is to make you aware of these things, and get your creative juices thinking about how they impact you, your work, and the insurance industry.

6

Overview

- Embedded Insurance
- Virtual Currency, Blockchain, Hashgraph
- Medical / Recreational Marijuana
- Cosmic Roulette / Solar Storms
- Autonomous Vehicles
- Price Optimization / Big Data
- Drones
- Nanotechnology
- Ride Sharing, Car Sharing and Slugging

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SECTION I:

Embedded Insurance, and Artificial Intelligence

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Embedded Insurance

- $3 Trillion Dollar Opportunity
- What is it ?
- More than Cross-selling
- Would you like the extended warranty ?
- EI offers relevant and meaningful products and services based upon what is know about the insured and their needs

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Examples

- If you purchased a Home Alarm system from our company, would you be interested in HO Insurance also ? (we already have lots of data about you)
- HO Insurance sold at the point of sale
- Gig Economy / Gig Workers – Not getting benefits. Integrated in the apps they use are a wide variety of offers:
  - Rent Protect: Disability Insurance in case they can't work and pay rent
  - HO/Auto Insurance

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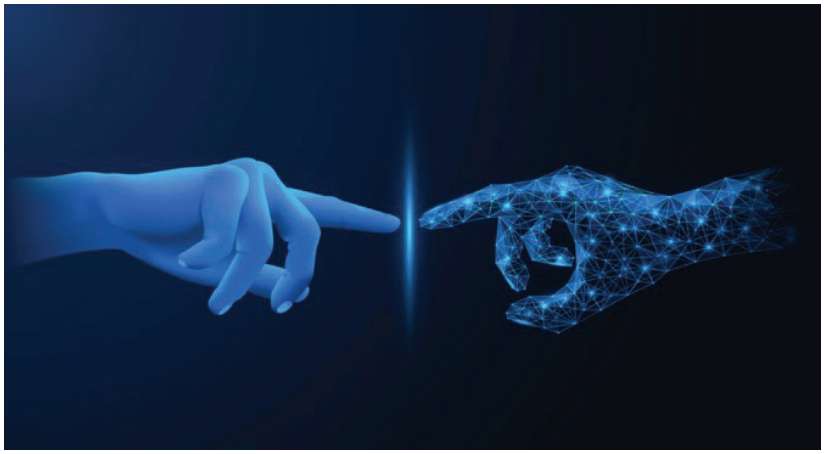
Examples

- GM offering Auto Insurance through their OnStar product – lots of telematic information -- GM Financial Ins. Co. Also offering safety and security services (car maintenance, rental, towing/labor services, etc. We know when you have had an accident)
- Replacement / Repair costs for EV's
- Constructive Totals for EV's are problematic for the insurance industry.
- Tesla Insurance Company

11

How will CHAT GPT and AI Impact Insurance ?



Let's Ask it !

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There are a number of ways that artificial intelligence (AI) is expected to transform the property and casualty insurance industry in the coming years. Some of the key areas where AI is likely to have an impact include:

1. Risk assessment: AI algorithms can help insurers more accurately assess the risk of insuring a particular property or individual. This can be done by analyzing a wide range of data sources, including property characteristics, location, and past claims history.
2. Underwriting: AI can assist insurers in the underwriting process by automating the collection and analysis of data needed to make underwriting decisions. This can speed up the process and improve the accuracy of underwriting decisions.
3. Claims processing: AI can help insurers automate and streamline the claims process by identifying patterns in claims data and using this information to predict future claims. This can help insurers to more efficiently process claims and reduce the time and effort required to resolve claims.
4. Fraud detection: AI can help insurers identify and prevent fraudulent claims by analyzing data and detecting patterns that may indicate fraudulent activity.

Overall, the use of AI in the property and casualty insurance industry is expected to increase efficiency, improve risk assessment and underwriting, and reduce the cost of insurance for consumers

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SECTION II:

Virtual Currency, Blockchain, Hashgraph and other things you may have never heard of, that are impacting the Insurance Industry.

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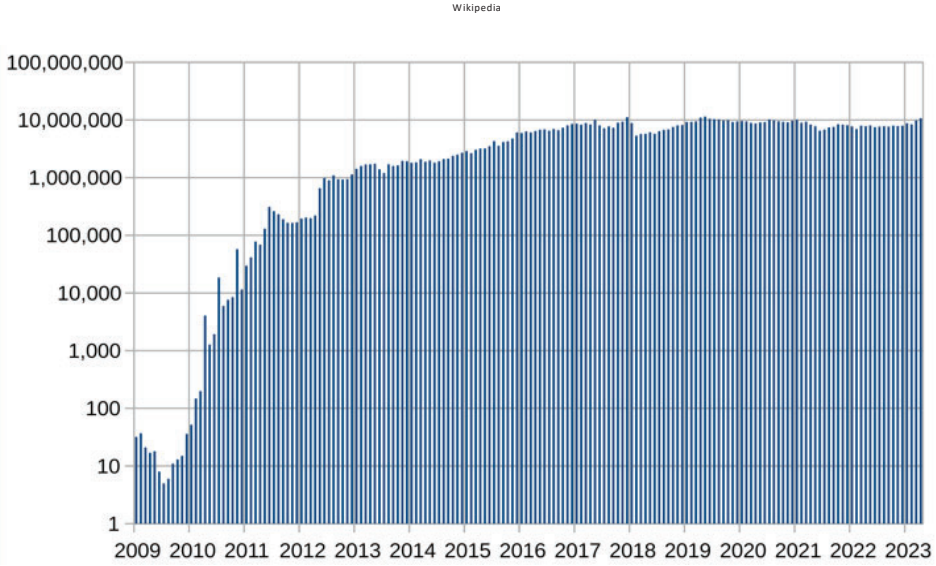
Bitcoin Info

- Started in 2009, bitcoin is a digital currency created and exchanged independent of banks or governments.
- It resides in a virtual wallet on your computer or smart phone, and is accepted by many retailers, and some local governments
- Only 21 million can be produced, making the currency inflation-proof. 19.4 million have been mined as of 8/2/23. We expect to mine all 21 million bitcoin by 2041.
- By 2014 there were 60,000 bitcoin transactions per day, including sites such as EBay, Overstock, Expedia, Dell, political parties, United Way. During this same time, VISA alone had over 150 million transactions per day
- Bitcoin and other Cryptocurrency's peek the interest of investors and retailers, as the currency of the future
- In March of 2014, the IRS rules that Bitcoin and other virtual currency is property, not currency.
- Today, there are approximately 390,000 daily Bitcoin transactions

15

of Bitcoin Transactions per Month



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Bitcoin Valuation

- Bitcoin was designed to make consumer financial transactions fast and frictionless.
- At a bank it can take days for a check to clear.
- With bitcoin its instant.

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Who regulates Bitcoin ?

- It doesn't have any of the consumer protections available with debit and credit cards, and there isn't the equivalent of FDIC.
- There's no remedy from a third party (such as a credit card issuer) in the event of fraudulent transactions.
- The Consumer Financial Protection Bureau has warned consumers about the risks of Bitcoin transactions and investments, and there is proposed regulatory regulations in several states.

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Worlds Youngest Bitcoin Millionaire

- Erik Finman, age 12, from Idaho
- His grandmother gave him $1000 for his college education
- Instead of putting it away in a savings account, he went online and bought 100 Bitcoin @ $10
- He dropped out of school to trade and speculate
- In 2011 he held 446 Bitcoin and is was worth $4.5 million
- Today, he is a Silicon Valley millionaire and has launched two Cryptocurrencies himself

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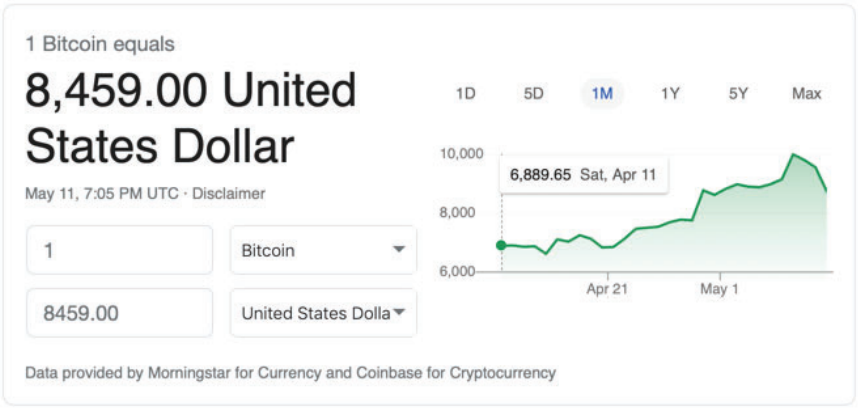
Bitcoin Pizza Day- May 22

- May 22 is known as Bitcoin Pizza Day, marking the 11th anniversary date where in 2010 a Florida man Laszlo Hanyecz paid for two pizzas with the cryptocurrency. Hanyecz is also the first person to use bitcoin in a commercial transaction.
- **In May 22, 2010, Laszlo Hanyecz agreed to pay 10,000 Bitcoins for two delivered Papa John's pizzas.**
- Since then, Hanyeczs' pizzas have got more and more expensive. Nine months after the purchase, Bitcoin reached parity with the US dollar making the two pizzas worth $10,000, while in the year 2015, the two pizzas were valued at $2.4 million.
- On its 11th anniversary in 2021, bitcoin price reached a high of $63,000. So, the two pizzas were worth $630 million. Today in 2023, they would be worth $ 290 million.

20

May 11, 2020



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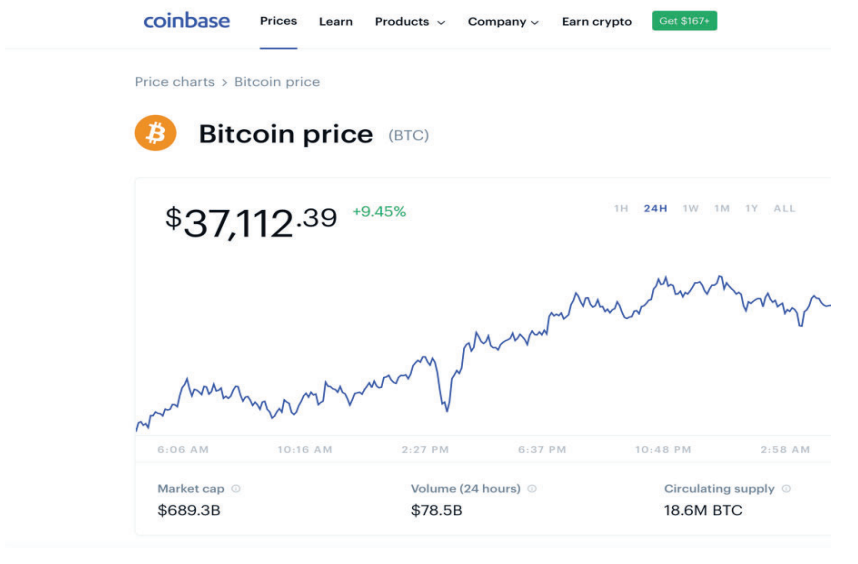
January 7, 2021



22

January 8, 2021

Bitcoin hits new all-time high of $41,000 as investors shrug off recent volatility and pile into cryptocurrency

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How much will Bitcoin be worth in the Future ?

Shervin Pishevar – $100,000 (by 2022)

@shervin

Shervin Pishevar is a venture capitalist and angel investor who co-founded Hyperloop One and Sherpa Capital. He has also made investments in several companies including big names such as AirBnb and Uber.

Pishevar has called for Bitcoin to reach $100,000 by the end of 2021 via Twitter. The prediction came not long after a December 2020 meeting with MicroStrategy CEO Michael Saylor, whose company invested more than $1 billion in Bitcoin during 2020.

Given his meeting with Saylor and his previous predictions of a decline in the US economy, it's no surprise that Pishevar has become bullish on Bitcoin.

Thomas Fitzpatrick – $318,000 (by 2022)

Thomas Fitzpatrick

Citibank's Thomas Fitzpatrick is the global head of their market insights product, CitiFX Technicals. He made headlines for his Bitcoin prediction of $318,000 by 2022, which surfaced after his report was leaked onto the internet in late 2020.

His analysis drew similarities between the gold market of the 1970s and Bitcoin's price action, in particular gold's $20 to $35 range before its surge in 1971. He also cited the acceleration in money-printing by central banks since the emergence of COVID-19, which may fuel the Bitcoin run.

Winklevoss Twins – $500,000 (by 2030)

Winklevoss twins – the famous Bitcoin billionaires have said Bitcoin has the potential to reach a price of $500,000 by 2030, which would put its market cap on par with that of gold (around $9 trillion).

@tylerwinklevoss

Tyler Winklevoss said, "Our thesis is that bitcoin is gold 2.0, that it will disrupt gold, and if it does that, it has to have a market cap of 9 trillion, so we think it could price one day at $US500,000 of bitcoin."

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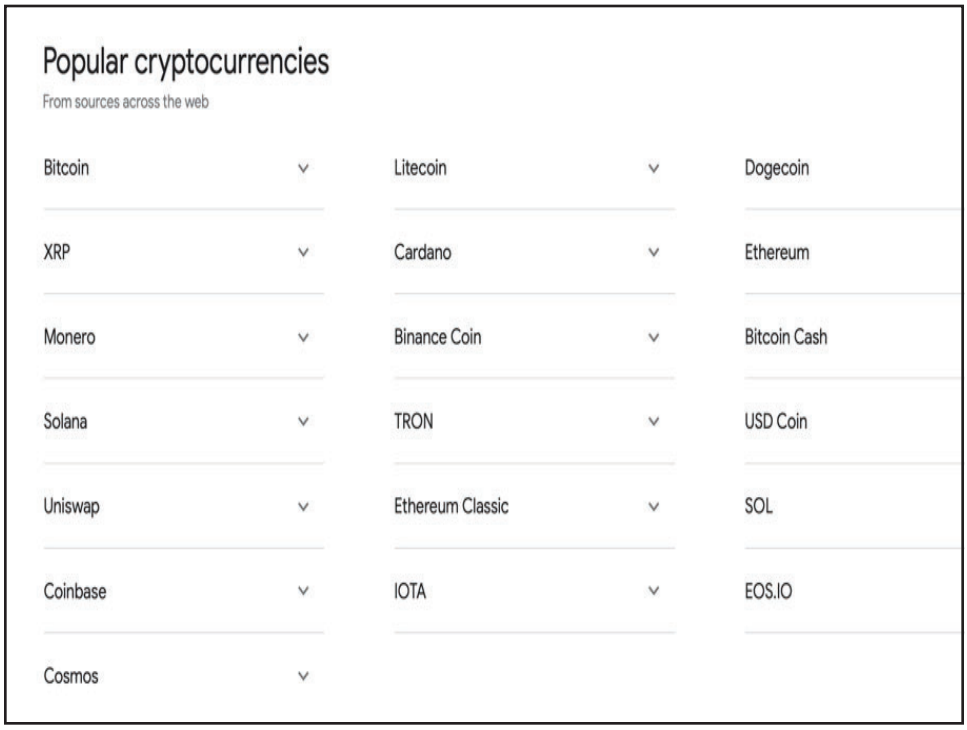
Key Cryptocurrency Statistics:

1. Between 2012 and 2022, the price of Bitcoin has increased by over **540,000%**.
2. **300+ million** people around the world use/own cryptocurrencies in 2022.
3. The global crypto market cap is **$1.06 trillion** as of August 1, 2022.
4. Approximately **$112 billion** is traded in cryptocurrency per day.
5. **65%** of cryptocurrency users are bitcoin owners.
6. **$22** invested in Bitcoin in 2012 would be **$1 million** today.
7. The top 10 cryptocurrencies make up **88%** of the total market value.
8. There are more than **6,000** different types of cryptocurrency.
9. Bitcoin is posted about on social media every **3 seconds**.
10. The global blockchain market will reach **$23.3 billion** by 2023.
11. India has more cryptocurrency holders than any other country - more than **100 million**.
12. Bitcoin had a market capitalization of **$1,072.21 billion** as of Febuary 21st, 2021.
13. **18,000** businesses are already accepting cryptocurrency payments.

26



27

ISO Crime Endorsements

- CR 25 45 -- Include Virtual Currency as Money
- Can be added to Employee Theft, Computer Fraud and Fund Transfer coverages
  (what about Social Engineering /Fraudulent Impersonation ?)
- Value determined by The Exchange at the close of business day of loss
- A growing number of retail merchants, Fortune 500 companies, and States and Local Governments accept Virtual Currencies.

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Other Crypto Uses / Issues

- Worlds First Crypto Mortgage by MILO a Miami based licensed mortgage broker
  - Insurance carrier seem to be OK with it !
- Worlds first Reinsurance Contract digitally singed and issued on the Etherium blockchain platform by B3i, involving Swiss Re and Allianz
- Non Fungible Tokens (NFT's)

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NFT's

- Non-Fungible = one of a kind
- Token = unit of currency on the Blockchain
- Digitized Assets / Digitized Collectable
  - Artwork, GIF's, music, video, sneakers, etc.
  - One original certificate of ownership on the Etherium blockchain platform
  - Inventor of Twitter- His first tweet sold for $2.5mil
  - Markets to buy NFT's are many: NBA Hot Shot, Rarible, Open Sea

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Risks with NFT's

- Authenticity- deal directly with the artist/creator
- Royalties owed ?
- Copyright Ownership
- Insurance

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Understanding Blockchain

(A 20,000 foot simplistic overview)

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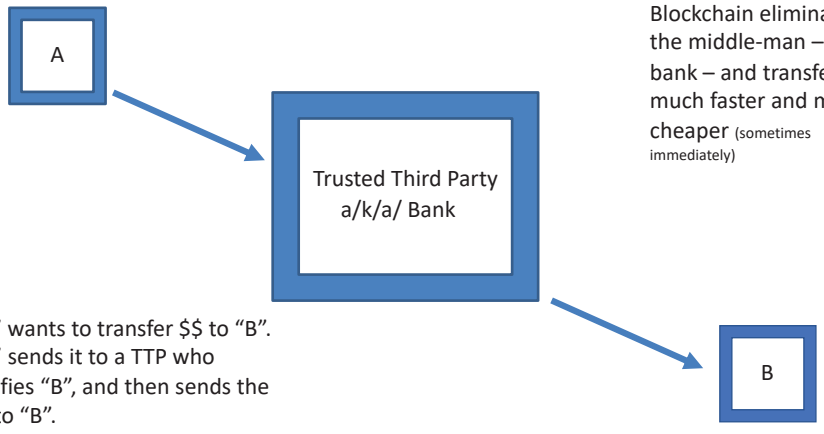
Problem - Solution

- PROBLEM:
  - Inefficient, Costly Transfer of Money
- SOLUTION:
  - Create a common language across businesses and technology to efficiently and cost-effectively transfer money

33

Traditional Money Transfer



Blockchain eliminates the middle-man –a/k/a bank – and transfers $$ much faster and much cheaper (sometimes immediately)

-"A" wants to transfer $$ to "B".
-"A" sends it to a TTP who verifies "B", and then sends the $$ to "B".
-TTP charges a fee to do so.
-Usually takes 2-3 days.

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Whose Ledger do you Trust ?

- Lehman Brothers ?
- Washington Mutual ?
- Wachovia ?

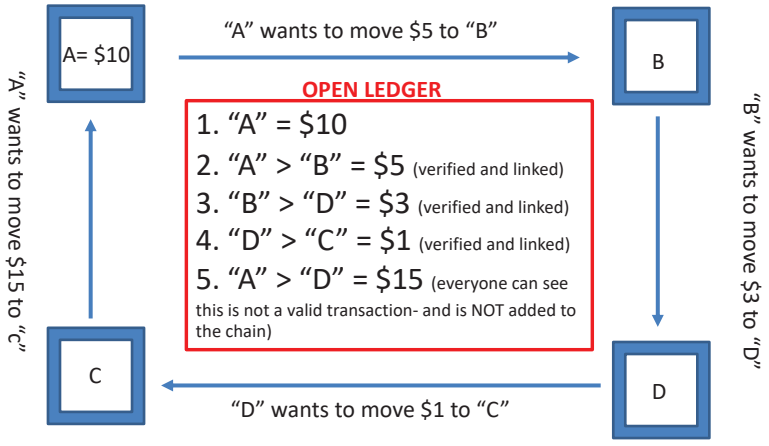
- Money is not tangible –it's just a paper ledger entry

35

OPEN LEDGER

A "Chain" of verified Transactions

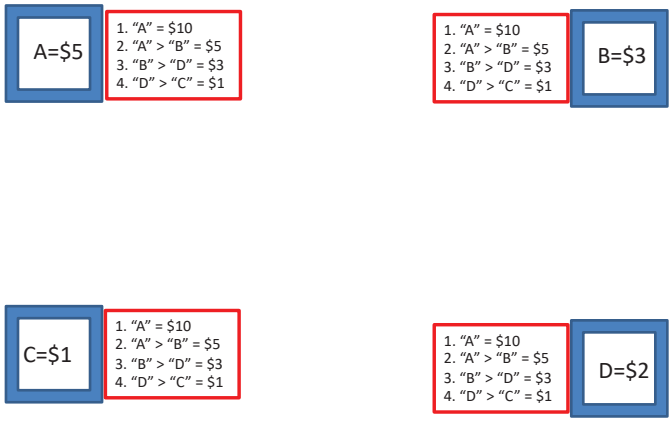
- To understand blockchain, you have to understand the concept of an open ledger



36

DISTRIBUTED LEDGER

- Each party can have a copy of the ledger and see the chain of events. Don't need centralized ledger anymore. Open and Distributed ledger for all to see. No trusted third party.



37

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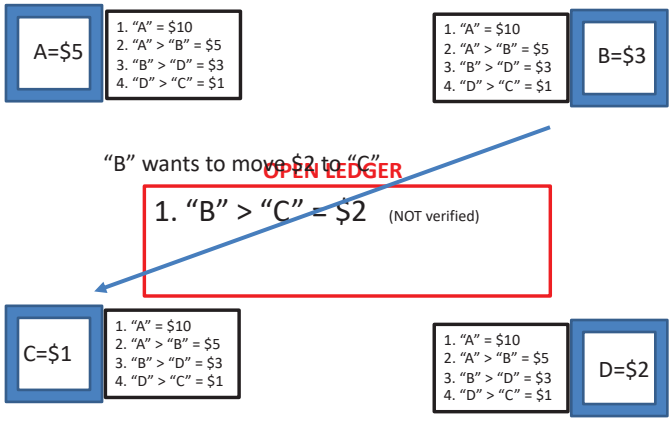

38

How Does a Transaction Get Verified?

- All copies of ledger have to be synchronized across all parties, so everyone sees the same thing. How do you do that ?
- MINERS !
- There are millions of miners all over the world
- Miners are special nodes
- Miners compete against each other to validate transactions and put them on the open ledger
- The first miner to properly validate a posted transaction, receives a financial reward
- Miners must do two things to receive reward:
  - Validate the transaction as to parties and amount
    - That's easy because it is an open ledger for all to see
    - Everyone can see that "B" has $2 to transfer to "C"
  - Have to find the "Key"
    - The key is random. The miner is repeatedly guessing at the key until it is discovered. This takes time and tremendous computing power
    - Once validated, "B" will publish the key to the entire network and validate transaction, which everyone can add to their ledger

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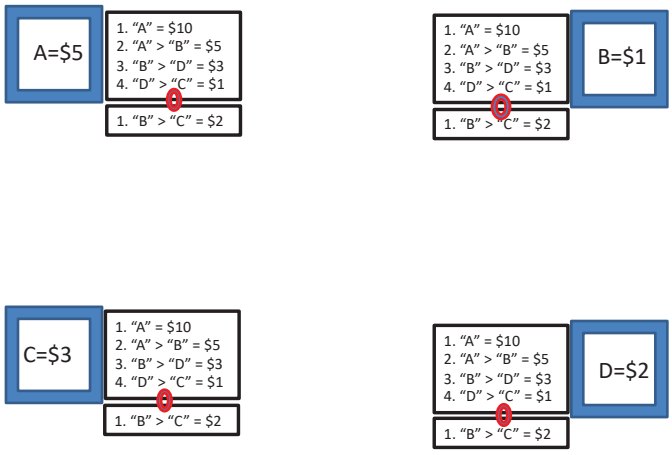
BLOCKCHAIN = A Chain of Verified Transactions

- Each party can have a copy of the ledger and see the chain of events. Don't need centralized ledger anymore. Open and Distributed ledger for all to see. No trusted third party.



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Conclusion

- Whose ledger do you trust ?
- We now replace trust with mathematical proof !
- Thousands of transactions are put together in a block and attached to a chain
- Cryptographically connected and cannot be hacked
  - Someone would have to hack every transaction in the chain !
- Blockchain is NOT limited to financial transactions
  - Voting
  - Patents
  - Music Streaming
  - Chain of title
  - Wills / Trusts
  - Big Data /Cloud storage *
  - Insurance policies, billing and claims transactions
- No longer have to trust Banks, Google, Facebook, Amazon, ISP's, etc.

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IMAGINE - If you lived in a world where…

- YOU controlled your money …not banks
- The Government can't erode your wealth by printing more money, backed by debt
- You can see every dollar you have and all your wealth on a smartphone
- You can instantly send money anywhere, to anyone at anytime; with little to no cost
- Your already living in it !

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- Etherium is a decentralized, trustless, global computer (it exists everywhere and nowhere)
  - It autonomously runs on a blockchain programs called “Smart Contracts”
  - **Etherisc**
    - Etherisc developed smart contract tools to create bespoke insurance policies on the Ethereum blockchain. The first application, FlightDelay, enables users to obtain insurance against the risk that their flight will be delayed or cancelled. Individuals purchase the insurance policy using a credit card and, in the event their flight is delayed by 45 minutes or more, they are paid automatically without any need to submit additional paperwork.
    - Another Etherisc application allows Puerto Ricans to insure their homes against hurricane risk for up to $5,000. Under the policy, insureds receive an automatic payout if their homes are damaged by a hurricane, as validated by an agreed upon weather source. The developers of this policy are currently seeking investors to underwrite the risk.

- **B3i / Canopy (Risk Block Alliance - Institutes)**
  - RiskBlock Alliance has created a blockchain-based framework called Canopy, comprised of interconnecting blockchains, each of which pertaining to a different category of the insurance sector (across different geographic areas).
  - The first application on Canopy enables proof of insurance for auto which allows drivers and law enforcement to confirm insurance coverage in real time. The second application covers first notice of loss which streamlines the initial process of filing a claim. Christopher emphasized that, although the first two applications are exciting, the launch of Canopy is revolutionary, adding “the differentiator here is that with Canopy there is one set of plumbing upon which all applications across the insurance industry can be built.”

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- **Black Insurance**
  - The Black Insurance platform connects brokers with investors to cover the risk. Risto explains that his business model replicates that of Lloyds of London with the very same building blocks: brokers, syndicates and investors. Black Insurance does not take on insurance risk, but rather provides the platform that issues and tracks the products and the underlying loan agreements between the syndicates and the investors. Smart contracts capture the rules governing the loans so that the entire value chain can be automated, everything from the insurance premiums to the interest payments made to investors. Syndicates are formed by insurance professionals who already have a book of business.

- **Nexus Mutual – London**
  - Walid reports that the insurance sector is abuzz with innovation, and points to Insurwave, a blockchain platform that was developed for marine hull insurance, as a prime example of game changing innovation, as well as Nexus Mutual which advertises itself as, “a decentralized alternative to insurance.” Based in London, Nexus Mutual is building a tokenized community that enables individuals to share risk collectively.

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Hedera Hashgraph

- Hashgraph does not need high computation power and electrical supply.
- Every blockchain platform has a different speed in terms of transactions per second.
- For example, Bitcoin can make 7-10 transactions in a second, Ethereum has potential to perform 15-20 transactions per second and Hyperledger Sawtooth can make thousands of transactions in a second.
- Hedera Hashgraph allows hundreds of thousands of transactions per second, as the information travels exponentially.

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Benefits and Uses

- Streamlining premium and claims payments
- Improving data on new policyholders by verifying accuracy of application information
- Reducing fraud
- Reducer human error
- Improve communication and understanding
- Better using the vast amount of data we have as an industry

- SMART CONTRACTS
- DISTRIBUTED LEDGER ADVANCED TECHNOLOGY
- DATA SECURITY

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Companies Using Blockchain to Revolutionize Insurance

- LEMONAIDE
- GUARDTIME
- ETHERISC
- FIDENTIAX
- B31
- BEENEST
- DYNAMIS
- FIZZY
- TEAMBRELLA

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PARAMETRIC INSURANCE

- Recoop Insurance
- FloodFlash
- Exante
- Arbol
- Descartes Underwriting
- Jumpstart
- Parachute
- Skyline
- Bounce

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Zurich Construction Weather Parametric Insurance

ZURICH

Helping protect your profits from extreme weather and climate events

Parametric insurance in action

Situation:

A first-time Florida stadium builder faced the potential for severe wind during the construction project. A key component of this project is the coordination of four large crawler cranes the contractor is renting. These cranes are very expensive and can only operate if wind speeds stay below a certain threshold. The contractor has very thin margins on this job and is fearful the Florida storm season could result in several days where cranes can't be operated.

Solution:

The storm season generally runs from June through November in this location, so the Parametric Insurance policy was written for that specific period. It covered 12 days when the maximum hourly average wind speed was at, or in excess of, 40 miles-per-hour during work hours. Protecting its crane rental costs was a smart way for this contractor to kick off the stadium project.

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SECTION III:

Medicinal and Recreational Marijuana

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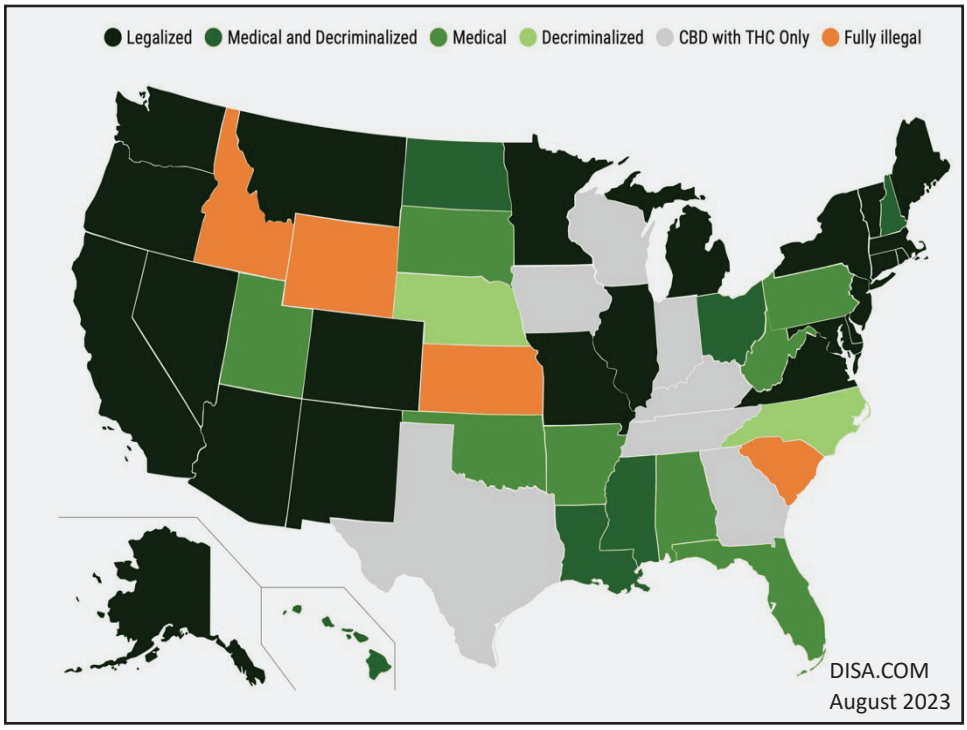

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DISA OUR SERVICES INDUSTRIES DISA DIFFERENCE INDUSTRY NEWS CONTACT US

State	Legal Status	Medicinal	Decriminalized	State Laws
Alabama	Mixed	Yes	No	View State Laws
Alaska	Fully Legal	Yes	Yes	View State Laws
Arizona	Fully Legal	Yes	Yes	View State Laws
Arkansas	Mixed	Yes	No	View State Laws
California	Fully Legal	Yes	Yes	View State Laws
Colorado	Fully Legal	Yes	Yes	View State Laws
Connecticut	Fully Legal	Yes	Yes	View State Laws
Delaware	Fully Legal	Yes	Yes	View State Laws
District of Columbia	Fully Legal	Yes	Yes	View State Laws
Florida	Mixed	Yes	No	View State Laws
Georgia	Mixed	CBD Oil Only	No	View State Laws
Hawaii	Mixed	Yes	Yes	View State Laws
Idaho	Fully Illegal	No	No	View State Laws
Illinois	Fully Legal	Yes	Yes	View State Laws
Indiana	Mixed	CBD Oil Only	No	View State Laws

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Iowa	Mixed	CBD Oil Only	No	View State Laws
Kansas	Fully Illegal	No	No	View State Laws
Kentucky	Mixed	CBD Oil Only*	No	View State Laws
Louisiana	Mixed	Yes	Yes	View State Laws
Maine	Fully Legal	Yes	Yes	View State Laws
Maryland	Fully Legal	Yes	Yes	View State Laws
Massachusetts	Fully Legal	Yes	Yes	View State Laws
Michigan	Fully Legal	Yes	Yes	View State Laws
Minnesota	Fully Legal	Yes	Yes	View State Laws
Mississippi	Mixed	Yes	Yes	View State Laws
Missouri	Fully Legal	Yes	Yes	View State Laws
Montana	Fully Legal	Yes	Yes	View State Laws
Nebraska	Fully Illegal	No	Yes	View State Laws
Nevada	Fully Legal	Yes	Yes	View State Laws
New Hampshire	Mixed	Yes	Yes	View State Laws

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New Jersey	Fully Legal	Yes	Yes	View State Laws
New Mexico	Fully Legal	Yes	Yes	View State Laws
New York	Fully Legal	Yes	Yes	View State Laws
North Carolina	Fully Illegal	No	Yes	View State Laws
North Dakota	Mixed	Yes	Yes	View State Laws
Ohio	Mixed	Yes	Yes	View State Laws
Oklahoma	Mixed	Yes	No	View State Laws
Oregon	Fully Legal	Yes	Yes	View State Laws
Pennsylvania	Mixed	Yes	No	View State Laws
Rhode Island	Fully Legal	Yes	Yes	View State Laws
South Carolina	Fully Illegal	No	No	View State Laws
South Dakota	Mixed	Yes	No	View State Laws
Tennessee	Mixed	CBD Oil Only	No	View State Laws
Texas	Mixed	CBD Oil Only	No	View State Laws
Utah	Mixed	Yes	No	View State Laws

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Vermont	Fully Legal	Yes	Yes	View State Laws
Virginia	Fully Legal	Yes	Yes	View State Laws
Washington	Fully Legal	Yes	Yes	View State Laws
West Virginia	Mixed	Yes	No	View State Laws
Wisconsin	Mixed	CBD Oil Only	No	View State Laws
Wyoming	Fully Illegal	No	No	View State Laws

As of August 2023

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Medical Marijuana

Tracy v. USAA Cas. Ins. Co.,
No. 11-00487 (March 16, 2012).

56

Background

- Ms. Tracy lives in Hawaii
- Hawaii law allows residents to possess and grow medical marijuana for their personal use, under a doctor's prescription and care
- Ms. Tracy legally owns 12 marijuana plants – 9 are fully mature and 3 are less mature
- Someone breaks into Ms. Tracy's home and steals all of her plants

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Background

- Ms. Tracy puts in a claims with her HO policy, issued by USAA
- Are the stolen marijuana plants Ms. Tracy's personal property, and covered under her policy ?
- Does she legally possess them under the laws of the state of Hawaii ?
- They are her contents and she does legally possess them

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Background

- Ms. Tracy values her 9 mature plants at $4000 each, and her 3 less mature plants at $3200; demanding $45,600 from USAA
- How does one establish the value of these plants ?
- USAA offers Ms. Tracy $8801
- How does USAA establish with this value ?
- Is marijuana “contraband” ?

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ISO HO 00 03 - 0511

3. Trees, Shrubs And Other Plants
We cover trees, shrubs, plants or lawns, on the "residence premises", for loss caused by the following Perils Insured Against:

a. Fire or Lightning;
b. Explosion;
c. Riot or Civil Commotion;
d. Aircraft;
e. Vehicles not owned or operated by a resident of the "residence premises";
f. Vandalism or Malicious Mischief; or
g. Theft.

We will pay up to 5% of the limit of liability that applies to the dwelling for all trees, shrubs, plants or lawns. No more than $500 of this limit will be paid for any one tree, shrub or plant. We do not cover property grown for "business“ purposes. This coverage is additional insurance.

60

- The court first held that Tracy had an insurable interest in her marijuana plants in accordance with Hawaii's medical marijuana laws.
- Turning next to the Controlled Substances Act (CSA), however, the court ruled that Tracy's possession and use of marijuana violated federal law. The court explained that, although Tracy possessed marijuana in compliance with state law, Hawaii law permitting medical use of marijuana was in direct conflict with the CSA's prohibitions of such use. And if there is a conflict between state and federal law, federal law preempts state law.
- **The court concluded that Tracy's medical use of marijuana, although permitted by state law, violated federal law and, therefore, the insurance policy purportedly covering her marijuana plants was an illegal contract that could not be enforced. Consequently, the insurer had no obligation to cover Tracy's stolen marijuana plants.**

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What is Marijuana ?

- Schedule “1” Drug
- Other Schedule “1” drugs include:
  - Heroin
  - LSD
- Why classify as Schedule “1” ?
  - Highly Addictive
  - No legal medicinal use
    - In order to have legal medicinal use, there must be comprehensive FDA studies and approvals

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Personal Liability

- Visiting Child gets a hold of edible marijuana product and has a bad reaction or dies ?
- Duty to hide and protect. Keep out of site and locked up –like Rx ?

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E. Coverage E – Personal Liability And Coverage
F. F – Medical Payments To Others

Coverages E and F do not apply to the following:

8. Controlled Substance

"Bodily injury" or "property damage" arising out of the use, sale, manufacture, delivery, transfer or possession by any person of a Controlled Substance as defined by the Federal Food and Drug Law at 21 U.S.C.A. Sections 811 and 812. Controlled Substances include but are not limited to cocaine, LSD, marijuana and all narcotic drugs.

However, this exclusion does not apply to the legitimate use of prescription drugs by a person following the lawful orders of a licensed health care professional.

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ISO 2022 Homeowner Program Cannabis Changes

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Change No. 23 – Property and Liability Revisions Addressing Cannabis

Introduction

We are revising:

- The base Homeowners policies to introduce a definition of "cannabis";
- Section I - Property Coverages, Property Not Covered to add a provision addressing controlled substances, including cannabis; and
- Section II - Liability Coverages, Controlled Substance Exclusion to restate existing references to "marijuana" with "cannabis".

We are also introducing two new endorsements to provide optional coverages with respect to certain property and liability exposures related to cannabis.

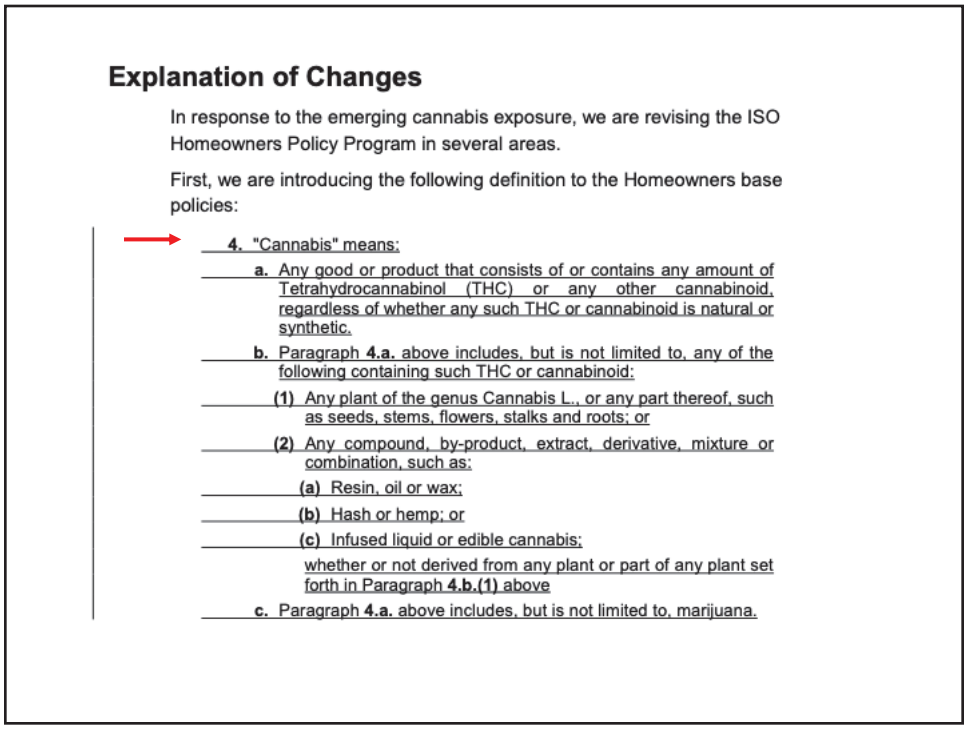
Background

As laws are passed in more and more states generally designed to make cannabis possession, growth and use legal at the state level for medical and/or adult recreational use, some insurers have expressed an interest in policy changes to address these new exposures, along with additional coverage options.

Currently, under the ISO Homeowners Policy Program, Section II Liability Coverages contains a Controlled Substances Exclusion, addressing bodily injury and property damage arising out of Controlled Substances. Under this provision, controlled substances includes, but is not limited to, marijuana.

Section I - Property Coverages, does not currently contain provisions to address controlled substances.

66



Explanation of Changes

In response to the emerging cannabis exposure, we are revising the ISO Homeowners Policy Program in several areas.

First, we are introducing the following definition to the Homeowners base policies:

4. "Cannabis" means:

a. Any good or product that consists of or contains any amount of Tetrahydrocannabinol (THC) or any other cannabinoid, regardless of whether any such THC or cannabinoid is natural or synthetic.

b. Paragraph **4.a.** above includes, but is not limited to, any of the following containing such THC or cannabinoid:

(1) Any plant of the genus Cannabis L., or any part thereof, such as seeds, stems, flowers, stalks and roots; or

(2) Any compound, by-product, extract, derivative, mixture or combination, such as:

(a) Resin, oil or wax;

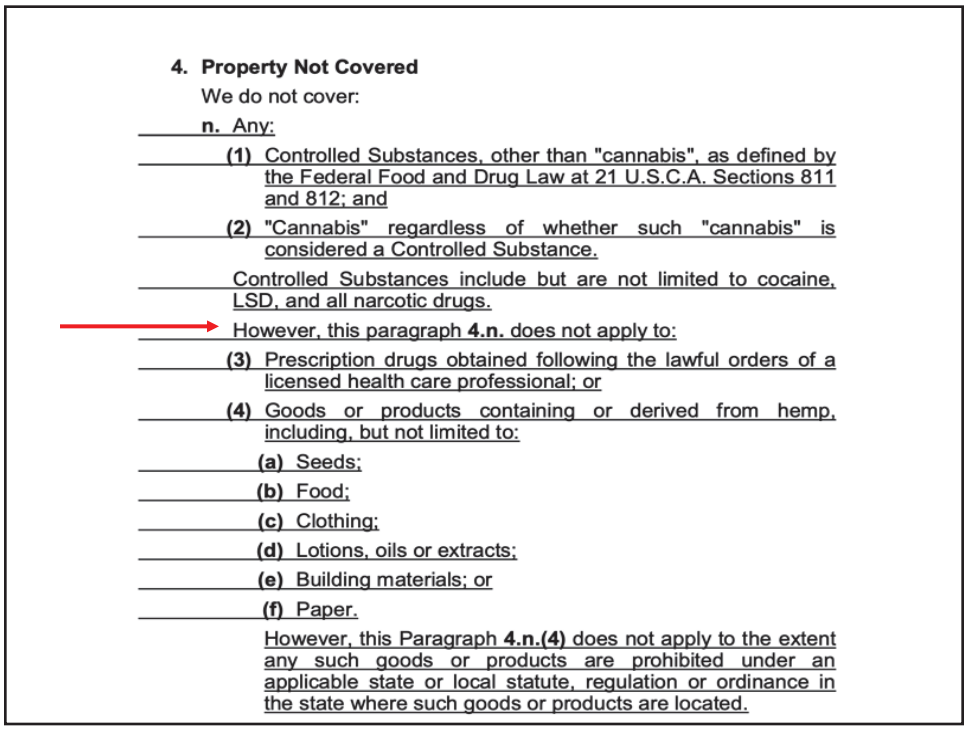
(b) Hash or hemp; or

(c) Infused liquid or edible cannabis;

whether or not derived from any plant or part of any plant set forth in Paragraph **4.b.(1)** above

c. Paragraph **4.a.** above includes, but is not limited to, marijuana.

67



4. Property Not Covered

We do not cover:

n. Any:

(1) Controlled Substances, other than "cannabis", as defined by the Federal Food and Drug Law at 21 U.S.C.A. Sections 811 and 812; and

(2) "Cannabis" regardless of whether such "cannabis" is considered a Controlled Substance.

Controlled Substances include but are not limited to cocaine, LSD, and all narcotic drugs.

However, this paragraph **4.n.** does not apply to:

(3) Prescription drugs obtained following the lawful orders of a licensed health care professional; or

(4) Goods or products containing or derived from hemp, including, but not limited to:

(a) Seeds;

(b) Food;

(c) Clothing;

(d) Lotions, oils or extracts;

(e) Building materials; or

(f) Paper.

However, this Paragraph **4.n.(4)** does not apply to the extent any such goods or products are prohibited under an applicable state or local statute, regulation or ordinance in the state where such goods or products are located.

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In addition, since the noted cannabis definition also expressly addresses "any plant…or any part thereof", we are revising the Section I - Additional Coverage for Trees, Shrubs and Other Plants as follows to indicate that this coverage does not apply to cannabis:

3. Trees, Shrubs And Other Plants

We cover trees, shrubs, plants or lawns, on the "residence premises", for loss caused by the following Perils Insured Against:

a. Fire or Lightning;

b. Explosion;

c. Riot or Civil Commotion;

d. Aircraft;

e. Vehicles not owned or operated by a resident of the "residence premises";

f. Vandalism or Malicious Mischief; or

g. Theft.

We will pay up to 5% of the limit of liability that applies to the dwelling for all trees, shrubs, plants or lawns. No more than $500 of this limit will be paid for any one tree, shrub or plant. We do not cover "cannabis" or property grown for "business" purposes.

This coverage is additional insurance.

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SECTION II – EXCLUSIONS

E. Coverage E – Personal Liability And Coverage F – Medical Payments To Others

Coverages **E** and **F** do not apply to the following:

8. Controlled Substance

"Bodily injury" or "property damage" arising out of the use, sale, manufacture, delivery, transfer or possession by any person of:

a. aA Controlled Substance as defined by the Federal Food and Drug Law at 21 U.S.C.A. Sections 811 and 812; or

b. Any "cannabis" regardless of whether such "cannabis" is considered a Controlled Substance.

Controlled Substances include but are not limited to cocaine, LSD, ~~marijuana~~ and all narcotic drugs.

However, this exclusion does not apply to the legitimate use of prescription drugs by a person following the lawful orders of a licensed health care professional.

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2022 ISO Homeowner Program

We are also introducing two new endorsements:

- **HO 06 01,** Limited Cannabis Property Coverage, will provide the ability to purchase limited coverage for property losses to "cannabis", for certain specified perils.
- **HO 24 01,** Cannabis Liability Coverage, will provide flexibility for insurers to provide broadened liability coverage, for bodily injury and property damage, arising out of the lawful use or possession of "cannabis" by any person.

The optional endorsements will be introduced in all applicable states, even in states where laws have not yet been enacted that are expressly designed to make recreational use of cannabis legal at the state level. This approach can help serve two main purposes:

- Given that coverage for personal property is generally available for such property owned or used by an "insured" *while it is anywhere in the world,* such coverage may be useful for insureds when they travel or are in possession of such property in states which have enacted laws expressly designed to make such use legal at the state level; and
- As the law of states continue to evolve in this area, it will facilitate availability of such options in related states.

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Other Issues

- Attorneys
- Banks
- Life Insurance Carriers
- Workers Compensation Claims
  - As of May 2023 six states require payment of medical marijuana WC claims: CT, MN, NH, NJ, NM, NY
- EPLI
- Landlords / Rental Property
- Host Liquor / Liquor Liability [D.U.I.]
- What happens when you test positive for marijuana at work ?

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Cannabis Watch

Bank of America shuts down bank account of FDA-approved cannabis research firm

Last Updated: Oct. 21, 2021 at 3:01 p.m. ET
First Published: Oct. 20, 2021 at 12:49 p.m. ET

By Steve Gelsi

3

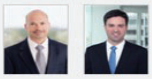
Cannabis banking remains illegal under federal law, although this program was OK'd by the FDA

73

Sixth Circuit Appeal Underscores Numerous Marijuana Operations Insurance Coverage Issues

Blog Business Immigration Insights

Hunton Andrews Kurth LLP



HUNTON ANDREWS KURTH

USA | February 6 2018

Commercial landlord KVG Properties Inc. has appealed a district court summary judgment ruling dismissing its claims under a first-party property policy issued by Westfield Insurance Company, arguing that the district court improperly rejected its claim because KVG's tenants' use of the property for marijuana growing operations was illegal under federal law. The appeal underscores the growing divide between state and federal marijuana laws and raises several important insurance coverage issues that will likely continue in the future.

KVG leased commercial office space to several tenants in Novi, Michigan. In October 2015, the Drug Enforcement Agency raided the rental units in connection with an investigation into marijuana growing operations. Following the raid, KVG evicted the tenants and filed a property damage claim with its insurer, Westfield, for the tenants' vandalism to the leased spaces, which included removing walls, cutting holes in the roof, adding HVAC ductwork, adding gas lines, and modifying heat and humidity levels in the leased spaces.

In denying coverage for the claim, Westfield cited three exclusions: (1) the illegal and dishonest acts exclusion; (2) the inadequate maintenance exclusion; and (3) the humidity and moisture exclusion. In the ensuing coverage lawsuit, the federal district court granted summary judgment in Westfield's favor, concluding in part that "[t]he tenants' use of the units to grow marijuana was illegal or at the very least dishonest." The district court also held that Westfield properly denied KVG's claim under the humidity and moisture exclusion due to uncontroverted evidence from Westfield's engineer that the units were exposed to prolonged moisture levels for one year or more.

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Insurance Case Finder

Marijuana Use Exclusion Bars Coverage for Mayhem-Type Incidents

An appellate court ruled that a marijuana use exclusion barred coverage for an insured high on marijuana that backed into a Starbucks and subsequently hit two vehicles after fleeing.

Filing/Decision Date: December 02, 2022

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Summary

A Starbucks employee was asked to leave work after admitting to "smoking weed." The angered employee left the store, backed up her vehicle and proceeded to drive it through the front window of the store. As the employee was driving through the window, she struck and injured a store patron.

The employee then put her vehicle in reverse and exited the Starbucks. She nearly struck another patron, who sustained injuries when jumping out of the way to avoid being hit. As the employee entered oncoming traffic, she struck a motor vehicle. The employee fled the scene. Shortly thereafter, she hit a second vehicle.

Coverage was sought under the employee's personal auto liability policy, issued by Grange Insurance. The employee's personal auto liability insurer filed a coverage lawsuit contesting that it owed no coverage for any of the incidents. Grange contended that coverage was excluded by the intentional act exclusion, the criminal acts exclusion, and the controlled substances exclusion. Regarding the controlled substances exclusion, the insurer contended that it did not have a duty to defend the claimant because she admitted in her deposition that she was high from smoking marijuana at the time of the accidents and that, had she not been high, they would not have happened.

Farmers Insurance, the auto insurer of the second vehicle hit by the insured, was also added to the coverage lawsuit. Farmers argued that Grange owed coverage. The trial court ruled in favor of the insurer, finding that the controlled substances and criminal acts exclusions barred coverage. An appeal followed.

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Court's Ruling

The Ohio Court of Appeals, Sixth Appellate District, agreed with the trial court's conclusion that coverage was not owed for the multiple incidents caused by the employee. In reaching this result, the court addressed the controlled substances exclusion, which the court termed the "marijuana use" exclusion. Arguing for coverage, Farmers contended that the exclusion was ambiguous because it did not link marijuana usage to the operation of a motor vehicle. The court rejected this argument, finding that the insured admitted in her deposition that the accident directly resulted from her use of marijuana.

Additionally, Farmers further argued that it violated public policy to exclude coverage for marijuana use when auto insurance policies are prevented from doing so for alcohol use. The court noted that, although many states have eased their regulations regarding the distribution and use of marijuana, it remains a controlled substance under federal law. Further, the court noted that Ohio has legalized marijuana for medical use only. Thus, the court concluded that public policy did not bar the exclusion, as there were clear reasons to treat marijuana use differently than alcohol use.

The court ruled that the criminal act exclusion further precluded coverage. The court noted that the exclusion was not limited to intended criminal acts. Also, the court found that the insured committed aggravated vehicular assault and, acting recklessly, committed vehicular assault. In fact, the court relied on the fact that the insured admitted in her deposition to having a prior adverse reaction—blacking out—after smoking marijuana. Accordingly, the court ruled that she knowingly disregarded the risks associated with her smoking marijuana and driving a motor vehicle, triggering the criminal acts exclusion.

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Other Cases

- A customer is suing an Casino after being told he could not smoke medical marijuana inside the hotel, even though he is a registered medical-marijuana patient
- An Transit worker, a registered medical-marijuana patient who uses it to treat nerve pain, tested positive for the drug and was promptly suspended and sent to rehab; has sued his employer in March. That case is pending.
- A 14 year old boy who is epileptic and a registered user, was prohibited from using marijuana while in the hospital (Hackensack University Medical Center). Mother complains that hospital policy is over-riding state law and is illegal. She gave him the drug anyway while he was in the hospital. Most Hospital's prohibit the use of any outside drugs when being admitted and treated.
- A Wal-Mart employee in Michigan had cancer and used legal marijuana on his own time to treat the pain and was fired. A federal appellate court sided with Wal-Mart.

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Medical marijuana and the workplace

Because marijuana is prohibited under the federal Controlled Substances Act of 1970, workers who use medical marijuana are not covered by the Americans with Disabilities Act.

When marijuana was illegal under both state and federal law, employers would typically prohibit employees or employment candidates from using marijuana off-duty as a condition of employment.

But as states have begun to permit medical marijuana, things have gotten a bit hazier.

No state requires accommodating on-duty marijuana use. As with recreational marijuana, no state that permits medical marijuana requires employers to accommodate on-duty marijuana use, possession, or impairment. States will often explicitly state that medical marijuana laws do not affect an employer's drug-free workplace policy.

Some states have explicit protections for medical marijuana users for off-duty use. Regarding off-duty medical marijuana use, some states affirmatively protect a patient from an adverse employment action due to their off-duty use of marijuana. Usually the only exception to this is if the employer would lose federal benefits for permitting off-duty marijuana use.

But most states do not – and the courts have gotten involved. Most states with medical marijuana programs do not explicitly protect medical marijuana users from adverse employment actions. As such, courts have typically held that if a state does not explicitly protect medical marijuana use, then there is no protection from adverse employment action. This may change in the future.

Disability accommodation is a developing trend. A recent case out of the Supreme Court of Massachusetts involved the question of whether off-duty medical marijuana use is subject to disability accommodation requirements. On that question, the court ruled, in part, that yes, the plaintiff was a handicapped person and the state's medical marijuana law intended to accommodate medical marijuana use outside the workplace. There may be more cases arguing for disability accommodation under medical marijuana programs in the future.

Insurance Information Institute- iii.org

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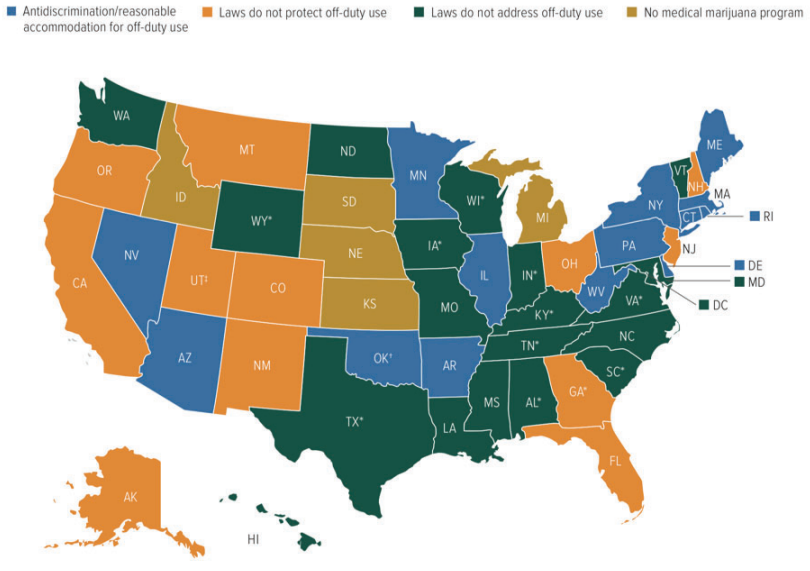
Off-duty medical marijuana use and employment protections



*CBD/Low THC medical program.
†Oklahoma has not yet released its final medical marijuana rules.
‡Provides limited protections to state employees.
Source: Insurance Information Institute, 2019.

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State	Pre-Employment Drug Screening	Off-Duty Use Protected	Testing Existing Employees	Additional Notes
Alaska	Allowed	No	Allowed	Alaska does not offer employee protections for recreational use.
Arizona	Allowed	No	Employers cannot fire or refuse to hire an applicant based on a positive drug test alone, though typical exemptions exist, i.e., safety-sensitive roles or employers with federal licenses.	Employers cannot discriminate against workers, as well as job applicants, who have a medical marijuana card.
California	Employers cannot refuse to hire a prospective employee solely for the presence of marijuana in a drug test.	Yes, under a new law passed in the fall of 2022.	Yes, though employers cannot take adverse action against an employee solely for the presence of marijuana in a drug test.	The off-duty protection begins Jan. 1, 2024, and does not apply to employees in certain industries.
Colorado	Allowed	No	Follows federal law when required.	Legislation to protect employees from adverse action because of off-duty use has been introduced in the Colorado Legislature.

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State	Pre-Employment Drug Screening	Off-Duty Use Protected	Testing Existing Employees	Additional Notes
Connecticut	In most cases, an employer may not take adverse action against an employee or potential employee for use of marijuana prior to applying for or working at the job.	Somewhat. Employers cannot discharge or take adverse action against an employee due to legal offduty marijuana use unless failure to do so would cause employer to violate federal contract or lose federal funding.	Since July 1, 2022, positive drug tests cannot be used as the lone reason for taking adverse action, unless it would violate federal law, the employee is high at work, etc. However, tests can be performed in safety-sensitive jobs.	Employers in certain industries, such as manufacturing and healthcare, are considered exempt from the employment provisions of the law, which also erased certain marijuana-related convictions between Oct. 1, 2015, and Jan. 1, 2020.
Delaware	Allowed	No	Allowed	Delaware in late April 2023 legalized recreational marijuana.
Illinois	The law prohibits employers from refusing to hire, terminate, or discipline individuals who use lawful products during off-duty time.	Yes	Allowed	If an employer finds that a worker is under the influence of marijuana, the employer must allow the employee a reasonable opportunity to contest that determination.

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State	Pre-Employment Drug Screening	Off-Duty Use Protected	Testing Existing Employees	Additional Notes
Maine	Allowed after employee receives drug-testing policy.	Yes	Allowed	Testing is only allowed if a company has a drug testing policy that has been approved by the Maine Department of Labor.
Maryland	Allowed; the ballot measure did not address marijuana in the workplace.	No; the ballot measure did not address marijuana in the workplace.	Allowed; the ballot measure did not address marijuana in the workplace.	Adults 21 and older will be able to purchase recreational marijuana legally beginning July 1, 2023, following a voter-approved ballot referendum.
Massachusetts	Allowed after a job offer has been made.	No	Allowed, but must be job-related and consistent with business necessity.	The state offers little guidance on workplace issues.
Michigan	Allowed	No	Allowed	The law does not require accommodations for recreational use.
Minnesota	Allowed	No	Allowed	Minnesota's law is effective Aug. 1, 2023.
Missouri	Yes, but employers may not discriminate for a positive test from a medical marijuana user.	No	Allowed	Sales of recreational marijuana in Missouri began in February 2023.

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State	Pre-Employment Drug Screening	Off-Duty Use Protected	Testing Existing Employees	Additional Notes
Montana	Allowed	Yes	Allowed, but the state has a restrictive drug-testing statute.	Montana in January 2022 updated its law to include marijuana use as a "lawful activity."
Nevada	It is unlawful for employers in Nevada to refuse to hire someone based on the presence of marijuana in pre-employment drug screenings. It does not apply to: • Firefighters • Emergency personnel • Drivers • Safety-sensitive positons	No – the Nevada Supreme Court ruled that off-duty marijuana use was not a lawfully protected activity in August 2022.	Cannot test within the first 30 days of employment.	Nevada was the first state to pass a law that makes it illegal to not hire an applicant based on the presence of marijuana in a pre-employment drug test.
New Jersey	Employers may not refuse to hire an applicant due to positive marijuana test.	Yes	Allowed if the employer suspects a worker is high on the job, if the employee was involved in an accident or the employer has a reasonable suspicion of use on the job.	The law prohibits employers from discharging workers based on a positive marijuana test unless the employer can show the employee was impaired at work.

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State	Pre-Employment Drug Screening	Off-Duty Use Protected	Testing Existing Employees	Additional Notes
New Mexico	Allowed	No	Allowed	Sales of recreational marijuana in New Mexico began April 1, 2022.
New York	Employers cannot reject applicants based on the presence of marijuana in a pre-employment screening.	Yes	Employers cannot test for recreational marijuana use unless certain situations are involved or as a result of another applicable law, notably federal issues.	There are certain jobs that do allow for pre-employment screenings, including law enforcement, construction workers on public projects, jobs requiring a commercial license, jobs involving the care of vulnerable people and those that impact health or safety of the public.
Oregon	Allowed if the employer has a reasonable suspicion the applicant may be under the influence of a controlled substance.	No	Allowed	A proposed bill would allow employees to use marijuana while not on the job, but would allow employers to use a drug screening test to ensure that no use is occurring while on duty.

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State	Pre-Employment Drug Screening	Off-Duty Use Protected	Testing Existing Employees	Additional Notes
Rhode Island	Generally, employers can't take adverse action against an applicant for a positive marijuana test.	Yes, unless it conflicts with federal law, is barred under a collective bargaining agreement or the employee's job involves work that is "hazardous, dangerous or essential to public welfare and safety."	Employers cannot take adverse action against an employee for a positive marijuana test in most instances.	The law does not require a showing of on-the-job impairment, includes automatic expungement of some prior civil or criminal marijuana possession charges and allows employers to ban use in the 24-hour period before a scheduled shift for safety-sensitive jobs.
Vermont	Testing allowed with advance written notice to applicant, after offer of employment has been made, and if test is part of pre-employment physical.	No	Allowed	Legalization of marijuana use and possession began July 1, 2021. The date was moved up from 2024, when sales will be legal.

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State	Pre-Employment Drug Screening	Off-Duty Use Protected	Testing Existing Employees	Additional Notes
Virginia	Allowed	No	Once an employee is hired, Virginia law generally prohibits employers from requesting or requiring that an employee submit to a drug test as an expressed or implied condition of employment.	Employers are prohibited from requiring applicants to disclose information regarding an arrest, criminal charge, or conviction for simple marijuana possession during the hiring process, including disclosures on any application for hire.
Washington	Employers are prohibited from discrimination in hiring due to an applicant's lawful off-duty use of marijuana.	No, with the hiring exception.	Allowed	Exceptions for federal contracts, those receiving federal funding or licensing, safety-sensitive positions.
Washington, D.C.	Employers cannot refuse to hire or take adverse action against an employee for using recreational marijuana or participating in a medical marijuana program or failing to pass a drug test for marijuana (exceptions apply).	Yes, so long as there is no indication of on-site impairment.	Allowed	New employment protections were signed into law in July 2023, though they generally do not apply to jobs in safety-sensitive fields.

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Marijuana, Hemp and CBD Distinctions

- Marijuana is a plant of the species Cannabis Sativa
- The genus, Cannabis, includes both marijuana and hemp
- Marijuana contains THC, the active chemical that causes intoxication
- Hemp is a cannabis plant that contains little or no THC, and does not cause intoxication
- CBD is a non-psychoactive cannabinoid chemical found in marijuana plants. There is some evidence that CBD may have therapeutic uses
- Marijuana is NOT a prescription drug. It is not prescribed by doctors like opioids. Physicians will "certify" or "authorize" that a patient qualifies under a state program to purchase and use marijuana products.
- Unlike alcohol, THC levels in a user body, may not be an accurate indication of user impairment -THC persistence.
- There are no standard testing procedures
- Studies have shown that marijuana use in the workplace increases the likelihood of a work -related accident, other studies have shown no significant correlation between the two.

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Hemp Business Journal

STRATEGIC INFORMATION AND DATA FOR THE HEMP INDUSTRY

a division of New Frontier Data

Hot consumer products made from Hemp

Industrial hemp can be used in an estimated 50,000 different products across a wide spectrum of industries: from textiles to food products, building materials to bio-plastics, nutraceuticals to nanomaterials, ethanol to animal bedding.

The introduction of industrial hemp-based materials in the consumer products marketplace has been growing steadily over the last two decades as more industrialized countries allow farming, processing and manufacturing. Here's a sample of intriguing products that use industrial hemp as either a primary or secondary raw material.

Sunglasses and Ski Goggles

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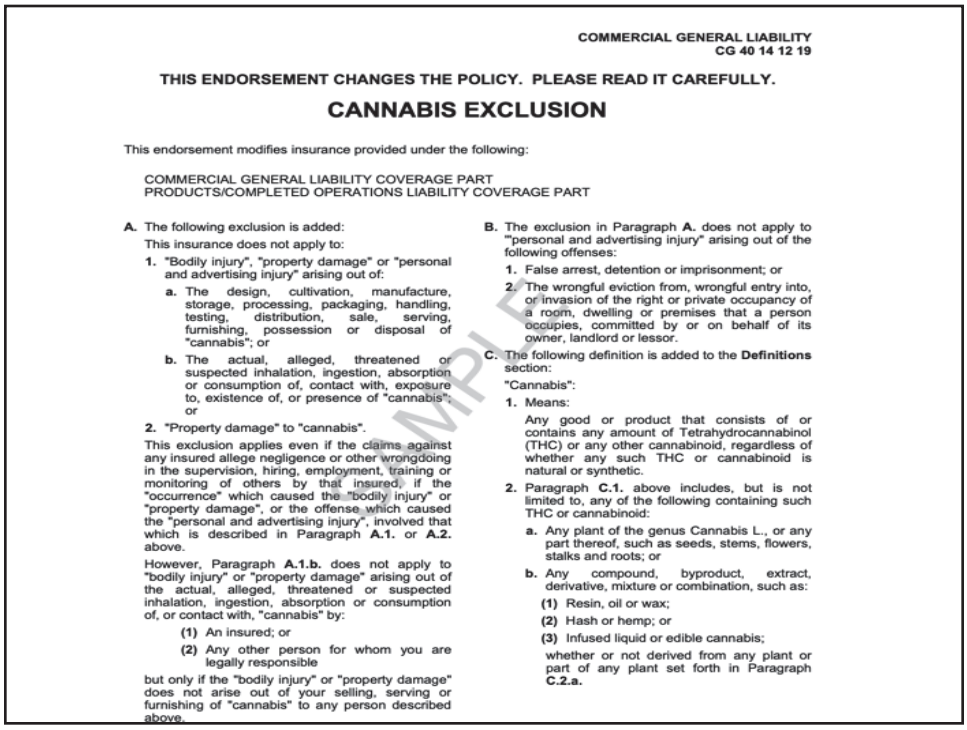

COMMERCIAL GENERAL LIABILITY
CG 40 14 12 19

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CANNABIS EXCLUSION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

A. The following exclusion is added:

This insurance does not apply to:

1. "Bodily injury", "property damage" or "personal and advertising injury" arising out of:

a. The design, cultivation, manufacture, storage, processing, packaging, handling, testing, distribution, sale, serving, furnishing, possession or disposal of "cannabis"; or

b. The actual, alleged, threatened or suspected inhalation, ingestion, absorption or consumption of, contact with, exposure to, existence of, or presence of "cannabis"; or

2. "Property damage" to "cannabis".

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved that which is described in Paragraph **A.1.** or **A.2.** above.

However, Paragraph **A.1.b.** does not apply to "bodily injury" or "property damage" arising out of the actual, alleged, threatened or suspected inhalation, ingestion, absorption or consumption of, or contact with, "cannabis" by:

(1) An insured; or

(2) Any other person for whom you are legally responsible

but only if the "bodily injury" or "property damage" does not arise out of your selling, serving or furnishing of "cannabis" to any person described above.

B. The exclusion in Paragraph **A.** does not apply to "personal and advertising injury" arising out of the following offenses:

1. False arrest, detention or imprisonment; or

2. The wrongful eviction from, wrongful entry into, or invasion of the right or private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor.

C. The following definition is added to the **Definitions** section:

"Cannabis":

1. Means:

Any good or product that consists of or contains any amount of Tetrahydrocannabinol (THC) or any other cannabinoid, regardless of whether any such THC or cannabinoid is natural or synthetic.

2. Paragraph **C.1.** above includes, but is not limited to, any of the following containing such THC or cannabinoid:

a. Any plant of the genus Cannabis L., or any part thereof, such as seeds, stems, flowers, stalks and roots; or

b. Any compound, byproduct, extract, derivative, mixture or combination, such as:

(1) Resin, oil or wax;

(2) Hash or hemp; or

(3) Infused liquid or edible cannabis;

whether or not derived from any plant or part of any plant set forth in Paragraph **C.2.a.**

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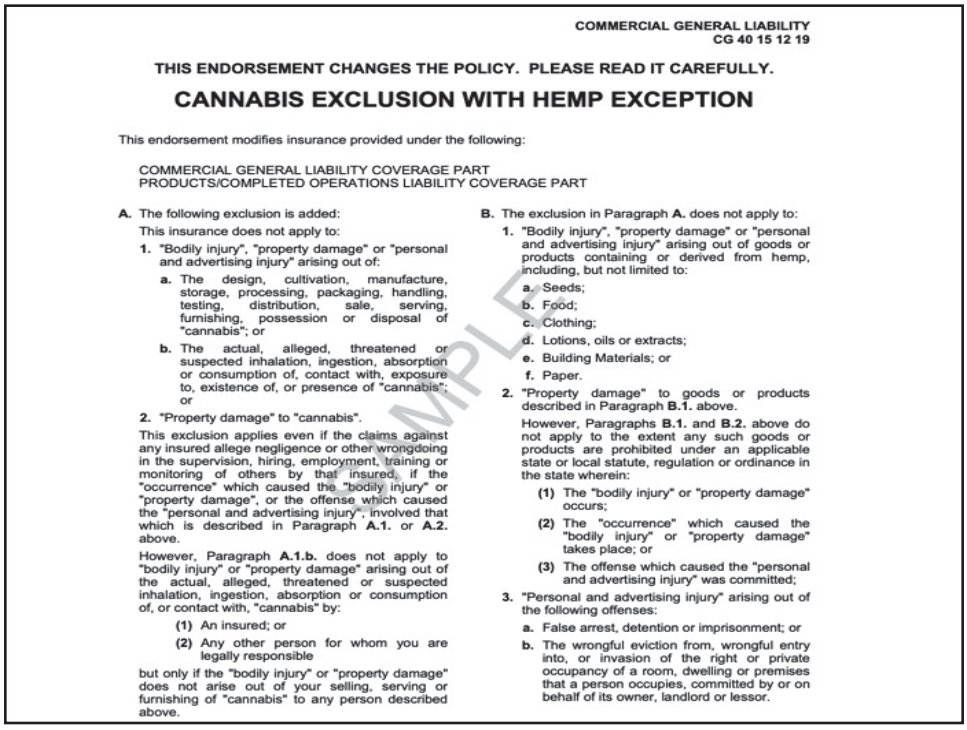

COMMERCIAL GENERAL LIABILITY
CG 40 15 12 19

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CANNABIS EXCLUSION WITH HEMP EXCEPTION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

A. The following exclusion is added:

This insurance does not apply to:

1. "Bodily injury", "property damage" or "personal and advertising injury" arising out of:

a. The design, cultivation, manufacture, storage, processing, packaging, handling, testing, distribution, sale, serving, furnishing, possession or disposal of "cannabis"; or

b. The actual, alleged, threatened or suspected inhalation, ingestion, absorption or consumption of, contact with, exposure to, existence of, or presence of "cannabis"; or

2. "Property damage" to "cannabis".

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved that which is described in Paragraph **A.1.** or **A.2.** above.

However, Paragraph **A.1.b.** does not apply to "bodily injury" or "property damage" arising out of the actual, alleged, threatened or suspected inhalation, ingestion, absorption or consumption of, or contact with, "cannabis" by:

(1) An insured; or

(2) Any other person for whom you are legally responsible

but only if the "bodily injury" or "property damage" does not arise out of your selling, serving or furnishing of "cannabis" to any person described above.

B. The exclusion in Paragraph **A.** does not apply to:

1. "Bodily injury", "property damage" or "personal and advertising injury" arising out of goods or products containing or derived from hemp, including, but not limited to:

a. Seeds;

b. Food;

c. Clothing;

d. Lotions, oils or extracts;

e. Building Materials; or

f. Paper.

2. "Property damage" to goods or products described in Paragraph **B.1.** above.

However, Paragraphs **B.1.** and **B.2.** above do not apply to the extent any such goods or products are prohibited under an applicable state or local statute, regulation or ordinance in the state wherein:

(1) The "bodily injury" or "property damage" occurs;

(2) The "occurrence" which caused the "bodily injury" or "property damage" takes place; or

(3) The offense which caused the "personal and advertising injury" was committed;

3. "Personal and advertising injury" arising out of the following offenses:

a. False arrest, detention or imprisonment; or

b. The wrongful eviction from, wrongful entry into, or invasion of the right or private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor.

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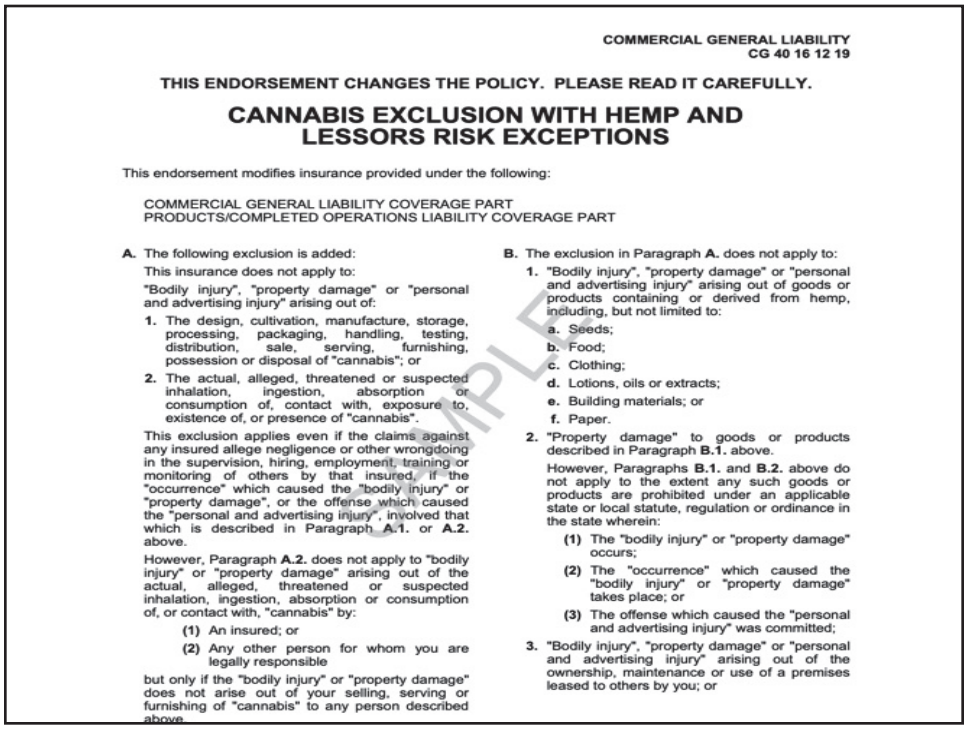

COMMERCIAL GENERAL LIABILITY
CG 40 16 12 19

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CANNABIS EXCLUSION WITH HEMP AND LESSORS RISK EXCEPTIONS

This endorsement modifies insurance provided under the following:

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PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

A. The following exclusion is added:

This insurance does not apply to:

"Bodily injury", "property damage" or "personal and advertising injury" arising out of:

1. The design, cultivation, manufacture, storage, processing, packaging, handling, testing, distribution, sale, serving, furnishing, possession or disposal of "cannabis"; or

2. The actual, alleged, threatened or suspected inhalation, ingestion, absorption or consumption of, contact with, exposure to, existence of, or presence of "cannabis".

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved that which is described in Paragraph **A.1.** or **A.2.** above.

However, Paragraph **A.2.** does not apply to "bodily injury" or "property damage" arising out of the actual, alleged, threatened or suspected inhalation, ingestion, absorption or consumption of, or contact with, "cannabis" by:

(1) An insured; or

(2) Any other person for whom you are legally responsible

but only if the "bodily injury" or "property damage" does not arise out of your selling, serving or furnishing of "cannabis" to any person described above.

B. The exclusion in Paragraph **A.** does not apply to:

1. "Bodily injury", "property damage" or "personal and advertising injury" arising out of goods or products containing or derived from hemp, including, but not limited to:

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c. Clothing;

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(1) The "bodily injury" or "property damage" occurs;

(2) The "occurrence" which caused the "bodily injury" or "property damage" takes place; or

(3) The offense which caused the "personal and advertising injury" was committed;

3. "Bodily injury", "property damage" or "personal and advertising injury" arising out of the ownership, maintenance or use of a premises leased to others by you; or

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SECTION IV:

Cosmic Roulette and Solar Storms

94

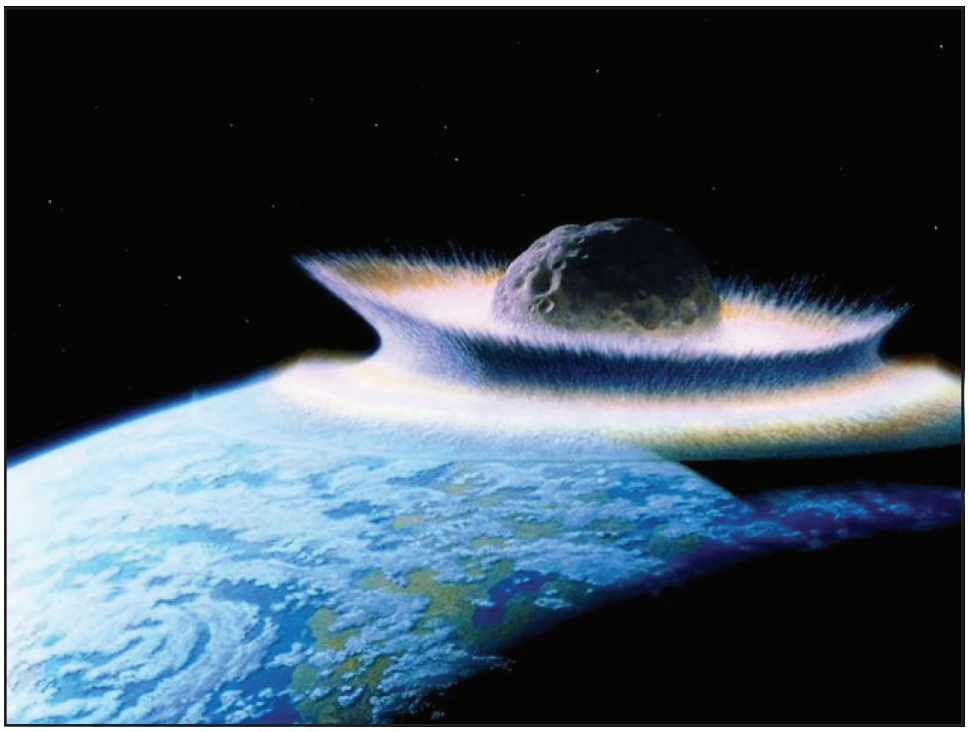
Massive Asteroid 'narrowly' Missed Earth

Washington DC
Associated Press
10/21/13

95

- An asteroid nearly hit our planet earlier this month. If we'd been hit, the impact would have felt like a thousand atomic bombs -- and NASA has figured out when it's coming back.

96



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Big asteroid buzzes past Earth and will again in 19 years

- **(CNN)** -- One of the most dangerous asteroids on record zipped close by Earth last month.
- It made headlines on Thursday, when reports said that there's a chance it could strike our planet in less than 20 years. Such a collision could unleash a force as powerful as a couple of thousand atomic bombs.
- But NASA was quick to calm nerves and point out some very good news. The most dangerous known asteroids don't really pose much of a threat. And there are very few of them.
- Also, the chances that this one, which the Ukrainian astronomers who discovered it named 2013 TV135, will collide with Earth are extremely slim, NASA said in a statement it called "a reality check."
- The space agency is 99.998% certain that when it whooshes back around the planet in 2032, it will simply sail past us again.
- **The probability of it striking Earth currently stands at 1:63,000**, and even those odds are fading fast, as scientists find out more about the asteroid.

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- 2013 TV135 was discovered on October 8, while NASA was closed during the government shutdown. And already it looks to soon be joining the ranks of the more than 10,000 known near-Earth objects that are virtually certain to cause us no harm.
- Two behemoths asteroids in that size range will pass by planet Earth in the next three months at similar distances as 2013 TV135. NASA says that neither will hit us.
- **Near asteroid passes are common. They pretty much occur daily, if not two or three times a day, NASA says. They come, and they go, and they leave the Earth in peace. In addition, particles from space bombard our planet every minute -- at a rate of 100 tons a day, NASA says. You eat them; you drink them; you breathe them. Much of you and everything else on Earth contains them.**

Distant catastrophe

- Though it seems Earth is safe for now, there is such a thing as a doomsday asteroid. Scientists say it is likely that the impact of an asteroid over six miles wide wiped out dinosaurs along with much of the life on Earth 65 million years ago. More like it will come, NASA says. But they only turn up once every "few million years." That may give humanity some time to find a way of dealing with it.

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Other Odds

- Scoring a hole in one 1:12,500
- Being killed by a hornet, wasp or bee 1:54,000
- **Asteroid striking earth 1:63,000**
- Becoming an Olympic athlete 1:500,000
- Being hit by a Meteorite 1:700,000
- Winning the Lottery 1:140,000,000
- Becoming a Movie Star 1:1,505,000
- Being struck by Lightning 1:10,000,000
- Getting attacked by a shark 1:11,500,000
- Dying in a plane crash 1:20,000,000
- Becoming a Saint 1:22,000,000

100

February 16, 2013

Russian Meteor's Air Blast Was One for the Record Books

Meteor that exploded over Chelyabinsk in early 2013 topped 500 kilotons and indicates higher risk of future blasts.

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- For a long time, astronomers saw the asteroids and comets that come close to Earth as useless debris -- space rocks that blocked our view of distant galaxies. Not anymore. They're now viewed as scientifically important and potentially very dangerous if they were to collide with our planet. The odds of that happening on any given day are remote, but over millions of years scientists believe there have been lots of impacts, and few doubt there are more to come. **A former astronaut told us it's like a game of "cosmic roulette," and one mankind cannot afford to lose.**
- Concern over our ability to detect these objects that come near the Earth grew after an incident in Russia this February, when an asteroid crashed into the atmosphere with many times the energy of the bomb dropped on Hiroshima, narrowly missing a city of one million.
- The asteroid in Russia, was barreling toward Earth at 40,000 miles an hour. It exploded into pieces 19 miles above and 25 miles south of the city of Chelyabinsk. People thought it had missed them entirely, until minutes later, when the shock wave arrived.
- Shattering glass, crushing doors, and knocking some people right off their feet. More than a thousand were injured. http://youtu.be/-qZ6oiaSm00

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- When the sun rose over Russia's Ural Mountains on Friday, Feb. 15th, many residents of nearby Chelyabinsk already knew that a space rock was coming. Later that day, an asteroid named 2012 DA14 would pass by Earth only 17,200 miles above Indonesia. There was no danger of a collision, NASA assured the public.

  Maybe that's why, when the morning sky lit up with a second sun and a shock wave shattered windows in hundreds of buildings around Chelyabinsk, only a few people picking themselves off the ground figured it out right away. This was not a crashing plane or a rocket attack.

  "It was a meteor strike--the most powerful since the Tunguska event of 1908," says Bill Cooke of NASA's Meteoroid Environment Office.

- **In a coincidence that still has NASA experts shaking their heads, a small asteroid completely unrelated to 2012 DA14 struck Earth only hours before the publicized event. The impactor flew out of the blue, literally from the direction of the sun where no telescope could see it, and took everyone by surprise.**

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Anderson Cooper: How much warning did people in Chelyabinsk have?

Paul Chodas: None. *Paul Chodas is a scientist at NASA's jet propulsion laboratory in Pasadena, Calif. He and his boss Don Yeomans have been trying to track near-Earth objects for decades.*

Paul Chodas: We didn't see it coming. It was coming from the general direction of the sun, so it was in the daytime sky as it approached.

Anderson Cooper: So how did you find out about it?

Paul Chodas: Twitter and YouTube-- when we first saw the images.

Anderson Cooper: So the first people at NASA that heard about it was Twitter?

Paul Chodas: Exactly.

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Home > News

An asteroid barely missed Earth last week, and no one knew it was coming

By Mindy Weisberger published November 02, 2021

The space rock was a cosmic visitor that no one expected.

In this artist's illustration, an asteroid passes close to Earth. (Image credit: Science Photo Library/Andrzej Wojcicki/Getty Images)

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NATION

Equivalent to '30 tons of TNT': Meteor explodes in Pennsylvania on New Year's Day

Michelle Shen USA TODAY

Published 12:48 p.m. ET Jan. 3, 2022 | Updated 5:42 p.m. ET Jan. 3, 2022

View Comments

Top astronomy events for January 2021

The new year begins with a quick but effective bang with the peak of the Quadrantid meteor shower. Then it slows down, capping off the end of January with a bright full moon. *Accuweather*

On New Year's Day, people in southwestern Pennsylvania heard an explosion around 11:20 a.m. EST.

An initial tweet by the National Weather Service in Pittsburgh said the most likely explanation was a "meteor explosion."

People all over Pittsburgh took to social media, saying the boom was incredibly loud and shook their house. Others posted footage capturing the crackling sounds of the explosion.

The National Weather Service Pittsburgh noticed a flash captured by its satellite's Geostationary Lightning Mapper in neighboring Washington County.

"This flash does not appear to be connected to any lightning activity in the area. One possible explanation is that a meteor exploded at some level above the ground," the weather service said in a post on Facebook.

106

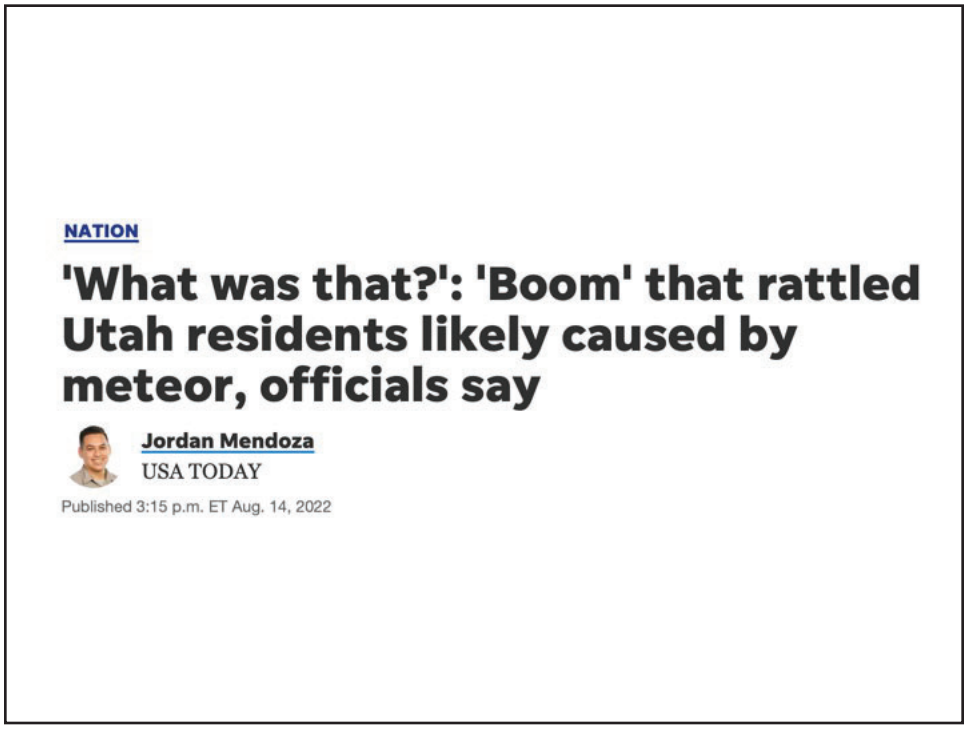
News > World

Nasa asteroid warning: Eiffel Tower-sized asteroid 'narrowly' missed earth in December

A monster asteroid larger than London's tallest building whizzed past the earth in a scenario similar to that seen in the film Don't Look Up

By Henry Sandercock
Thursday, 13th January 2022, 5:07 pm

107

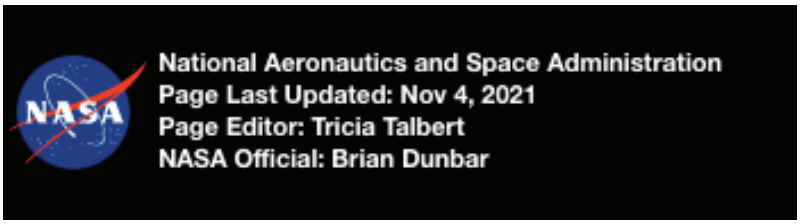


NATION

'What was that?': 'Boom' that rattled Utah residents likely caused by meteor, officials say

Jordan Mendoza
USA TODAY
Published 3:15 p.m. ET Aug. 14, 2022

108



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How can we prevent an asteroid from hitting Earth?

Currently, an asteroid impact is the only natural disaster we might be able to prevent. There are a few methods that NASA is studying to deflect an asteroid on a course to impact Earth. One of these techniques is called a gravity tractor—it involves a spacecraft that would rendezvous with an asteroid (but not land on its surface) and maintain its relative, optimal position to use the mutual gravity attraction between the satellite and the asteroid to slowly alter the course of the asteroid. A gravity tractor spacecraft could even enhance its own gravitational attraction by first plucking a boulder off the surface of the asteroid to add to its own mass.

A kinetic impactor is currently the simplest and most technologically mature method available to defend against asteroids. In this technique, a spacecraft is launched that simply slams itself into the asteroid at several km per second speed. Scientists will test the kinetic impact technique by the Double-Asteroid Redirect Test mission (DART) on an asteroid system called Didymos in 2022. DART's target is a binary asteroid system where one football-stadium-sized asteroid (Didymos B) is orbiting a half-mile-wide asteroid (Didymos A). NASA's goal is to send the car-sized DART spacecraft slamming into Didymos B at 25,000 kilometers per hour (16,000 miles per hour) to determine by how much the impact can shift the orbit of Didymos B around Didymos A. After all, we'd only need to nudge an asteroid's orbit enough to make it either seven minutes early or seven minutes late in its intersection with Earth's orbit. It takes seven minutes for the Earth to travel the distance of its diameter, so if an asteroid arrives seven minutes early or late—it'll miss us completely.

Nuclear explosive device methods are considered the last resort when it comes to NEO deflection, though they may be the most effective for preventing a cataclysmic event. When warning time is short or the asteroid is large, deploying a nuclear device is the most effective option. A standoff detonation is the method with the most controllability and predictability for using a nuclear device to deflect an asteroid. This method works by detonating a nuclear device at a few hundred meters above the surface of the asteroid. The energy from the device is primarily in the form of X-rays, which near instantly strike the surface of the asteroid. The material in the top layers of the asteroid is super-heated and vaporized by this radiation, causing a blow-off of material from the surface. The momentum push from the vaporized and blown off surface material imparts momentum to the rest of the asteroid and pushes it onto a new trajectory. Therefore, it is not the force from the explosion itself that moves the asteroid but rather the force of the radiated energy onto the surface of the asteroid.

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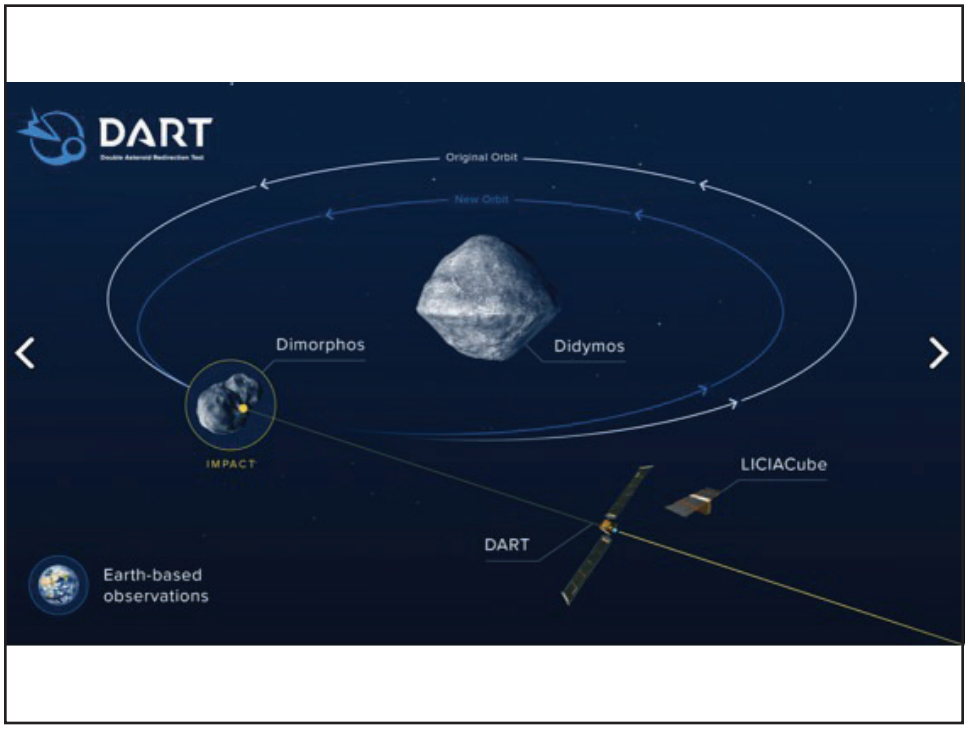
DART
Double Asteroid Redirection Test
NASA'S FIRST
PLANETARY
DEFENSE MISSION

111


DART
Original Orbit
New Orbit
Dimorphos
Didymos
IMPACT
LICIACube
DART
Earth-based
observations

112

Falling Satellites, Debris, Space Junk

- **NASA's Upper Atmosphere Research Satellite, or UARS, will break into pieces, and scientists say the chances that somebody somewhere on Earth will get hurt are 1 in 3,200, and any one person's odds of being struck have been estimated at 1 in 21 trillion.**
- Insurers would likely pick up the tab for damage claims filed under home, commercial property and comprehensive coverage in auto policies. But where would someone without insurance, someone seriously injured, or an insurer looking to recover payment, turn?
- "**Basically there's an international treaty that has to do with liability from space debris that was signed in 1972,"** Cole said.
- The 1972 Convention on International Liability for Damage Caused by Space Objects sets forth rules for liability for damage caused by space objects, and since the U.S. is a party to that convention, "any United States government liability to other treaty parties for damage caused by Upper Atmosphere Research Satellite upon reentry would be determined in accordance with its terms," Cole added.
- The convention was adopted by the General Assembly of the United Nations and was signed by all participating nations. When the U.S. signed the convention, it agreed to be "**absolutely liable** to pay compensation for damage caused by its space object on the surface of the Earth or to aircraft in flight."
- Under the convention insurers have a year to recover damages from the U.S. government, or any government that has launched a satellite that happens to be falling back to Earth.

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- However, that still leaves a coverage gap given the numerous private satellites put into orbit in the last few decades.
- Tim Wright, a space underwriter for Global Aerospace, a London-based company owned by Berkshire Hathaway and Munich Re, is one of a handful of specialists in what he sees as a growing market niche.
- "It's a very small insurance market," Wright said of space coverage, a segment that operates very much like the aerospace insurance market, and with many of the same players.
- "The market has actually covered similar events," he said.
- When Mir station was decommissioned and brought down in a controlled reentry in 2001, the Soviet Union took the extra step of purchasing reinsurance, Wright said.
- "The Russians didn't exactly know where it was going to land," he said. "The Russian operators actually went out and bought a third-party liability policy for this event."
- **Space insurance policies are available for coverage up to roughly $500 million, he added.**

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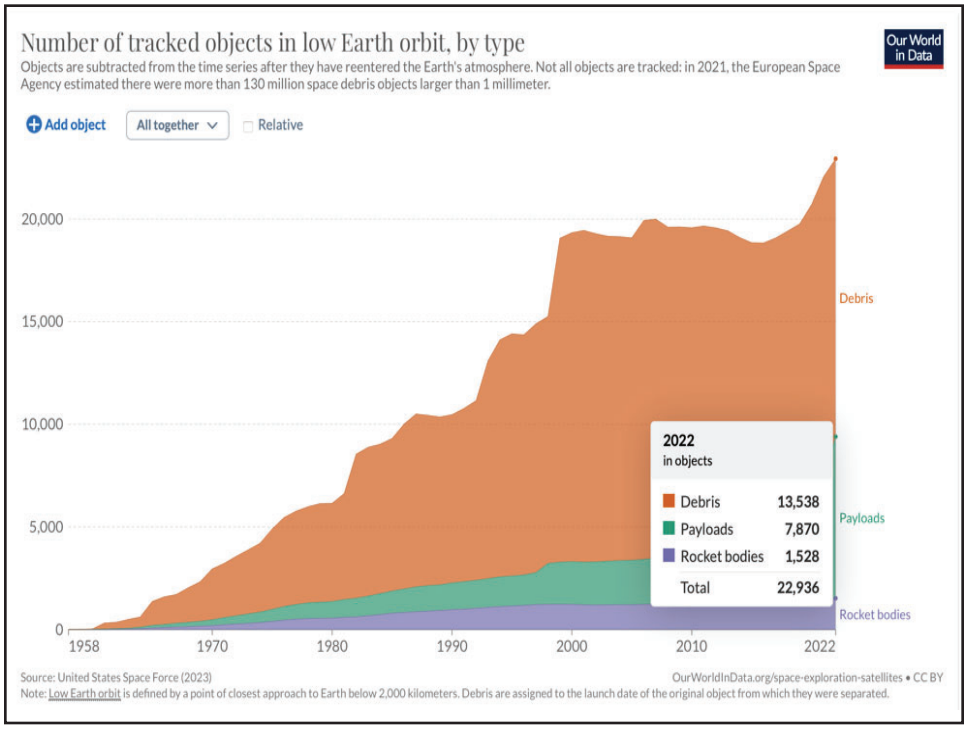
- "A number of satellite operations buy this," he said, noting that satellites operators like DirectTV, Google Inc. and SiriusXm are insured for a variety of damages that satellites can cause, as well as malfunctions during launch and they are insured that they operate effectively once in orbit.
- It may be a small sector of the insurance industry, but it's a big business.
- More than 20,000 manmade objects at least four inches in diameter are being tracked in orbit. It's mostly a threat to astronauts in space, rather than people on Earth. In June, the six residents of the International Space Station took shelter in their docked Soyuz lifeboats because of passing debris. The unidentified object came within 1,100 feet of the complex, the closest call yet.

115



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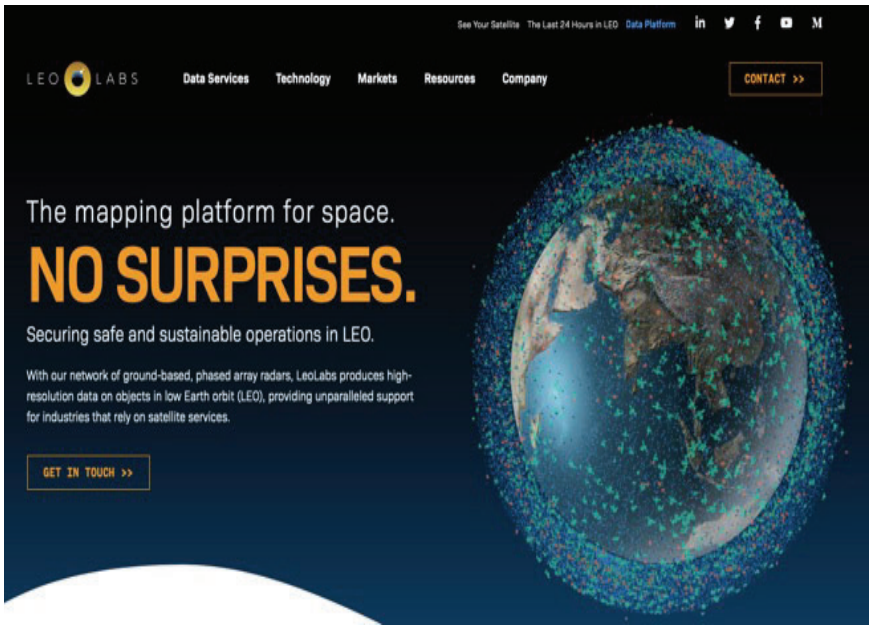
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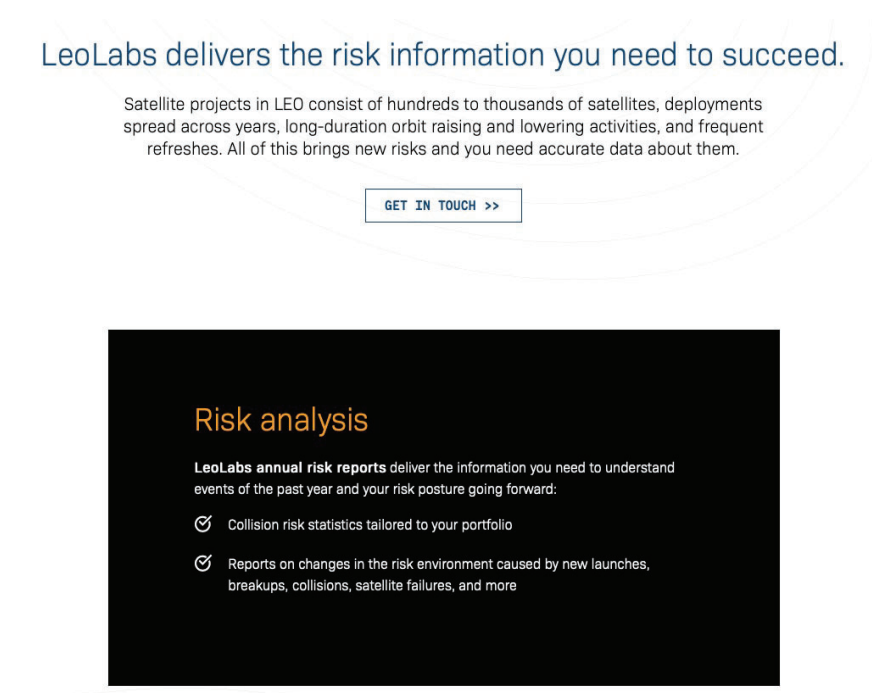
GET IN TOUCH >>

117


LeoLabs delivers the risk information you need to succeed.
Satellite projects in LEO consist of hundreds to thousands of satellites, deployments spread across years, long-duration orbit raising and lowering activities, and frequent refreshes. All of this brings new risks and you need accurate data about them.
GET IN TOUCH >>
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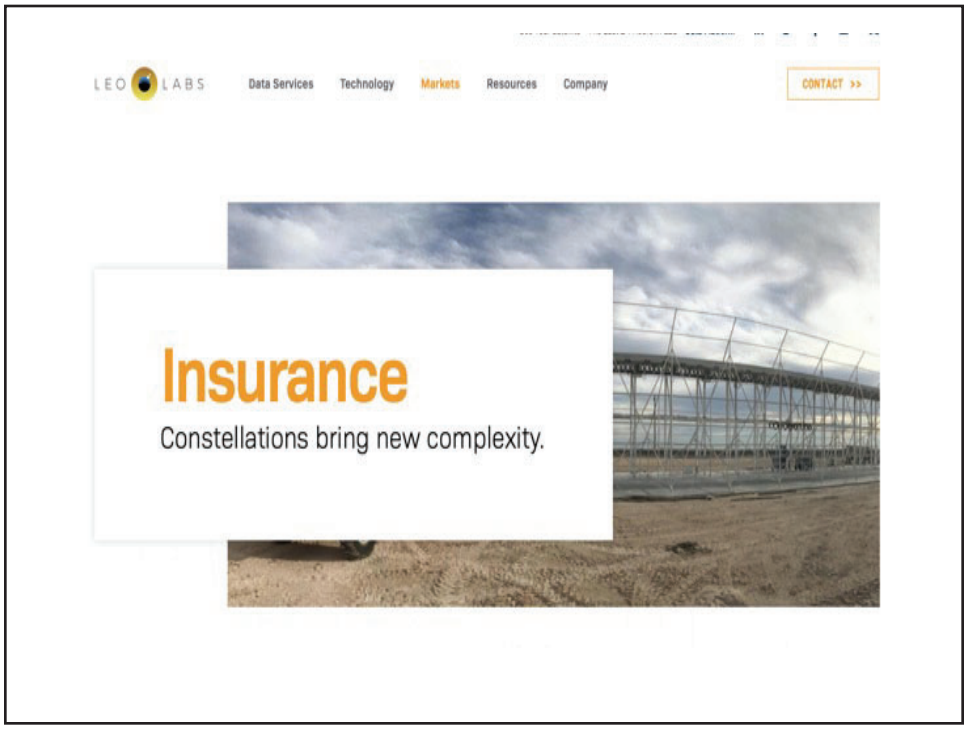
LeoLabs annual risk reports deliver the information you need to understand events of the past year and your risk posture going forward:
Collision risk statistics tailored to your portfolio
Reports on changes in the risk environment caused by new launches, breakups, collisions, satellite failures, and more

118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Data Services
Technology
Markets
Resources
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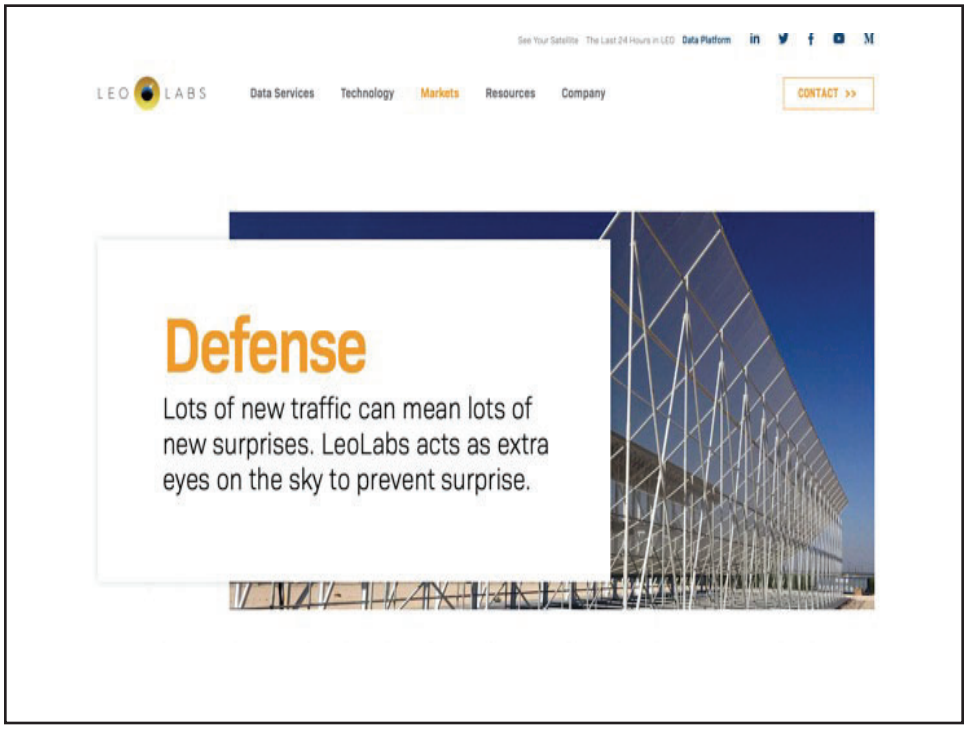
Insurance
Constellations bring new complexity.

119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Data Services
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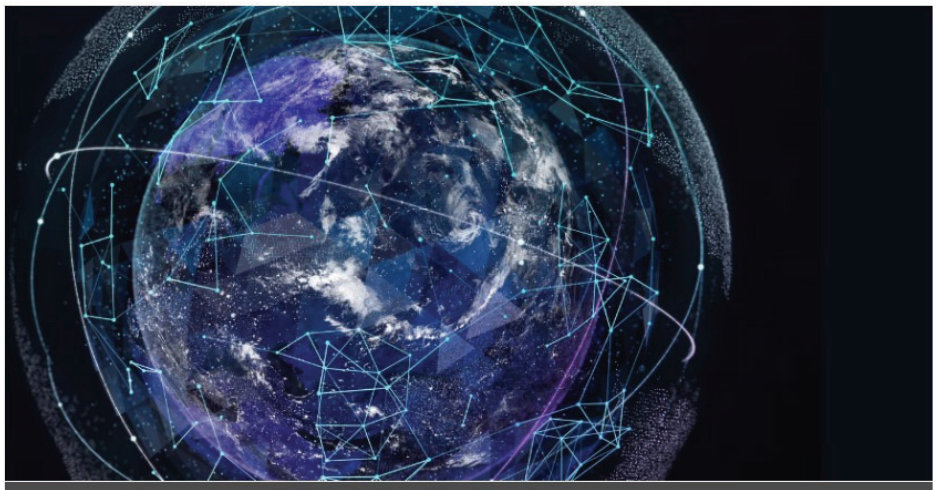
Markets
Resources
Company
CONTACT >>
Defense
Lots of new traffic can mean lots of new surprises. LeoLabs acts as extra eyes on the sky to prevent surprise.

120

by **Miles Lifson** and **Richard Linares** — January 4, 2022



Currently, there are more than 4,500 active satellites in orbit. While it took more than five decades to reach a thousand simultaneous active satellites, the growth in the active orbital population has exploded over the last decade, driven largely by companies like SpaceX designing satellite constellations to provide internet access. Credit: Mirexon via Canva.com

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Coverage ?

- While claims are handled on a case-by-case basis--you might be surprised to learn damage from satellite debris, a.k.a. **space junk, likely would be covered under most insurance policies.** **[farmers commercial]**

- Under a homeowners policy the damage likely would be covered as an accidental direct physical loss that is not otherwise excluded. Some insurance policies include the terms "falling objects" and "aircraft," which includes self-propelled missiles (meteors) and spacecraft. Damage to property inside the building would be covered if the falling debris first damages and penetrates the building roof or walls, then damages the property on the inside.

- Damage to vehicles caused by a falling object such as satellite debris likely would be covered under comprehensive coverage. Comprehensive coverage, under many automobile policies, would include losses due to missiles, falling objects, windstorm, hail, fire, explosion, earthquake, water, theft, vandalism, riot, or being hit by a bird or animal. Falling objects aren't covered by Collision coverage.

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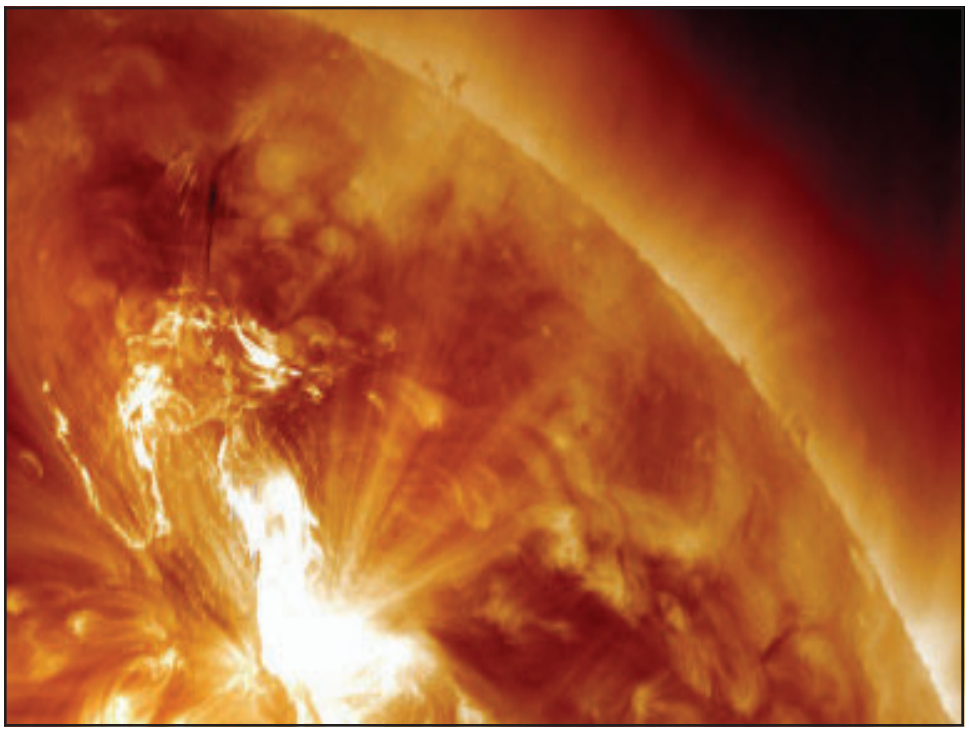
Other issues

- "Blue Ice"
- Flying Saucers / Air or spacecraft [sputnick]
- Drones
- Model aircraft

123

Solar Storm Now Hitting Earth

124



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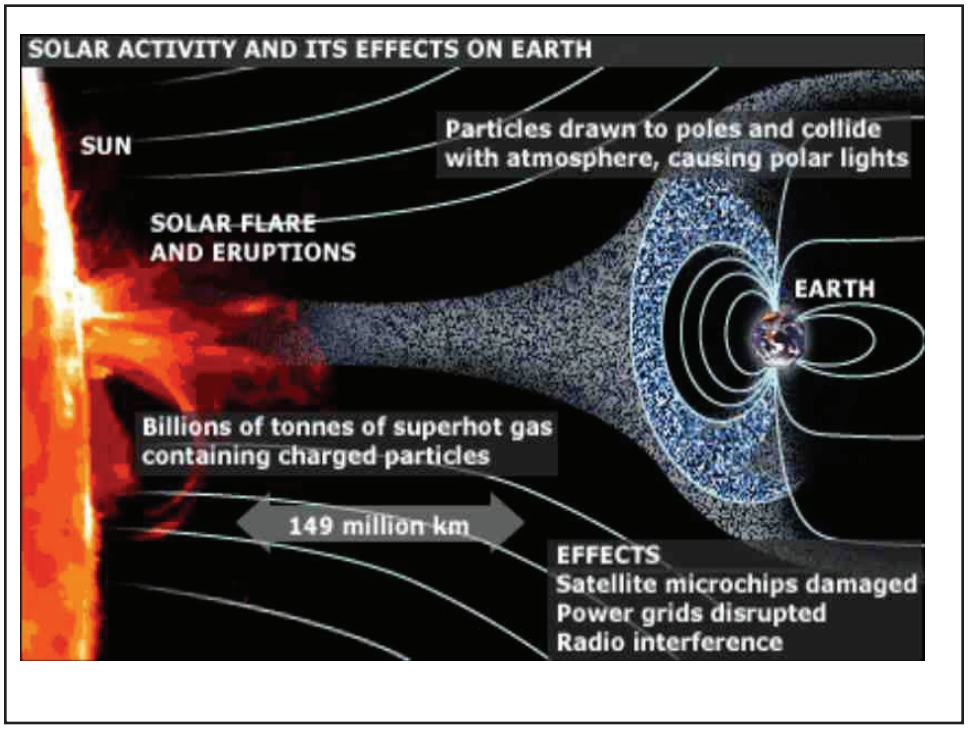
SOLAR ACTIVITY AND ITS EFFECTS ON EARTH
SUN
Particles drawn to poles and collide with atmosphere, causing polar lights
SOLAR FLARE AND ERUPTIONS
EARTH
Billions of tonnes of superhot gas containing charged particles
149 million km
EFFECTS
Satellite microchips damaged
Power grids disrupted
Radio interference

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Solar Storm Now Hitting Earth, Called Strongest Since 2005,

- WASHINGTON -- The sun is bombarding Earth with radiation from the biggest solar storm in more than six years with more to come from the fast-moving eruption.
- The solar flare occurred at about 11 p.m. EST Sunday and will hit Earth with three different effects at three different times. The biggest issue is radiation, according to the National Oceanic and Atmospheric Administration's Space Weather Prediction Center in Colorado.
- The radiation is mostly a concern for satellite disruptions and astronauts in space. It can cause communication problems for polar-traveling airplanes, said space weather center physicist Doug Biesecker.
- Radiation from Sunday's flare arrived at Earth an hour later and will likely continue through Wednesday. Levels are considered strong but other storms have been more severe. There are two higher levels of radiation on NOAA's storm scale – severe and extreme – Biesecker said. Still, this storm is the strongest for radiation since May 2005.
- The radiation – in the form of protons – came flying out of the sun at 93 million miles per hour.

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Sun Unleashes Major Solar Flare

By Tariq Malik, Managing Editor
April 25, 2014 06:47am ET

- The sun erupted with a massive solar flare late Thursday (April 24), triggering a temporary communications blackout on some parts of Earth.
- The powerful flare peaked at 8:27 p.m. EDT Thursday (0027 April 25 GMT), and ranked as an X1.3-class solar storm, one of the strongest types of flares the sun can experience, according to a report from the U.S. Space Weather Prediction Center.
- The solar flare erupted from an active sunspot region known as Region 2035 located on the far western side (or limb) of the sun as seen from Earth. Because of its position, the flare sparked a high-frequency radio blackout for about an hour on the daytime side of Earth, most likely over the Pacific Ocean and Eastern Pacific Rim, according to the SWPC update

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At Risk

- Satellites
- Space Station
- Commercial Aircraft
- GPS technology
- Communications
- Electrical Grid **
  - What would it be like without electricity ?

129

RETURN TO THE STONE AGE

- It is hard to quantify how serious and pervasive a sudden and complete loss of electrical power could be for a modern economy, but this is precisely what a 2008 report from the U.S. National Academy of Sciences tried to do. The result was alarming.
- The effects of an extended outage lasting more than a few hours would include, “disruption of the transportation, communication, banking, and finance systems, and government services; the breakdown of the distribution of potable water owing to pump failure, and the loss of perishable foods and medications because of lack of refrigeration.”
- A separate NASA-backed report in 2007 estimated a Carrington-scale solar storm would cost the satellite operators a minimum of $30 billion. That’s without the loss of revenues to the telecoms and broadcasting companies that rely on them and the hole it could leave in military security networks.
- Andrew Richards said National Grid started commissioning research on the threat around 1996 and the company now monitors solar activity on a daily basis.
- “We want to be prepared if something did happen,” he said. “There is a human tendency that if it hasn’t happened for a long time, to forget all about it.”

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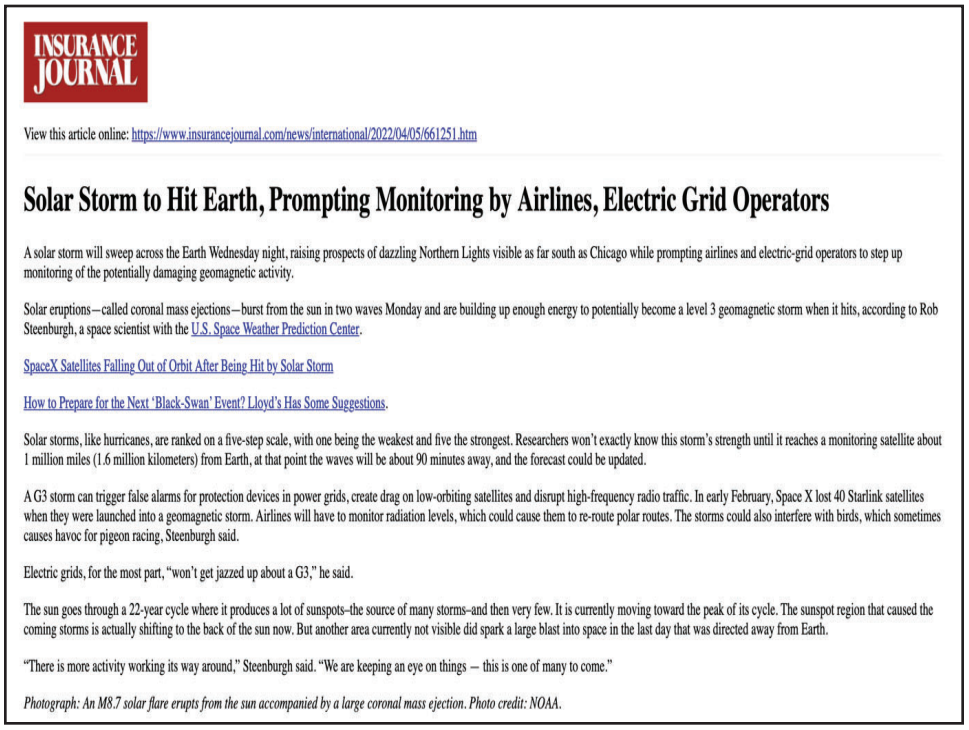

INSURANCE JOURNAL

View this article online: https://www.insurancejournal.com/news/international/2022/04/05/661251.htm

Solar Storm to Hit Earth, Prompting Monitoring by Airlines, Electric Grid Operators

A solar storm will sweep across the Earth Wednesday night, raising prospects of dazzling Northern Lights visible as far south as Chicago while prompting airlines and electric-grid operators to step up monitoring of the potentially damaging geomagnetic activity.

Solar eruptions—called coronal mass ejections—burst from the sun in two waves Monday and are building up enough energy to potentially become a level 3 geomagnetic storm when it hits, according to Rob Steenburgh, a space scientist with the U.S. Space Weather Prediction Center.

SpaceX Satellites Falling Out of Orbit After Being Hit by Solar Storm

How to Prepare for the Next 'Black-Swan' Event? Lloyd's Has Some Suggestions.

Solar storms, like hurricanes, are ranked on a five-step scale, with one being the weakest and five the strongest. Researchers won't exactly know this storm's strength until it reaches a monitoring satellite about 1 million miles (1.6 million kilometers) from Earth, at that point the waves will be about 90 minutes away, and the forecast could be updated.

A G3 storm can trigger false alarms for protection devices in power grids, create drag on low-orbiting satellites and disrupt high-frequency radio traffic. In early February, Space X lost 40 Starlink satellites when they were launched into a geomagnetic storm. Airlines will have to monitor radiation levels, which could cause them to re-route polar routes. The storms could also interfere with birds, which sometimes causes havoc for pigeon racing, Steenburgh said.

Electric grids, for the most part, "won't get jazzed up about a G3," he said.

The sun goes through a 22-year cycle where it produces a lot of sunspots–the source of many storms–and then very few. It is currently moving toward the peak of its cycle. The sunspot region that caused the coming storms is actually shifting to the back of the sun now. But another area currently not visible did spark a large blast into space in the last day that was directed away from Earth.

"There is more activity working its way around," Steenburgh said. "We are keeping an eye on things — this is one of many to come."

Photograph: An M8.7 solar flare erupts from the sun accompanied by a large coronal mass ejection. Photo credit: NOAA.

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INSURANCE JOURNAL

View this article online: https://www.insurancejournal.com/news/national/2017/01/26/440084.htm

Extreme Solar Blackouts May Cost U.S. More Than $40 Billion Daily

The daily U.S. economic cost from solar storm-induced electricity blackouts could be in the tens of billions of dollars, with more than half the loss from indirect costs outside the blackout zone, according to a new study published in a science journal.

Previous studies have focused on direct economic costs within the blackout zone, failing to take into account indirect domestic and international supply chain loss from extreme space weather, according to this latest report.

"On average the direct economic cost incurred from disruption to electricity represents only 49 percent of the total potential macroeconomic cost," says the paper published in Space Weather, a journal of the American Geophysical Union.

The paper was co-authored by researchers from the Cambridge Centre for Risk Studies at University of Cambridge Judge Business School; British Antarctic Survey; British Geological Survey and University of Cape Town.

Under the study's most extreme blackout scenario, affecting 66 percent of the U.S. population, the daily domestic economic loss could total $41.5 billion plus an additional $7 billion loss through the international supply chain.

Electrical engineering experts are divided on the possible severity of blackouts caused by "Coronal Mass Ejections," or magnetic solar fields ejected during solar flares and other eruptions. Some believe that outages would last only hours or a few days because electrical collapse of the transmission system would protect electricity generating facilities, while others fear blackouts could last weeks or months because those transmission networks could in fact be knocked out and need replacement.

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Piece of sun breaks off, stuns scientists: 'Very curious'

By Brooke Kato

February 9, 2023 | 7:04pm | Updated

A part of the Sun broke off, leaving everyone stunned. Astronomers saw a huge plasma filament erupt from the Sun, surprisingly pulling itself apart. And after getting detached, it furiously rotated till it reached the star's north pole, creating a terrifying vortex, just like a gigantic tornado. But how is it possible for a solar chunk to break apart? What's the physics behind this intriguing event? Finally, and most importantly, does it mean that a solar tsunami is on its way to hit our planet? These are some critical questions, and to answer them, let's look at what happens on the Sun step by step.

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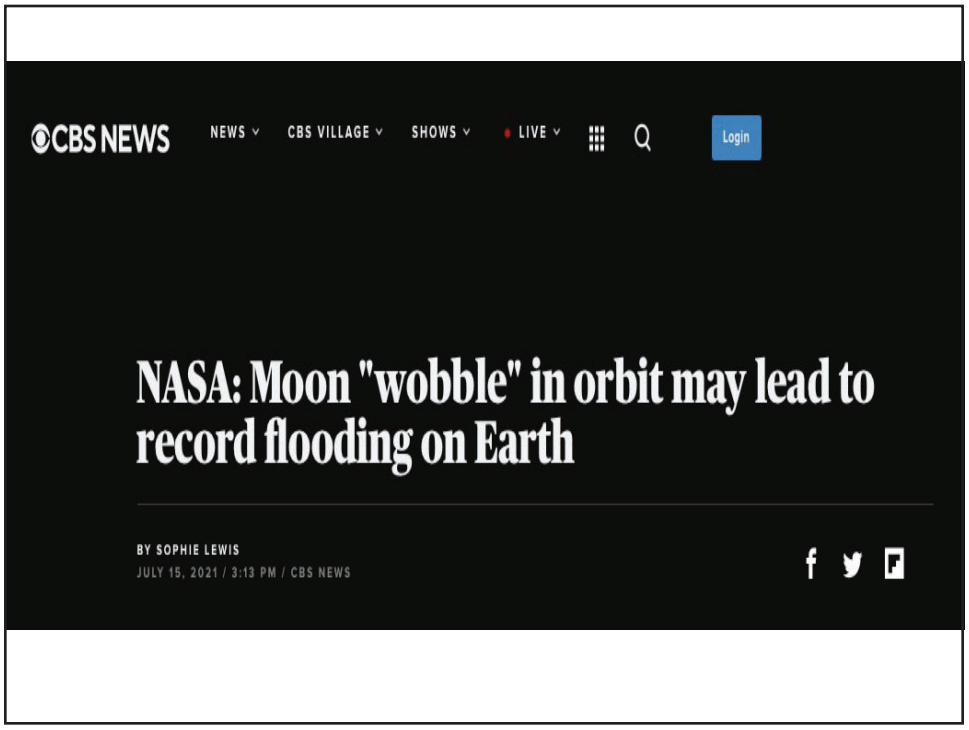
135

In addition to Climate Change…..

136



137

Every coast in the U.S. is facing rapidly increasing high tide floods. NASA says this is due to a "wobble" in the moon's orbit working in tandem with climate change-fueled rising sea levels.

The new study from NASA and the University of Hawaii, published recently in the journal Nature Climate Change, warns that upcoming changes in the moon's orbit could lead to record flooding on Earth in the next decade.

Through mapping the National Oceanic and Atmospheric Administration's (NOAA) sea-level rise scenarios, flooding thresholds and astronomical cycles, researchers found flooding in American coastal cities could be several multiples worse in the 2030s, when the next moon "wobble" is expected to begin. They expect the flooding to significantly damage infrastructure and displace communities.

138

SECTION V:

Autonomous Vehicles

139

Autonomous Vehicles

- Nothing new !
- Concept goes back to 1939 World's Fair
- 1950 – GM's Firebird II – guided by wires embedded in roadway
- Stanley world's first autonomous vehicle developed out of Stamford University – 2005
- Google / Waymo's Self Driving Cars

140

Three levels of cars

- Fully automated
- Partially Automated
  - Think about what your car already does !
    - Speed Control
    - Lane Assist
    - Automatic Braking
    - Vehicle Parks itself
    - Hands Free Highway Driving
      - How small is the jump to fully automated ??
- Human Driver

141

How do Autonomous vehicles deal with….

- Bicyclists / Jaywalkers
- Stop Signs
- Other Motorists waving them on using hand signals
- Right on Red turns
- Snowstorm / Fog

142

Safety Issues

- According to the National Highway Traffic Safety Administration (NHTSA), there were approximately 5.3 million police-reported motor vehicle crashes in 2021*, resulting in 2,217,000 injuries and 32,367 deaths *latest info available
- The American Automobile Association (AAA) estimates that the cost of automobile accidents is around $300 billion annually which equates to around $1,500 per person in the U.S.
- ***NHTSA research suggests that 93% of accidents are caused by human error.***

  (alcohol is the #1 cause of death/injuries (14,219/497,000); driver distraction is the #2 cause of death/injuries (10,546/1,300,000).

143

Insurance / Other Issues

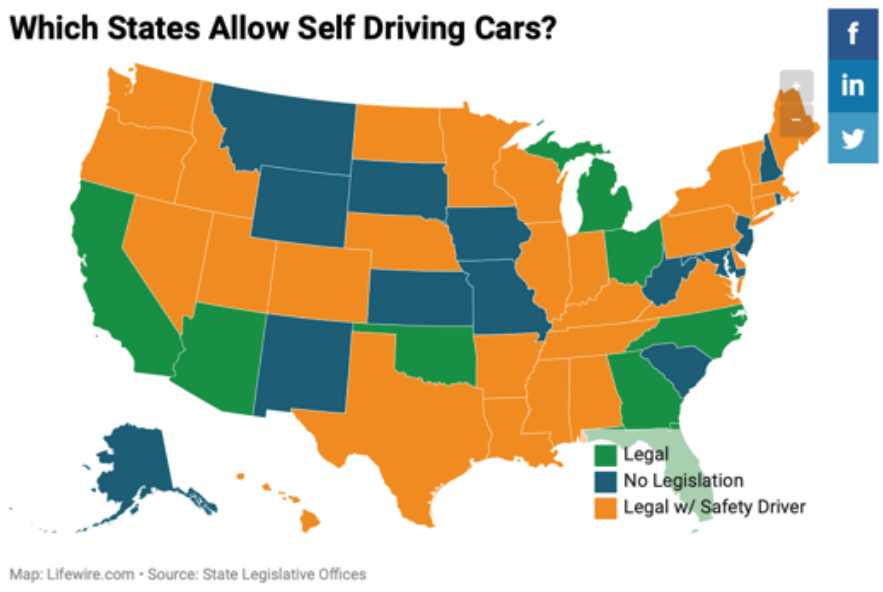
- Auto Rates reduced greatly
- Rating factors change significantly
- Owner Liability
- P.I.I.
- Traffic / Congestion
- Pollution reduction
- Product Liability
- Reliance on GPS Satellites
- Cyber Liability / Hacking
- Data – 750 Megabytes per minutes of driving
- Ethics

144

New Questions

- What if a driver does not install required software updates, will a product claim still exist against the manufacturer ?
- Will the inaccuracy of maps causing cars to run red lights, go down one way streets, fail to stop at a stop sign, etc… create liability for the GPS data providers and programmers ?
- Consumers worried about hacking into GPS and driving systems
- High end cars are increasingly being stolen by hacking
- How will insurers set rates when the loss data is not yet developed ?
- Products liability claims will result from accidents and recalls

145



146

Autonomous Vehicle Regulations

Lifewire.com

States That Explicitly Allow Self-Driving Cars to Be Deployed on Public Roads

The following states have explicitly legalized the deployment of self-driving cars on public rods—either through legislation or executive order:

Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin.

States That Require All Deployed Self-Driving Cars to Have a Human Operator in the Vehicle

As of 2021, Connecticut, District of Columbia, Illinois, Massachusetts, New Hampshire, New York, and Vermont require a human operator in the vehicle. Some states (Florida, Georgia, Nebraska, Nevada, North Carolina, North Dakota, Pennsylvania, and Washington) condition the need for a human operator to be present based on the level of the vehicle's automation.

147

Will the auto insurance industry be obsolete in 20 years?

JUL 30, 2015 | BY JAYLEEN R. HEFT, PROPERTYCASUALTY360.COM

148

Change is Coming….

- In today's world, change is inevitable, especially as technology quickly changes how we live and work. So, it's not surprising that an auto insurance market research analyst is predicting the end of the auto insurance business as we currently know it.
- That's right. No more auto insurance. WHY ?

- According to Deutsche Bank research analyst Joshua Shanker, in 20 years, instead of people owning and driving cars, it's possible that self-driving and ridesharing companies make up the majority of the automotive market. As such, the companies behind these services will be able to insure their cars like any other product, not based on the driving habits of millions of different drivers.

149

- In a July 19 research note about auto insurer Progressive, Shanker wrote that self driving cars and ridesharing are "disruptive technologies" that will likely influence how auto insurance is sold. He went on to predict an "accident-free" future where it becomes difficult to charge for premiums or differentiate among drivers.

Beginning of a state of disruption for the auto insurance industry

- The analyst downgraded Progressive, citing underlying fundamentals for the company, but also predicted that new technology will make Progressive's primary auto insurance business passé. The market research note acknowledged that Progressive may find its way to dominating a new kind of auto insurance world, but noted that the insurer also may find its products completely unnecessary by 2030.
- "Over the long term, we believe technological change in driving behaviors represents a massive threat to the personal auto insurance market," wrote Shanker. "The concurrent rise of instant ridesharing and autonomous vehicles presents real questions as to whether there will even be an auto insurance industry as we know it in 20 years, what percentage of cars on the road will be essentially accident-free in 10 years and whether to acknowledge in just 5 years that this isn't some 'George Jetson'fantasy."

150

3 Key Changes Coming

Three probable outcomes arising from the current trends in auto insurance were listed in the analyst's note as key to their conclusions:

1. *Accident frequency will decline* to where the difference among driving behaviors becomes negligible and it is difficult to charge a meaningful premium for insurance.

2. *Insurance will take the form of commercial product liability* instead of personal driver liability as we let the robots do the driving.

3. *Vehicle utilization will rise and cars on the road will decline* as one car can serve the driving needs of multiple travelers per day, which, in-turn, means fewer cars.

151

Young people not getting Licenses

- One recent survey from AAA found that just over half of teenagers get a license by the age of 18, a big drop from the past: "Some teens don't bother because they have no access to a car; being licensed no longer holds the social status it once did for many young people; there are other ways to get where they want to go; and the cost of gas and auto insurance are too high."

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- Fewer than half of them are applying for a driver's license when they reach legal age, according to a report issued Thursday by the AAA Foundation for Traffic Safety.
- Only 44 percent get a license within a year, and just over half of teenagers are licensed by the time they reach 18, an age at which two-thirds of teenagers were licensed 20 years ago.

153

TECHNOLOGY

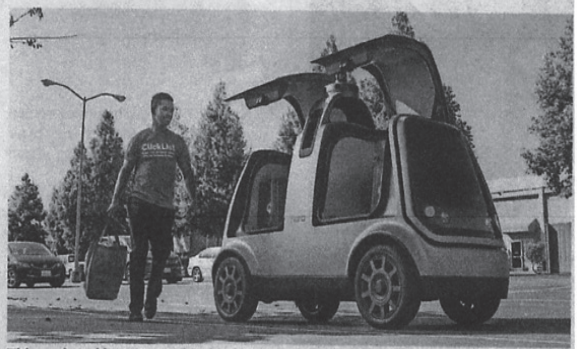
Grocery delivery, with no human drivers, is underway

ASSOCIATED PRESS

The nation's largest grocery chain leaped into the driverless delivery market, announcing last week that it is ready to bring milk, eggs and apples to some customers' homes in a vehicle with nobody at the wheel.

Although limited to delivering within about a mile of one Arizona supermarket, it represents the latest step for industries trying to lower delivery costs of everyday items as well as those trying to launch self-driving cars on public roads.

But Tuesday's launch also highlighted some of the many challenges that are still ahead for autonomous vehicles: The compact car didn't drive as planned at a media demonstration and had to be pushed up a ramp and onto a truck by several men before it could deliver the first loaf of bread.



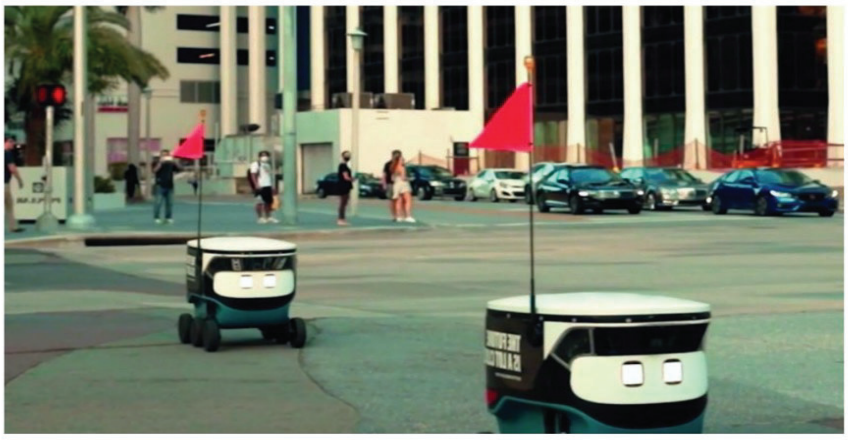
This undated image provided by The Kroger Co. shows an autonomous vehicle called the R1. Nuro and grocery chain Kroger are teaming up to bring unmanned delivery service to customers. AP

154

155

Grubhub Gears Up for Full Rollout of Campus Delivery Robots

BY **PYMNTS** | JUNE 13, 2022



As food delivery businesses look to make the economics of the model more efficient, Grubhub is rolling out autonomous delivery at college campuses.

The aggregator announced Monday (June 13) that, after a spring pilot test at Ohio State University, the company is making its partnership with self-driving robotics company Cartken available to colleges across the country. The aggregator has existing partnerships with over 250 U.S. college campuses.

156


ups
Hybrid Electric Vehicle

157


CAR AND DRIVER
SUBSCRIBE
SIGN IN
What's Going On with Autonomous Trucking?
They may not look like the future, but autonomous trucks are already up and running, hauling butter and saving UPS money.
BY ANNIE WHITE NOV 14, 2020

158

SLEEK DESIGN: The Yara Birkeland, due to launch in 2018, is the world's first autonomous container ship.

Alone at Sea

Autonomous ships will change how marine underwriters view risk and how insurers evaluate claims. But before crewless vessels hit international waters, they must navigate a sea of regulatory changes.

by Kate Smith

159

SNAPSHOT

The self-piloting helicopter

We have drones that record videos, fight fires and even deliver packages. EHang's 184 aims to one-up them all—by transporting a human. The all-electric creation, unveiled Jan. 6 at the CES tech show in Las Vegas, works much like a self-driving car: after specifying a destination, users hop in, sit back and enjoy the ride. Although EHang, based in Guangzhou, China, has successfully flown manned tests in its home country, safety remains a headwind; should the technology malfunction, there is no pilot to step in. Nonetheless, EHang plans to start selling the 184s this year in China, where drone regulations are less strict than they are in the U.S. CEO Huazhi Hu says they will cost $200,000 to $300,000. —*Alex Fitzpatrick*

160

ISO PP 00 01 (0918)

B. We do not provide Liability Coverage for the ownership, maintenance or use of:

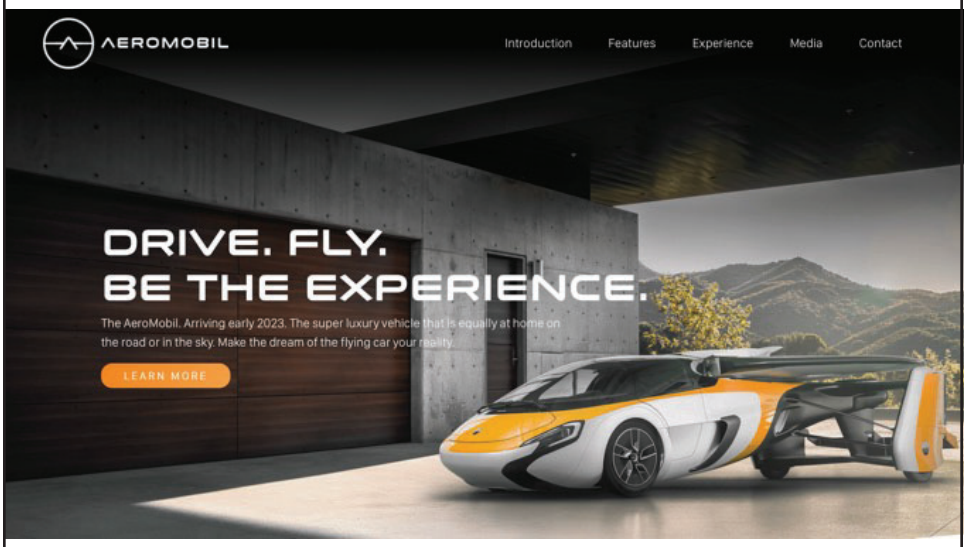
1. Any vehicle which:
   a. Has fewer than four wheels; or
   b. Is designed mainly for use off public roads.

.
.

4. Any vehicle, located inside a facility designed for racing, for the purpose of:

5. Any vehicle which is designed or can be used for flight.

161



162

New law could help flying car industry take off in NH

Roadable aircraft are just a few years away from hitting the skies, roads

August 14, 2020 by Liisa Rajala

Samson Sky's Switchblade is an experimental roadable aircraft that is partially built by its hobbyist owners.

On July 24, when Gov. Chris Sununu signed legislation laying out protocols for registering, inspecting and plating "roadable aircraft" — otherwise known as flying cars — national media broadcast another New Hampshire first-in-the-nation moment, and there's hope industry may take notice.

The vehicles are small aircraft with the capability to switch to an automobile setting so they can also be driven on the ground, and they are just a few years away from hitting the road and skies in consumers' hands.

163

SECTION VI:

Big Data / Price Optimization

164

Big Data

- Illegal ?
- Unethical ?
- Background Checks, MVR's, Clue Reports, etc.
- Credit Scoring / Computer Driven Underwriting
- Social Networking Information
- Price Optimization

165

At least 20 States Ban Price Optimization

- Alaska, Maryland, California,
- Ohio, Florida, Nevada,
- Vermont, Washington, Virginia
- Indiana, Pennsylvania,
- Maine, Washington, D.C.,
- Rhode Island, Montana,
- Delaware, Minnesota,
- Colorado, Connecticut, Missouri

166

Premonition Legal Analytics

- ATTORNEY WIN RATES
  - BY CASE
  - BY JURISDICTION
  - BY JUDGE

167

168

SECTION VII:

Drones

169

What is a “Drone”

- A/K/A
  - UAV’s [unmanned aerial vehicles]
  - UAS’s [unmanned aerial systems]
  - RPV’s [remotely piloted vehicles]
  - RPS’s [remotely piloted systems]

170

171

ISO Homeowner Policy (2011 Edition)

- **<u>Aircraft Definition</u>**: "any contrivance used or designed for flight,
- ***<u>except</u>* model or hobby aircraft not used or designed to carry people or cargo.**
  - A contrivance does not need a motor to be an aircraft; therefore hang gliders, parasail, or parachutes are aircraft.
  - No size restriction on model or hobby aircraft

172

Definition of "Hobby"

hob·by[1]

/ˈhäbē/

noun

1. an activity done regularly in one's leisure time for pleasure.
   "her hobbies are reading and gardening"
   synonyms: pastime, leisure activity, leisure pursuit; More
2. *archaic*
   a small horse or pony.

173

Aircraft – 2022 ISO Homeowners

4. Property Not Covered

We **do not** cover:

d. Aircraft meaning any contrivance used or designed for flight including any parts whether or not attached to the aircraft.

*We **do** cover model or hobby aircraft not used or designed to carry people or cargo; subject to a limit of $2000.*

174

Aircraft – 2022 ISO Homeowners

C. "Aircraft Liability"

This policy does not cover "aircraft liability".

175

DEFINITIONS

A. In this Policy, "you" and "your" refer to the "named insured" shown in the Declarations and the spouse if a resident of the same household. "We", "us" and "our" refer to the company providing this insurance.

B. In addition, certain words and phrases are defined as follows:

1. "Aircraft Liability", "Hovercraft Liability", "Motor Vehicle Liability" and "Watercraft Liability", subject to the provisions in **b.** below, mean the following:

a. Liability for "bodily injury" or "property damage" arising out of the:

(1) Ownership of such vehicle or craft by an "insured";

(2) Maintenance, occupancy, operation, use, loading or unloading of:

(a) An aircraft, hovercraft or watercraft by any person; or

(b) A motor vehicle by an "insured";

(3) Entrustment of such vehicle or craft by an "insured" to any person;

(4) Failure to supervise or negligent supervision of any person involving such vehicle or craft by an "insured"; or

(5) Vicarious liability, whether or not imposed by law, for the actions of a child or minor involving such vehicle or craft.

b. For the purpose of this definition:

(1) Aircraft means any contrivance used or designed for flight except model or hobby aircraft not used or designed to carry people or cargo;

176

Commercial Uses

- Farmers / Agri-business – crop spraying, etc.
- Real Estate
- Insurance adjusters / inspectors / underwriters
- Film / TV Industry *
- Search & Rescue Operations
- Fire / EMS / Police departments
- Weather / Storm Tracking
- Private Investigators
- Energy Companies *
- Delivery – Amazon, UPS, Dominos (DomiCopter), etc.
- Australian company delivers text books to students
- United Arab Emirates delivers government documents
- Lakemaid Beer tried delivering six-packs to ice fishers *
- Other uses ??

177

Claims Journal

Denise Johnson 3/3/2014

- "I envision a time when, after a catastrophe, an adjuster pulls up to a neighborhood and opens the trunk of his car and presses a few buttons on his tablet device and the drone does an immediate survey of everything and streams it all right to his tablet device, and he knows exactly where to go first and what's most significant…within minutes. Costing very little money, the insurance company has a sense of everything that needs to be done in a very short amount of time," Wolf said.

178

ISO CGL Exclusions

AIRCRAFT, Auto Or Watercraft

- **"Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of *any aircraft*, "auto" or watercraft owned or operated by or rented or loaned to any insured.** Use includes operation and "loading or unloading".
- This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involved the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft that is owned or operated by or rented or loaned to any insured.

- What's left ?
- *Coverage for Non-Owned aircraft--- since we do not own, operate, rent, or loan it.*

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Exceptions to Exclusion

This exclusion does not apply to:

(1) A watercraft while ashore on premises you own or rent;

(2) A watercraft you do not own that is:
(a) Less than 26 feet long; and
(b) Not being used to carry persons or property for a charge;

(3) Parking an "auto" on, or on the ways next to, premises you own or rent, provided the "auto" is not owned by or rented or loaned to you or the insured;

(4) Liability assumed under any "insured contract" for the ownership, maintenance or use of aircraft or watercraft;

- **For example, a HVAC contractor agrees to indemnify a project owner for liability arising out of the contractor's use of its own aircraft in connection with the contracted work.** (Watch CG 2426 or CG 2139)

- The contractor has no coverage for its own direct liability in connection with the use of its owned aircraft (because of the aircraft exclusion).

180

Property Exclusions

CP 00 10 (1012)

p. Vehicles or self-propelled machines (including aircraft or watercraft) that:

(1) Are licensed for use on public roads; or

(2) Are operated principally away from the described premises.

181

CYBER COVERAGE ?

- Cyber policy may be needed if data is destroyed or damaged that causes the drone to malfunction an injure or damage property
- Cyber hacking drone's computer systems , causing loss of control or re-programming of aircraft
- Interference with airspace and other aircraft
- Invasion of privacy
- Breach of private data being collected

182

ISO CGL (0413) Edition

14. "Personal and advertising injury" means injury, including consequential "bodily injury", arising out of one or more of the following offenses:
a. False arrest, detention or imprisonment;
b. Malicious prosecution;
c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor;
d. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;
e. Oral or written publication, in any manner, of material that violates a person's right of privacy;
f. The use of another's advertising idea in your "advertisement"; or
g. Infringing upon another's copyright, trade dress or slogan in your "advertisement".

183

Claims / Potential Problems

- Drone being used to film a marathon, failed and hit a runner
- A man operating a drone around a vehicle crash site interfered with a medical helicopters landing
- NY arrested for flying his drone too close to police helicopters
- Drone operator crashed his UAV into a hot spring at Yellowstone National Park, potentially damaging the spring.
- Man fined $10,000 for using a drone to create a video for University of Virginia.

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ISO Endorsements

Commercial General Liability Coverage Part:

- CG 21 09 06 15 – Exclusion – Unmanned Aircraft
- CG 21 10 06 15 – Exclusion – Unmanned Aircraft (Coverage A Only)
- CG 21 11 06 15 – Exclusion – Unmanned Aircraft (Coverage B Only)
- CG 24 50 06 15 – Limited Coverage For Designated Unmanned Aircraft
- CG 24 51 06 15 – Limited Coverage For Designated Unmanned Aircraft (Coverage A Only)
- CG 24 52 06 15 – Limited Coverage For Designated Unmanned Aircraft (Coverage B Only)

Commercial Liability Umbrella Coverage Part:

- CU 21 71 06 15 – Exclusion – Unmanned Aircraft
- CU 21 72 06 15 – Exclusion – Unmanned Aircraft (Coverage A Only)
- CU 21 73 06 15 – Exclusion – Unmanned Aircraft (Coverage B Only)
- CU 24 50 06 15 – Limited Coverage For Designated Unmanned Aircraft
- CU 24 51 06 15 – Limited Coverage For Designated Unmanned Aircraft (Coverage A Only)
- CU 24 52 06 15 – Limited Coverage For Designated Unmanned Aircraft (Coverage B Only)

185

ISO Endorsements

(2023 Edition to be Released Shortly)

- CA 27 05 11 20 - Unmanned Aircraft Exclusion For General Liability Coverages
- CA 27 06 11 20 - Unmanned Aircraft Exclusion For General Liability Coverages - (Bodily Injury And Property Damage Liability Only)
- CA 27 07 11 20 - Unmanned Aircraft Exclusion For General Liability Coverages - (Personal And Advertising Injury Liability Only)
- CA 27 08 11 20 - Limited General Liability Coverage For Designated Unmanned Aircraft
- CA 27 09 11 20 - Limited General Liability Coverage For Designated Unmanned Aircraft - (Bodily Injury And Property Damage Liability Only)
- CA 27 10 11 20 - Limited General Liability Coverage For Designated Unmanned Aircraft - (Personal And Advertising Injury Liability Only)

186

Mandatory FAA Registration

- It's here! The Federal Aviation Administration's (FAA) Small Unmanned Aircraft System (UAS) registry is now live and ready for UAS owners to use at www.faa.gov/uas/registration. Registration is free for the first 30 days with a rebate, then $5 after that.
- During the registration process, each owner must provide his or her name, home address and e-mail address. When registration is complete, the web application will generate a Certificate of Aircraft Registration/Proof of Ownership including a unique identification number for the UAS owner, which must be marked on the aircraft.
- Owners using the model aircraft for hobby or recreation will only have to register once and may use the same identification number for all of their model UAS. The registration is valid for three years.
- **All aircraft weighing more than 0.55 pounds (250 grams) and less than 55 pounds (approx. 25 kilograms), including payloads such as on-board cameras, must be registered.**
- Under this rule, owners who previously operated an unmanned aircraft exclusively as a model aircraft prior to December 21, 2015, must register no later than February 19, 2016. Owners of any other UAS purchased for use as a model aircraft after December 21, 2015 must register before the first flight outdoors. Owners may use either the paper-based process or the new streamlined, web-based system. Owners using the new streamlined web-based system must be at least 13 years old to register.

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FAA Regulations- Hobby/Model Drones

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FAA Regulations – ***Commercial*** Drones

- Operator Certification
  - Pass written exam at FAA approved testing center to obtain operator's certificate
  - TSA will screen applicants and operator's will have to pass a recurrent knowledge test every 24 months
  - No requirements to date for training, operating hours or liability insurance

189

FAA Regulations – Commercial Drones

- Implications
  - Total cost to take FAA exam and apply for operators certificate is estimated at $150 No definitive resources are listed for knowledge or skills training. Companies will have to develop their own internal standards
- Hardware Requirements
  - Drones must weigh less than 55 lbs. and have a maximum speed of 100 mph
  - Aircraft must be registered with FAA and have visible registration number on craft ($50 renewable every 3 years)
  - Inspection and Maintenance records must be kept

190

FAA Regulations – Commercial Drones

- Operational Limitations
  - Operator must maintain visual line-of-sight and may not operate over persons not directly involved in the operation.
  - Only daylight operations are permitted
  - Minimum visibility of 3 miles
  - Not closer than 500 feet below and 2000 feet horizontal from clouds, with a maximum altitude of 500 feet
  - Operation in B,C, D, and E airspace requires Air Traffic Control (ATC) permission
  - Operation is not permitted in areas where FAA restrictions are in place (problem Tri-State area)
  - Less stringent restriction for "Micro-Drones" <4.4lbs, <34.5mph
  - March 24, 2015 the FAA announced it would award "blanket" certification allowing companies to be exempt from a U.S. ban on commercial drones, to begin using the aircraft at altitudes of up to 200 feet during daylight hours and within the operator's visual line of sight.
  - 333 exemption for commercial use / 127 exemption S.U.A.S. - $150

191

UPS Drones Win Milestone FAA Permission to Take Off Shackles

By Thomas Black and Alan Levin | October 1, 2019

192

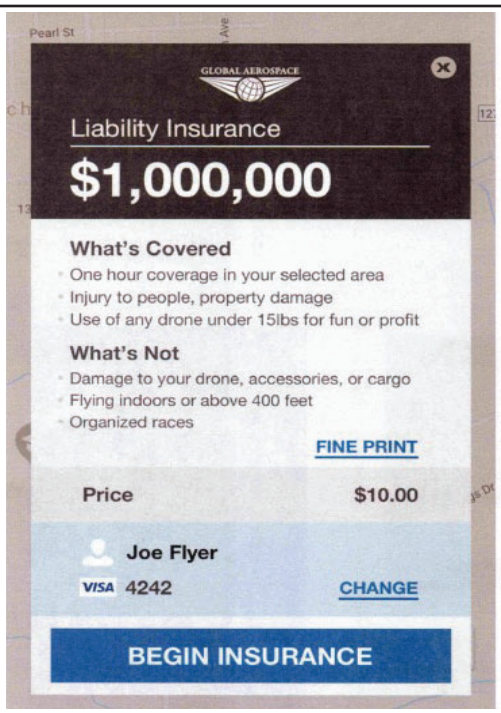
But Remember Some Really, Really Good Things...

193

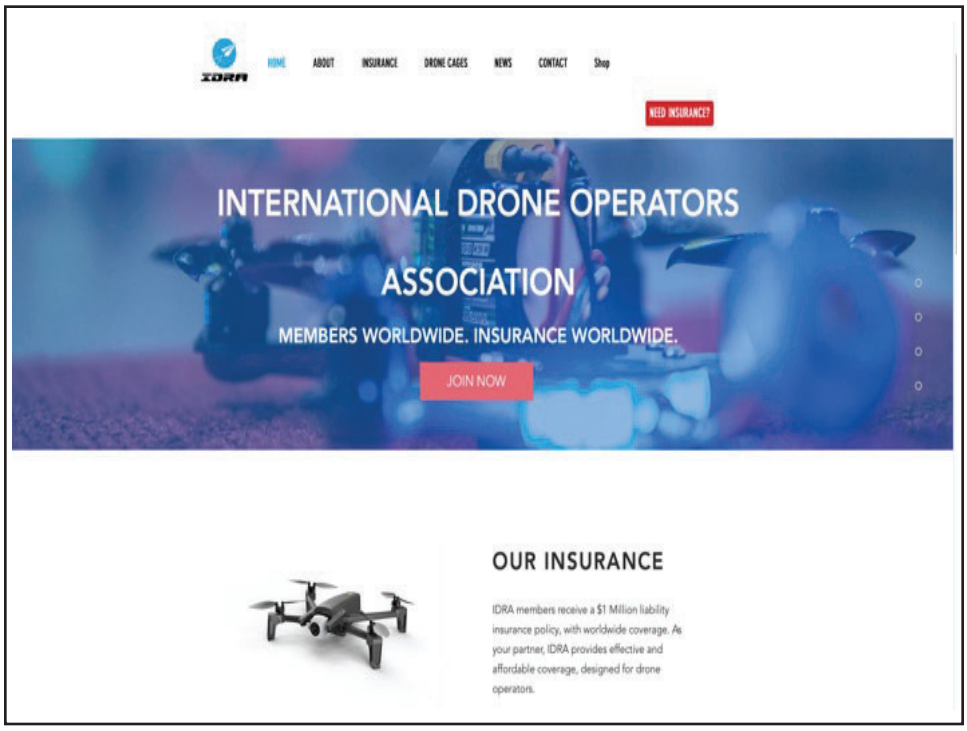
Drones are Aircraft

- A drone is an "aircraft" under the Federal Aviation Regulations.
- Shooting down an aircraft is a federal crime. The penalties include 20 years in prison, and a *threat* to shoot down an aircraft can get you five years in prison (18 U.S.C. §32). The government also can impose fines of up to $250,000.

194


Pearl St
GLOBAL AEROSPACE
Liability Insurance
$1,000,000
What's Covered
One hour coverage in your selected area
Injury to people, property damage
Use of any drone under 15lbs for fun or profit
What's Not
Damage to your drone, accessories, or cargo
Flying indoors or above 400 feet
Organized races
FINE PRINT
Price
$10.00
Joe Flyer
VISA 4242
CHANGE
BEGIN INSURANCE

195


IDRA
HOME
ABOUT
INSURANCE
DRONE CAGES
NEWS
CONTACT
Shop
NEED INSURANCE?
INTERNATIONAL DRONE OPERATORS
ASSOCIATION
MEMBERS WORLDWIDE. INSURANCE WORLDWIDE.
JOIN NOW
OUR INSURANCE
IDRA members receive a $1 Million liability insurance policy, with worldwide coverage. As your partner, IDRA provides effective and affordable coverage, designed for drone operators.

196

Self Piloting Drones

Time Magazine

January 2016

197

SNAPSHOT

The self-piloting helicopter

We have drones that record videos, fight fires and even deliver packages. EHang's 184 aims to one-up them all—by transporting a human. The all-electric creation, unveiled Jan. 6 at the CES tech show in Las Vegas, works much like a self-driving car: after specifying a destination, users hop in, sit back and enjoy the ride. Although EHang, based in Guangzhou, China, has successfully flown manned tests in its home country, safety remains a headwind; should the technology malfunction, there is no pilot to step in. Nonetheless, EHang plans to start selling the 184s this year in China, where drone regulations are less strict than they are in the U.S. CEO Huazhi Hu says they will cost $200,000 to $300,000. —*Alex Fitzpatrick*

198

SECTION VIII:

Nanotechnology

199

Nanotechnology

[study of particles at the molecular level (atomic and subatomic particles)]

- **Nanotechnology is the understanding and control of matter at dimensions between 1 and 100 nanometers. Nanoparticles, are measured in billionths of a meter. Nanoscale materials are generally less than 100 nanometers in diameter. A sheet of paper, in comparison, is 100,000 nanometers thick. A human hair is 80,000 nanometers thick.**

- **Nanotechnology will have a significant impact on the economy. It is anticipated that sales of nano-enabled products will reach $1.0 trillion .**

200

Nanotechnology Market Outlook - 2025

- Nanoscience and nanotechnology are the study of nanoparticles and devices, which find their application across all the science fields such as chemical, bio-medical, mechanics, and material science among others. Nanotechnology market encompasses the production and application of physical, chemical, and biological systems and devices at scales ranging from individual atoms or molecules to around 100 nanometers.
- Nanotechnology carries a significant impact, and serves as a revolutionary and beneficial technology across various industrial domains, including communication, medicine, transportation, agriculture, energy, materials & manufacturing, consumer products, and households. Emerging use cases and application is expected to be one of the key factors contributing towards the growth of nanotechnology market size. The U.S. National Nanotechnology Initiative has estimated that around 20,000 researchers are working in the field of nanotechnology

201

Nanotechnology Capital of USA ?

- **Albany NY and surrounding Capital Region is a leading mecca for the nanotechnology field.**

202

ISO Classification Table

- ISO has revised its GL Classification Table to introduce several new classes addressing Nanotechnology, including nano-distributors and manufacturers

203

Nanoparticles

- **Particles at the nanoscale are below the wavelength of visible light**
- **Fluorescent nanoparticles, or quantum dots have a whole range of possible applications. They are invisible until 'lit up' by ultraviolet light**

Uses

- Such nanoparticles are ideal for crime prevention, where goods can be invisibly 'tagged', preventing counterfeiting; stolen goods can be traced by their invisible 'bar code' and illicit drugs by the fact they have no legal identification.
- In some countries, cheap agricultural fuel is 'laced' with harmless nanoparticles, making it easy for police to identify a stolen consignment, merely by using ultraviolet light.
- Other uses of nanoparticles include sunscreens and stay-clean windows

204

Carbon Nanotubes

wwwlatestnanotechnology.blogspot.com

- **Carbon nanotubes are a recently discovered unique material possessing amazing electronic, thermal, and structural properties. They are highly conductive both to electricity and heat, with an electrical conductivity as high as copper, and a thermal conductivity as great as diamond. They offer amazing possibilities for creating future nanoelectronic devices, circuits and computers. Carbon nanotubes also have extraordinary mechanical properties - they are 100 times stronger than steel, while only one sixth of the weight.**
- These mechanical properties offer huge possibilities, for example, in the production of new stronger and lighter materials for military, aerospace and medical applications. Other applications include lubricants, coatings, catalysts and electro-optical devices.
- Individuals may have access to new products containing nanomaterials almost every day. The purported benefits of these "new and improved" products is often clearly stated on product packaging and advertisements. Examples include waterproof pants, stain-resistant shirts, socks that eliminate foot odor, pacifiers that fight bacteria, and computers that run faster, molecular targeted therapies, diagnostic imaging, tennis balls more airtight/last longer, bandages nano-coasted with silver to help wounds heal faster, sunscreens, cosmetics, toothpaste, vehicles, electronics, etc., etc.

205

8 Incredible Nanotechnologies that Actually Exist Today

Annalee Newitz- Gizmodo 12/10/12 1:04pmo

1. Super Condoms

Using a simple nano-fabrication technique called electro-spinning, researchers have successfully manufactured a fabric woven from sperm-blocking fibers knitted together with anti-HIV drug delivery fibers. The result is a female condom that prevents pregnancy, guards against HIV transmission, and then evaporates within hours or days depending on how it's manufactured. It's the world's perfect condom, and the Bill and Melinda Gates Foundation has just given the researchers $1 million to manufacture them for a mass market.

206

- **2. Molecule Printers**
  We already have 3D printers that can print out everything from toys to skin. And now a research group has figured out how to output the results of a CAD program to a printer that will build functional molecules piece-by-piece. This is an ideal way to create personalized medicine.

207

- **3. Stretchable Gold**
  Why should circuit boards be brittle and stiff? Now they don't have to be, because scientists have invented stretchable gold that can be printed onto rubber circuit boards. With circuits made of stretchable gold, you can bend and torque your devices as much as you want, or have a squeezy computer.

208

- **4. Artificial Muscles**
  Carbon nanotubes are used in a lot of nanoscale devices and applications, and turning into an artificial muscle is just another of its amazing properties. When a carbon nanotube is dipped into charged solution, it absorbs ions, expanding and coiling up. And when it releases those ions, it uncoils in the other direction, stretching out. This motion — coiling and expanding, then uncoiling and stretching — emulates the action of a muscle. It means we've got a molecular outboard motor that can drive other molecules around. Coming soon to your blood vessels or oil spills everywhere!

209

- **5. Stain-repellant Fabric Coating**
  Materials scientists working at the nano-scale with fabric aren't just interested in condoms. They're also making the next generation of water-resistant, unstainable clothing. This isn't just cotton that is easy to wash. It actually "shrugs off" stains because it's made of several nano-layers of positively and negatively charged films that actively repel everything from water to acids. Deadly chemicals might actually jump off your clothing.

210

- **6. Highly-Targeted Drug Delivery Capsules**
One of the big problems with cancer treatment is that doctors want to deliver medicines to the precise region of your body where the cancer is active. Now, using nanoscale drug capsules, they can. Basically, the drugs are placed inside these nanoscopic capsules, which are attracted to the specific form of cancer the patient is suffering from. Once in range of the cancerous cells, the capsules unleash their medicine — leaving the cancer blighted, but the rest of your body unharmed. Eventually, we could even inject nanoscale machines into your body that would act as tiny pharmaceutical labs, using your body's natural resources (from enzymes to proteins) to manufacture and deliver drugs.

211

- **7. Plastic that Bleeds and Heals Itself**
Self-healing materials, from concrete that fills in its own cracks to ship hulls that knit back together, are becoming commonplace in the nanofabrication era. One of the most uncanny examples of a self-healing material is a plastic that "bleeds" when it rips, using the extruded "blood" to repair damage and become whole again.

212

- **8. Electricity-Generating Viruses**
  A team of researchers have figured out how to engineer viruses to convert pressure into electrical energy. Paint these viruses onto the bottom of your shoes and you could power up your smart phone. Or paint a dance floor with them and power your whole club.

213

Insurance Exposures

- What do we know about nano-particles ?
  - Not much
  - Dermal, Inhalation, Ingestion
  - Research and exploration is outpacing regulation
  - Inevitable comparison to Asbestos [carbon non-tubes]
    - $200 B losses
- Work Comp
  - Immediate Injury
  - **Latent Effects**
  - Third Party Suits
  - Voluntary vs. Involuntary marketplace [WCIP]
- CGL
  - Products Liability
    - Standard
    - Non-Standard
    - Claims Made Forms
  - Pollution Exclusion
    - No specific reference to nano-particles
    - Very Broad Definition
- Environmental
  - Release during production / use

*IP Claims for rights

214

Nanomaterial Recommended Exposure Reduced

- The National Institute for Occupational Safety and Health (NIOSH) reported the results of animal studies that show that certain types of nanomaterials can affect the lungs. In light of those studies, and in an attempt to further protect workers from suffering similar harmful effects, NIOSH lowered its **recommended** exposure levels and issued additional recommendations for employers related to the continued assessment of potential hazards **as the hazards are still largely unknown.**

215

FDA Guidelines

- The Food and Drug Administration issued **tentative guidelines** Friday for food and cosmetic companies interested in using nanoparticles (not medical companies)
- The draft guidance suggests the FDA may require food companies to provide data establishing the safety of any packaging using nanotechnology.
- The FDA has previously stated its position that nanotechnology is not inherently unsafe; however, materials at the nano scale can pose different safety issues than do things that are far larger.
- "This is an emerging, evolving technology and we're trying to get ahead of the curb to ensure the ingredients and substances are safe,"

216

Lloyds of London

- Insurers have noted that nanoproducts hold the potential to lead to a variety of risks. Lloyd's of London, for example, has hypothesized several possible risk scenarios:
  - Pollution spill from a nanoparticle production facility
  - Nanoparticle manufacture workers develop chronic illness
  - Nanoparticles leach from products to accumulate in the environment
  - Product recall due to research findings indicating product is a hazard
  - Liability claims on a company, directors and officers regarding a product that was indicated by research to be unsafe, but subsequently released to the consumer market

217

Nano-Particle Exclusion

- **Most commercial insurance policies do not contain definitions, or exclusions for nanoproducts / nanotechnology.**
- Continental Western Group, attempted to exclude losses relating to nanoproducts:

  bodily injury, property damage, and personal and advertising injury related to the exposure of nanotubes or nanotechnology in any form. This includes the use of, consumption of, ingestion of, inhalation of, absorption of, contact with, existence of, presence of, proliferation of, discharge of, dispersal of, seepage of, migration of, release of, escape of, or exposure to nanotubes or nanotechnology.

- It is questionable as to whether the courts would uphold this exclusion as it appears to be vague and ambiguous, and does not adequately describe exactly what is excluded.

218

Many Existing Insurance Policies May Already Cover Nanotechnology

Lloyd's of London has written that nanoparticle toxicity "could impact a suite of liability covers" and that nanotechnology risks could "require the insurer to pay for:

- Clean-up costs of land and water contamination
- Medical costs of treatment of human exposure
- Liability claims from persons directly affected, environmental groups and shareholders
- Unexpected life, health and workers compensation
- Latent liability claims of persons affected
- Business interruption while facility is investigated
- Cost of product recall.

219

Many Existing Insurance Policies May Already Cover Nanotechnology

- Property
  - **if real or personal property becomes permeated with nanoparticles in such a way that the property either cannot be used or loses value, does that constitute property damage**
- CGL
  - **are nano-particles pollutants ? Does the current CGL pollution exclusion apply ?**
  - **Products exception**
- Workers Compensation
- D&O / Professional / Other

220

NAIC

- **According to A.M. Bests, of all the technology risks now emerging, nanotechnology product exposures may be the most similar to asbestos. Inhaling carbon nanotubes could be as harmful as breathing asbestos**.
- The unusual properties that make nanoscale materials attractive may pose unexpected risk that could take years or even decades to surface.
- The expanding use of Nanotechnology in industry and consumer products may be the most important, yet most ignored, emerging issue facing P&C insurers today.

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SECTION VIII:

Ride Sharing, Car Sharing and Slugging

222

Raiser Software Sublicense & Online Services Agreement

Raiser-CA, LLC / Raiser, LLC and
Uber Technologies, Inc.
June 21, 2014

223

Overview

- Raiser is in the business of providing lead generation to transportation providers
- *Raiser does NOT provide transportation services, and is NOT a transportation carrier. In fact, the Company neither owns, leases nor operates any vehicles.*
- You are an independent contractor
- You own or lease and are in lawful possession of a motor vehicle which complies with all federal, state and local laws

224

Overview

- You shall have no obligation to use the Service at any specific time or for any specific duration. You will have complete discretion when you will be available.
- If you accept a request, you must perform according to Users specification. Failure to provide promised services constitutes a material breach.
- Company shall have no right to require you to display Raisers, name, logo or colors or request your driver wear a uniform
- Company has no right to, and shall not, control the manner or prescribe the method you use to perform accepted Requests
- You are an Independent Contractor who: 1) possesses a valid drivers license, 2) and all licenses, permits or other legal pre-requisites necessary to perform rideshare of P2P services as required by the state/localities in which you operate

225

Overview

- You agree that you shall maintain a vehicle that is a model approved by the Company
- Any such vehicle shall be no more than 10 model years old, and shall be in good operating condition
- Prior to executing this agreement you shall provide to the Company a description of each vehicle and a copy of the vehicle registration
- You agree to notify the Company of any changes in your fleet
- You are solely responsible to all costs and expenses incident to our personnel and equipment – ie fuel taxes fees permits
- Any intentional misrepresentation shall deem a material breach of this Agreement

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Insurance Provision

Insurance

Vehicle Insurance. As an express condition of doing business with the Company, and at your sole expense, you agree to maintain current during the life of this Agreement, third-party automobile insurance of the types and amounts specified herein for every vehicle used to perform services under this Agreement. You acknowledge that failure to secure or maintain the third-party automobile insurance of the types or amounts specified herein shall be deemed a material breach of this Agreement and shall result in the immediate suspension of the Agreement and the loss of your right to receive Requests under this Agreement.

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Indemnification

By entering into this Agreement, you agree to defend, indemnify, protect and hold harmless the Company, its licensors and each such party's parent organizations, subsidiaries, affiliates, officers, directors, members, employees, attorneys and agents, from any and all claims, demands, damages, suits, losses, liabilities, expenses (including attorneys' fees and costs), and causes of action arising directly or indirectly from out of or in connection with (a) your actions (or omissions) arising from the performance of services under this Agreement, including personal injury or death to any person (including you and/or your employees); (b) liability for civil and/or criminal conduct (e.g., assault, battery, fraud); (c) any liability arising from your failure to comply with the terms of this Agreement, including with respect to payment of wages, benefits or expenses due your employees, agents, or subcontractors; and (d) your use (or misuse) of the Software or Service.

228

Damage or Injury Claims

You shall be liable to the User for all claims of damage and/or injury to any User sustained while being transported by you. You agree to notify the Company of any damage or injury as soon as practicable after the damage or injury occurs. You understand that insurance may or may not provide coverage for damage or injury, or it may provide coverage for some, but not all, damage or injury.

You agree to fully cooperate with the User and/or the Company to resolve injury or damage claims as quickly as possible. You further acknowledge that, in the event of damage or an insurance claim, the Company may inform your insurance provider, or the insurance provider of any other party involved, of the claim and provide information about your acceptance or performance of a Request at the time of the damage or incident underlying a claim.

You agree that, in the event the Company is held liable for any injury or damage to any person caused by you, the Company shall have the right to recover such amount from you. Similarly, should the Company voluntarily elect to pay any amount owed to any person for damage or injury to that person caused by you or for which you are responsible and/or liable, the Company shall have the same right as the injured party to recover from you (i.e., the Company stands in the shoes of the injured party).

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Relationship of Parties

This Agreement is between two co-equal, independent business enterprises that are separately owned and operated. The Parties intend this Agreement to create the relationship of principal and independent contractor and not that of employer and employee. The Parties are not employees, agents, joint venturers or partners of each other for any purpose.

As an independent contractor, you recognize that you are not entitled to unemployment benefits following termination of the Parties' relationship.

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The following acts or occurrences shall constitute a material breach of this Agreement:

i. Your failure to maintain current insurance coverage in the amounts and types required herein.

ii. Failure by the Company to remit to you all Service Fees due and owing within 30 days of the date the amount became due.

iii. Your refusal to reimburse a User or the Company for any damage or injury caused by you.

iv. Refusal by the Company to provide documentation requested by you reasonably relating to a damage or injury claim arising under this Agreement.

v. Your refusal to fully complete Request after acceptance without waiver by the User or the Company.

vi. Failure by either party to maintain all licenses and permits required by law and/or this Agreement.

vii. Your allowing any other person to access the Software, Service, or Device to receive requests for transportation services, or allowing anyone to log into the Software using your Driver ID.

viii. A major driving violation, such as a citation for reckless driving, while transporting a User.

ix. Your loss of license and/or full driving privileges, or your use of a driver who is not fully and properly licensed and approved by the Company to perform the job offered through the Service.

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x. Intentional misrepresentations by you, your employees, agents or subcontractors to a User or the Company, including intentionally taking an indirect route to the User's specified destination.

xi. Violation by either party of the Intellectual Property Ownership provision of the Agreement.

xii. Documented complaint by a User that you and/or your employee or subcontractor engaged in conduct that a reasonable person would find physically threatening, highly offensive or harassing.

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Arbitration Provision

Important Note Regarding this Arbitration provision:

- Arbitration does not limit or affect the legal claims you may bring against the Company. Agreeing to arbitration only affects where any such claims may be brought and how they will be resolved.
- Arbitration is a process of private dispute resolution that does not involve the civil courts, a civil judge, or a jury. Instead, the parties' dispute is decided by a private arbitrator selected by the parties using the process set forth herein. Other arbitration rules and procedures are also set forth herein.
- Unless the law requires otherwise, as determined by the Arbitrator based upon the circumstances presented, you will be required to split the cost of any arbitration with the Company.
- IMPORTANT: This arbitration provision will require you to resolve any claim that you may have against the Company or Uber on an individual basis pursuant to the terms of the Agreement unless you choose to opt out of the arbitration provision. This provision will preclude you from bringing any class, collective, or representative action against the Company or Uber. It also precludes you from participating in or recovering relief under any current or future class, collective, or representative action brought against the Company or Uber by someone else.

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UBER INSURANCE UPDATE

January 5, 2020

234

Driver insurance built to protect you

When you drive with us, Uber maintains auto insurance on your behalf. We partner with top national auto insurance companies to protect you in the event of a covered accident.

Allstate. You're in good hands.
FARMERS INSURANCE
Liberty Mutual INSURANCE
PROGRESSIVE

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Insurance for rideshare drivers with Uber

Offline or Uber app is off

- Your chosen personal insurance company and coverages apply

Available or waiting for a ride request

Uber maintains the following auto insurance on your behalf in case of a covered accident

Third-party liability if your personal auto insurance doesn't apply[1]

- $50,000 in bodily injury per person
- $100,000 in bodily injury per accident
- $25,000 in property damage per accident

En route to pick up riders and during trips

Uber maintains the following auto insurance on your behalf in case of a covered accident

- $1,000,000 third-party liability
- Uninsured/underinsured motorist bodily injury[2]
- Contingent comprehensive and collision[3]
  - Up to actual cash value of car ($1,000 deductible)

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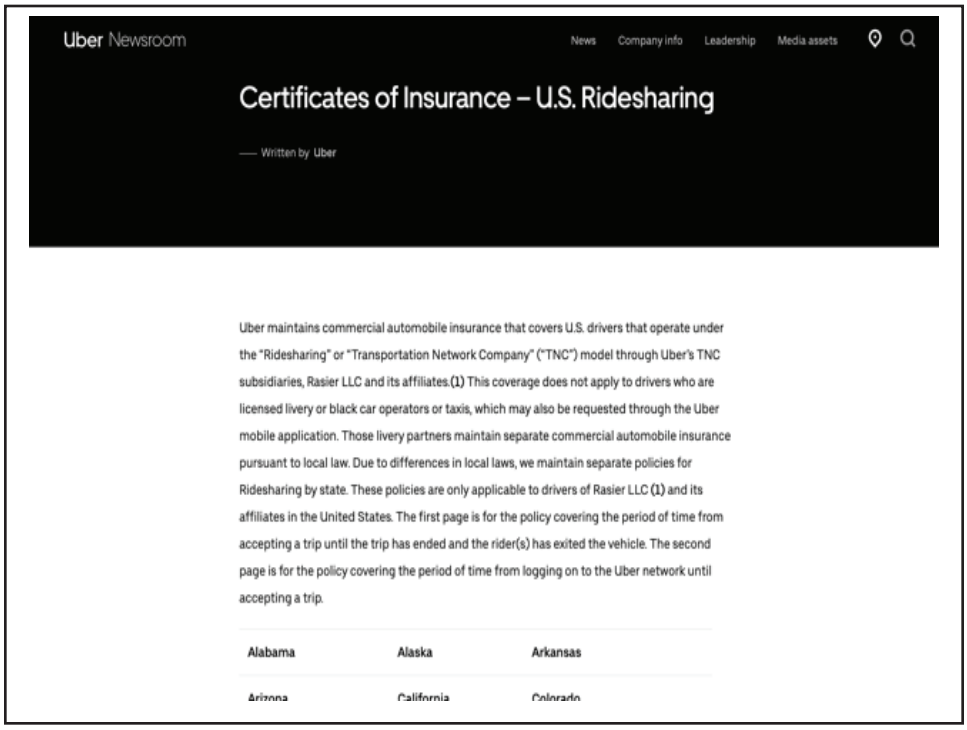

Uber Newsroom

News Company info Leadership Media assets

Certificates of Insurance – U.S. Ridesharing

— Written by Uber

Uber maintains commercial automobile insurance that covers U.S. drivers that operate under the "Ridesharing" or "Transportation Network Company" ("TNC") model through Uber's TNC subsidiaries, Rasier LLC and its affiliates.(1) This coverage does not apply to drivers who are licensed livery or black car operators or taxis, which may also be requested through the Uber mobile application. Those livery partners maintain separate commercial automobile insurance pursuant to local law. Due to differences in local laws, we maintain separate policies for Ridesharing by state. These policies are only applicable to drivers of Rasier LLC (1) and its affiliates in the United States. The first page is for the policy covering the period of time from accepting a trip until the trip has ended and the rider(s) has exited the vehicle. The second page is for the policy covering the period of time from logging on to the Uber network until accepting a trip.

Alabama	Alaska	Arkansas
Arizona	California	Colorado

237

Liability Exclusions
2018 ISO PAP

5. For that "insured's" liability arising out of the ownership or operation of a vehicle while it is being used as a public or livery conveyance. This includes but is not limited to any period of time a vehicle is being used by any "insured" who is logged into a "transportation network platform" as a driver, whether or not a passenger is "occupying" the vehicle.

This exclusion **(A.5.)** does not apply to:

a. A share-the-expense car pool; or

b. The ownership or operation of a vehicle while it is being used for volunteer or charitable purposes.

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PUBLIC or LIVERY Conveyance

What does it mean ?

239

Q & A

- **Coverage for day-care transport ?**

  Our insured provides family day-care in her home. When she is driving the children in her car, would any accident be covered under her personal auto policy, or does she need a commercial policy?

  The personal auto policy will cover your insured's liability for injuries to passengers in her auto, including children for whom she is providing day-care. You need not be concerned over Part A—Liability exclusion (5) directed at "liability arising out of the ownership or operation of a vehicle while it is being used as a public or livery conveyance" (as quoted from the 2005 edition of the ISO Personal Auto Policy). It is not applicable here. **The vehicle is neither rented to the general public (livery) nor rented with a driver (public). The historical intent of this exclusion is to eliminate coverage for taxi, limousine and rental-car operations.**

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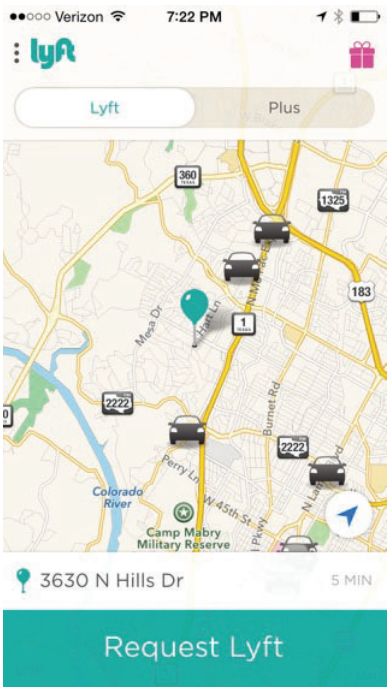
ENDORSEMENTS

Transportation Network Driver Coverage (No Passenger) (PP 23 41)

Phases 1 & 2

Limited Transportation Network Driver Coverage (No Passenger) (PP 23 45)

Phase 1



242

Uber Drivers Directly Soliciting Rides ?

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- A client of mine took her nephew to Austin, TX to look at colleges. She called for an UBER car to get her from the airport to the hotel.
- The car was prompt and the driver courteous.
- When the UBER driver dropped them off at the hotel, he told my client to call him direct at home, and not to use the UBER app, and if my client paid in cash, he could give her a better rate than UBER !!!

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DELIVERY
VS.
LIVERY

245

The Washington Post

Business

Walmart is asking employees to deliver packages on their way home from work

246

2018 ISO PERSONAL AUTO POLICY
Liability Exclusions

EXCLUSIONS

A. We do not provide Liability Coverage for any "insured":

7. Maintaining or using any vehicle while that "insured" is employed or otherwise engaged in any "business" (other than farming or ranching) not described in Exclusion **A.6.**

This exclusion **(A.7.)** does not apply to the maintenance or use of a:

a. Private passenger auto;

b. Pickup or van; or

c. "Trailer" used with a vehicle described in **a.** or **b.** above.

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		Progressive	ISO
Liability	Exclusions—public or livery conveyance	Exclusion also specifically precludes any losses arising from the delivery of magazines, newspapers, food, or any other product.	No specific reference to these delivery services in exclusion.

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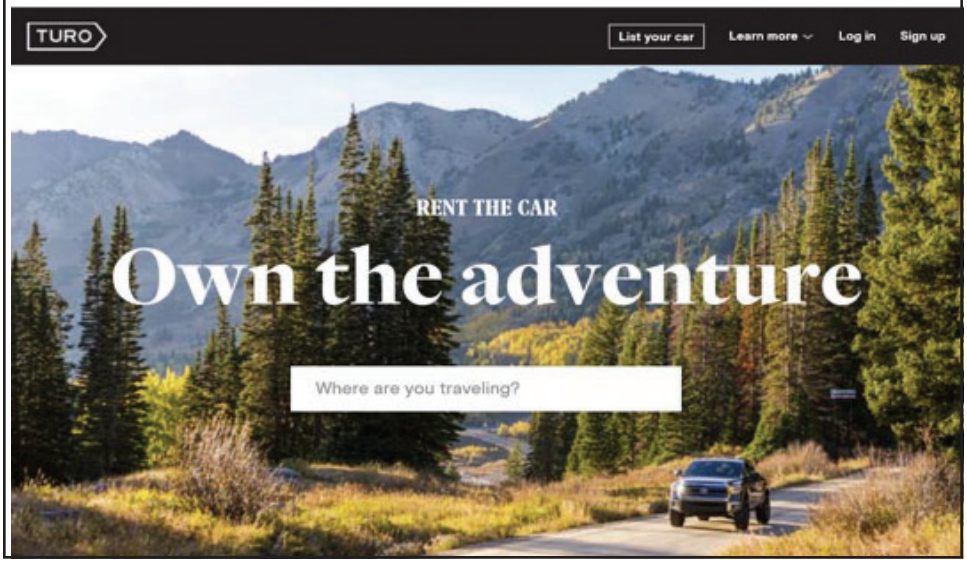
TURO

Formerly Relay Rides



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TURO

Formerly Relay Rides

Fuel an adventure

RENT OUT YOUR CAR, EARN EXTRA CASH

Car collecting dust? Turn that depreciating asset into an earning engine by renting it out to our community of approved drivers.

Your car is covered by our $1 million insurance policy and we'll be here to guide you every step of the way.

List your car | Learn more

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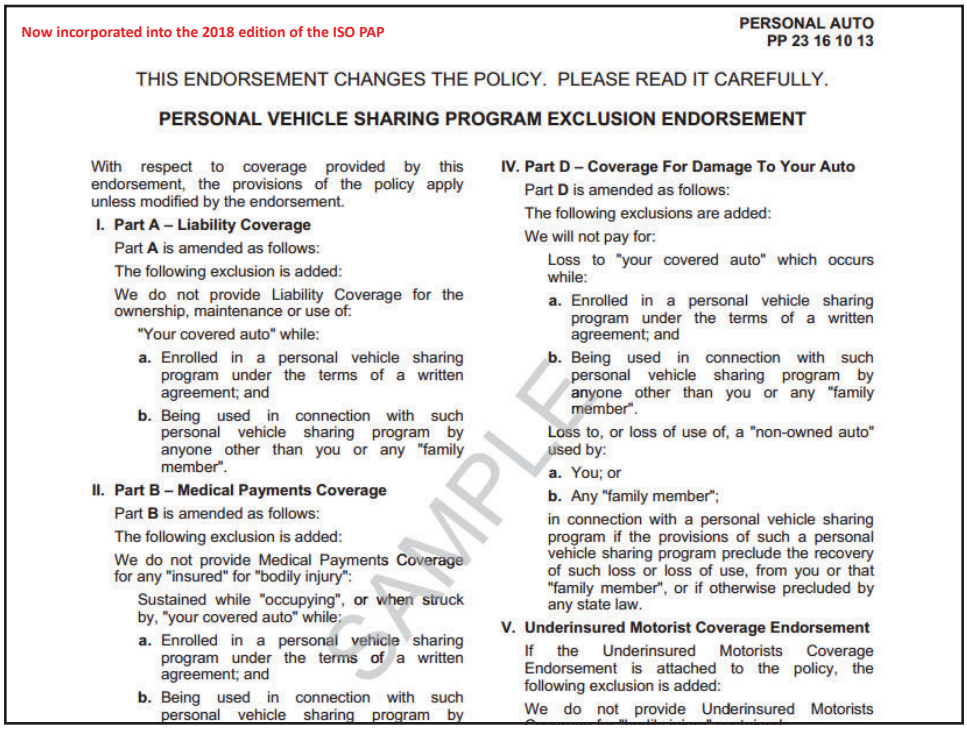

Now incorporated into the 2018 edition of the ISO PAP

PERSONAL AUTO
PP 23 16 10 13

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PERSONAL VEHICLE SHARING PROGRAM EXCLUSION ENDORSEMENT

With respect to coverage provided by this endorsement, the provisions of the policy apply unless modified by the endorsement.

I. Part A – Liability Coverage

Part **A** is amended as follows:

The following exclusion is added:

We do not provide Liability Coverage for the ownership, maintenance or use of:

"Your covered auto" while:

a. Enrolled in a personal vehicle sharing program under the terms of a written agreement; and

b. Being used in connection with such personal vehicle sharing program by anyone other than you or any "family member".

II. Part B – Medical Payments Coverage

Part **B** is amended as follows:

The following exclusion is added:

We do not provide Medical Payments Coverage for any "insured" for "bodily injury":

Sustained while "occupying", or when struck by, "your covered auto" while:

a. Enrolled in a personal vehicle sharing program under the terms of a written agreement; and

b. Being used in connection with such personal vehicle sharing program by

IV. Part D – Coverage For Damage To Your Auto

Part **D** is amended as follows:

The following exclusions are added:

We will not pay for:

Loss to "your covered auto" which occurs while:

a. Enrolled in a personal vehicle sharing program under the terms of a written agreement; and

b. Being used in connection with such personal vehicle sharing program by anyone other than you or any "family member".

Loss to, or loss of use of, a "non-owned auto" used by:

a. You; or

b. Any "family member";

in connection with a personal vehicle sharing program if the provisions of such a personal vehicle sharing program preclude the recovery of such loss or loss of use, from you or that "family member", or if otherwise precluded by any state law.

V. Underinsured Motorist Coverage Endorsement

If the Underinsured Motorists Coverage Endorsement is attached to the policy, the following exclusion is added:

We do not provide Underinsured Motorists

SAMPLE

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Slugging

- Slugging is a term used to describe a unique form of commuting found in the Washington, DC area sometimes referred to as "Instant Carpooling" or "Casual Carpooling". It's unique because people commuting into the city stop to pickup other passengers even though they are total strangers! However, slugging is a very organized system with its own set of rules, proper etiquette, and specific pickup and drop-off locations.
- It has thousands of vehicles at its disposal, moves thousands of commuters daily, and the best part, it’s FREE! Not only is it free, but it gets people to and from work faster than the typical bus, metro, or train. I think you'll find that it is the most efficient, cost-effective form of commuting in the nation.

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How Slugging Works

- The system of slugging is quite simple. A car needing additional passengers to meet the required 3- person high occupancy vehicle (HOV) minimum pulls up to one of the known slug lines. The driver usually positions the car so that the slugs are on the passenger side. The driver either displays a sign with the destination or simply lowers the passenger window, to call out the destination, such as "Pentagon," "L'Enfant Plaza," or "14th & New York." The slugs first in line for that particular destination then hop into the car, normally confirming the destination, and off they go.
- No money is exchanged because of the mutual benefit: the car driver needs riders just as much as the slugs need a ride. Each party needs the other in order to survive. Normally, there is no conversation unless initiated by the driver; usually the only words exchanged are "Thank you" as the driver drops off the slugs at the destination.

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EXCLUSIONS

- ***A. We do not provide <u>Liability Coverage</u> for any "insured":***
  - For that "insured's" liability arising out of the ownership or operation of a vehicle while it is being used as a public or livery conveyance. This includes but is not limited to any period of time a vehicle is being used by any "insured" who is logged into a "transportation network platform" as a driver, whether or not a passenger is "occupying" the vehicle.
    - **This exclusion (A.5.) does not apply to:**
    - **A share-the-expense car pool; or**
    - The ownership or operation of a vehicle while it is being used for volunteer or charitable purposes.

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Car Subscriptions

Insurance Journal

May 4, 2018

CARROLL LACHNIT, Edmunds

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Car Subscriptions Offer Alternative to Purchase, Hold Down Insurance Costs

- People use monthly subscriptions to pay for lots of things they used to buy: music, smartphones, books and even clothes.
- Why not cars?
- That's the thinking behind car subscription services that are cropping up in Los Angeles, San Francisco, the New York metro area, Atlanta, and several other cities in the South and Midwest. For a monthly fee and a minimal commitment, you get a car with a warranty, maintenance, roadside assistance, a prescribed mileage allowance and, typically, insurance.
- Several carmakers have launched subscription services: Access by BMW, Book by Cadillac, Porsche Passport, Care by Volvo, and Canvas, which offers Ford and Lincoln models. Mercedes-Benz's Collection service starts in June.
- Car dealership groups and startup companies also are latching onto the idea. With the exception of Volvo, the cars are not brand new, but with a few exceptions, they are from the current or just-prior model year.
- Only Care by Volvo is available nationally. But companies are expanding their service areas, so if there isn't a program near you now, there might be soon.

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HOW SUBSCRIPTIONS WORK

- Most often, you apply via an app or a website, agree to a check of your driving record, and enter credit card information. Some services also do a "soft" credit check.
- If you're approved, you pay a startup fee of around $500. The monthly fees range from $250 to $3,700, depending on the program and the car. Almost always, a concierge delivers the vehicle you've selected, freshly detailed.

SUBSCRIPTION VARIETIES

- There are variations, but here are three common subscription models:
- "Flip" services: These allow car changes, sometimes unlimited, within a month. When the programs are run by a carmaker, such as BMW, Cadillac, Porsche or Mercedes-Benz, you choose from that company's vehicles. When they're run by a dealership group or startup, you have access to cars from different makers. Monthly costs range from $800 or more in dealership programs to $3,700 for BMW's highest tier: its M performance vehicles.
- One-car services: This is Care by Volvo's approach. It offers an all-inclusive two-year lease for the forthcoming 2019 Volvo XC40 at a cost of $600 or $700 per month, depending on the trim level. That includes insurance and maintenance. When the redesigned 2019 Volvo V60 debuts, it also will be available through a subscription. Lexus has said it will offer its UX subcompact crossover SUV through a subscription when the car debuts later this year.
- "Stay awhile" services: Canvas and Fair, two California-based startups, offer pricing that makes cars more affordable if you stay in them longer. Monthly prices start at around $400 for Canvas, assuming a one-year subscription. If you picked a shorter duration for your subscription, the monthly price goes up. Fair's cars start at around $235 per month with a start-up fee that's about 2.5 times that of the monthly fee, making a subscription more cost effective if the start-up fee is spread over a longer period of time.

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- **COMPARING COSTS**
- Since services and users vary so much, there's no universal answer as to whether subscriptions are cheaper than buying or leasing.
- Take, for instance, the difference between subscribing and leasing a 2017 Cadillac Escalade. Book by Cadillac charges $1,800 a month to its subscribers plus a $500 sign-up fee. For that, you'd get 2,000 miles a month and could change cars up to 18 times a year. If you were to lease the same vehicle, your monthly payment would be $1,500 plus the $500 sign-up fee, assuming the same 2,000 miles per month. But you would also have to pay for insurance, which by one Edmunds' estimate would add another $375 to your monthly tab.
- The winner? Book by Cadillac.
- Now take the difference between subscriptions versus buying used. We chose a 2015 Ford Escape in the Titanium trim level from Canvas, with 1,250 miles allotted per month. For a one-year subscription, the monthly cost worked out to $580, including taxes. That compares with $461 per month to buy a comparable certified pre-owned 2015 Escape, assuming a five-year, zero-down loan, plus $240 per month for insurance by one Edmunds' estimate, for a total monthly cost of $701.
- The winner in this scenario in terms of monthly payments is Canvas. On the other hand, if you had financed the Escape, you'd own it at the end of five years.
- EDMUNDS SAYS: If you want a car with a minimal commitment, a subscription can make sense. Run the numbers and read the fine print before you sign up.

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The Lowest Bidder

It is unwise to pay too much, but it is worse to pay too little. When you pay too much, you lose a little money—that is all. When you pay too little, you sometimes lose everything, because the thing you bought is incapable of doing what it was bought to do. The common law of business balance prohibits paying a little and getting a lot—it can't be done. If you deal with the lowest bidder, it is well to add something extra for the risk you run. And if you do that, you will have enough to pay for something better"

John Ruskin (1819-1900)

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James K. Ruble Seminar

a proud member of The National Alliance for Insurance Education & Research

Section 4

Innovations in Long-Term Care Funding with Life Insurance

Innovations in Long-Term Care Funding with Life Insurance

Presented by

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Innovations in Long-Term Care Funding with Life Insurance

Learning Objectives:

1 The "Long Term Care" dilemma - *trading "dying too young for suffering too long"*.

2 The role played by the State and Federal Government concerning the funding of a Long Term Care / Skilled Nursing setting.

- Medicare

- Medicaid

3 The Long Term Care Insurance contract (LTCI) - coverage, options and underwriting.

4 Innovations with permanent and term life insurance concerning funding for chronic illness and Long-Term Care events.

Notes	To Do

DISCLAIMER

Insurance policy forms, clauses, rules, court decisions, and laws change constantly. Policy forms and underwriting rules vary from company to company. This outline is intended as a general guideline and may not apply in each and every situation.

For any matters of legal and/or tax issues one should consult with competent counsel or advisor for the matter in question and in the jurisdiction in question.

This speaker, and any organization for whom this program is conducted shall have neither liability nor responsibility to any person or entity with respect to any loss or damage alleged to be caused directly or indirectly as a result of the information contained in this outline.

I. The "Long Term Care" dilemma - *trading "dying too young for suffering too long"*

A. The Problems that many American families face today

1. The "ageing problem"

a. Mortality vs. morbidity

b. Your chances of needing advanced care at older ages

2. The "Problem with Modern Medicine" in the United States

a. Americans are not dying-off like they once did and many are receiving care from their family (The "Sandwich Generation")

b. Social Security - Age 65

3. The "Family Flight Problem"

a. Consider how your grandparents lived

(1) They – and their children – usually lived, worked and raised a family in the general area where they were born

(a) It is very rare to see this demographic make-up today

b. **Might this be a snapshot of today's families?** - *Mom & Dad raised their family in Syracuse. They retired and moved to Tampa years ago. Dad passed away a few years back. Mom is now having some significant medical issues, and beginning to have problems caring for herself. The daughter lives in Boston, one son lives in Buffalo and the other son lives in Atlanta*.

Notes

To Do

Selected Long-Term Care Stats (see Pages 59-62 for additional stats and their sources)

- Annually 8,357,100 people receive support from the 5 main long-term care services; home health agencies (4,742,500), nursing homes (1,383,700), hospices (1,244,500), residential care communities (713,300) and adult day service centers (273,200). The numbers will rise dramatically in the future as modern medicine are keeping Americans alive longer with chronic conditions. [Updated February 2021]
- Most, but not all persons in need of long-term care are elderly. Approximately 63% are persons aged 65 and older (6.3 million); the remaining 37% are 64 years of age and younger (3.7 million).
- The lifetime probability of becoming disabled in at least two activities of daily living ***or*** of being cognitively impaired is 68% for people age 65 and older.
- By 2050, the number of individuals using paid long-term care services in any setting (e.g., at home, residential care such as assisted living, or skilled nursing facilities) will likely double from the 13 million using services in 2012, to 27 million people. This estimate is influenced by growth in the population of older people in need of care.

U. S. Life Expectancy

Year	Male	Female
1900	48	51
1920	56	58
1940	63	67
1960	68	74
1980	71	78
2000	75	80

* Age rounded to nearest whole number

Source: http://www.infoplease.com/ipa/A0005140.html

The Sandwich Generation

- **Traditional:** those sandwiched between aging parents who need care and/or help and their own children.
- **Club Sandwich:** those in their 50s or 60s, sandwiched between aging parents, adult children and grandchildren. OR, those in their 30s and 40s, with young children, aging parents and grandparents.
- **Open Faced:** anyone else involved in elder care.

(**Source of Definitions:** sandwichgeneration.com)

Interesting Fact: For every person in a nursing home there are 6 receiving home health care. (U.S. Census Bureau, Economic Census, 2011)

B. **What are the sites where care can be rendered should an unfortunate Long Term Care need arise?**

1. Various sites

   a. Your Home, or the personal residence of another person

      (1) Is a competent family-member care giver available?

      (2) Numerous private providers exist

   b. The Skilled Nursing Facility (SNF)

   c. The Assisted Living Facility (ALF)

      (1) One must be able to preform at some least minimal Activities of Daily Living to be eligible to reside in an ALF

   d. Other sites

2. Pros and Cons for the various sites

   a. Availability

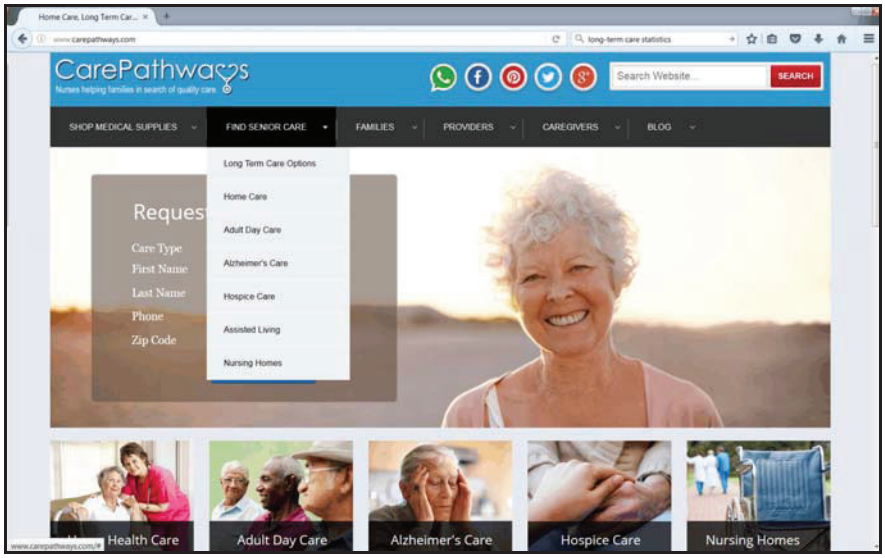
   b. Convenience

   c. Competent care givers

   d. Cost

Notes

To Do



CarePathways.com – a good site for reviewing nursing home and assisted living facilities.

USCare.com - a excellent web-sites for research on LTC trends, legislation and current events.

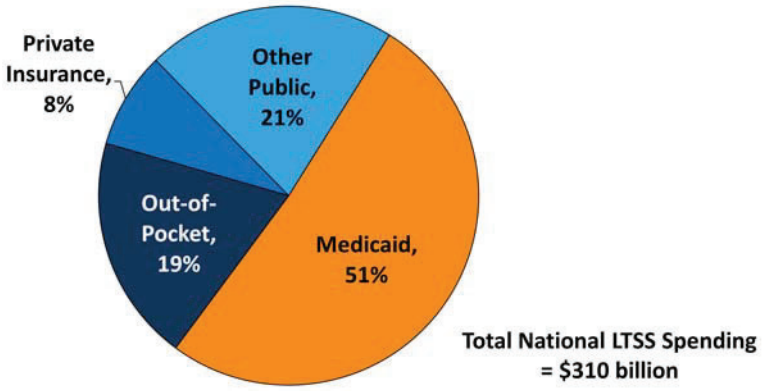
NYSPLTC.org - Reviews NY rules concern "Partnership Plans". Has a map showing cost by regions of the state.

Elderlawanswers.com - Excellent site for research regarding Medicaid rules by state.

KFF.org - and great site to search health care information and statistics.

Figure 3

Medicaid is the Primary Payer for Long-Term Services and Supports (LTSS), 2013



NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care ($74.1 billion in 2013). All home and community-based waiver services are attributed to Medicaid.
SOURCE: KCMU estimates based on CMS National Health Expenditure Accounts data for 2013.

THE HENRY J. KAISER FAMILY FOUNDATION

C. **What is the approximate cost for care at the various sites**?

1. The Nursing Home

    a. Associations and Internet sites for research

2. The Assisted Living Facility (approximately ½ to ⅔ the cost of a Skilled Nursing Home in the same geographic area)

    a. Associations and Internet sites for research

3. The private home of the person needing care

    a. Associations and Internet sites for research

    b. It is possible it is the home of an adult child or other relative

    c. **NOTE:** The cost of care in a private residence ***MAY*** be the highest cost of all

4. Breakdown of "who pays now"? (see chart on page 6)

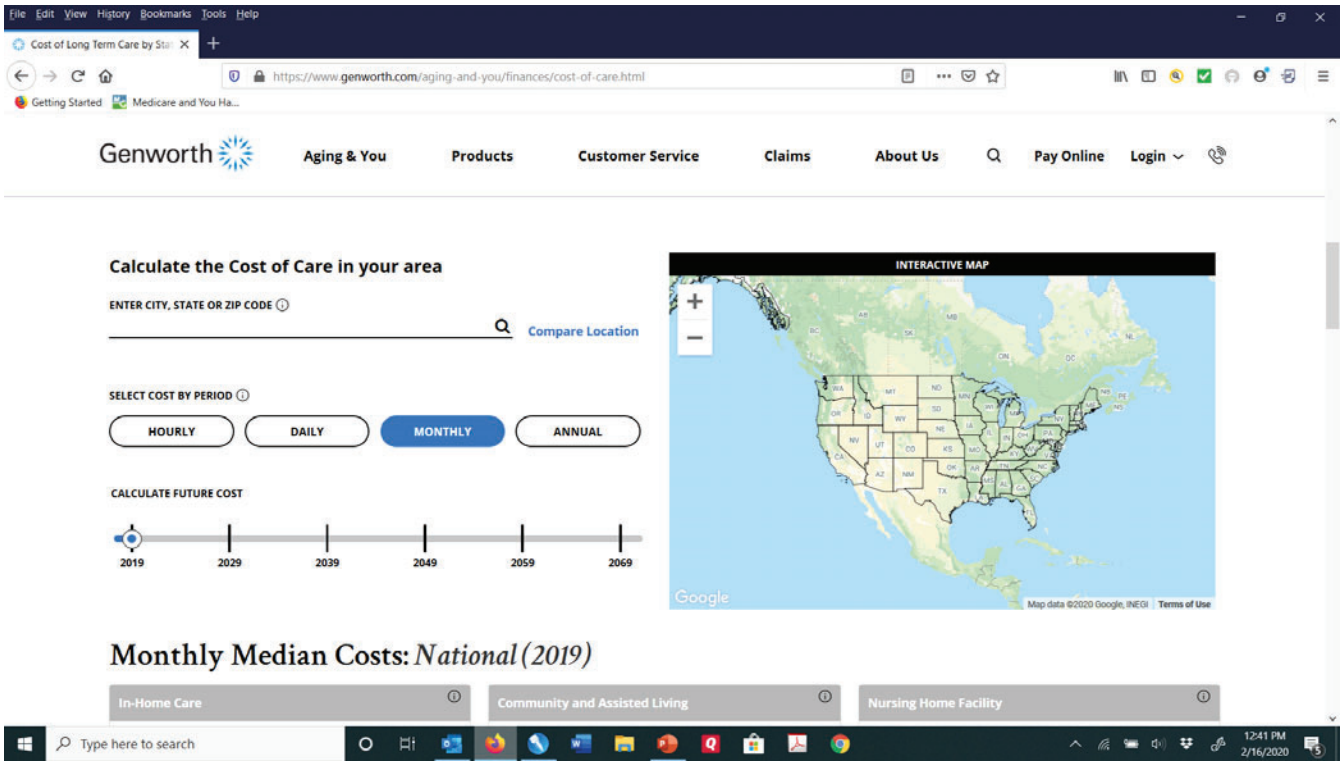
    a. Out-of-pocket - including the family (Cash, Savings, Retirement Plans, Reverse Mortgage, Senior Life Settlements, etc.)

    b. The Government (Medicare and or Medicaid)

    c. Insurance (LTCI)

    d. Other sources (retirement benefit with some companies, church or religious organizations, etc.)

Notes	To Do



https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html (2019 LTC Study)

Semi-Private Room at a Skilled Nursing Facility - 2022 CA State Average: $288 day / $8,760 month / $105,120 annual CO State Average: $269 day / $8,197 month / $98,368 annual FL State Average: $278 day / $8,547 month / $102,565 annual IL State Average: $195 day / $5,931 month / $71,175 annual NY State Average: $400 day / $12,166 month / $146,000 annual SC State Average: $234 day / $7,123 month / $85,472 annual	

D. **An LTC "event" - The Affects on the "Family"**

1. Who is really the "family"?

2. Immediate and extended members

   a. Keep in mind it is not only the person needing the care who will be place under an emotional, physical and financial strain that could be experienced for several years

   b. Some may help greatly and other may not (or can not)

E. **What is the "cost" of such care to the family?**

1. Financial

   a. Where will the money come from and how much is needed? (Savings, investment, reverse mortgage, retirement assets, etc., of the person needing care)

      (1) Money contributed by the adult children

      (2) With cost of care ranging from $20,000 -$30,000 per year (assistance at home or a low-end Assisted Living Facility) to over $100,000 (high-end Nursing Home in some areas) it will not take long to deplete a life's savings!

         (a) If the asset is real estate or a family business consider the "buyer's market vs seller's market" scenario when the need arises

2. Emotional / stress / mental / physical

   a. Virtually impossible to place a dollar figure

Notes	To Do

Where Do Your Parents Live? FILIAL

'Filial responsibility laws' in 29 states can potential force adult children to be financially responsible for their parent's care. Currently, 29 states have filial responsibility laws. Rencently, the state of PA made an adult child (son) responsible for his mother's $93,000 nursing home bill.

Alaska	Arkansas	California	Connecticut	Delaware
Georgia	Idaho	Indiana	Iowa	Kentucky
Louisiana	Maryland	Massachusetts	Mississippi	Montana
Nevada	N. Hampshire	New Jersey	N. Carolina	N. Dakota
Ohio	Oregon	Pennsylvania	Rhode Island	S. Dakota
Tennessee	Utah	Vermont	Virginia	W. Virginia

What is the definition of FILIAL? – 1) pertaining to, or befitting a son or daughter. 2) pertaining to the sequence of generations following the parental generation.

A Mom and Dad can (and will) care for four children. But can (and will) four grown children care for Mom and / or Dad?

II. The role played by the State and Federal Government concerning the funding of a Long Term Care / Skilled Nursing setting

A. MEDICARE

1. What is the basic intent of Medicare regarding an LTC situation?

a. Let's see what Medicare says:

(1) While there are a variety of ways to pay for long-term care, it is important to think ahead about how you will fund the care you get. **Generally, Medicare doesn't pay for long-term care.** Medicare pays only for medically necessary skilled nursing facility or home health care. However, you must meet certain conditions for Medicare to pay for these types of care. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. **Medicare doesn't pay for this type of care called "custodial care".** Custodial care (non-skilled care) is care that helps you with activities of daily living. It may also include care that most people do for themselves, for example, diabetes monitoring. You may have to pay some of the costs. (Source: Medicare website)

(2) Last year, about nine million men and women over the age of 65 needed long-term care. By 2025, 12 million older Americans will need long-term care. Most will be cared for at home; family and friends are the sole care-givers for 70 percent of the elderly. A study by the U.S. Department of Health and Human Services shows that people who reach age 65 will likely have greater than a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will stay there five years or more. (Source: Medicare website)

Notes	To Do

Medicare.gov

Key Medicare Definitions:

- ❒ **Skilled Nursing Care** - A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

- ❒ **Custodial Care** - Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare does not pay for custodial care.

2. History and Background of Medicare's role in LTC

    a. The official website - **http://www.medicare.gov/**

    b. The History of Medicare in the United States
    http://www.ssa.gov/history/corningintro.html

3. Defining rules and purpose of Medicare as it relates to LTC

    a. Short term

    b. Rehabilitation

    c. Continually improving

B. **How does a person qualify for Medicare as it relates to a stay in a Skilled-Nursing Facility?**

1. 3 days in a hospital

2. Must enter an approved Rehabilitation Facility (or Nursing Facility) within 30 days of being discharged from the hospital. A written treatment and Rehabilitation plan must be written by a physician and approved by Medicare.

3. Skilled care and continually improving

4. No cost for first 20 days. After day 21 and until day 100 there is a $200.00 per day deductible (2023).

5. After day 100 there is no coverage available under Medicare

Notes	To Do
	Medicare's payout facts concerning a Long Term Care need: 1. The beneficiary must be confined to a hospital for 3 consecutive days. 2. The beneficiary must enter an approved Medicare facility (and receive SKILLED care) within 30 days of the original hospital discharge. 3. If approved, Medicare will pay 100% of the cost for the first 20 days. 4. For Medicare's payment to continue, the beneficiary must "continually be improving". 5. If the beneficiary continues to meet all requirements after the first 20 days, Medicare continues to pay, but there is a $200.00 daily deductible (2023) until day 100, then Medicare pays nothing. **NOTE:** The above are national numbers and national rules. They do no vary by state.

C. **How does Medicare respond regarding a person requiring an LTC need?**

1. Medicare Nursing Home requirement rules

    a. **Skilled care** for the chronically ill or disability

2. Medicare “at-home” requirement rules

    a. Various degrees of therapy provided

    b. Certain necessary equipment

3. Understanding what Medicare will **not** provide in an LTC situation

    a. No coverage for ...

        (1) Long term needs (over 100 days)

        (2) Care other than “skilled care” in a facility

        (3) Most care needs at home (nursing/ in-home caregiver, meals, cleaning, etc.)

Notes	To Do

Medicare's Home Health Benefit

elderlawanswers.com

If you qualify, Medicare will cover your home health benefits entirely and with no limit on the length of time you are covered.

Medicare home health benefits can mean the difference between you or a family member continuing to stay at home, or your health deteriorating until hospital care or nursing home placement become necessary. But due to changes made as part of the Balanced Budget Act of 1997, home health benefits are being denied Medicare patients in more and more cases.

You are entitled to Medicare coverage of your home health care if you meet the following requirements:

- you are confined to your home (meaning that leaving it to receive services would be a "considerable and taxing effort"):
- your doctor has ordered home health services for you; and
- at least some element of the services you receive are "skilled" (intermittent skilled nursing care, physical therapy or speech therapy).

What you get: If you need an element of "skilled" care, then you will also be entitled to Medicare coverage of social services, part-time or intermittent home health aide services, and necessary medical supplies and durable medical equipment. You can receive up to 35 hours of services a week, although few beneficiaries actually get this level of service. You are entitled to the same level of services whether you are a member of an HMO or are enrolled in traditional fee-for-service Medicare.

What you pay: Nothing, with the exception of 20 percent of the cost of medical supplies and equipment, which is covered by some Medigap policies.

While the government insists that it has not changed the criteria for who is eligible for home care services, home health agencies have inevitably cut back on services they provide in order to make their own budgets balance.

What you can do: All this means that Medicare recipients must advocate for the services they need. If you have to appeal a termination of service, the good news is that most people who appeal Medicare home health benefits win their cases. At the first level of review, 39 percent are successful, and on appeal to an administrative law judge, 81 percent are successful. The bad news is that you have to pay privately for the care in order to have an appealable issue. This is because the issue on appeal is not the termination of a service, but the denial of Medicare payment for the service. As a result, many beneficiaries simply try to make do without the care or hire help on their own without the training and supervision provided by home health agencies.

Most Medicare beneficiaries are not informed of their appeal rights when given notice that their home health care benefits will be terminated. Attorneys have filed a nationwide class action suit on behalf of homebound seniors seeking advance notice of any termination of benefits for Medicare home health coverage, as well as notice of the ability to appeal such a denial before the termination occurs. If your benefits or those of a family member are reduced or terminated, you should take the following steps:

1. Ask your home health agency to explain the cutback and write down its answer. Ask the agency to give you written notice of the cutback or termination of service.

2. Ask your physician to call the agency to urge it not to cut back the services and to provide a letter verifying the level of care you need. This can be essential to whether you ultimately receive the benefits you deserve.

3. Consult your attorney or a Medicare assistance agency in your state to determine whether you likely would be successful on appeal.

4. If you decide to appeal, do so immediately, and arrange with the home health agency to pay privately for the services pending the result of the appeal.

D. **Medicare Supplement Insurance**

1. What is the basic intent of these insurance contracts?

   a. Fill the "gaps" in coverage from Medicare (Part A or B)

      (1) Most coverage is "following form" language

2. Some Medicare Supplement owners feel they need no less than a 100 day wait for their Long Term Care Insurance

   a. This can be seriously "Flawed Thinking" as Medicare (followed by the Supplement Plan) will only provide and pay in the LTC facility if:

      (1) If you stayed minimum of three (3) days in a hospital,

      (2) You received Skilled Care in the "rehabilitation facility", and,

      (3) You are "Continually Improving".

3. How do these contracts respond to an LTC need?

   a. Nursing Home

      (1) Only if approved by Medicare

   b. Assisted Living Facility or at Home

      (1) No coverage (this is not Skilled Care)

12 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS – 2023												
CORE BENEFITS	**A**	**B**	**C**	**D**	**E**	**F***	**G**	**H**	**I**	**J**	**K**	**L**
Part A Hospital (Days 61-90)	X	X	X	X	X	X	X	X	X	X	X	X
Lifetime Reserve (Days 91-150)	X	X	X	X	X	X	X	X	X	X	X	X
365 Life Hospital Days - 100%	X	X	X	X	X	X	X	X	X	X	X	X
Parts A and B Blood	X	X	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance - 20%	X	X	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Skilled Nursing Facility Coinsurance (Days 21-100)			X	X	X	X	X	X	X	X	50%	75%
Part A Deductible		X	X	X	X	X	X	X	X	X	50%	50%
Part B Deductible			X			X				X		
Part B Excess Charge						100%	80%		100%	100%		
Foreign Travel Emergency			X	X	X	X	X	X	X	X		
At-Home Recovery				X			X		X	X		

Core Benefits pay the patient's share of Medicare's approved amount for physician services (20%) after $226 annual deductible, the patient's cost of a long hospital stay ($400/day for days 60-90, $800/day for days 91-150 [2023], all approved cost not paid by Medicare after day 150 to a total of 365 days lifetime), and charges for the first 3 pints of blood not covered by Medicare. Part A In-Patient 2023 deductible is $1,600.

Prescription drugs: As of January 1, 2006, a person can not buy a Medicare Supplement Policy with prescription drug coverage. If a plan was purchased with this coverage prior to 01-01-2006, the contract must decide if they wish to keep that specific coverage.

Each of the 12 plans has a letter designation ranging from “A” through “L”. Insurance companies are **not** permitted to change these designations or to substitute other names or titles. They may, however, add names or titles to these letter designations. While companies are not required to offer all of the plans approved for sale by the individual states, they all must make Plan A available if they sell any of the other plans in a state. **NOTE:** Some plans changed June 01, 2010.Starting June 1, 2010, the types of Medigap Plans that can be purchased will change: There will be two new Medigap Plans offered—Plans M and N. Plans E, H, I, and J will no longer be available to buy. If a person purchased Plan E, H, I, or J before June 1, 2010, it may be retained. * Plan “J” is no longer available starting 2020.

Non-covered items (*partial listing)*:

- Adult diapers
- Bathroom safety equipment
- Hearing aides
- Syringes/needles
- Van lifts or ramps
- Exercise equipment
- Humidifiers/Air Purifiers
- Raised toilet seats
- Massage devices
- Stair lifts
- Emergency communicators
- Low Vision Aides
- Grab bars

Source: http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf

E. **MEDICAID**

1. What is “Medicaid” and its basic intent?

2. How does a person qualify for Medicaid?

a. The State Application form

(1) Basic requirements

b. The rules and specific number vary by state, but there are two “test” that must be passed:

(1) **INCOME RULES TEST**

(a) What is (and is not) “income” under Medicaid’s rules?

(b) How is Social Security income viewed under Medicaid?

(2) **ASSET RULES TEST**

(a) The “things” you own (land, savings accounts, CDs, personal assets, money in qualified plans, etc.)

Notes

Medicaid Qualification For a Long-Term Care stay - FL (2023)

- Maximum Monthly Income (Single Individual) - $2,465*
- Medicaid takes all income in excess of $65 per month
- Married Couple - Complicated rules / numbers

* - in FL the numbers change July 1st of each year

Medicaid – 2023

Countable Assets	Exempt Assets
Bank Accounts, CD's	Home ★
Stocks, Bonds, Mutual Funds	One Auto
Retirement Accounts, IRAs	Household Goods
Income on Vacation Property	Personal Effects
Revocable Living Trust	Pre-Paid Burial Funds
Boats, Motors Home	Certain Life Insurance ★

Spend Down to $2000

Interesting Fact: Over 60 percent of all nursing home residents receive Medicaid benefits that help pay for their care.
(Source: Quickguides.org)

To Do

How Can Life Insurance Affect My Medicaid Qualification

In order to qualify for Medicaid, you can't have more than $2,000 in assets (in most states). Many people forget about life insurance when calculating their assets, but depending on the type of life insurance and the value of the policy, it can count as an asset. Life insurance policies are usually either "term" life insurance or "whole" life insurance. If a Medicaid applicant has term life insurance, it doesn't count as an asset and won't affect Medicaid eligibility because this form of life insurance does not have an accumulated cash value. On the other hand, whole life insurance accumulates a cash value that the owner can access, so it can be counted as an asset. That said, Medicaid law exempts small whole life insurance policies from the calculation of assets. If the policy's face value is less than $1,500, then it won't count as an asset for Medicaid eligibility purposes. However, if the policy's face value is more than $1,500, the cash surrender value becomes an available asset. For example, suppose a Medicaid applicant has a whole life insurance policy with a $1,500 death benefit and a $700 cash surrender value (the amount you would get if you cash in the policy before death). The policy is exempt and won't be used to determine the applicant's eligibility for Medicaid. However, if the death benefit is $1,750 and the cash value is $700, the cash surrender value will be counted toward the $2,000 asset limit.

If you have a life insurance policy that may disqualify you from Medicaid, you have a few options:

- Surrender the policy and spend down the cash value.
- Transfer ownership of the policy to your spouse or to a special needs trust. If you transfer the policy to your spouse, the cash value would then be part of the spouse's community resource allowance.
- Transfer ownership of the policy to a funeral home. The policy can be used to pay for your funeral expenses, which is an exempt asset.
- Take out a loan on the cash value. This reduces the cash value and the death benefit, but keeps the policy in place.

Source: Elderlawanswers.com

Introduction to Medicaid (- Elderlawanswers.com)

Medicaid (called "Medi-Cal" in California and "MassHealth" in Massachusetts) is a joint federal-state program that provides health insurance coverage to low-income children, seniors and people with disabilities. In addition, it covers care in a nursing home for those who qualify. In the absence of any other public program covering long-term care, Medicaid has become the default nursing home insurance of the middle class.

As for home care, Medicaid offers very little except in New York, which provides home care to all Medicaid recipients who need it. Recognizing that home care costs far less than nursing home care, more and more states are providing Medicaid-covered services to those who remain in their homes.

While Congress and the federal Centers for Medicare and Medicaid Services (CMS) set out the main rules under which Medicaid operates, each state runs its own program. As a result, the rules are somewhat different in every state, although the framework is the same throughout the country.

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Resource (Asset) Rules

These are general federal guidelines. The specific rules in your state may differ somewhat.

In order to be eligible for Medicaid benefits a nursing home resident may have no more than $2,000 in "countable" assets (the figure may be somewhat higher in some states).

The spouse of a nursing home resident--called the "community spouse" -- is limited to one half of the couple's joint assets up to $119,220 (in 2016) in "countable" assets (see Medicaid, Protections for the Healthy Spouse). This figure changes each year to reflect inflation. In addition, the community spouse may keep the first $25,000 (this is the approximate amount in 2016 since it varies substantially by state), even if that is more than half of the couple's assets. This figure is higher in some states, even up to the full maximum of $119,220 (in 2016). All assets are counted against these limits unless the assets fall within the short list of "noncountable" assets. These include the following:

- Personal possessions, such as clothing, furniture, and jewelry
- One motor vehicle is excluded, regardless of value, as long as it is used for transportation of the applicant or a household member. The value of an additional automobile may be excluded if needed for health or self-support reasons. (Check your state's rules.)
- The applicant's principal residence, provided it is in the same state in which the individual is applying for coverage (the states vary in whether the Medicaid applicant must prove a reasonable likelihood of being able to return home). Under the Deficit Reduction Act of 2005 (DRA), principal residences may be deemed noncountable only to the extent their equity is less than $552,000, with the states having the option of raising this limit to $828,000 (in 2016). In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there
- Prepaid funeral plans and a small amount of life insurance
- Assets that are considered "inaccessible" for one reason or another

The Home

Depending on the state, nursing home residents do not have to sell their homes in order to qualify for Medicaid. But as noted above, under the DRA principal residences may be deemed noncountable only to the extent their equity is less than $552,000, with the states having the option of raising this limit to $786,000. In some states, the home will not be considered a countable asset for Medicaid eligibility purposes as long as the nursing home resident intends to return home; in other states, the nursing home resident must prove a likelihood of returning home. In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there.

The Transfer Penalty

The second major rule of Medicaid eligibility is the penalty for transferring assets. Congress does not want you to move into a nursing home on Monday, give all your money to your children (or whomever) on Tuesday, and qualify for Medicaid on Wednesday. So it has imposed a penalty on people who transfer assets without receiving fair value in return. These restrictions, already severe, have been made even harsher by enactment of the DRA.

This penalty is a period of time during which the person transferring the assets will be ineligible for Medicaid. The penalty period is determined by dividing the amount transferred by what Medicaid determines to be the average private pay cost of a nursing home in your state.

Example: For example, if you live in a state where the average monthly cost of care has been determined to be $5,000, and you give away property worth $100,000, you will be ineligible for benefits for 20 months ($100,000 /

$5,000 = 20).

Another way to look at the above example is that for every $5,000 transferred, an applicant would be ineligible for Medicaid nursing home benefits for one month. In theory, there is no limit on the number of months a person can be ineligible.

Example: The period of ineligibility for the transfer of property worth $400,000 would be 80 months ($400,000 / $5,000 = 80).

However, for transfers made prior to enactment of the DRA on February 8, 2006, state Medicaid officials will look only at transfers made within the 36 months prior to the Medicaid application (or 60 months if the transfer was made to or from certain kinds of trusts). But for transfers made after passage of the DRA the so-called “lookback period” for all transfers is 60 months.

The second and more significant major change in the treatment of transfers made by the DRA has to do with when the penalty period created by the transfer begins. Under the prior law, the 20-month penalty period created by a transfer of $100,000 in the example described above would begin either on the first day of the month during which the transfer occurred, or on the first day of the following month, depending on the state. Under the DRA, the 20-month period will not begin until (1) the person making the transfer has moved to a nursing home, (2) he has spent down to the asset limit for Medicaid eligibility, (3) has applied for Medicaid coverage, and (4) has been approved for coverage but for the transfer.

For instance, if an individual transfers $100,000 on April 1, 2015, moves to a nursing home on April 1, 2016, and spends down to Medicaid eligibility on April 1, 2017, that is when the 20-month penalty period will begin, and it will not end until December 1, 2018.

Exceptions to the Transfer Penalty

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. These exempt recipients include the following:

- A spouse (or a transfer to anyone else as long as it is for the spouse's benefit)
- A blind or disabled child
- A trust for the benefit of a blind or disabled child
- A trust for the sole benefit of a disabled individual under age 65 (even if the trust is for the benefit of the Medicaid applicant, under certain circumstances).

In addition, special exceptions apply to the transfer of a home. The Medicaid applicant may freely transfer his or her home to the following individuals without incurring a transfer penalty:

- The applicant's spouse
- A child who is under age 21 or who is blind or disabled
- Into a trust for the sole benefit of a disabled individual under age 65 (even if the trust is for the benefit of the Medicaid applicant, under certain circumstances)
- A sibling who has lived in the home during the year preceding the applicant's institutionalization and who already holds an equity interest in the home
- A "caretaker child," who is defined as a child of the applicant who lived in the house for at least two years prior to the applicant's institutionalization and who during that period provided care that allowed the applicant to avoid a nursing home stay.

Congress has created a very important escape hatch from the transfer penalty: the penalty will be "cured" if the transferred asset is returned in its entirety, or it will be reduced if the transferred asset is partially returned. However, some states are not permitting partial returns. Check with your attorney.

Is Transferring Assets Against the Law?

You may have heard that transferring assets, or helping someone to transfer assets, to achieve Medicaid eligibility is a crime. Is this true? The short answer is that for a brief period it was, and it's possible, although unlikely under current law, that it will be in the future.

As part of a 1996 health care bill, Congress made it a crime to transfer assets for purposes of achieving Medicaid eligibility. Congress repealed the law in 1997, but replaced it with a statute that made it a crime to advise or counsel someone for a fee regarding transferring assets for purposes of obtaining Medicaid. This meant that although transferring assets was again legal, explaining the law to clients could have been a criminal act.

In 1998, Attorney General Janet Reno determined that the law was unconstitutional because it violated the 1st Amendment protection of free speech, and she told Congress that the Justice Department would not enforce the law. Around the same time, a U.S. District Court judge in New York said that the law could not be enforced for the same reason. Accordingly, the law remains on the books, but it will not be enforced. Since it is possible that these rulings may change, you should contact your elder law attorney before filing a Medicaid application.

Treatment of Income

The basic Medicaid rule for nursing home residents is that they must pay all of their income, minus certain deductions, to the nursing home. The deductions include a $60-a-month personal needs allowance (this amount may be somewhat higher or lower in particular states), a deduction for any uncovered medical costs (including medical insurance premiums), and, in the case of a married applicant, an allowance for the spouse who continues to live at home if he or she needs income support. A deduction may also be allowed for a dependent child living at home.

In some states, known as "income cap" states, eligibility for Medicaid benefits is barred if the nursing home resident's income exceeds $2,199 a month (for 2016), unless the excess above this amount is paid into a "(d)(4)(B)" or "Miller" trust. If you live in an income cap state and require more information on such trusts, consult an elder law specialist in your state.

For Medicaid applicants who are married, the income of the community spouse is not counted in determining the Medicaid applicant's eligibility. Only income in the applicant's name is counted in determining his or her eligibility. Thus, even if the community spouse is still working and earning $5,000 a month, she will not have to contribute to the cost of caring for her spouse in a nursing home if he is covered by Medicaid.

Protections for the Healthy Spouse

The Medicaid law provides special protections for the spouse of a nursing home resident to make sure she has the minimum support needed to continue to live in the community.

The so-called "spousal protections" work this way: if the Medicaid applicant is married, the countable assets of both the community spouse and the institutionalized spouse are totaled as of the date of "institutionalization," the day on which the ill spouse enters either a hospital or a long-term care facility in which he or she then stays for at least 30 days. (This is sometimes called the "snapshot" date because Medicaid is taking a picture of the couple's assets as of this date.)

In general, the community spouse may keep one half of the couple's total "countable" assets up to a maximum of @118,000 (in 2016 - varies by state). Called the "community spouse resource allowance," this is the most that a state may allow a community spouse to retain without a hearing or a court order. The least that a state may allow a community spouse to retain is @$25,000 (in 2016).

Example: If a couple has $100,000 in countable assets on the date the applicant enters a nursing home, he or she will be eligible for Medicaid once the couple's assets have been reduced to a combined figure of $52,000 -- $2,000 for the applicant and $50,000 for the community spouse.

Some states, however, are more generous toward the community spouse. In these states, the community spouse may keep up to @$118,000 (in 2016), regardless of whether or not this represents half the couple's assets. Example: If the couple had $100,000 in countable assets on the "snapshot" date, the community spouse could keep the entire amount, instead of being limited to half.

In all circumstances, the income of the community spouse will continue undisturbed; he or she will not have to use his or her income to support the nursing home spouse receiving Medicaid benefits. But what if most of the couple's income is in the name of the institutionalized spouse, and the community spouse's income is not enough to live on? In such cases, the community spouse is entitled to some or all of the monthly income of the institutionalized spouse. How much the community spouse is entitled to depends on what the Medicaid agency determines to be a minimum income level for the community spouse. This figure, known as the minimum monthly maintenance needs allowance or MMMNA, is calculated for each community spouse according to a complicated formula based on his or her housing costs. The MMMNA may range from a low of @$2,000 to a high of @$3,000 a month (in 2016). If the community spouse's own income falls below his or her MMMNA, the shortfall is made up from the nursing home spouse's income.

Example: Mr. and Mrs. Smith have a joint income of $3,000 a month, $1,700 of which is in Mr. Smith's name and $700 is in Mrs. Smith's name. Mr. Smith enters a nursing home and applies for Medicaid. The Medicaid agency determines that Mrs. Smith's MMMNA is $2,000 (based on her housing costs). Since Mrs. Smith's own income is only $700 a month, the Medicaid agency allocates $1,300 of Mr. Smith's income to her support. Since Mr. Smith also may keep a $60 a month personal needs allowance, his obligation to pay the nursing home is only $340 a month ($1,700 - $1,300 - $60 = $340).

In exceptional circumstances, community spouses may seek an increase in their MMMNAs either by appealing to the state Medicaid agency or by obtaining a court order of spousal support.

Estate Recovery and Liens

Under Medicaid law, following the death of the Medicaid recipient a state must attempt to recover from his or her estate whatever benefits it paid for the recipient's care. However, no recovery can take place until the death of the

recipient's spouse, or as long as there is a child of the deceased who is under age 21 or who is blind or disabled.

While states must attempt to recover funds from the Medicaid recipient's probate estate, meaning property that is held in the beneficiary's name only, they have the option of seeking recovery against property in which the recipient had an interest but which passes outside of probate. This includes jointly held assets, assets in a living trust, or life estates. Given the rules for Medicaid eligibility, the only probate property of substantial value that a Medicaid recipient is likely to own at death is his or her home. However, states that have not opted to broaden their estate recovery to include non-probate assets may not make a claim against the Medicaid recipient's home if it is not in his or her probate estate.

In addition to the right to recover from the estate of the Medicaid beneficiary, state Medicaid agencies must place a lien on real estate owned by a Medicaid beneficiary during her life unless certain dependent relatives are living in the property. If the property is sold while the Medicaid beneficiary is living, not only will she cease to be eligible for Medicaid due to the cash she would net from the sale, but she would have to satisfy the lien by paying back the state for its coverage of her care to date. The exceptions to this rule are cases where a spouse, a disabled or blind child, a child under age 21, or a sibling with an equity interest in the house is living there.

Whether or not a lien is placed on the house, the lien's purpose should only be for recovery of Medicaid expenses if the house is sold during the beneficiary's life. The lien should be removed upon the beneficiary's death. However, check with an elder law specialist in your state to see how your local agency applies this federal rule.

Summary of the New Medicaid Rules (the DRA)

On February 8, 2006 President Bush signed into law the Deficit Reduction Act of 2005 (DRA), which cuts nearly $40 billion over five years from Medicare, Medicaid, and other programs. Of greatest interest to the elderly and their families, the law placed severe new restrictions on the ability of the elderly to transfer assets before qualifying for Medicaid coverage of nursing home care.

The DRA made significant changes to Medicaid's long-term care rules, including the look-back period; the transfer penalty start date; the undue hardship exception; the treatment of annuities; community spouse income rules; home equity limits; the treatment of investments in continuing care retirement communities (CCRCs); promissory notes and life estates; and state long-term care partnership programs.

Following is a brief summary of the Medicaid laws before and after enactment of the DRA in these areas. Also, bear in mind that states are gradually coming into compliance with the new transfer rules. For the status of the rules in your state, check with a qualified elder law attorney there. (To find an attorney in your state, click here.)

The Look-Back Period

A person applying for Medicaid coverage of long-term care must disclose all financial transactions he or she was involved in during a set period of time--frequently called the "look-back period." The state Medicaid agency then determines whether the Medicaid applicant transferred any assets for less than fair market value during this period. Congress does not want a person to be able to give away all of their assets one day and then qualify for public benefits the next.

The DRA extends Medicaid's "look-back" period for all asset transfers from three to five years. Previously, the agency reviewed transfers made within 36 months of the Medicaid application (60 if the transfer was to or from certain kinds of trusts). Now, the look back period for all transfers is 60 months. The extension of the look-back period will make the application process more difficult and could result in more applicants being denied for lack of documentation, given that they will need to produce five years worth of records instead of three.

The Penalty Period Start Date

The penalty period is the period during which a Medicaid applicant is ineligible for Medicaid payment for long term care services because the applicant transferred assets for less than fair market value during the look-back period.

Before the DRA, the penalty period began either when the transfer was made or on the first day of the following month. It was possible for the penalty period to expire before the individual actually needed nursing home care. The DRA changes the start of the penalty period to the date when the individual transferring the assets enters a nursing home and would otherwise be eligible for Medicaid coverage but for the transfer. In other words, the penalty period does not begin until the nursing home resident is out of funds and has no money to pay the nursing home for however long the penalty period lasts.

This change could have negative consequences for both nursing homes and residents. Nursing homes would be on the hook for the care of residents waiting out extended penalty periods. If nursing homes end up flooded with residents who need care but have no way to pay for it, they will begin looking for alternatives. In states that have so-called "filial responsibility laws," nursing homes may seek reimbursement from the residents' children. These

rarely-enforced laws, which are on the books in 30 states, hold adult children responsible for financial support of indigent parents and, in some cases, medical and nursing home costs.

In addition, some states have passed laws providing that if a transfer occurs within 5 years of a Medicaid application, the state can assume the transfer was made to establish Medicaid eligibility and can retrieve the value of the Medicaid care services from the person who received the property.

Home Equity Limits

Before the DRA's enactment an individual could still qualify for long-term care services even if he or she had substantial assets in his or her home. Under the DRA, states will not cover long-term care services for an individual whose home equity exceeds $552,000, although states have the option of increasing this equity limit to $828,000. In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there.

Change in Community Spouse Income Rules

The DRA requires all states to follow the "income-first" rule for supplementing a community spouse's income. For more on this, click here.

The Treatment of Annuities

The DRA added requirements for disclosing immediate annuities, which have been useful long-term care planning tools. In its simplest form, an immediate annuity is a contract with an insurance company under which the consumer pays a certain amount of money to the company and the company sends the consumer a monthly check for the rest of his or her life or a prescribed time period.

An immediate annuity can be used to convert assets into an income stream for the benefit of an institutionalized Medicaid applicant or the applicant's spouse. The state will not treat the annuity as an asset countable toward Medicaid's asset limit ($2,000 in most states plus up to @$118,000 for the healthy spouse) as long as the annuity complies with certain requirements. The annuity must be: (1) irrevocable the annuitant cannot take funds out of the annuity except for the monthly payments, (2) non-transferable the annuitant cannot be able to transfer the annuity to another beneficiary, and (3) actuarially sound - the payment term cannot be longer than the annuitant's life expectancy and the total of the anticipated payments have to equal the cost of the annuity.

To these requirements, the DRA added an additional requirement. The state must be named the remainder beneficiary of any annuities up to the amount of Medicaid benefits paid on the nursing home resident's behalf. If the Medicaid recipient is married or has a minor or disabled child, the state must be named as a secondary beneficiary. The Medicaid application must now also inform the applicant that if he or she obtains Medicaid benefits, the state automatically becomes a beneficiary of the annuity.

In addition, all annuities must be disclosed by an applicant for Medicaid regardless of whether the annuity is irrevocable or treated as a countable asset. If an individual, spouse, or representative refuses to disclose sufficient information related to any annuity, the state must either deny or terminate coverage for long-term care services or else deny or terminate Medicaid eligibility.

Promissory Notes and Life Estates

Prior to the DRA's enactment, a Medicaid applicant could show that a transaction was an (uncountable) loan to another person rather than (countable) gift by presenting promissory notes, loans, or mortgages at the time of the Medicaid application. A promissory note is normally given in return for a loan and it is simply a promise to repay the amount. Classifying transfers as loans rather than gifts is useful because it allows parents to "lend" assets to their children and still maintain Medicaid eligibility.

Congress considered this to be an abusive planning strategy, so the DRA imposes restrictions on the use of promissory notes, loans, and mortgages. In order for a loan to not be treated as a transfer for less than fair market value it must satisfy three standards: (1) the term of the loan must not last longer than the anticipated life of the lender, (2) payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments, (3) and the debt cannot be cancelled at the death of the lender. If these three standards are not met, the outstanding balance on the promissory note, loan, or mortgage will be considered a transfer and used to assess a Medicaid penalty period.

Prior to the DRA's passage, another common estate planning technique was for an individual to purchase a life estate (a legal right to live in and possess a property) in the home of another person, such as a child. By doing this, the individual was able to pass assets to his or her children without triggering a transfer penalty. The DRA still allows the purchase of a life estate in another person's home, but to avoid a transfer penalty the individual purchasing the life estate must actually reside in the home for at least one year after the purchase.

Notes	To Do

3. **Single and Married Couples** rules for Medicaid qualification

   c. Income / Asset

   d. "Spend-Down"

   e. "Community spouse" (the "well-spouse")

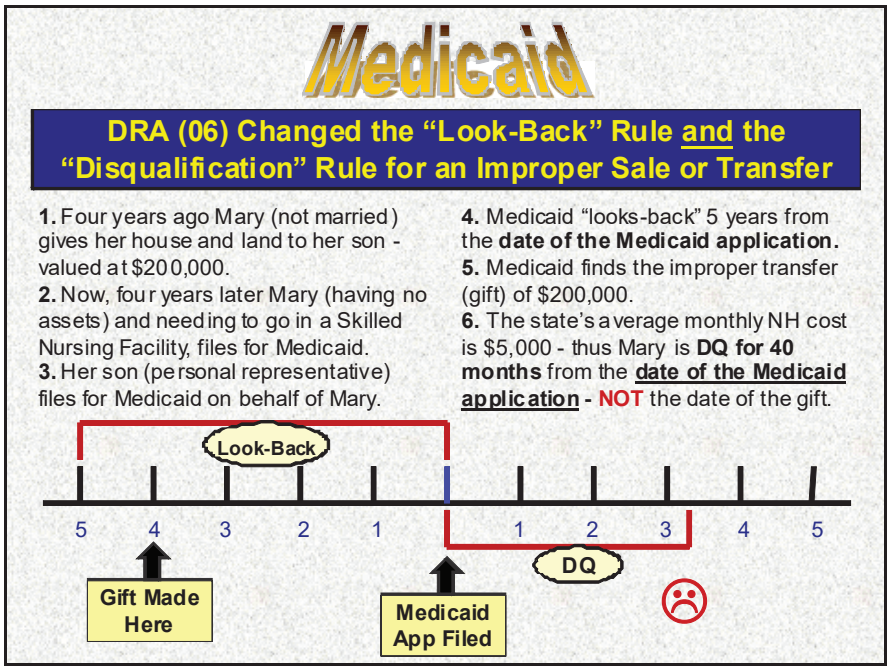
   f. "Institutionalized spouse" (the "sick-spouse")

3. Federal law changes - **Deficit Reduction Omnibus Reconciliation Act of 2005** (DRA - effective 02/07/2006)

   a. 60 months "look-back" rule concerning transfer of assets to another person (or entity, such as a trust) or sold for below-market value.

      (1) When does the "look-back" period begin? - At the time of application.

      (2) What if a person is "disqualified" for violation of transfer rule ... when does the qualification time-frame begin? At the time of application ... not the time of the gift!



Notes

Basic Medicaid Math

Bill and Sue

$2,000 / $65 $120,000 CS

Asset	Value	Keep
House	100,000	100,000
CDs, Savings, MuFund	50,000	-0-
IRA / Retirement (Bill)	200,000	-0-
IRA / Retirement (Sue)	150,000	120,000
Bill's Life Ins (CV)	10,000	-0-
Vacant Lot	25,000	-0-
	535,000	220,000

$315,000

Medicaid

- **Monday** – you have $200,000
- **Tuesday** – you move into a Nursing Home
- **Wednesday** – you give your $200,000 to your children
- **Thursday** – you try to qualify for Medicaid because you are "poor"!

Medicaid

- Assume your state's average Nursing Home monthly cost is $5,000
- Gift / transfer was $200,000
- Divide the transfer ($200,000) by the average NH cost ($5,000) and this will give the number of months (40) the applicant must WAIT before being eligible for Medicaid.

To Do

"I'll just giving away my assets to my kids so I can become *POOR-ON-PAPER* under Medicaid's rules."

- The "Look-Back" period (60 months)
- The Disqualification Penalty

It's already bad news for Medicaid. The most recent analysis of Medicaid expenditures found that:

☹ Only 7% of Medicaid beneficiaries are using long-term care services

☹ But this accounts for 52% of total Medicaid expenditures

Source: Kaiser Family Foundation - 2015

III. The Long Term Care Insurance contract (LTCI) - coverage, options and underwriting

A. Background of the LTCI marketplace

1. History of “nursing-home insurance”

2. Evolution of LTCI

3. Current trends in coverage, contract language and pricing (see comments on page 30)

B. Coverage options found in today’s LTCI contracts

1. Activities of Daily Living (ADL) **OR** Cognitive Impairment - (standard ‘coverage trigger’ as per HIPPA)

2. Dollar limits

    a. Written on a Daily, Weekly, or Monthly benefit basis

3. Waiting period options

    a. Difference in pricing - the long the waiting period, the lower the cost

4. Riders or optional “add-ons”

    a. Benefits and pricing

5. Indemnity vs Reimbursement

6. Issue ages (minimum & maximum)

Notes

Recent LTC Innovations and Trends

Ambulance Expense	Guaranteed Benefit Increase
Assisted Living Facility	Joint Waiver of Premium
Bed Reservation (30-50 days)	Issued to age 84
Care Giver Training	Lump-Premium Discount
Daily/ Weekly/ Monthly Benefit	Outside US Coverage
Drug Benefit	Policy Sharing Benefit
Endorsement Discount	Rate Guarantees (10 yr & longer)
Equipment Benefit	Single Pool of Benefit Money

The Cost of Waiting to Purchase LTC
— Assume Age 65 at 100% Premium —

Age	Cost	Age	Cost
53	33%	67	123%
54	36%	68	135%
55	39%	69	150%
56	42%	70	167%
57	46%	71	186%
58	50%	72	206%
59	55%	73	231%
60	61%	74	259%
61	67%	75	291%
62	74%	76	328%
63	81%	77	375%
64	90%	78	428%
65	**100%**	79	491%
66	111%	80	558%

LTC Claim Triggers

- ADL
  - * Eating
  - * Dressing
  - * Bathing
  - * Toileting
  - * Transferring
  - * Continence

Any 2 of 6

* OR, Cognitive Impairment

To Do

Indemnity vs. Reimbursement

Many Long-Term Care insurance carriers are currently going through substantial changes in contract language, riders and pricing structure. The LTCI marketplace - which can provide long-term funding for those that experience various critical and chronic medical conditions - has seen many carriers abandon the sale of the product in the last 10 years or so. Of those that remain, many have increased the renewal premiums for their in-force contracts. Pricing for new sales have also see an increase. Increasing claims (far exceeding what was projected, by some carriers), and poor return-on-investment have triggered the erosion of the marketplace and pressure on increase pricing.

C. LTC Insurance (Policy Forms – Trends – Innovations) (Individual / Non-Group)

1. John Hancock - Custom Care (NOTE: This product is no longer written as "new business")

   a. Purchase a **Daily Benefit** (minimum of $50 - maximum of $500, in $10 increments), or **Monthly Benefit** (minimum of $1,500 - maximum of $15,000, in $100 increments) based on current age, sex, state of residency and medical history (issue age 18-84).

      (1) Nursing Home Benefit, Assisted Living Facility Benefit, and Home Health Care Benefit are all covered at 100% of the "single pool of money" benefit.

   b. **Waiting (or Elimination) Period:** (30, 60, 90, 180, 365 days)

      (1) Rates are (+20/+10/+0/-10/-20%) of base rates for 30/60/90/180/365 respectively.

   c. **Benefit Period: (**2, 3, 4 , 5, 6, 10 years or Lifetime)

   d. **Discounts:** @ 21½% "Partner Discount". Available only for "Select Rates".

   e. Traditional **ADL** (**2 of 6 ADLs for Nursing Home or for HHC**) *or* **Cognitive Impairment** "trigger" to activate coverage.

   f. Standard policy benefits (no additional premium): **Respite Care, Bed Hold, Care Advisory, Stay at Home Benefit, Upgrade Privilege,** and **waiver of Premium**.

   g. See the corresponding page for a reprint of the Agents FACT Sheet.

John Hancock - Custom Care ™ Long Term Care Insurance

Benefit Trigger
* 2 of 6 ADL's
* Hands-on or standby assistance
* Cognitive impairment
* Standardized tests
* 90 Day certification

Policy Limit - 1 pool of money

Issue Ages
* 18-84
* 80-84 restricted benefits

Maximum Benefits - daily/weekly/monthly

LTC Benefit Amount:
Covers NH, ALF, ADC, Home Care, and Hospice Care

LTC Benefit Amount Options:

1. **Monthly**
* $1,500 to $15,000 for ages 18-79
* $1,500 to $7,500 for ages 80-84
* in $100 increments

2. **Daily Benefits**
* $50 to $500 for ages 18-79
* $50 to $250 for ages 80-84
* in $10 increments

Benefit Periods
2, 3, 4▲, 5▲, 6▲, or 10▲ yrs, or Lifetime.
▲ options not available for ages 80-84

Elimination Periods
* 30▲, 60▲, 90, 180 or 365 days
* True cumulative EP, days do not need to be consecutive or within same claim
* 1-7=7. i.e. At least one day of HHC in a week equals 7 days towards EP
* Base rates include the 90 day EP
* Rates are (+20/+10/+0/-10/-20%) of base rates for 30/60/90/180/365 respectively.
▲options not available for ages 80-84

Inflation Options
* 5% Compound
* 5% Simple
* Guaranteed Purchase Option
* Increase = 5, 10 or 15% of original LTC Benefit amount. Offered every 3 years if no benefits have been paid within past 2 years and PH is < = 91
* Default if inflation not chosen
* None (for limited pay, Family Care or employer-pay all situations)
* All inflation may be dropped

Nursing Home Benefits
* Part of LTC benefit
* 100% of actual NH Facility charges are covered, up to the LTC Benefit Amount
* All benefits will be deducted from this one LTC Benefit Amount

Assisted Living Facilities Benefit
* Part of the LTC benefit
* 100% of actual ALF charges are covered, up to the LTC Benefit Amount
* All benefits will be deducted from this one LTC Benefit Amount

Home Health Care Benefit
* Part of the LTC benefit
* 100% of HHC services are covered, up to the LTC Benefit Amount
* Service covered include: Adult Day Care, Professional Care in your home, Hospice Care services, and Incidental homemaker services
* All benefits will be deducted from this one LTC Benefit pool.

Respite Care Benefits
* Monthly Option: Respite Care = up to 21 days times 1/30th of the LTC benefit amount per calendar year
* Daily Option: Respite Care = up to 21 days at the LTC benefit amount per calendar year
* Not subject to nor does it satisfy the EP. (Weeks in which respite care is received do not count toward EP.)
* Reduces policy limit
* After the EP, respite care is paid under the LTC benefit

Bed Hold Benefit
* Part of LTC benefit amount
* Covers 60 days of bed-hold per calendar year
* Any reason
* Subject to EP
* Reduces policy limit

Care Advisory Services
* Monthly: Care Advisory: actual charges up to 1/3 of LTC (monthly) benefit amount per calendar year
* Daily: Care Advisory: actual charges up to 10x the LTC benefit per calendar year
* Not subject to nor does it satisfy the EP
* Will not reduce policy limit

Stay at Home Benefit
* "Stay at home benefit" pays for home modifications, emergency alert systems, home safety check, caregiver training, provider care check designed to enable a claimant to remain at home
* **Monthly:** Separate lifetime pool equal to 1 times the Monthly LTC Benefit
* **Daily:** Separate lifetime pool equal to 30 times the Daily LTC Benefit
* Not subject to nor does it satisfy the EP

Upgrade Privilege
* Provisions in contract to offer an upgrade if PH is eligible
* Reserved the right to use attained age rates and underwriting required
* Must meet issue requirements under new product and no benefits have been paid under the current policy
* Any refusal may impact the availability of future offers

Waiver of Premium
* After EP is met and while benefits are payable
* See also Survivor Waiver and Waiver of EP for HHC Riders

Exclusions
This policy does not cover care, treatment, or charges:
* For intentionally self-inflicted injury
* Required as a result of alcoholism or drug addiction (unless the drug addiction was a result of the administration of drugs as part of treatment by a physician)
* Due to war (declared or undeclared) or any act or war, or service in any of the armed forces or auxiliary units
* Due to participation in a felony, riot, or insurrection
* Normally not made in the absence of insurance
* Provided by a member of your immediate family, unless:
* The family member is one of the following professionals: a duly licensed registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, licensed social worker, or registered dietician;
* The family member is a regular employee of an organization (e.g., nursing home, assisted living facility, adult day care center, or home health care agency) which is providing the services;
* The organization receives the payment for the services; and
* The family member receives no compensation other than the normal compensation for employees in his or her job category
* Provided outside the 50 United States and the District of Columbia, except as described in the International Coverage section of the policy

International Coverage
* Paid on reimbursement basis up to 75% of the LTC benefit amount
* All services covered except Stay at Home, Respite Care & Care Advisory
* No restrictions on countries, but it is up to the policyholder to provide acceptable proof
* If the 10-Year or lifetime BP is elected, benefits paid outside the U.S. will be limited to a 6 year BP

Nonforfeiture
* If the client stops paying their premium after the third year, the past premiums will still be available to pay for services.
* Contingent NF will be automatically included in the policy in the event that traditional NF is declined

Limited Pay Options (Varies by state)
* 10 pay, paid up at age 65
* Guaranteed renewable during premium paying period, non-cancelable after
* Not available with GPO
* Paid-up to 65 only available to ages up to 55

Partners
A partner is defined as:
* a spouse of a married couple
* same sex or opposite sex partners that have lived together for 5 years
* family members of the same generation that have lived together for 5 years

2. **Sample LTCI illustration of a major carrier**

    a. Illustration options

3. **Different carriers and how they market to contract**

    a. Traditional policy form

        (1) Usually reimbursement (most offer indemnity option for additional premium) with life time premium payment

        (2) The contract are “guaranteed renewal”

            (a) Premium can increase if uniformly adjusted for everyone in the policy class and approved by the state DOI

            (b) Restrictive riders (or contract language) can never be added once the contract is issued

    b. Limited pay contracts

        (1) Single pay / 10 year pay

    c. Life insurance with an LTC rider or Living Benefit (discussed later)

Premium Illustration

Presented by: Jerry Rhinehart

Benefit Selection	**Custom Care**	**Custom Care**
State	Florida	Florida
Name	Paul Warren	Judy Warren
Age	66	64
Risk Class	Preferred	Preferred
LTC Benefit Amount [1]	$140 Daily	$140 Daily
Benefit Period	5 Years	5 Years
Policy Limit	$255,500	$255,500
Elimination Period	90 Days	90 Days
Inflation Option	5% Compound	5% Compound
Stay at Home Benefit	$4,200	$4,200
Total Base Annual Premium:	$3,020.22	$2,651.08

Optional Benefit Riders [2]

Total Optional Rider Annual Premium

Discount [3](Partner)	$710.64	$623.78
Payment Type	Life Pay	Life Pay

Premium Payment Options [4]	**Total Modal Premium**	**Total Annual Cost of Premium**	**Total Modal Premium**	**Total Annual Cost of Premium**
Annual	$2,309.58	$2,309.58	$2,027.30	$2,027.30
Semi-Annual	$1,200.98	$2,401.96	$1,054.20	$2,108.40
Quarterly	$612.04	$2,448.16	$537.23	$2,148.92
Bank Draft - Monthly only	$207.86	$2,494.32	$182.46	$2,189.52

	Total Combined Premium	**Total Modal Premium**	**Total Annual Cost of Premium**
Annual		$4,336.88	$4,336.88
Semi-Annual		$2,255.18	$4,510.36
Quarterly		$1,149.27	$4,597.08
Bank Draft - Monthly only		$390.32	$4,683.84

Tax-qualified Long Term Care Insurance policy premiums may be deductible from income. Please consult with your tax advisor.

1 Subject to increases due to inflation coverage.
2 Available at an additional cost. Premiums will vary with choice of benefits selected.
3 Discounts are calculated on Select rates.
4 Please note that the more often you pay, the higher your premium amount will be per year.

This illustration is a general description of coverage and is not a contract.

Policy Option Spreadsheet - *Premium rates of different plans based on the LTC Benefits selected in the original illustration.*

Presented by: Jerry Rhinehart
State: Florida
Name: Paul Warren
Age: 66

LTC Benefit: $140 Daily

Inflation Option	Elimination Period	Benefit Period 3 Years	4 Years	5 Years	6 Years	10 Years
5% Compound	30 Days	$2,125	$2,402	$2,772	$3,018	$3,449
	60 Days	$1,948	$2,202	$2,541	$2,766	$3,162
	90 Days	$1,771	$2,002	$2,310	$2,515	$2,874
	180 Days	$1,594	$1,801	$2,079	$2,263	$2,587
5% Simple	30 Days	$1,786	$2,063	$2,310	$2,464	$2,741
	60 Days	$1,637	$1,891	$2,117	$2,258	$2,512
	90 Days	$1,488	$1,719	$1,925	$2,053	$2,284
	180 Days	$1,340	$1,547	$1,732	$1,848	$2,056
GPO	30 Days	$1,170	$1,324	$1,509	$1,632	$1,848
	60 Days	$1,073	$1,214	$1,383	$1,496	$1,694
	90 Days	$975	$1,103	$1,257	$1,360	$1,540
	180 Days	$878	$993	$1,132	$1,224	$1,386

Rates include optional benefit premiums and discounts selected in the original illustration.
Subject to increases due to inflation coverage.
Discounts are calculated on Select rates.
Please note that the more often you pay, the higher your premium amount will be per year.

This illustration is a general description of coverage and is not a contract.

Premium Illustration

Presented by: Jerry Rhinehart

Benefit Selection	**Custom Care**	**Custom Care**
State	Florida	Florida
Name	Paul Warren	Judy Warren
Age	66	64
Risk Class	Preferred	Preferred
LTC Benefit Amount [1]	$4,200 Monthly	$4,200 Monthly
Benefit Period	5 Years	5 Years
Policy Limit	$252,000	$252,000
Elimination Period	90 Days	90 Days
Inflation Option	5% Compound	5% Compound
Stay at Home Benefit	$4,200	$4,200
Total Base Annual Premium:	$3,213.00	$2,820.30

Optional Benefit Riders [2]

Total Optional Rider Annual Premium

Discount [3](Partner)	$756.00	$663.60
Payment Type	Life Pay	Life Pay

Premium Payment Options [4]	**Total Modal Premium**	**Total Annual Cost of Premium**	**Total Modal Premium**	**Total Annual Cost of Premium**
Annual	$2,457.00	$2,457.00	$2,156.70	$2,156.70
Semi-Annual	$1,277.64	$2,555.28	$1,121.48	$2,242.96
Quarterly	$651.11	$2,604.44	$571.53	$2,286.12
Bank Draft - Monthly only	$221.13	$2,653.56	$194.10	$2,329.20

	Total Combined Premium	**Total Modal Premium**	**Total Annual Cost of Premium**
Annual		$4,613.70	$4,613.70
Semi-Annual		$2,399.12	$4,798.24
Quarterly		$1,222.64	$4,890.56
Bank Draft - Monthly only		$415.23	$4,982.76

Tax-qualified Long Term Care Insurance policy premiums may be deductible from income. Please consult with your tax advisor.

1 Subject to increases due to inflation coverage.
2 Available at an additional cost. Premiums will vary with choice of benefits selected.
3 Discounts are calculated on Select rates.
4 Please note that the more often you pay, the higher your premium amount will be per year.

This illustration is a general description of coverage and is not a contract.

4. **Company, State and Federal requirements**

a. General underwriting procedures by the insurance carriers

(1) What is the normal underwriting process?

(2) Is the underwriting process different from life or health insurance?

(a) Personal interview

(3) Medical requirements by the carriers

(4) Handling impaired risk

b. **"Snap-shot" of the typical LTCI contract sold today**

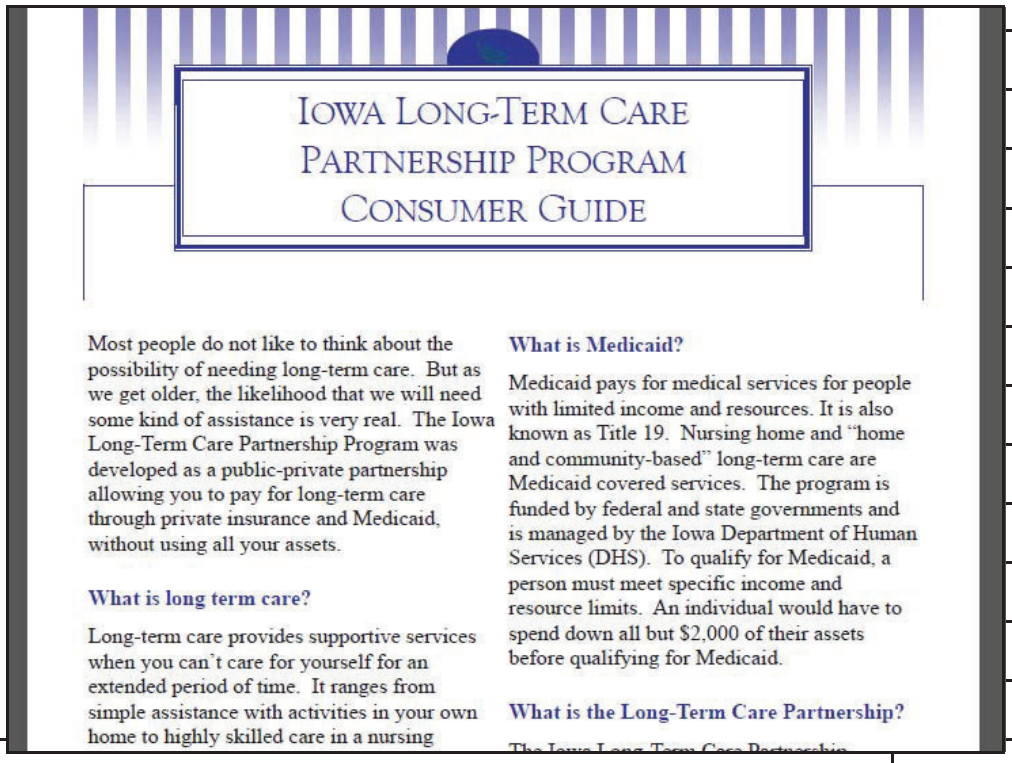
(1) See page 38

c. **State Regulations**

(1) Contracts are regulated by the state DOI

(2) The agents must provide an "Information Guide" to the buyer

Notes	To Do



IOWA LONG-TERM CARE PARTNERSHIP PROGRAM CONSUMER GUIDE

Most people do not like to think about the possibility of needing long-term care. But as we get older, the likelihood that we will need some kind of assistance is very real. The Iowa Long-Term Care Partnership Program was developed as a public-private partnership allowing you to pay for long-term care through private insurance and Medicaid, without using all your assets.

What is long term care?

Long-term care provides supportive services when you can't care for yourself for an extended period of time. It ranges from simple assistance with activities in your own home to highly skilled care in a nursing

What is Medicaid?

Medicaid pays for medical services for people with limited income and resources. It is also known as Title 19. Nursing home and "home and community-based" long-term care are Medicaid covered services. The program is funded by federal and state governments and is managed by the Iowa Department of Human Services (DHS). To qualify for Medicaid, a person must meet specific income and resource limits. An individual would have to spend down all but $2,000 of their assets before qualifying for Medicaid.

What is the Long-Term Care Partnership?

The Iowa Long-Term Care Partnership

http://www.shiip.state.ia.us/Resources/Partnership%20consumer%20guide%20final%209-09.pdf

Note: All states have LTC guides. Simply conduct an Internet search for your state and LTC

What is a "Typical LTCI Contract" sold today?

- Average age at purchase: 58
- Purchased by Gender: Female 53% - Male 47%
- Benefit Period: 5 years
- Elimination Period: 90 days
- Premium Paying Option: Pay for life (greater than 90%)
- Benefit Payout: Reimbursement

d. **Federal requirements**

(1) **HIPAA** and its role in LTCI

(a) "Qualified LTCI" vs "non-qualified LTCI"

i) Tax rules regarding deductibility of premiums

NOTE: What is your state's rule regarding state income tax deduction for the qualified LTC premium? Currently 29 states allow some amount of tax deduction against that state's income tax filing for the qualified LTC premium paid by the resident. Please check out the Internet site on the corresponding page for a states' specific tax rules.

ii) Tax rules regarding the receipt of policy benefits - see page 40 for specific information.

(b) Contracts paid by an employer for the benefit of an employee (spouse of an employee, or retiree) (Note: The LTC insurance must meet the definition of a "Qualified LTC Plan")

i) The premiums are tax deductible if they are paid on the behalf of an "employee"

ii) These employer-paid premiums are not reported as income to the employee

iii) There will be no income tax on the LTC benefits when they are received by the employee (or spouse, or retiree). Maximum limits do apply.

Notes	To Do
Premiums paid for qualified LTC insurance can be deducted by individuals as medical expenses. However, the medical expense deduction is limited to expenses in excess of 10% of adjusted gross income, meaning that many individual premium payers will not benefit from this deduction (assuming no other substantial medical expenses). **The deductions for premiums paid in 2023 is further limited according to the insured's age**: $480 if age 40 or less; $890 if age 41 through 50; $1,790 if age 51 through 60; $4,770 if age 61 through 70; $5,960 if age 71 and over. These limitations are adjusted annually for inflation and are "per person". (See IRS Publication #502 - www.irs.gov)	
Qualified vs. Non-Qualified ☛ **Possible tax deduction of premiums?** **Q – Yes / NQ - No** ☛ **Tax free benefits?** **Q – Yes / NQ – Yes*** ☛ **ADLs for Coverage Trigger?** **Q – 2 of 6 / NQ – Maybe 1 of 6** ☛ **Cost to purchase?** **Q – Less $$* / NQ – More $$***	**EXAMPLE OF POTENTIAL TAX DEDUCTION OF A Q-LTCI** ■ Mary (age 61) – $50,000 Adjusted Gross income (2023) ■ Owns a tax-qualified LTCI - $3,000 (annual premium) ■ 10% of Mary's AGI = $5,000 ■ Mary has an additional $2,500 of un-reimbursed medical expenses in 2023. Tax rules allow the owner of a Q-LTCI to deduct the premiums as a medical expense (*lesser* of actual premium or federally mandated age-based premium - $4,770 in her case in 2023) ■ $3,000 + $2,500 = $5,500 - $5,000 = $500 (the amount she may deduct on her IRS form 1040) To research specific LTCI tax rules by state, please see the following web-site.: http://longtermcareinsurancepartner.com/long-term-care-insurance/2015-long-term-care-insurance-tax-deduction
TAX HELP FROM HIPPA ref LTCI	**Taxability of Benefits Received:** Generally, benefits received from a tax-qualified LTCi policy that was purchased by an individual are non-taxable and therefore excluded from Adjusted Gross Income. Benefits paid under an indemnity policy are not taxed unless they exceed the higher of the cost of qualified long-term care or $390-per-day (the 2023) limit). These limitations are adjusted annually for inflation and are "per person". (See IRS Publication #502 - www.irs.gov)

Note: See the chart on page 51 for the various tax deducible rules for business entities.

IV. Innovations with Annuities and Life Insurance concerning the Long-Term Care Funding Dilemma

A. Overview - the introduction by carriers of the "Living Benefit" rider or provision

1. A handful of annuity carriers began using variations of LTC funding with their single-premium annuity in the mid to late 1990's. Normally, it was a waiver of the Surrender Charges provision in the contract if the LTC (or terminal illness) "trigger" was met. The Surrender Charges were typically no longer than the first 7 to 10 years of the contract. So, someone with a severe illness - or nursing home confinement - could access a percentage of the annuity value without a surrender charge being applied.

2. In just the last 7-10 years some life insurance carriers began to introduce innovative ways to "accelerate" a portions (or percentage) of the death benefit if certain triggers were met. In just the last 2-3 years a few carriers now have this benefit available with selected term insurance policies.

B. Annuities sold today and the "Living Benefit" rider or provision

1. Today, most annuity issuers continue the "waiver of surrender charge" language for certain coverage triggers. Some have become more innovative:

Guaranty Income Life Company - Flex Plus 10 Fixed Annuity

Sales Charge - None

Surrender Charges - 10 years decreasing every year (9, 8, 7, 6, 5, 4, 3, 2, 1, 0)

Penalty Free Withdrawals - 100% of Accumulated Interest, or 10% of Year End Accumulate Value after 1st year

Rider (Bonus Care 10)

1) Terminal Illness - after one year of contract ownership, should you be diagnosed with a terminal illness, you can withdraw up to 75% of your premium and all interest penalty free.
2) Nursing Home Confinement - after one year of contract ownership, if you require Nursing Home Confinement, you can withdraw up to 25% of your premium and all your interest annually to help pay for your Nursing Home expenses.
3) Enhanced Payout for Long-Term Expenses - after four (4) years of contract ownership, if you are unable to perform two of six Activities of Daily Living, you can elect enhanced Annuitization to help pay for LTC expenses. The amount of enhanced income will be determined by your age at the time you choose to elect the benefit. After the tenth year, if you are unable to perform two of six Activities of Daily Living and elect enhanced Annuitization, you will automatically be credited a 10% bonus to help pay for LTC expenses.

Do I have to answer any medical questions when I apply for an FlexPlus with Bonus Care 10?

No. There are no medical questions or exams. The additional benefits are guaranteed issue and are provided at no additional premium cost to you.

Why are the enhanced annuitization benefits different for males and females?

Females have a longer life expectancy than males. The enhanced benefits are based on life expectancy at the time the benefit is elected. Although the male benefit is somewhat higher, female owners will likely receive their enhanced benefits for a longer period of time.

Will my spouse have the same benefits if he or she inherits my annuity?

Yes. If your spouse becomes the owner of the annuity, he or she will have the same enhanced benefit options as the original owner.

How do I qualify for enhanced annuitization and Bonus Care 10?

You are eligible for enhanced annuitization after four years. To qualify, you must be certified by a Licensed Health Care Practitioner as being unable to perform two of six Activities of Daily Living. If you qualify for enhanced annuitization after ten years and choose to elect this benefit, **your account value will automatically be credited with a bonus of 10% of your Accumulation Value.**

What happens if I choose not to use my enhanced benefits?

If you qualify for any of the enhanced benefits, you may elect not to use them. In this case, your annuity will continue to grow tax deferred. You may choose to elect enhanced benefits any time after you meet the qualifications.

About the Company

The FlexPlus Accumulation Values are guaranteed by contract and protected by the financial strength of Guaranty Income Life Insurance Company.

Guaranty Income was founded in 1926. In addition to annuity programs, Guaranty Income has cost-effective insurance products to help families meet their financial needs today and in the future.

Guaranty Income and its producers or representatives do not give tax, legal or accounting advice. See contract for complete details. Please consult your attorney, accountant or tax advisor to determine the suitability of this annuity based on your needs and financial situation.

GUARANTY
Income Life Insurance Company

800.535.8110 / 225.383.0355
Fax: 225.343.1747
Web site: www.gilico.com
e-mail: sales@gilico.com

2. **IMPORTANT TO UNDERSTAND:** Unless a single-premium annuity is of sizable value ($250,000 or more), it will not provide the long-term funding needs should a chronic care need arise. A quality LTC policy, or a Life Insurance contact with the Living Benefit provision will normally have more options and funds for this expensive need.

C. Life Insurance sold today and the "Living Benefit" rider or provision

1. Obviously, there is the Death Benefit and Cash Value with the permanent life policies. If the contract is a Term policy, there will be no cash value. The Living Benefit (LB) language provides additional coverages. Generally, there are "Three Buckets" with the LB.

a. The first coverage "bucket" is generally referred to as "Critical Illness". Here the claimant can file for up to some maximum amount against the contract – meaning, the life insurance death benefit amount – should they have a defined medical procedure. A physician's certification will be required.

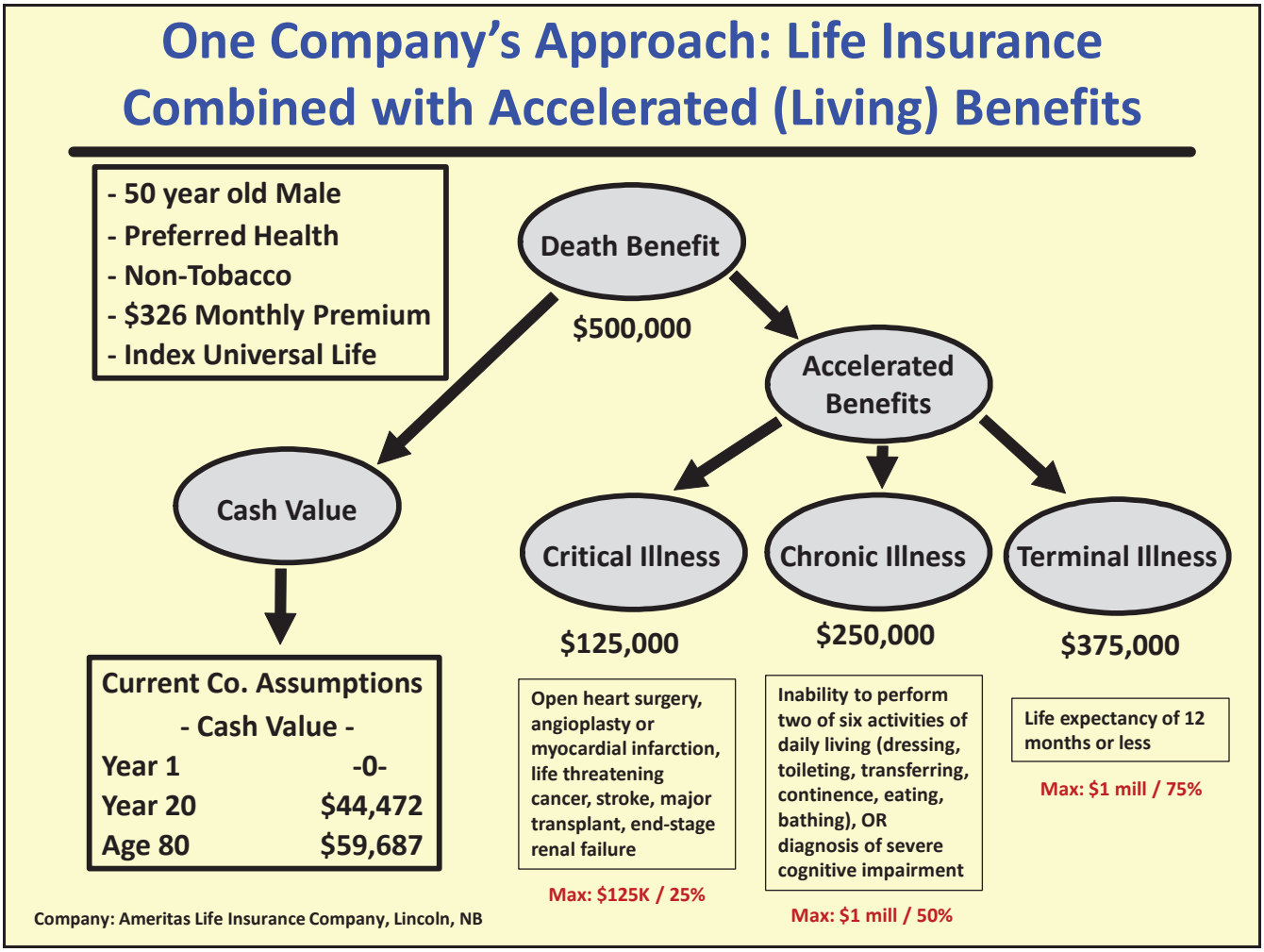
b. One company's language defines it as: **"open heart surgery, angioplasty or myocardial infarction, life threatening cancer, stroke, major transplant or end-stage renal failure."** The limit may be a flat maximum amount (such as $25,000) or some maximum percent of the death benefit (such as 25%), but not to exceed some specified dollar amount (one company's maximum is $125,000).

An example: John (who is self-employed) has a $500,000 life insurance policy that contains the LB provision. He becomes ill and ultimately receives a kidney transplant. He is responsible for a sizable medical insurance deductible and can't work for 4 months – so he sustains a significant loss of income. He decides to take an advance against his policy of $100,000. He still has $400,000 of death benefit coverage, since this is considered a lien against the contract.

Most companies will charge an administrative fee when such a claim is made. A one-time fee of $150 to $250 is common.

c. The second "bucket" is generally defined as "Chronic Illness". Here the claimant will be required to provide a physician's certification that shows the individual is unable to perform any 2 of 6 ADLs (eating, dressing, bathing, toileting, transferring or continence), **OR**, has been diagnosed as having Severe Cognitive Impairment. **You will note this is the exact language we discussed with a traditional LTCI contract.** Carriers may require the "coverage-trigger" to be for a minimum and continuous time frame – perhaps 90 days.

Notes	To Do



Please see pages 52 - 56 for an article on this topic.

d. As with Critical Illness, there will be some maximum limit. With many life insurance companies, it will generally be up to 50% of the death benefit, with some overall maximum total. One company's maximum benefit payout is $1,000,000. One company's language states: ***"The sum of all accelerated benefits may not exceed either 50% of the specified amount (the death benefit) at the time of the first acceleration, or $1,000,000".*** Additionally, the company may limit how benefits are paid under this provision. Some may pay annual installments, but not to exceed the maximum LTC benefit as defined under HIPAA. Some may pay a maximum monthly benefit (such as 2% installments over 50 months).

An example: Sharon is 45 years old and has a $400,000 life policy that contains the LB provision. She has developed a degenerative muscle disorder and is no longer able to care for herself. She can no longer walk nor feed herself. She and her husband take an advance of $200,000 from her policy to modify their home and help pay for a home health aide. She will still have $200,000 death benefit protection.

e. The final "bucket" is defined as "Terminal Illness". Most contract's LB language states the owner can access this benefit if the insured individual's life expectancy is 12 months or less. Generally, the maximum benefit will be 50% to 75% of the death benefit, not to exceed some specified amount, perhaps $1,000,000.

An example: Robert has a $350,000 life policy that contains the LB provision. He has an inoperable tumor and his physician has given him 5 months to live. He requests a $50,000 advance against his contract - so he, his wife, and adult kids can take a cruise they have discussed for years. Upon Robert's death, his wife receives the remaining $300,000 death benefit.

2. Key questions / concerns / comparison regarding the traditional LTCI and the Living Benefit Rider / Provision found in many contract today*:

Key Issues / Questions	Traditional LTCI	Life with Living Benefit
Is the owner eligible for a federal (and state) tax deduction when the insurance premium is paid?	Yes, if the contract meets the HIPAA definition as a Qualified LTC. If so, the owner is eligible for an individual federal tax deduction and also eligible with some states. The owner may deduct the lesser of the actual premium or an age-based specific amount as mandated by the IRS. This was addressed on page 40 of this outline. The IRS mandated amount increases annually.	No

Key Issues / Questions	Traditional LTCI	Life with Living Benefit
Is there any state or federal income tax payable by the owner when benefits are received?	**Reimbursement Contracts**: If the contract is a Qualified LTC (as defined by HIPAA), any reimbursed amount for defined benefits are income tax free. **Indemnity Contracts:** No taxation, unless payments exceed the IRS maximum per diem daily rate ($340 per day in 2017). This amount is adjusted annually.	Benefits are considered a lien against the life insurance contact. Thus, they are not subject to federal nor state income tax. Any remaining death benefit paid to the beneficiary will not be subject to any federal income tax, with minor exceptions. (Note: see disclaimer on page 47)
If the covered individual receives a Living Benefit or LTC benefit, must the premium continue to be paid? (Waiver of Premium)	No – Generally, when the LTC insurance commences benefit payments, the premiums are waived until the individual recovers or benefits are exhausted. Rules and waiting periods vary by carrier. This is normally a Policy Provision, thus built-in to the contract.	Generally, yes. However, should the contract include the Waiver of Premium rider and the insured meets the definition of "total disability", the premium (or mortality cost) is waived. This rider generally terminates at age 65, unless already qualified for Waiver of Premium.
Once the coverage triggers are met, can the Living Benefit or LTC benefit be used in any facility, location or home? Are there any restrictions as to how the benefit can be used?	If written as a **Reimbursement Contract**, it will only pay (reimburse) certain expenses as defined in the contract. Generally this means charges associated with care at a Skilled Nursing Facility, Assisted Living Facility or care in a private residence. If written as an **Indemnity Contract** (or Rider), use of the paid benefit will normally be more liberal. Benefits are only payable after the elimination period is met.	Once approved, there are no limitations on how, or where, the benefits can be used.
Can the premium be increased by the insurance company?	Premiums may be increased by the company if filed and approved by the state. Premiums cannot be increased based on an individual's age, or their health status. An approved premium increase is only for a contract classification (a "book of business") for that state.	As long as premiums are paid, and sufficient to keep the life insurance contract in-force, the Living Benefit provision will be available.
Can the Living Benefit or LTC benefit be used to compensate a family member for the care at a private residence?	Generally no. Some contracts allow this to be added as a rider.	Once approved, there are no limitations on how, or where, the benefits can be used.
What is payable if the covered individual dies?	When an insured individual dies, no death benefit , or residual value, is generally available. Some companies offer a return of premium option at an additional cost. This feature provides a death benefit to be paid to the beneficiary, equal to the cumulative premiums less the benefits that have been received, if any. In some policies only a proportion --such as 90% of excess premiums -- would be returned. In some policies, death must occur before a certain age such as 65 or 70. Also, there may be a minimum number of premiums to be paid before the return of premium feature is payable.	When a Living Benefit is paid it is considered a "lien" against the life insurance contract. The death benefit is reduced by LB proceeds that are paid. The remaining death benefit is payable to the beneficiary when the insured dies, less any and all interest on the "lien". See page 48 for a discussion on this policy provision.

Key Issues / Questions	Traditional LTCI	Life with Living Benefit
Can the Living Benefit or LTC benefit be used outside the USA?	Generally No – the benefit must be used in the coverage territory as defined in the contract. Generally, this is the United States and its territories. Some carriers have liberalization rules in this area.	Once approved, there are no limitations on how, or where, the benefits can be used.
What (if any) is the Waiting Period (or Elimination Period) before benefits are paid or payable?	A waiting-period is elected at time of application. They generally range from a 14 day-wait to 180 days. When the covered individual meets the coverage-trigger, benefits are then payable after the waiting, or elimination, period.	Generally, waiting periods do apply before benefit are payable. Typically they do not exceed 90 days. Once the insured individual, 1) meets the published waiting period, 2) meets the coverage-trigger and, 3) files for the benefit, the benefit is eligible for payment as per the contract terms.
Is there any administration fees, additional cost, interest, or contract charges to file a claim?	No	Yes. A $75 to $150 Living Benefit administrative fee is common. This amount will be added to the lien. Additionally, there will be interest charged against the LB amount received. The interest rate can fluctuate (generally quarterly or annually), but will not exceed a contract-stated amount. See discussion on page 48.
How is this contract underwritten? Is there an age limitation for a new application.	An application is submitted and full medical underwriting (u/w) will be conducted. An attending physician statement (APS) will be obtained from most, or all, of the applicant's medical providers. Rarely do LTC carriers require an insurance medical exam to be conducted. The normal time-frame before an u/w determination is made will generally be four to six weeks. The maximum age for consideration is generally age 79. This maximum age varies by carrier.	An application is submitted and full medical underwriting (u/w) will be conducted. Depending on the age of the applicant and the amount of death benefit, a full medical exam may be required. An attending physician statement (APS) will normally be obtained from most, or all, of the applicant's medical providers. The normal time-frame before an u/w determination is made will generally be four to six weeks. The maximum age for consideration may be as high as age 95. The maximum age varies by carrier. **Note:** even if the life contract is "rated" due to medical issues, hobbies, or vocation, the LB provision may still be available. This varies by carrier.

*__Disclaimer:__ This chart and its comparisons are general statements only. Additionally, this chart is not intended to provide legal or tax advise. Language and benefits found in the life insurance contracts that provide the Living Benefit Provision (or Rider) vary greatly. This benefit / rider is referred to as an Accelerated Benefit by some carriers. Consult the specifics insurance contract for exact wording. Always consult a qualified attorney or accountant for information or advise regarding those topics. (rev. 09-18-2016)

Notes	To Do

General Company Rules Regarding the Living Benefit Rider or Provision

(Rules varies by company)

- **Underwriting:** Specific underwriting rules will apply for this rider. This rider will generally not be available should the base life insurance coverage be approved at a higher rate class - maybe Table B or higher. It may not be available for certain hazardous activities (sports or occupations). Generally, the carriers will not approve the rider (or delete the provision) for foreign nationals.

- **Waiting Periods:** There may no waiting period for Critical Illness or Terminal Illness benefits to be payable. There is typically a 90 day waiting period for Chronic Illness benefit to be payable. Medical certification (and company approval) will be required in all cases for accessing this benefit. Some carriers may require the policy be in-force for a certain minimum time frame before accessing the Living Benefit is allowed.

- **Charges and Interest:** There will be an administration (or filing) charge to access a Living Benefit. A $150 - $250 fee is common. Additionally, there will be interest on any and all benefits received. This will be considered a ”lien” against the death benefit, and the rate will generally be @8% annually.

  Example: A $500,000 life insurance policy has been issued that contains the Living Benefit provision. A year later a $100,000 Chronic Illness benefit is filed, approved and taken.

  What is payable from the policy when the insured dies 10 years later?

  $320,000. Simple interest (annually) of 8% on the 100,000 for 10 years is $80,000. $500,000 less the $100,000 Chronic Benefit, less the $80,000 accrued interest.

North American Company
for Life and Health Insurance
Since 1886

Custom Guarantee (Gen 8)

A Universal Life Insurance Policy Proposal

Prepared for:

Sample
Male, Age 55 (Based on Nearest Birthday), Preferred Non-Tobacco
Death Benefit: $500,000 Initial DB Option: Level
Initial Annual Premium: $6,119.17
1035: $0.00 (Month 1) Non-1035: $0.00 (Month 1)
Riders: Chronic Illness Accelerated Benefit Rider
Rating: None

Agent:

Valued Agent
1317 W Busch Blvd
Tampa, FL 33612
813-936-9193

EXPLANATION OF POLICY PROPOSAL (CONT.)

Because this is a flexible premium policy, you have the option to stop or reduce premium payments for a period of time. Even if this proposal shows premium payments for just one year or several years only, North American will continue to deduct the cost of insurance and policy expenses from your policy's account value each month. Depending on actual results, you may need to continue or resume premium outlays. If at any time the account value is not sufficient to cover the monthly charges and expenses, and absent an applicable no lapse guarantee, you would have to make sufficient premium payments to cover the charges and expenses in order to continue coverage.

Surrender Value

The surrender value is the amount you receive if you cancel your policy. Your surrender value is equal to:

- your account value;
- minus any outstanding policy loans and loan interest;
- minus surrender charges.

The surrender charge reduces to zero at the end of 20 years.

Processing Changes at Age 100

The normal maturity date for your policy is the policy anniversary nearest your age 120. If your policy is in force at age 100, death benefit coverage will continue to age 120 unless the accrued value of any outstanding loan causes the policy to lapse prior to age 120. Certain changes will occur for the years beyond age 100:

- No mortality or expense charges will be deducted, and no further premium payments will be accepted.
- Loan repayments will be accepted, and loan interest will continue to accrue.
- Rider charges, if any, will continue to be assessed.

Accelerated Death Benefit Endorsement

Allows for the policy owner to accelerate a portion of the policy's death benefit if the insured is diagnosed with a qualifying illness. The policy owner specifies the amount to accelerate up to the maximum allowed. There is no premium or charge for this endorsement; however, there is an administrative fee when an accelerated death benefit payment is made for the Terminal Illness benefit. Since this benefit is paid prior to death, the benefit payment to the policy owner will be discounted from the amount accelerated. An election to accelerate benefits will reduce the remaining death benefit and account values in the policy. If the policy has a loan balance, a portion of the payment will be used to reduce the policy debt. This endorsement provides accelerated death benefits for Terminal Illness. The maximum death benefit we will accelerate on the policy is $1,000,000.

North American Company
for Life and Health Insurance
Since 1886

Custom Guarantee (Gen 8)

A Universal Life Insurance Policy Proposal

Prepared for:

Sample
Male, Age 55 (Based on Nearest Birthday), Preferred Non-Tobacco
Death Benefit: $500,000 Initial DB Option: Level
Initial Annual Premium: $6,119.17
1035: $0.00 (Month 1) Non-1035: $0.00 (Month 1)
Riders: Chronic Illness Accelerated Benefit Rider
Rating: None

Agent:

Valued Agent
1317 W Busch Blvd
Tampa, FL 33612
813-936-9193

EXPLANATION OF POLICY PROPOSAL (CONT.)

The maximum amount available for election is dependent on the actual Death Benefit at the time of election. As shown in the Policy Illustration, the actual Death Benefit can vary based on many factors, such as interest credited and the use of guaranteed or current charges. Policy Values such as the Net Cash Surrender Value and Policy Debt can have an impact on your payment at the time of election. Any payment amounts illustrated for accelerated benefits are not guaranteed and can only be determined at the time of the actual acceleration of the Death Benefit.

Terminal Illness: The insured qualifies as terminally ill if a physician has certified that the insured's life expectancy is 12 months or less. The minimum Terminal Illness benefit election is 10% of the Death Benefit on the Election Date or $100,000, if smaller. The maximum Terminal Illness benefit is 75% of the Death Benefit on the Election Date or $750,000, if smaller.

The ***accelerated death benefit*** payment amount that is received from the Terminal Illness benefit is based on the following factors.

1. The benefit discount rate that the Company is required to use at the time of election. A higher discount rate results in a lower payment.
2. The insured's life expectancy used by the Company. The longer the Company assumes the insured lives with a Terminal Illness, the lower the payment.

Chronic Illness Accelerated Benefit Rider This rider allows for the policy owner to accelerate a portion of the policy's death benefit if the insured is diagnosed with a qualifying illness. The policy owner specifies the amount to accelerate up to the maximum allowed. There is no premium or charge for this rider; however, there is an administrative fee when an accelerated death benefit payment is made. Since this benefit is paid prior to death, the benefit payment to the policy owner will be discounted from the amount accelerated. An election to accelerate benefits will reduce the remaining death benefit and account values in the policy. If the policy has a loan balance, a portion of the payment will be used to reduce the policy debt.

Note that if the insured is converting a North American term policy to this universal life plan, the Chronic Illness Accelerated Benefit Rider is only available if requested by the insured and evidence of insurability is provided.

The insured qualifies as chronically ill if a physician has certified that the insured is permanently unable to perform, for at least 90 consecutive days without substantial assistance from another person, at least two Activities of Daily Living or suffers from severe cognitive impairment. (Activities of Daily Living include bathing, continence, dressing, eating, toileting and transferring.) The minimum Chronic Illness benefit election is 5% of the Death Benefit on the initial Election Date or $75,000, if smaller. The maximum Chronic Illness benefit per year is 24% of the Death Benefit on the initial Election Date or $240,000, if smaller.

Notes	To Do

Tax Advantages for Businesses - Qualified Long Term Care Insurance

Business Type	Situation	Business Tax Benefit	Personal Tax Benefit
C Corporation	Business / 501c organization pays premium	100% of premium deductible	Premium is not considered taxable income; benefits are income tax free.
S Corporation	Business pays premium for employees and/or shareholders who owns less than a 2% interest.	100% of premium deductible	Premium is not considered taxable income; benefits are income tax free.
	Business pays premium for employees and/or shareholders who owns more than a 2% interest.	Shareholder employee may deduct 100% of eligible premium* as an above-the-line business expense.	Premium is considered taxable income; personal deduction may be taken for business expense premium not counted as a business expense, subject to personal medical threshold.
Partnership	Business pays premium for non-partner employee	100% of premium deductible	Premium is not considered taxable income; benefits are income tax free.
	Business pays premium for partner not covered by another plan through any employer	100% of eligible premium* as an above-the-line business expense.	Premium is included in partner's gross income; any benefits are tax free; personal deduction for remained of premium subject to personal medical threshold.
Self-Employed (Not a C Corp)	Business pays premium for individual not covered by an LTC policy maintained by his / her spouse's employer	100% of eligible premium* as an above-the-line business expense.	Personal deduction for remainder of premium subject to personal medical threshold.

* The amount of premium treated as a medical expense as defined in Section 213(d) of the IRC. Eligible premiums are based on attained age. See chart on page 40 for specific number for 2016. See also IRS Publication 502 (www/irs.gov).

Innovations in Long-Term Care Funding with Life Insurance

By: Jerry Rhinehart, CIC, CLU, ChFC, RHU – Panama City, FL (Fall – 2016)

As most of us are aware a prolonged nursing home stay can easily deplete a person's savings, liquidate their assets, and possibly erode their retirement money. And modern medicine – which is keeping us alive longer – is only making this possibility a bit more likely for most. If Long-Term Care (LTC) is needed, most people would like to remain in their home, rather than residing in a Skilled Nursing Facility (SNF). And they probably think the cost will be substantially less at their home than the expense at a SNF. That is possible if the individual has a friend or relative that can provide the hands-on care. But what if no such person is available? Consider this: A certified in-home care-giver runs a minimum of $20 per hour in most parts of the country. Do the math… three 8-hour shifts will be approaching $500 per day! That may be twice the cost of a SNF in the same general area.

According to the 2016 study by Genworth Insurance the national average cost for care is staggering:

The Average Monthly / Annual Cost (Nationally):

- Assisted Living Facility - $3,628 / $43,536
- Skilled Nursing Facility (Semi-Private) - $6,844 / $82,128
- Skilled Nursing Facility (Private) - $7,698 / $92,376

Site: genworth.com/about-us/industry-expertise/cost-of-care.html

With this site, it is very easy to search for your state's averages as well as most major cities in your state.

Ok, so what are the LTC funding options should the need arise? There are really only three options: **1) Be Rich**, **2) Be Poor**, or **3) Be Insured**.

The 1st option (**Be Rich**) eliminates the vast majority of people.

The 2nd option (**Be Poor** … meaning Medicaid). What usually happens is the person needing cares uses their money and assets FIRST and they become destitute, and then meet Medicaid eligibly rules. Every state has specific rules regarding Medicaid qualification: 1) the applicant must spend down their assets to a mandated amount – generally $2,000, and 2) their income can't exceed a certain level ($2,199 per month in Florida in 2016, as an example).

The 3rd option (**Be Insured**) usually meets with resistance due to, 1) the perceived high cost of the premium of Long Term Care insurance (LTCI), and, 2) many people simply do not think this issue will affect them. No question about it… a traditional LTCI contract is pricy! And, there is rarely any benefit payable should the person die before using the coverage. What is the "trigger" for a covered claim with a LTCI? Typically, it mean they can't perform any 2 of 6 Activities of Daily Living (ADLs). ADLs are defined as eating, dressing, bathing, toileting, transferring or continence. The second "claims-trigger" is the insured must have a medical diagnoses of Severe Cognitive Impairment. A person with a dementia impairment (maybe Alzheimer's disease) might be able to perform all 6 ADLs, but obviously should not be left without someone to look after them. So, how is a claim approved? The insured individual meets **either of the two defined claims-triggers** – any 2 of 6 ADLS **OR** Severe Cognitive Impairment. Once an individual claim's qualification is met, benefits are payable until they recover from the medical issue, or the "insurance bucket of money" is empty. What is meant by the term "… until they recover"? Well, most think of this coverage for older people with severe (and irreversible) medical situations. But what about a person of any age that has a serious medical event (heart, cancer, accident, etc.) and is in need of care for several months and then recovers? The benefit would be payable for that period of time if the claims-trigger and the elimination period are met.

We have discussed the dilemma, various options and the traditional LTCI approaches. **What about recent innovation and trends for this issue?** A few years ago, we started seeing some life insurance carriers include a novel approach regarding the LTC benefit. Many refer to it as a Living Benefit (LB). Some call it an Accelerated Benefit. Now, keep in mind not all carriers include this coverage. For those that do, some make it a rider (with a published additional cost) while most make it a policy provision or contract feature, thus no published additional cost. Additionally, the LB contract language and pay-out provisions vary greatly with the companies that participate in this benefit. It is even available in varying degrees with some annuity contracts.

How does the LB provision generally work? First, the life insurance contract obviously has the death benefit. But as part of the death benefit, the contract will generally provide three "buckets" of money that can be accessed by the owner if the insured has a qualifying event or meets a "claims-trigger" provision. Note that just because a company's life policy is approved in a particular state, this rider may not. Always check with your company.

The first coverage "bucket" is generally referred to as "**Critical Illness**". Here the claimant can file for up to some maximum amount against the contract – meaning, the life insurance death benefit amount – should they have a defined medical procedure. A physician's certification will be required. One company's language defines it as: **"open heart surgery, angioplasty or myocardial infarction, life threatening cancer, stroke, major transplant or end-stage renal failure."** The limit may be a flat maximum amount (such as $25,000) or some maximum percent of the death benefit (such as 25%), but not to exceed some specified dollar amount (one company's maximum is $125,000). *An example:* John (who is self-employed) has a $500,000 life insurance policy that contains the LB provision. He becomes ill and ultimately receives a kidney transplant. He is responsible for a sizable medical insurance deductible and can't work for 4 months – so he sustains a significant loss of income. He decides to take an advance against his policy of $100,000. He still has $400,000 of death benefit coverage, since this is considered a lien against the contract. Most companies will charge an administrative fee when such a claim is made. A one-time fee of $150 is common.

The second "bucket" is generally defined as "**Chronic Illness**". Here the claimant will be required to provide a physician's certification that shows the individual is unable to perform any 2 of 6 ADLs (eating, dressing, bathing, toileting, transferring or continence), **OR**, has been diagnosed as having Severe Cognitive Impairment. You will note this is the exact language we discussed with a traditional LTCI contract. Carriers may require the "coverage-trigger" to be for a minimum and continuous time frame – perhaps 90 days. As with Critical Illness, there will be some maximum limit. With many life insurance companies, it will generally be up to 50% of the death benefit, with some overall maximum total. One company's maximum benefit payout is $1,000,000. One company's language states: ***"The sum of all accelerated benefits may not exceed either 50% of the specified amount (the death benefit) at the time of the first acceleration, or $1,000,000".*** Additionally, the company may limit how benefits are paid under this provision. Some may pay annual installments, but not to exceed the maximum LTC benefit as defined under HIPAA. Some may pay a maximum monthly benefit (such as 2% installments over 50 months). *An example:* Sharon is 45 years old and has a $400,000 life policy that contains the LB provision. She has developed a degenerative muscle disorder and is no longer able to care for herself. She and her husband take an advance of $200,000 from her policy to modify their home and help pay for a home health aide. She will still have $200,000 death benefit protection.

The final "bucket" is defined as "**Terminal Illness**". Most contract's LB language states the owner can access this benefit if the insured individual's life expectancy is 12 months or less. Generally, the

maximum benefit will be 50% to 75% of the death benefit, not to exceed some specified amount, perhaps $1,000,000. *An example:* Patrick has a $300,000 life policy that contains the LB provision. He has an inoperable tumor and his physician has given him 5 months to live. He requests a $50,000 advance against his contract - so he, his wife, and adult kids can take a cruise they have discussed for years. Upon Patrick's death, his wife receives the remaining $250,000 death benefit.

Note that a number of life insurance carriers have the LB provision as part of their Whole Life, Universal Life and even Variable Life contracts. A few carriers even have this part of selected Term Life contracts. **An important point:** when the LB benefit is received, it is considered a lien against the life insurance policy. The company will have some fee associated with each transaction ($150 as an example), *plus*, they will charge interest against the lien as specified in the contract. The company will always state the maximum interest – such as 8%. With a lien, the interest is charged against the ultimate remaining death benefit payout. By doing this, the amount received from the LB, should be free of taxation. Always recommend your clients check with their tax specialist for their advice and interpretation.

As mentioned, variation of this benefit is available with some annuity carriers. One such enhancement is the Waiver of Surrender Charge Provisions with many carriers. This provision has been around with most carriers for a number of years. ***How does this work?*** Should the annuitant have a terminal illness, or be confined to a nursing home (many define confinement as 12 months or longer), the individual can access the annuity account value without a surrender charge. Another variation is the ADL trigger provision (or rider). ***How does this work?*** Should the annuitant meet the LTC "claims-trigger" (2 of 6 ADLs, or Severe Cognitive Impairment), they can access a greater percentage of their annuity account value on an annual basis without a surrender charge. A 10% annual withdrawal with no surrender charge is common without this provision. This LB provision will increase this percentage to a higher amount – perhaps 20% annually – without a surrender charge. Currently, very few annuity carriers have this last provision available. Either of these annuity variations are a benefit to a person or family that has the long term care funding need. But neither will be as attractive as the life insurance with LB unless the annuity is very sizable.

What are the major advantages of an insured LTC funding program? With either a good quality LTC insurance contract or a somewhat sizable life insurance policy with the LB, the unpleasant thought of 1) running out of money, 2) having to liquidate their assets, or 3) trying to qualify for Medicaid, can be eliminated or greatly postponed. Most of us will work 30 or 40 years to amass a sizable amount of money in our qualified plans (401-k, IRA, SEP, ROTH, etc.) so our retirement years can be financially low-stress. As stated previously, to qualify for Medicaid, you must spend-down your assets to a certain threshold. Are you aware that Medicaid rules require you to spend down your qualified money (401-k, IRA, SEP, ROTH, etc.) in additional to all your other assets? **Think of a quality insured LTC funding program as a FIRE-WALL around all your qualified money**!

Numerous questions might arise concerning this innovative LB provision. Others may come up about LTC funding options with an annuity. The questions may include: What are the tax rules, limitations on the use of the funds, coverage territory issues, and waiver of premium concerns … just to list a few. The comparison table found with this article should address most of the issues and questions that might come up for agents and their prospects. Since coverage language and benefit options vary greatly with life and annuity contracts that offer one or more of these funding choices, it is highly recommended that agents thoroughly research what is available with their carriers. Another alternative is to discuss these contracts and options with a knowledgeable life insurance brokerage agency that works in this area, and has a good relationship with numerous quality life insurance companies.

Key Questions and Concerns Regarding the Living Benefit Provision with Life Insurance and Annuities as it Compares to the Traditional Long Term Care Insurance Contact.*

Key Issues / Questions	Traditional Long Term Care Insurance	Single Premium Annuity with Living Benefit	Life Insurance with Living Benefit
Is the owner eligible for a federal (and state) tax deduction when the insurance premium is paid?	Yes, if the contract meets the HIPAA definition as a Qualified LTC. If so, the owner is eligible for an individual federal tax deduction and also eligible with some states. The owner may deduct the lesser of the actual premium or an age-based specific amount as mandated by the IRS. The IRS mandated amount increases annually.	No	No
Is there any state or federal income tax payable by the owner when benefits are received?	Reimbursement Contracts: If the contract is a Qualified LTC (as defined by HIPAA), any reimbursed amount for defined benefits are income tax free. Indemnity Contracts: No taxation, unless payments exceed the IRS maximum per diem daily rate ($340 per day in 2017). This amount is adjusted annually.	Proceeds received from a non-qualified annuity are "interest first, principal lasts. So, any interest will be subject to ordinary income tax.	Benefits are considered a lien against the life insurance contact. Thus, they are not subject to federal nor state income tax. Any remaining death benefit paid to the beneficiary will not be subject to any federal income tax, with minor exceptions. (Note: see disclaimer below)
If the covered individual receives a Living Benefit or LTC benefit, must the premium continue to be paid? (Waiver of Premium)	No – Generally, when the LTC insurance commences benefit payments, the premiums are waived until the individual recovers or benefits are exhausted. Rules and waiting periods vary by carrier. This is normally a Policy Provision, thus built-in to the contract.	N/A	Yes. However, should the contract include the Waiver of Premium rider and the insured meets the definition of "total disability", the premium (or mortality cost) is waived. This rider generally terminates at age 65, unless already qualified for Waiver of Premium.
Once the coverage triggers are met, can the Living Benefit or LTC benefit be used in any facility, location or home? Are there restrictions as to how the benefit can be used?	If written as a Reimbursement Contract, it will only pay (reimburse) certain expenses as defined in the contract. Generally this means charges associated with care at a Skilled Nursing Facility, Assisted Living Facility or care in a private residence. If written as an Indemnity Contract (or Rider), use of the paid benefit will normally be more liberal. Benefits are only payable after the elimination period is met.	Once approved, there are no limitations on how, or where, the benefits can be used.	Once approved, there are no limitations on how, or where, the benefits can be used.
Can the premium be increased by the insurance company?	Premiums may be increased by the company if filed and approved by the state. Premiums cannot be increased based on an individual's age, or their health status. An approved premium increase is only for a contract classification (a "book of business") for that state.	N/A	As long as premiums are paid, and sufficient to keep the life insurance contract in-force, the Living Benefit provision will be available.
Can the Living Benefit or LTC benefit be used to compensate a family member for the care at a private residence?	Generally no. Some contracts allow this to be added as a rider.	Once approved, there are no limitations on how, or where, the benefits can be used.	Once approved, there are no limitations on how, or where, the benefits can be used.
What is payable if the covered individual dies?	When an insured individual dies, no death benefit , or residual value, is generally available. Some companies offer a return of premium option at an additional cost. This feature provides a death benefit to be paid to the beneficiary, equal to the cumulative premiums less the benefits that have been received, if any. In some policies only a proportion --such as 90% of excess premiums -- would be returned. In some policies, death must occur before a certain age such as 65 or 70. Also, there may be a minimum number of premiums to be paid before the return of premium feature is payable.	Any remaining annuity value is payable to the beneficiary.	When a Living Benefit is paid it is considered a "lien" against the life insurance contract. The death benefit is reduced by LB proceeds that are paid. The remaining death benefit is payable to the beneficiary when the insured dies.

Key Questions and Concerns Regarding the Living Benefit Provision with Life Insurance and Annuities as it Compares to the Traditional Long Term Care Insurance Contact.*

Key Issues / Questions	Traditional Long Term Care Insurance	Single Premium Annuity with Living Benefit	Life Insurance with Living Benefit
Can the Living Benefit or LTC benefit be used outside the USA?	Generally No – the benefit must be used in the coverage territory as defined in the contract. Generally, this is the United States and its territories. Some carriers have liberalization rules in this area.	Once approved, there are no limitations on how, or where, the benefits can be used.	Once approved, there are no limitations on how, or where, the benefits can be used.
What (if any) is the Waiting Period (Elimination Period) before benefits are paid or payable?	A waiting-period is elected at time of application. They generally range from a 14 day-wait to 180 days. When the covered individual meets the coverage-trigger, benefits are then payable after the waiting, or elimination, period.	Generally, waiting periods do apply before benefit are payable. They may be as short as 90 days or as long as 365 days. They varies greatly by carriers that provide this benefit.	Generally, waiting periods do apply before benefit are payable. Typically they do not exceed 90 days. Once the insured individual meets the published waiting period, meets the coverage-trigger and files for the benefit, the benefit is eligible for payment as per the contract terms.
Is there any administration fees, additional cost, interest, or contract charges to file a claim?	No	Surrender Charges usually apply in the early years of an annuity contract. The first 7 to 10 years is common. Should the contract contains a "Waiver of Surrender Charge" provision (or Rider) – such as a Nursing Home Waiver, or a Terminal Illness Waiver, and the individual meets the "claims-trigger", then no Surrender Charges apply at any time. No other cost normally applies to file a claim.	Yes. A $75 to $150 Living Benefit administrative fee is common. This amount will be added to the lien. Additionally, there will be interest charged against the LB amount received. The interest rate can fluctuate (generally quarterly or annually), but will not exceed a contract-stated amount.
How is this contract underwritten? Is there an age limitation for a new application.	An application is submitted and full medical underwriting (u/w) will be conducted. An attending physician statement (APS) will be obtained from most, or all, of the applicant's medical providers. Rarely do LTC carriers require an insurance medical exam to be conducted. The normal time-frame before an u/w determination is made will generally be four to six weeks. The maximum age for consideration is generally age 79. The maximum age varies by carrier.	N/A	An application is submitted and full medical underwriting (u/w) will be conducted. Depending on the age of the applicant and the amount of death benefit, a full medical exam may be required. An attending physician statement (APS) will normally be obtained from most, or all, of the applicant's medical providers. The normal time-frame before an u/w determination is made will generally be four to six weeks. The maximum age for consideration may be as high as age 95. The maximum age varies by carrier. Note: even if the life contract is "rated" due to medical issues, hobbies, or vocation, the LB provision may still be available. This varies by carrier.

* **Disclaimer:** This chart and its comparisons are general statements only. Additionally, this chart is not intended to provide legal or tax advise. Language and benefits found in the life insurance contracts or annuity contracts that provide the Living Benefit Provision (or Rider) vary greatly. Consult the specifics insurance contract for exact wording. Always consult a qualified attorney or accountant for information or advise regarding those topics. (rev. 02-19-2017)

I.II.III.Glossary of Long Term Care Terms

Acute Care - Care provided by a doctor or other medical professional designed to treat an illness, injury or condition.

ADL (Activities of Daily Living) - These activities include things like bathing, dressing, eating, toileting, transferring (moving in or out of a bed or chair), and continence. They are used by insurance companies to determine eligibility for long-term care benefits.

Adult Day Care Center - A facility that provides long-term care to adults during the day.

Assisted Living Facility - An appropriately licensed facility that provides 24-hour a day care sufficient to assist clients who need long term care. This facility provides three meals a day, has arrangements for emergency medical care as required, and has methods and procedures to administer prescribed drugs. It uses aides trained or certified to provide a broad menu of services ranging from personal care to health maintenance. It is a facility with many of the resources of a nursing home in a more residential atmosphere.

Cash Benefit Rider- The Cash Benefit Rider allows the covered person to use benefit payments in any manner they see fit, including the payment of informal care-givers. (Informal care is care that is provided without charge, and is typically provided by family, friends or neighbors.) This payment method pays the total Home and Community-Based Care Daily Maximum Benefit times the number of days in the month regardless of whether services we provided.

Cognitive Impairment - Certain conditions, such as Alzheimer's disease, require the same kind of long-term care as you would need if you had a physical disability, and would trigger your eligibility for benefits in the same way as the inability to perform Activities of Daily Living.

Custodial Care - Services aimed at maintaining a person's health and/or preventing deterioration in the person's functional status, provided on an extended basis to a person who is chronically ill.

Daily Benefit - The money an insurance policy pays out in response to a claim. (see also **Monthly Benefit** and **Maximum Daily Benefit)**

Dual Waiver - Can be applied only when a policy covers both husband and wife. This rider provides for a waiver of premium for both of the insured in the event that either spouse needs to receive benefits.

Duration of Benefits - The length of time your insurance will pay your maximum daily benefits. For example, a four- year benefit is the amount of money your insurance would pay out in benefits at your maximum daily benefit. In fact, a four-year benefit can last considerably longer than four years, if the cost of care is less than the maximum Benefit amount. (see also **Lifetime (Unlimited) Benefit)**

Eligibility for Benefits - The conditions you need to satisfy to receive long-term care benefits under your policy.

Elimination Period - The number of days in which no payment of benefits will be made for eligible charges incurred. The longer the waiting period, the lower the premium.

Health Insurance Portability and Accountability Act (HIPAA) - The 1996 Federal legislation that makes long term care insurance premiums tax deductible if your non-reimbursable medical expenses, including part or all of your long term care premiums, exceed 7.5% of your gross income. You may be able to deduct the cost of these premiums if you itemize your deductions on your Federal Income Tax return. The deductibility of such premiums is subject to limitations based on your age. The same law also lets you exclude long-term care insurance benefits from your taxable income. Not all long-term care insurance coverage qualifies for the benefit.

Home Health Care - A wide variety of services that bring long-term care to the home and can also include skilled or skilled or unskilled nursing, physical therapy, and assistance with ADL's. This care can also include non-medical services, such as housekeeping, shopping, laundry, money management, meal preparation, or help with ADL's.

Inflation Protection - This feature increases the amount of your benefit by a fixed percentage automatically every year, to adjust for inflation.

Informal Care - Care you receive at home from friends, neighbors or relatives who are not health-

care professionals. Some plans allow a benefit that provides some compensation to cover this care.

Lifetime (Unlimited) Benefit - A feature that continues for your lifetime, no matter how long you require care. (see also **Duration of Benefits)**

Long-Term Care - As opposed to acute- care, long term care is chronic - provided to people who need help with the activities of everyday life. This care can be delivered in a nursing home or other facility or at home.

Maximum Daily Benefit - The greatest amount your policy will pay for a day's care. (see also Daily **Benefit and Monthly Benefit)**

Medicare - Congress established Medicare in 1965 as Title XVIII of the Social Security Act. It is a Federal health insurance program wholly funded by the Federal government with no state participation. Its coverage is divided into Part A and Part B. The former basically covers acute care in hospitals and limited post-hospital care in a skilled nursing facility and at home. Part B is a voluntary supplement medical insurance for a variety of outpatient hospital services.

Medicaid - Medicaid (Title XIX of the Social Security Act) is a medical assistance program financed jointly by the state and Federal governments. Medicaid is a means-tested program. Unlike Medicare, which is available regardless of financial need to most person's age 65 or older and to certain disabled individuals, Medicaid is available only to individuals with limited income and assets.

Modal Factors - Your mode of payment. Could either be Annually, Semi-Annually, Quarterly, or Monthly Bank Draft.

Monthly Benefit - Some insurance plans offer their home care benefit as a monthly rather than a daily benefit. The monthly benefit offers you the flexibility of spending the money when you need it - for example if you had someone come in three times a week instead of every day, you could still have the full amount available. (see also Daily Benefit and Maximum Daily **Benefit)**

Non-forfeiture Benefit - After you've paid for coverage for a certain length of time, some companies guarantee you a benefit, even if you discontinue the coverage, or stop paying the premium.

Nursing Home - A licensed facility that provides 24 hour-a-day nursing care sufficient to assist clients who need long-term care. The facility provides three meals a day, has arrangements for emergency medical care as required, and has methods and procedures to administer prescribed drugs. It uses aides supervised by a nurse, who are trained or certified to provide a broad menu of services ranging from personal care to health maintenance.

Periodic Inflation Protection - Under this option your initial premium pays for the coverage you choose. From time to time, you will be offered an opportunity to increase your coverage. As long as you take this extra coverage periodically, you will be entitled to receive it without taking a medical exam. The premium will be increased based on your attained age.

Rate Class - Could be Preferred, Standard, Select, Class 1 or Class 2 depending on the company and product.

Restoration of Benefits - Some plans allow the full benefit amount to restored if an insured goes on claim and then goes off claim for the number of days specified in the contract.

Shared Care - Some plans allow for additional Daily Benefit to be purchased at certain times and can be used by either spouse.

Spousal Discount or Marital Discount - A percentage discount given to married couples or for just being married or for couples who share financial responsibility for a household but are not legally married. Each plan is different review the outline of coverage.

Survivorship Benefit - Some policies will not require a surviving spouse to pay premiums after the death of one spouse if the death occurs after the policy has been held for a specific period of time, usually 10 year but could be less.

Waiver of Premium - After you receive care in your home, a nursing home or and alternate care facility for "x" number of days, as specified in your contract.

Selected Long-Term Care Statistics

What is Long-Term Care?

Individuals need long-term care when a chronic condition, trauma, or illness limits their ability to carry out basic self-care tasks, called activities of daily living (ADLs), (such as bathing, dressing or eating), or instrumental activities of daily living (IADLs) (such as household chores, meal preparation, or managing money). Long-term care often involves the most intimate aspects of people's lives—what and when they eat, personal hygiene, getting dressed, using the bathroom. Other less severe long-term care needs may involve household tasks such as preparing meals or using the telephone.

A report prepared by the U.S. Senate Special Committee on Aging (February, 2000) described long-term care as follows:

It [long-term care] differs from other types of health care in that the goal of long-term care is not to cure an illness, but to allow an individual to attain and maintain an optimal level of functioning….

Long-term care encompasses a wide array of medical, social, personal, and supportive and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or disabling condition.

Because long-term care needs and services are wide-ranging and complex, statistics may vary from study to study. Sources for the following information are cited at the conclusion of this Fact Sheet. For additional information, see the Family Caregiver Alliance Fact Sheet on Selected Caregiving Statistics.

Who Needs Long-Term Care?

Annually 8,357,100 people receive support from the 5 main long-term care service; home health agencies (4,742,500), nursing homes (1,383,700), hospices (1,244,500), residential care communities (713,300) and adult day service centers (273,200).[1][Updated February 2015]

An estimated 12 million Americans needed long-term care in 2007.[2] [Updated February 2015]

Most but not all persons in need of long-term care are elderly. Approximately 63% are persons aged 65 and older (6.3 million); the remaining 37% are 64 years of age and younger (3.7 million).[3]

The lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68% for people age 65 and older.[4]

By 2050, the number of individuals using paid long-term care services in any setting (e.g., at home, residential care such as assisted living, or skilled nursing facilities) will likely double from the 13 million using services in 2000, to 27 million people. This estimate is influenced by growth in the population of older people in need of care.[5]

Of the older population with long-term care needs in the community, about 30% (1.5 million persons) have substantial long-term care needs (three or more ADL limitations). Of these, about 25% are 85 and older and 70% report they are in fair to poor health. [6]

In 2012, 14.8% of the 65+ population were reported to be below the poverty level. [7] [Updated February 2015]

Among the population aged 65+, 69% will develop disabilities before they die, and 35% will eventually enter a nursing home.[8] [Updated February 2015]

Nearly a fifth of older people will incur more than $25,000 in lifetime out-of-pocket long-term costs before they die. [9] [Updated February 2015]

The prevalence of cognitive impairment among the older population increased over the past decade, while the prevalence of physical impairment remains unchanged.[10]

In 2002, the percentage of older persons with moderate or severe memory impairment ranged from about 5% among persons aged 65–69 to about 32% among persons aged 85 or older.[11]

Individuals 85 years and older, the oldest old, are one of the fastest growing segments of the population. In 2012, there are an estimated 5.9 million people 85+ in the United States.[12] [Updated February 2015] This figure is expected to increase to 19.4 million by 2050.[13] This means that there could be an increase from 1.6 million to 6.2 million people age 85 or over with severe or moderate memory impairment in 2050.[14]

Where do People Receive Long-Term Care and from Whom?

1 - Family and Informal Caregivers

Informal caregiver and family caregiver are terms used to refer to unpaid individuals such as family members, partners, friends and neighbors who provide care. These persons can be primary (i.e. the person who spends the most time helping) or secondary caregivers, full time or part time, and can live with the person being cared for or live separately. Formal caregivers are volunteers or paid care providers associated with a service system.[15,16]

Estimates vary on the number of family and informal caregivers in the U.S., depending on the definitions used for both caregiver and care recipient as well as types of care provided.

65.7 million informal and family caregivers provide care to someone who is ill, disabled or aged in the U.S.[17] [Updated February 2015]

52 million caregivers (or one out of every five households) are involved in caregiving to persons aged 18 or over.[18] [Updated February 2015]

43.5 million caregivers provide care for someone aged 50+ and 14.9 million care for someone who has Alzheimer's or other Dementia.[19] [Updated February 2015]

27.3 million family caregivers provide personal assistance to adults (aged 15+) with a disability or chronic illness.[20]

5.8 21to 7 22million people (family, friends and neighbors) provide care to a person (65+) who needs assistance with everyday activities.[23]

8.9 million informal caregivers provide care to someone aged 50+ with dementia.[24]

By the year 2007, the number of caregiving households in the U.S. for persons aged 50+ could reach 39 million.[25]

Two out of three (66%) of older people with disabilities who receive LTSS at home get all their care exclusively from their family caregiver, mostly wives and daughters. Another quarter (26%) receives some combination of family care and paid help; only 9% receive paid help alone.[26] [Updated February 2015]

Even among the most severely disabled older persons living in the community, about two-thirds rely solely on family members and other informal help, often resulting in great strain for the family caregivers.[27]

The use of informal care as the only type of assistance by older Americans aged 65 and over increased from 57% in 1994 to 66% in 1999. The growth in reliance upon informal care between 1994 and 1999 is accompanied by a decline in the use of a combination of informal and formal care from 36% in 1994 to 26% in 1999.[28]

30% of persons caring for elderly long-term care users were themselves aged 65 or over; another 15% were between the age of 45–54.[29]

Lost income and benefits over a caregiver's lifetime is estimated to range from a total of $283,716 for men to $324,044 for women, or an average of $303,880.[30] [Updated February 2015]

2 - Home and Community-Based Care

The vast majority- 80%- of elderly people receiving assistance, including many with several functional limitations, live in private homes in the community, not in institutions.[31] [Updated February 2015]

.Elderly people with limitations in three or more ADL's who live in the community receive an average of 9 hours of assistance per day (counting both formal and informal sources of care) and people age 85 or older with that degree of impairment typically receive about 11 hours of assistance per day.[32,33] [Updated February 2015]

The trend towards community-based services as opposed to nursing home placement was formalized with the Olmstead Decision (July, 1999)—a court case in which the Supreme Court upheld the right of individuals to receive care in the community as opposed to an institution whenever possible.

The proportion of Americans aged 65 and over with disabilities who rely entirely on formal care for their personal assistance needs has increased to 9% in 1999 from 5% in 1984.[34]

Between 2000 and 2002, the number of licensed assisted living and board and care facilities increased from 32,886 to 36,399 nationally, reflecting the trend towards community-based care as opposed to nursing homes.[35] Most assisted living facilities, however, are unlicensed.

Most assisted living facilities (ALFs) discharge residents whose cognitive impairments become moderate or severe or who need help with transfers (e.g. moving from a wheelchair to a bed.) This limits the ability of these populations to find appropriate services outside of nursing homes or other institutions.[36]

3 - Nursing Home Care

Institutionalization is much more common at older ages; in 2010, about one in eight people age 85 or older (13 percent) resided in institutions, compared with 1 percent of people ages 65 to 74.[37] [Updated February 2015]

In 2012, there were 1.4 million people in nursing homes nationally.[38] [Updated February 2015]

Between 2002 and 2012, private-pay prices for a private or semiprivate room in a nursing home grew by an average of 4.0 percent and 4.5 percent, respectively, per year.[39] [Updated February 2015]

Of the population aged 65 and over in 1999, 52% of the nursing home population was aged 85 or older compared to 35% aged 75–84, and 13% aged 65–74.[40]

Between 1985 and 1999 the number of adults 65 and older living in nursing homes increased from 1.3 million to 1.5 million. In 1999, almost three-quarters (1.1 million) of these older residents were women.[41]

Long-Term Care Expenditures

In 2012, total spending (public, out-of-pocket and other private spending) for long-term care was $219.9 billion, or 9.3% of all U.S. personal health care spending. This is projected to increase to $346 billion in 2040.[42] [Updated February 2015]

In 2010, approximately 45% of Medicaid long-term care funding was spent on HCBS. About 55% was directed toward institutional long-term care, which includes nursing homes and intermediate care facilities for people with developmental disabilities, and mental health facility services.[43] [Updated February 2015]

Caregiver services were valued at $450 billion per year in 2009- up from $375 billion in year 2007.[44] [Updated February 2015]

Despite the trend toward community-based care as opposed to institutionalized care, only 18.2% of long-term care expenditures for the elderly are for community-based care.[45]

In 2002, 16.4 billion Medicaid dollars were spent for home and community-based services within long-term care. This figure has increased at a 25% rate annually since 1990.[46]

Expenditures for skilled nursing facility (SNF) care are much greater than care provided in other settings. Average expenses per older adult in a skilled nursing facility can be four times greater than average expenditures for that individual receiving paid care in the community.[47]

In 2003, Medicaid paid $83.8 billion dollars for long-term care services, roughly one-third of all Medicaid spending. 27.8 billion of these dollars were spent on community-based long-term care services. Home and community-based (HCBS) waivers accounted for roughly two-thirds of community-based long-term care expenditures.[48]

In 2000, spending for older adults aged 65 or older accounted for 57% of Medicaid dollars, with the remaining 43% spent on those under age 65.[49]

31.9% of the annual estimated home care expenditures were paid for by Medicare in 2003, a little over 18% were paid for out-of-pocket or by private insurance, and approximately 13% were covered by Medicaid.[50]

Only 7% of residents receive Medicaid coverage for assisted living.[51]

Studies have shown that the delivery of home or community-based long-term care services is a cost-effective alternative to nursing homes. Care in the

home or community—not nursing home care—is what most Americans would prefer.[52, 53]

In 2004, the average daily rate for a private room in a skilled nursing facility was $192 for a private room or $70,080 annually, and $169 or $61,685 annually for a semi-private room. The hourly rate for a home health aide was $18.12.[54]

In 2000, annual cost estimates were $13,000 for adult day care and $25,300 for assisted living.[55]

Over two-thirds of the current health care dollar goes to treating chronic illness; for older persons the proportion rises to almost 95%.[56]

The aging of the population, especially those 85+—the most in need of long-term care—is expected to result in a tripling of long-term care expenditures, projected to climb from $115 billion in 1997 to $346 billion (adjusted for inflation) annually in 2040.57

One in four people age 45 and over are not at all prepared financially if they suddenly required long-term care for an indefinite period of time.[58] [Updated February 2015]

Future Issues

Research suggests that if savings rates are not increased and government programs to assist the elderly are not strengthened, many retirees will face serious problems attaining needed health and long-term care services in the future. By 2030, many retirees will not have enough income and assets to cover basic expenditures or any expenses related to a nursing home stay or services from a home health provider.[59]

Shorter hospital stays and increased usage of outpatient procedures—changes that have increased the effectiveness of medical care—have shifted responsibility toward unpaid providers of care from paid providers, increasing burdens on family caregivers.[60]

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Resources

Family Caregiver Alliance
785 Market Street, Suite 750
San Francisco, CA 94103
(415) 434-3388 | (800) 445-8106 (toll free)
caregiver.org
info@caregiver.org

Family Caregiver Alliance (FCA) seeks to improve the quality of life for caregivers through education, services, research and advocacy.

Through its National Center on Caregiving, FCA offers information on current social, public policy and caregiving issues and provides assistance in the development of public and private programs for caregivers.

For residents of the greater San Francisco Bay Area, FCA provides direct family support services for caregivers of those with Alzheimer's disease, stroke, brain injury, Parkinson's and other debilitating cognitive disorders that strike adults.

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James K. Ruble Seminar

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Section 5

Endorsements: The Good, The Bad, and The Ugly

ENDORSEMENTS:

The Good, The Bad,
and the Ugly

LYON CONSULTING
SERVICES, LLC

Steven D. Lyon
CIC,CRM,CPCU,AAI,ARM,AIS,CRIS, MLIS, AFIS

Legal Disclaimer

The information provided and statements made in this seminar / panel discussion are for informational purposes and is not intended as legal or other professional advice. Please procure the appropriate legal or other professional advice and services to address your individual circumstances. There is no representation, guaranty or warranty made as to the sufficiency or accuracy of the information provided. Any legal cases discussed or cited, may or may not be enforceable and/or valid in your jurisdiction.

Endorsements

- Only one way to change a policy
- Must be requested by a Named Insured (PL) or First Named Insured (CL)
- Change Request to Carrier
- Issuance of Endorsement signed by President and Secretary

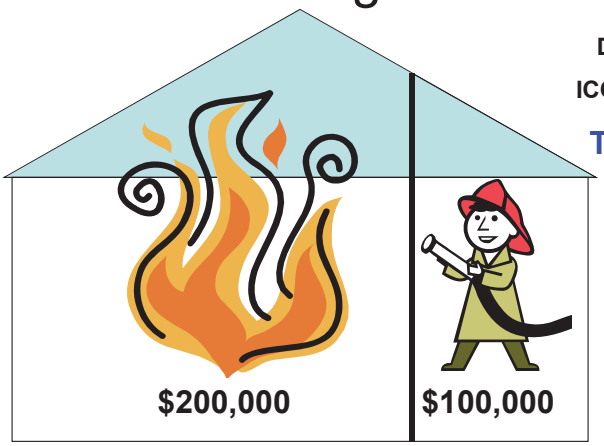
- Certificates of Insurance
- Third Party Requests

COMMERCIAL PROPERTY ENDORSEMENTS

ORDINANCE or LAW COVERAGE – CP 0405

- When more than 50% of a building is damaged, it is deemed structurally unsafe to rebuild and must be torn down.
  (Uniform Construction Code-most every town adopts)

$300,000 Building Coverage



Damaged Part Paid

Structure-$200,000

Demolition-$5000*

Debris Removal-$10,000*

ICC-$20,000* **(*up to policy limit)**

Total Paid $235,000

Undamaged Part-NOT Paid

Structure- $100,000

Demolition-$2500

Debris Removal-$5000

ICC-$10,000

Out of Pocket- $117,500

* Increased Cost of Construction

ORDINANCE or LAW COVERAGE- CP 0405

100% Building Replacement Cost

- Undamaged Part of Buidling (A)
- Demolition Cost (B)
- Increased Cost of Construction (C)
  - Current Building Code
  - Americans with Disabilities Act
  - Undersized Lot
  - Grandfathered Occupancy
  - $10,000 or 5% of Bldg limit; applies to ICC, *only if you have RC!!*
- Availability / Expensive

Ordinance or Law- Extended Period of Restoration- CP 1531

POLICY NUMBER: COMMERCIAL PROPERTY
CP 15 31 09 17

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ORDINANCE OR LAW – INCREASED PERIOD OF RESTORATION

This endorsement modifies insurance provided under the following:

BUSINESS INCOME (AND EXTRA EXPENSE) COVERAGE FORM
BUSINESS INCOME (WITHOUT EXTRA EXPENSE) COVERAGE FORM
EXTRA EXPENSE COVERAGE FORM

SCHEDULE

Described Premises:
Post-Loss Ordinance Or Law Option: Yes ☐ No ☐
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

9

Ordinance or Law- Extended Period of Restoration- CP 1531

A. If a Covered Cause of Loss occurs to a building(s) at the premises described in the Schedule, resulting in a "suspension" of "operations" covered under this policy, the "period of restoration" is extended to include the increased period required to comply with the minimum standards of an ordinance or law, provided that:

1. The ordinance or law regulates the demolition, construction or repair of buildings, or establishes zoning or land use requirements at the described premises; and
2. The requirements of the ordinance or law are in force at the time of loss. But if the Post-Loss Ordinance Or Law Option is indicated in the Schedule as being applicable, then Paragraph A.3. applies instead of this Paragraph A.2.
3. The requirements of the ordinance or law are in force at the time of loss; or the ordinance or law is promulgated or revised after the loss but prior to commencement of reconstruction or repair and provided that such ordinance or law requires compliance as a condition precedent to obtaining a building permit or certificate of occupancy.

However, coverage is not extended under this endorsement to include loss caused by or resulting from the enforcement of or compliance with any ordinance or law which requires:

1. The demolition, repair, replacement, reconstruction, remodeling or remediation of property due to contamination by "pollutants" or due to the presence, growth, proliferation, spread or any activity of "fungus", wet or dry rot or bacteria; or
2. Any insured or others to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of "pollutants", "fungus", wet or dry rot or bacteria.

B. The following definition is added:

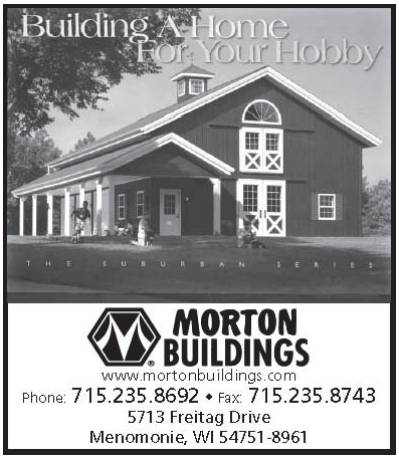
"Fungus" means any type or form of fungus, including mold or mildew, and any mycotoxins, spores, scents or by-products produced or released by fungi.

10

Valuation

- Based upon Principle of Indemnity
- Replacement Cost (Increase values if you choose this option)
- Actual Cash Value (RC – DEP)
- Market Value (willing buyer and willing seller)
- Broad Evidence Rule
- Functional Building Valuation – CP 0438
- Functional Personal Property Valuation – CP 0439
- Mfgrs. Selling Price – CP 9930 (Finished Stock Only)
- Agreed Value – (Optional Coverage - Suspends Coinsurance)
- Valued Policy Laws
- Diminution of Value

Functional Replacement Cost



Functional Building Valuation- CP 0438

POLICY NUMBER: COMMERCIAL PROPERTY
CP 04 38 09 17

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FUNCTIONAL BUILDING VALUATION

This endorsement modifies insurance provided under the following:

BUILDING AND PERSONAL PROPERTY COVERAGE FORM
CONDOMINIUM ASSOCIATION COVERAGE FORM

SCHEDULE

Premises Number	Building Number	Limit Of Insurance
		$
		$
		$
Post-Loss Ordinance Or Law Option: Yes ☐ No ☐		
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.		

Debris Removal

- For every 6000 sq ft of solid BRICK construction it takes $70,000 to haul it away
- For every 6000 sq ft of solid STEEL construction it takes $60,000 to haul it away
- For every 6000 sq ft of solid FRAME construction it takes $50,000 to haul it away

- These costs are about 60% dump fees and 40% labor/trucking

Debris Removal

- Increased limits available
- Building limit of $400,000
- $400,000 total building loss, with $75,000 Debris Removal costs
- Policy pays $400,000 + $25,000 Debris Removal (in excess of limit)
- $50,000 uninsured

Debris Removal

- Complicated !
- Remove debris of Covered Property - damaged from a Covered Cause of Loss
- No Pollution
- Notify company within180 days
- 25% of the Loss + Deductible and
- Sum of Loss Payable + Debris Removal < Limit
- Subject to Limit of Coverage
- $25,000 extra if you exceed limit
- CP 0415 – Debris Removal Additional Insurance

Debris Removal Example

• Limit of Insurance	$90,000
• Deductible	$ 500
• Loss	$50,000
• Loss Payable	$49,500
• Debris Removal Expense	$10,000
• Debris Removal Paid	$10,000

– 1. Max payable is 25%of Loss + Deductible
($49,500 x.25 = $12,375 +500= $12,875) OK!
– 2. Loss Payable + Debris Removal <Policy Limits
($49,500 + $10,000 < $90,000) OK!

Debris Removal Example

- Limit of Insurance $90,000
- Deductible $ 500
- Loss $80,000
- Loss Payable $79,500

- Debris Removal Expense $45,000
- Debris Removal Paid $10,500 + $25,000 addt'l

  – 1. Max payable is 25%of Loss + Deductible
    ($80,000 x.25 = $20,000 +500= $20,500) Problem !
  – 2. Loss Payable + Debris Removal < Policy Limits
    ($79,500 + $45,000 < $90,000) Problem!

Utility Services Endorsements

- Utility Services Direct Damage – CP 0417
  – Must be Direct Damage by a Covered Cause of Loss to the Utility Supply company designated in the schedule
  – Includes Water, Communication and/or Power, if designated
  – Does not include overhead power lines, unless indicated on the schedule
- Utility Services Time Element- CP 1545
  – Interruption must be Direct Damage by a Covered Cause of Loss to the Utility Supply company designated in the schedule
  – Includes Water, Wastewater Removal, Communication and/or Power, if designated
  – Does not include overhead power lines, unless indicated on the schedule

DEPENDENT PROPERTIES

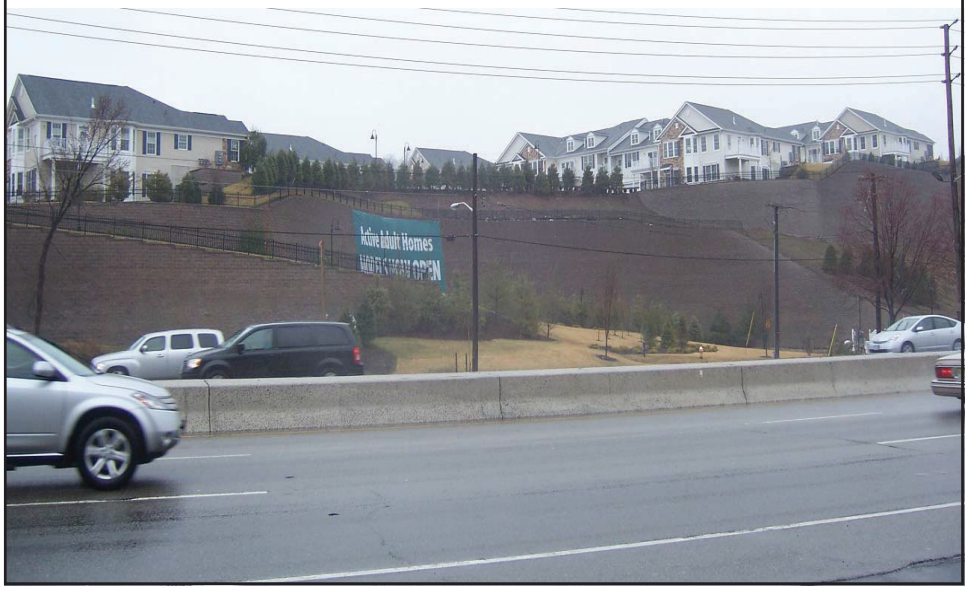
- Types
  - Leader Locations
  - Contributing Locations
  - Manufacturing Locations
  - Recipient Locations
- International Dependent Properties
  - Business Income from Dependent Properties Limited International Coverage – CP 15 01
  - Extra Expense from Dependent Properties International Coverage – CP 15 02

ISO Commercial Property Exclusions and Limitations Buy Backs

- CP 1410 – Additional Covered Property
- CP 1430 - Outdoor Trees, Shrubs and Plants
- CP 04 14 – Limited Coverage for Unmanned Aircraft (Scheduled and/or Blanket Coverage)

TYPE OF PROPERTY NOT COVERED	HOW TO BUY COVERAGE BACK	NOT INSURABLE
Accounts, bills, currency, food stamps or other evidences of debt, money, notes or securities.	Commercial Crime Coverage Forms	
Animals, unless "boarded" or "your stock"	CP 1410 Additional Covered Property, or Inland Marine Coverage Forms	
Autos held for sale	Auto Dealers Coverage Form	
Bridges, roadways, walks, patios or other paved surfaces	CP 1410 Additional Covered Property, or Inland Marine Coverage Forms	
Contraband, illegal transportation/trade	N/A	XXXXXXX
Excavations, grading, backfilling or filling	CP 1410 Additional Covered Property	
Foundations of buildings, structures, machinery	CP 1410 Additional Covered Property	
Land, water, growing crops or lawns	Crops or lawns -- Inland Marine Coverage Forms	
Airborne or waterborne personal property	Inland Marine Coverage Forms, or Ocean Marine Coverage Forms	
Bulkheads, pilings, piers, wharves or docks	CP 1410 Additional Covered Property, or Inland Marine Coverage Forms	
Property covered elsewhere	BPP Form pays excess	
Retaining walls	CP 1410 Additional Covered Property	
Underground pipes flues or drains	CP 1410 Additional Covered Property	
Electronic data	CP 0430 E-Commerce or Inland Marine Coverage Forms	
Research, replace, restore information on valuable papers and records	Valuable Papers & Records CP Form, or Inland Marine Coverage Forms	
Vehicles or self propelled machines...	CP 1410 Additional Covered Property	
Certain outdoor property	Fences -- CP 1410 Additional Covered Property Signs -- CP 1440 Outside Signs Antennas -- CP 1450 Radio or TV Antennas Trees -- CP 1430 Outdoor Trees, Shrubs and Plants, or Inland Marine Coverage Forms	
Unmanned Aircraft- Drones	CP 04 14 Limited Coverage Unmanned Aircraft	

Excluded Property--Retaining Walls



MOREYS PIERS

Wildwood, NJ

Tangible Property

- Is the Data in your computer BPP ?
- Is the postage in your mail machine BPP ?
- Are the minutes on your phone card BPP?
- Is the water in your pipes covered as your BPP ?

"Data" is not Tangible Property

- Therefore damage to data on your hard drive is not covered under your Commercial Property Forms [CP 00 10 provides additional coverage up to a limit of $2500]
- What about Contractors digging underground and cause damage to your server and data ?
- CG 0437 Electronic Data Liability End't.
  - Limited Buy-Back offered by some carriers
  - Must first have damage to tangible property
  - Proprietary
- CG 0065 Electronic Data Liability Coverage Form
  - No Damage to Tangible Property required
- CP 04 30 Electronic Commerce (E-Commerce)

CP 00 10 Building and Personal Property Coverage Form

- Understanding "Business Personal Property"
- CP 1460 – Leased Property
- CP 1420 – Additional Property Not Covered
- CP 1910 – Your BPP – Separation of Coverage

Business Personal Property

CP 00 10 Building and Personal Property Coverage Form

- Your Business Personal Property consists of the following property located in or on the building or structure described in the Declarations or in the open (or in a vehicle) within 100 feet of the building or structure or within 100 feet of the premises described in the Declarations, whichever distance is greater:
  - Furniture and fixtures
  - Machinery and Equipment
  - "Stock"
  - All other personal property owned and used by you
  - Labor, materials and services furnished by you on PPO
  - Your "Use Interest" in Tenants Improvements & Betterments
  - **Leased personal property which you must contractually insure** (CP1460-scheduled / agreed value)

Equipment Lease

Equipment Lease

14.**Loss And Damage.** Lessee shall bear the entire risk of loss, theft; damage or destruction of the equipment from any cause whatsoever, and no loss, theft, damage or destruction of the equipment *shall relieve Lessee of the obligation to pay rent or of any other obligation under this lease.*

In the event of damage to any item of equipment, Lessee shall immediately place the same in good repair. *The Lessee furthermore agrees to continue to pay rent after the expiration of this lease until any item of equipment is placed in good repair.*

If Lessor determines that any item of equipment is lost, stolen, destroyed or damaged beyond repair, Lessee at the option of Lessor shall:
(a)replace the same with like equipment in good repair and continue to pay rent after the expiration of this lease until replacement is concluded; or
(b)pay Lessor in cash all of the following:
(I) all amounts then owed by Lessee to Lessor under this lease,
(ii) an amount equal to ten percent (10%) of the actual cost of said item, AND
(iii) the unpaid balance of the total rent for the initial term of this lease attributable to said item. Upon Lessor's receipt of such payment, Lessee shall be entitled to whatever interest Lessor may have in said item, in its then condition and location, without warranty express or implied.
The parties hereto agree that the sum of the amounts numbered (ii) and (iii) will equal the fair value of said item on the date of such, loss, theft, damage or destruction, and the remaining rent payable here under shall be reduced by such amount as is paid under item
(iii) above prorated over the remaining term hereof.

Equipment Lease

10. <u>Insurance</u>.

Lessee shall procure and continuously maintain and pay for:

A. All risk insurance against loss of and damage to the Equipment for not less than the full replacement value of the Equipment, naming Lessor as loss payee, and;

B. Combined public liability and property damage insurance with limits as approved by Lessor, naming Lessor as additionally named insured and a loss payee.

The insurance shall be in such form and with such company or companies as shall be reasonably acceptable to Lessor, shall provide at least thirty (30) days advance written notice to Lessor of any cancellation, change or modification, and shall provide primary coverage for the protection of Lessee and Lessor without regard to any other coverage carried by Lessee or Lessor protecting against similar risks.

Problem with BPP and Leased Property

- "Leased property for which you have a contractual obligation to insure" is covered as BPP
- Client leases $40,000 of computer equipment
- Lease reads, " Renter shall during the rental term keep and maintain the property in good working condition and repair and shall be responsible for any loss, casualty, damage or destruction to said property.
- Submits claim for BPP –DENIED
- Carrier pays $2500 under Personal Property Of Others
- (CP1460) agreed value option

Business Personal Property

- Your Business Personal Property consists of the following property located in or on the building or structure described in the Declarations or in the open (or in a vehicle) within 100 feet of the building or structure or within 100 feet of the premises described in the Declarations, whichever distance is greater:
  - Furniture and fixtures
  - Machinery and Equipment
  - "Stock"
  - All other personal property owned and used by you
  - Labor, materials and services furnished by you on PPO
  - **Your "Use Interest" in Tenants Improvements & Betterments**
  - Leased personal property which you must contractually insure (CP1460-scheduled / agreed value)

Tenants Improvements and Betterments

- Made a part of the Building you do not own
- ***Made or acquired*** at your expense (previously installed-problem)
- Cannot legally remove when you leave

Settlement: "USE INTEREST ONLY"

- If others pay for repair/replace = nothing
- If you repair/replace promptly = ACV
- If you don't repair/replace promptly = proportionate value to lease (ACV only)
  - 5 years lease with 5 year option to renew
  - $100,000 Tenants Improvements
  - Loss happens halfway through the lease = $50,000

Tenants Improvements & Betterments

- Before

- After

TIB Claim Example

- Permanently installed TIB become property of the Landlord
- Tenant has responsibility to insure TIB
- Landlord may have serious Coinsurance problems !
  - Increase building limit
  - Duplicate coverage possibility
  - **CP 1420: Additional property not covered**
    - Can be added to landlords or tenants policy
- Endorse policy to read: "The sole interest of the named insured in all improvements and betterments at premises covered under this policy is hereby recognized, without regard to any terms of a lease". [Intent is to make certain insured recovery will be ACV/RC regardless of whether property is rebuilt or not.
- **CP1910- Your BPP Separation of Coverage** – Rate as Building.
- Potential Problem with Ordinance /Law Coverage which only applies to buildings – use **CP 14 15 Additional Building Property**

Leasehold Interest Coverage Form

(CP 0060)

- 9/11/01 – Relocation claims
- Worldwide broker's largest property loss was loss of lease !
- Example: (could add in undamaged TIB also)
  - Tenant paying $2000 /month rent
  - Equivalent space is $2800 / month rent
  - Gross leasehold interest = $800/ month
  - 32 months left on lease
  - Exposure: 32 months x $800 = $25,600
  - $25,600 discounted @ 8% = $23,070 NPV

TIB Claim Example with Leasehold Interest

- Insured Leased Commercial Building
- Made $50k TIB to the building
- Tenant is responsible for repairing / replacing TIB if damaged
- Buys $50k BPP
- Lease also has a 90 day untenantable clause, exercisable by either party to cancel lease
- Fire loss, partially destroys TIB
- BPP pays for ***damaged*** TIB's
- Landlord exercises option and cancels lease
- Tenant must secure new premises at unfavorable rate ($5000/mo. vs. $2500/mo.) – Leasehold Interest
- Leasehold Interest Form will pay Tenant for the unamortized value of TIB not damaged, they had to abandon due to termination of the lease by a covered cause of loss

Alcoholic Beverage Endorsements

- CP 9910 – Alcoholic Beverages Tax Exclusion
- CP 9905 – Distilled Spirits/Wines Market Value

Alcohol Beverage Tax Exclusion

CP 9910

- Within two days of a fire at a high-class restaurant noted for its wine collection, you see several men at the site using axes and light sledge hammers to break the hundreds of unopened wine bottles. Because the wine has been in a fire, the state health department has condemned it and all of the wine bottles have to be broken. Both federal and state alcohol tax officials oversee this process. The tax staff keeps track of the number of unopened bottles that are being broken. Their reason for this is quite simple. Since these bottles have not been opened, the restaurant does not owe any tax on them. Alcohol taxes are owed only on the bottles that already have been opened.
- Because the restaurant owner does not owe for taxes on the unopened bottles, no insurance payment will be made for the taxes. Without adding an endorsement, the insured could be in the position, to satisfy coinsurance values, of needing an amount of insurance high enough to cover the taxes on all of the unopened bottles yet would be unable to receive payment for the taxes.

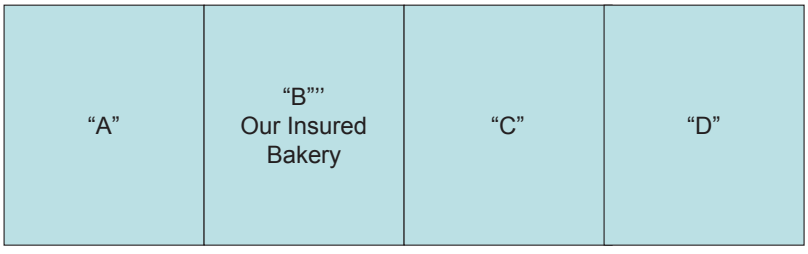
- **Distilled Spirits/Wines Market Value- CP 9905**

Damage to Premises Rented vs. Legal Liability Coverage

- CG 00 10 (0413) – CGL Coverage Form
- CP 00 40 -- LEGAL LIABILITY COVERAGE FORM

Damage to Premises Rented
a/k/a Fire Legal Liability

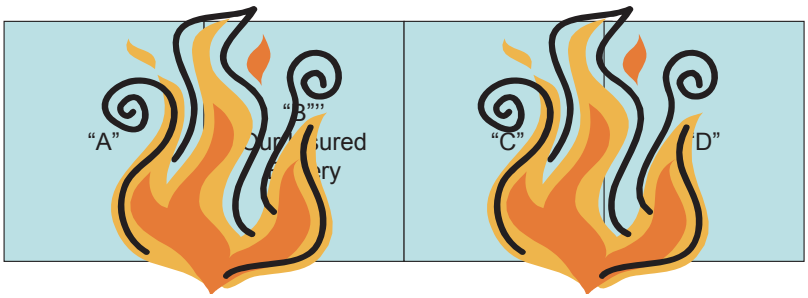
Landlord: $1,000,000 PROPERTY ---$250,000 each store



Tenant "B": BOP/CPP $50,000 BPP and $1,000,000 CGL and $50,000 DPR

Damage to Premises Rented
a/k/a Fire Legal Liability

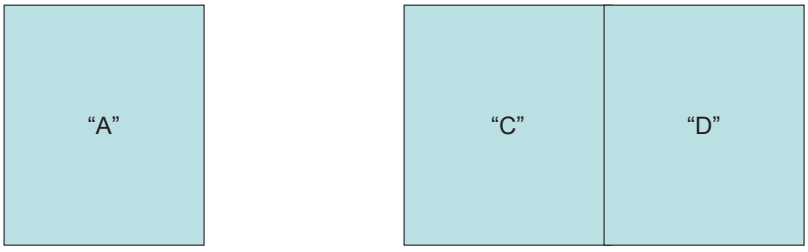
Landlord: $1,000,000 PROPERTY ---$250,000 each store



Tenant "B": BOP/CPP $50,000 BPP and $1,000,000 CGL and $50,000 DPR

Damage to Premises Rented
a/k/a Fire Legal Liability

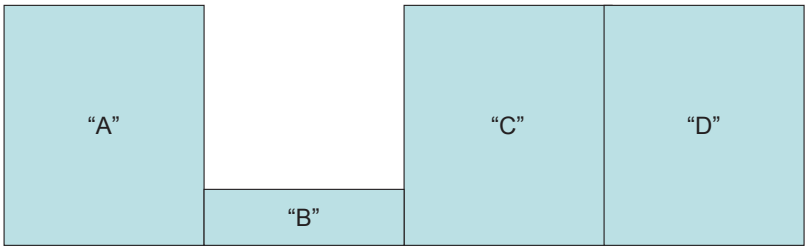
Landlord: $1,000,000 PROPERTY ---$250,000 each store



Tenant "B": BOP/CPP $50,000 BPP and $1,000,000 CGL and $50,000 DPR

Damage to Premises Rented
a/k/a Fire Legal Liability

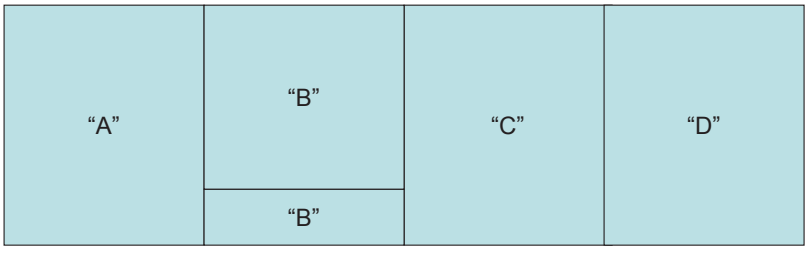
Landlord: $1,000,000 PROPERTY ---$250,000 each store



Tenant "B": BOP/CPP $50,000 BPP and $1,000,000 CGL and $50,000 DPR

Damage to Premises Rented
a/k/a Fire Legal Liability

Landlord: $1,000,000 PROPERTY ---$250,000 each store



Tenant "B": BOP/CPP $50,000 BPP and $1,000,000 CGL and $250,000 DPR

j. Damage to Property Exclusion

[Remember we are talking about a Liability Policy]

1) Excludes property you own, rent, or occupy [can't be liable to yourself] and the expenses to repair or maintain such property even if to prevent an injury or damage.

***Not for profit rents space in a local building for a fundraiser. Several rowdy guests damage the building and the building owner would like the not for profit to pay for the damage. Declined due to j(1)**

Damage to Premises Rented

Exhibit - Damage to Premises Rented To You (Named Insured)			
Cause of Damage	Property	7 days or less	More than 7 days
Fire, if negligent	Premises only while *rented to OR temporarily occupied* by the named insured	Covered	Covered
Other than fire	Premises & contents *rented* to the named insured	Covered	Not covered

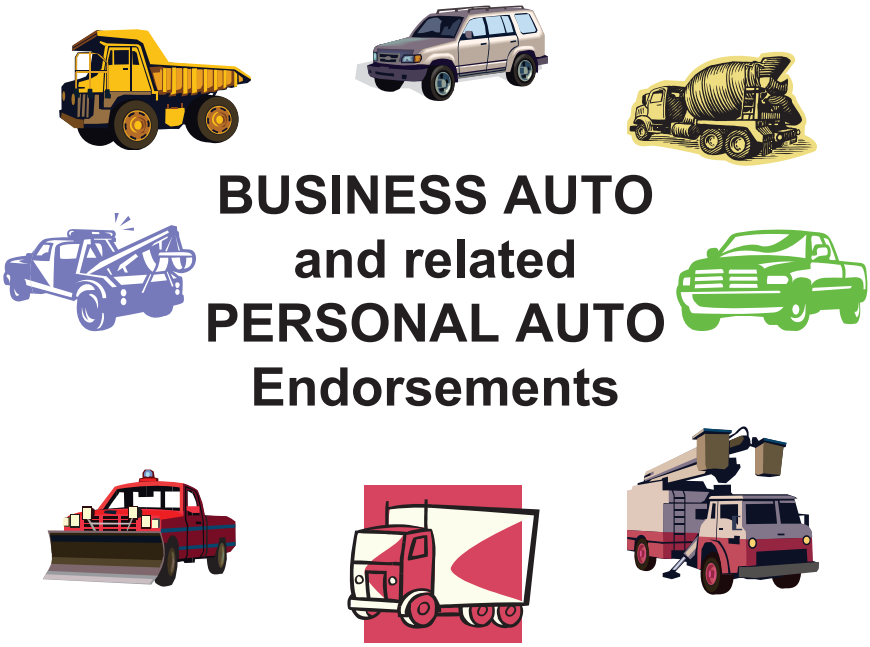
Damage to Premises Rented
a/k/a Fire Legal Liability

PROBLEMS and SOLUTIONS:

- Limited Coverage under CGL
- One Peril Only – FIRE !
- Need Legal Liability Coverage- CP 0040
- Can my Commercial Umbrella help ?
- Waiver of Subrogation

Commercial Property Endorsements

- Exclusion of Loss Due to Virus or Bacteria- CP 0140
  - Food / Product Contamination
  - Pandemic H5N1 / Swine Virus
  - Mandatory in most jurisdictions
- Joint Loss Agreement – CP 1270
  - ISO Equipment Breakdown form has this wording built in
  - Coordinates who is responsible for loss



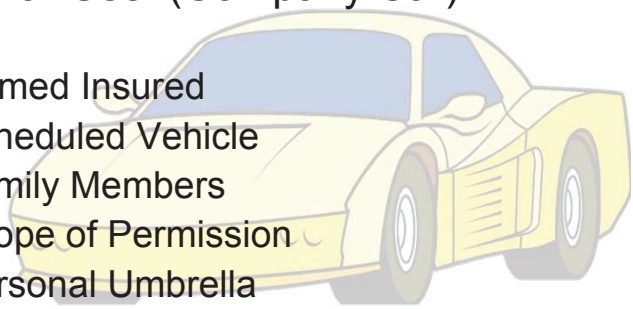
BUSINESS AUTO and related PERSONAL AUTO Endorsements

Extended Non-Owned Coverage – Vehicles Furnished or Available for your Regular Use

PP 03 06

Personal Auto Issues

- Vehicles Furnished or Available for your Regular Use (Company Car)
  - Named Insured
  - Scheduled Vehicle
  - Family Members
  - Scope of Permission
  - Personal Umbrella
  - Extended Non-Owned Coverage Endorsement



Extended Non-Owned Coverage

- It expands liability and medical payments coverages for certain non-ownership exposures of a named individual.
- The named individual can be either the named insured or a family member.
- The mechanism for providing coverage in this endorsement is the removal of exclusions, both under the liability coverage and the medical payments coverages.

B.2.b—Any vehicle other than "your covered auto" which is furnished or available for *your* regular use.

B.3.b.—Any vehicle other than "your covered auto" which is furnished or available for the regular use of *any "family member."*

- Employees often are furnished vehicles for their business and/or pleasure use.
  - Friends, neighbors and nonresident relatives may make their vehicles available for regular use.
  - Employees sometimes have access to a company's fleet of vehicles.
  - Travelers may rent vehicles for an extended length of time (more than one or two weeks).
- A little probing of your customer's activities may reveal "furnished or available for regular use" exposures.

Fellow-employee suits

- Another important consideration in the application of this endorsement is the protection against fellow employee suits.
- Business auto policies and commercial general liability policies exclude liability for suits of employees against fellow employees.
- The personal auto policy does not have such an exclusion.
- *Therefore, all the excluded business situations restored by this endorsement automatically provide fellow-employee coverage*.

Claim Example

Steve is a salesman for Lyon Insurance Agency. He is furnished a company car. Steve decides to take Ellen, his favorite CSR, out to visit a client to deliver the renewal. On the way to see the client, Steve is texting and hits a tree. Ellen is severely injured. What recourse does Ellen have for her injuries ?

Workers Compensation ?

- Yes, coverage for medical, wage, rehab and death
- No coverage for pain, suffering and loss of consortium

Business Auto ?

- No coverage due to fellow employee exclusion

Personal Auto ?

- Good news, no fellow employee PAP exclusion
- Bad News, no coverage for company cars

POLICY NUMBER:

PERSONAL AUTO
PP 03 06 01 05

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXTENDED NON-OWNED COVERAGE – VEHICLES FURNISHED OR AVAILABLE FOR REGULAR USE

SCHEDULE

Unless otherwise indicated below or in the Declarations, Extended Non-Owned Coverage is applicable only to the individual named in the Schedule or in the Declarations.

Name of Individual: _____

If indicated below or in the Declarations, Extended Non-Owned Coverage applies to:

☐ Named Individual and "Family Members" (including Named Individual's Spouse)

Coverage is provided where a premium is shown for the coverage.

Extended Non-Owned Coverage	**Premium**
Liability	$ _____
Medical Payments	$ _____
Total Premium	$ _____

SAMPLE

With respect to the individual(s) and coverages indicated in the Schedule or in the Declarations, the provisions of the policy apply unless modified by this endorsement.

I. Extended Non-Owned Coverage

The Extended Non-Owned Coverage provided by this endorsement does not afford coverage under Part **A** and Part **B** of the policy for any accident involving:

A. A vehicle owned by an individual named in the Schedule or in the Declarations;

B. A vehicle owned by a "family member"; or

C. A temporary substitute vehicle for such owned vehicle described in **A.** or **B.** above.

II. Part A – Liability Coverage

Part **A** is amended as follows with respect to the individual(s) shown as applicable in the Schedule or in the Declarations:

A. Exclusion **B.2.b.** does not apply to the coverages provided by this endorsement.

B. We will provide Liability Coverage for any vehicle, other than "your covered auto", which is furnished or available for the regular use of the named individual.

III. Part B – Medical Payments Coverage

Part **B** is amended as follows, if a premium is shown in the Schedule or in the Declarations for Medical Payments Coverage, with respect to the individual(s) shown as applicable in the Schedule or in the Declarations:

A. Exclusion **5.b.** does not apply to the coverages provided by this endorsement.

B. We will provide Medical Payments Coverage for "bodily injury" sustained while "occupying", or when struck by, any vehicle (other than "your covered auto") which is furnished or available for the regular use of the named individual.

This endorsement must be attached to the Change Endorsement when issued after the policy is written.

Extended Rental Period

Steve and his wife Liz, have two cars insured on a Personal Automobile Policy. Joshua, his son is away at college, so the two vehicles have been adequate.

Josh is coming home at the end of the school year, and Steve wants to rent a third car for the summer months. Steve would drive the rental car, and Joshua would drive one of the family's vehicles.

Will Josh have coverage for the rental car under the PAP?

Will Steve have coverage for the rental car under the PAP?

Named Non-Owner Policy

- If the carrier will not add DOC or employer does not want exposure (for other family members); then write a Named Non-Owned Policy
- NNOP is a policy for people who don't own any autos, but have an auto exposure
- NNOP provides Liability, Med Pay and UM only to specified person named in endorsement (no PIP or physical damage)
- Each family members must be named [or all family members triggered]
- Physical Damage is available, starting in the 2018 edition

Who is an Insured

- **You** for any **covered** "Auto"; (named insured may not be covered if not a covered auto)
- **Anyone** else using *with your permission* a *covered* "auto" **you** *own, hire or borrow* **except:** **(what's missing? n/o)**
  - The owner or anyone else from whom you hire or borrow a covered auto; (CA2001-Lessor AI&LP)
  - Your "employee" if the covered "auto" is owned by that employee or a member of their household; (CA9933 EE as Insureds)
  - Someone using a covered "auto" while in the auto services business; (unless its your business)
  - Anyone, other than your employees while moving property to or from a covered "auto"
  - A partner (if you are a partnership) or member (if LLC) for a covered "auto" owned by them or member of household.
- **Anyone** liable for the conduct of an "insured" (GC / Sub)

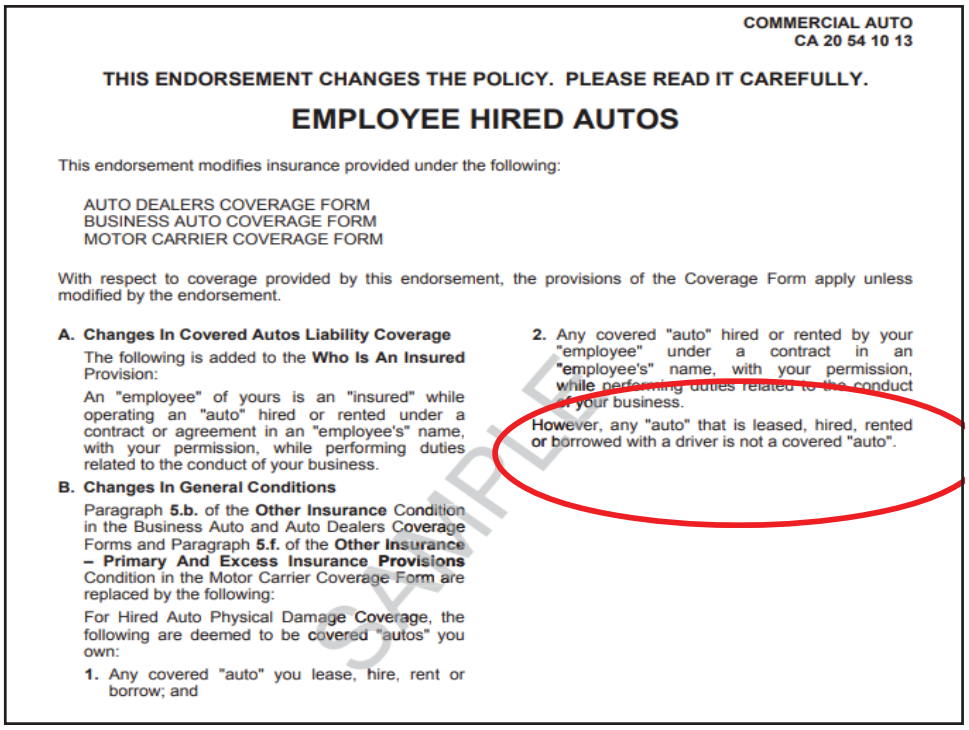
Symbol	Description Of Covered Auto Designation Symbols	
1	Any "Auto"	
2	Owned "Autos" Only	Only those "autos" you own (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to power units you own). This includes those "autos" you acquire ownership of after the policy begins.
3	Owned Private Passenger "Autos" Only	Only the private passenger "autos" you own. This includes those private passenger "autos" you acquire ownership of after the policy begins.
4	Owned "Autos" Other Than Private Passenger "Autos" Only	Only those "autos" you own that are not of the private passenger type (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to power units you own). This includes those "autos" not of the private passenger type you acquire ownership of after the policy begins.
5	Owned "Autos" Subject To No-fault	Only those "autos" you own that are required to have no-fault benefits in the state where they are licensed or principally garaged. This includes those "autos" you acquire ownership of after the policy begins provided they are required to have no-fault benefits in the state where they are licensed or principally garaged.
6	Owned "Autos" Subject To A Compulsory Uninsured Motorists Law	Only those "autos" you own that because of the law in the state where they are licensed or principally garaged are required to have and cannot reject Uninsured Motorists Coverage. This includes those "autos" you acquire ownership of after the policy begins provided they are subject to the same state uninsured motorists requirement.
7	Specifically Described "Autos"	Only those "autos" described in Item Three of the Declarations for which a premium charge is shown (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to any power unit described in Item Three).
8	Hired "Autos" Only	Only those "autos" you lease, hire, rent or borrow. This does not include any "auto" you lease, hire, rent or borrow from any of your "employees", partners (if you are a partnership), members (if you are a limited liability company) or members of their households.
9	Non-owned "Autos" Only	Only those "autos" you do not own, lease, hire, rent or borrow that are used in connection with your business. This includes "autos" owned by your "employees", partners (if you are a partnership), members (if you are a limited liability company) or members of their households but only while used in your business or your personal affairs.
19	Mobile Equipment Subject To Compulsory Or Financial Responsibility Or Other Motor Vehicle Insurance Law Only	Only those "autos" that are land vehicles and that would qualify under the definition of "mobile equipment" under this policy if they were not subject to a compulsory or financial responsibility law or other motor vehicle insurance law where they are licensed or principally garaged.

Employee Hired Autos – CA 20 54

1) An employee operating a hired or rented auto (without a driver) in his or her own name, with the named insured's permission, while performing duties related to the named insured's business, is an insured.

2) Generally no additional premium for the endorsement.

3) This endorsement also broadens physical damage coverage provided to employees of the named insured who hire or rent cars in their own names in the furtherance their employer's business. It changes the liability section's "Who is an Insured" provision to include such employees, and makes it clear that for physical damage coverage such autos are treated the same as other hired autos– that is, deemed to be owned covered autos and thus primary instead of excess. (This endorsement requires that hired auto coverage for physical damage and liability be in place)



COMMERCIAL AUTO
CA 20 54 10 13

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EMPLOYEE HIRED AUTOS

This endorsement modifies insurance provided under the following:

AUTO DEALERS COVERAGE FORM
BUSINESS AUTO COVERAGE FORM
MOTOR CARRIER COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by the endorsement.

A. Changes In Covered Autos Liability Coverage

The following is added to the **Who Is An Insured** Provision:

An "employee" of yours is an "insured" while operating an "auto" hired or rented under a contract or agreement in an "employee's" name, with your permission, while performing duties related to the conduct of your business.

B. Changes In General Conditions

Paragraph **5.b.** of the **Other Insurance** Condition in the Business Auto and Auto Dealers Coverage Forms and Paragraph **5.f.** of the **Other Insurance – Primary And Excess Insurance Provisions** Condition in the Motor Carrier Coverage Form are replaced by the following:

For Hired Auto Physical Damage Coverage, the following are deemed to be covered "autos" you own:

1. Any covered "auto" you lease, hire, rent or borrow; and
2. Any covered "auto" hired or rented by your "employee" under a contract in an "employee's" name, with your permission, while performing duties related to the conduct of your business.

However, any "auto" that is leased, hired, rented or borrowed with a driver is not a covered "auto".

SAMPLE

Employees as Insureds- CA 9933

- Many employers do not like to add this endorsement, as it exposes their policy limits and loss history
- Think about using your Personal Auto on your employers behalf and getting into a serious accident
- Who is automatically an insured under your Personal Auto policy
- Whose coverage goes First? Second?
- What happens when you exhaust your limit?
- Can your employers BAP carrier subrogate against you to recover its payment ?
- Aren't you an insured under the BAP, and therefore subrogation isn't allowed against an insured?

Designated Insured for Covered Autos Liability Coverage- CA 20 48

1) Allows insurers to respond to requests to add an entity's name to the BAP as an additional insured.

2) Although the "who is an insured" provision of the policy is broad enough to afford coverage for a person who is liable for the conduct of an insured, for example, the act of adding the person as an insured by name is more reassuring to the person making the request.

3) The endorsement has the advantage of bringing standardization to the process of naming an entity as an insured.

POLICY NUMBER:

COMMERCIAL AUTO
CA 20 48 10 13

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

DESIGNATED INSURED FOR COVERED AUTOS LIABILITY COVERAGE

This endorsement modifies insurance provided under the following:

AUTO DEALERS COVERAGE FORM
BUSINESS AUTO COVERAGE FORM
MOTOR CARRIER COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by this endorsement.

This endorsement identifies person(s) or organization(s) who are "insureds" for Covered Autos Liability Coverage under the Who Is An Insured provision of the Coverage Form. This endorsement does not alter coverage provided in the Coverage Form.

This endorsement changes the policy effective on the inception date of the policy unless another date is indicated below.

Named Insured:

Endorsement Effective Date:

SCHEDULE

Name Of Person(s) Or Organization(s):
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

Each person or organization shown in the Schedule is an "insured" for Covered Autos Liability Coverage, but only to the extent that person or organization qualifies as an "insured" under the Who Is An Insured provision contained in Paragraph **A.1.** of Section **II** – Covered Autos Liability Coverage in the Business Auto and Motor Carrier Coverage Forms and Paragraph **D.2.** of Section **I** – Covered Autos Coverages of the Auto Dealers Coverage Form.

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CA 2048

- Each person or organization shown in the Schedule is an "insured" for Covered Autos Liability Coverage, but only to the extent that person or organization qualifies as an "insured" under the Who Is An Insured provision contained in Paragraph A.1. of Section II – Covered Autos Liability Coverage in the Business Auto and Motor Carrier Coverage Forms and Paragraph D.2. of Section I – Covered Autos Coverages of the Auto Dealers Coverage Form.

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DRIVE OTHER CAR COVERAGE- Broadened Coverage for Named Individuals

CA 9910

Drive Other Car Coverage– CA 99 10

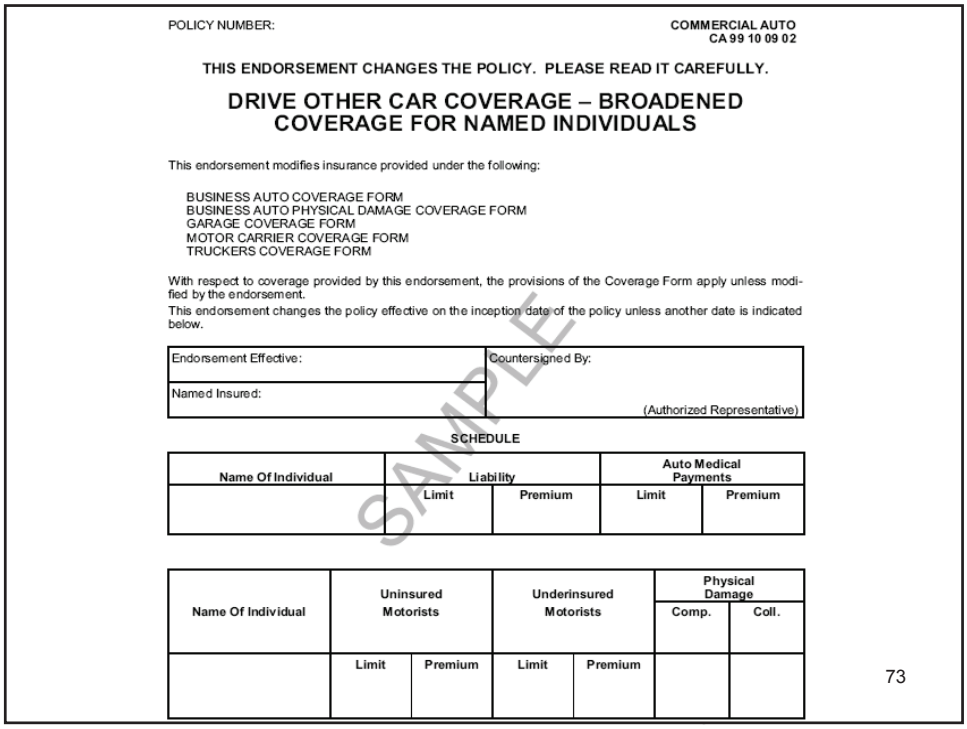
- *****IMPORTANT*****

1) Liability coverage is provided for any non-owned auto that is hired or borrowed except:
   a) autos owned by members of the insured's household,
   b) any auto used while working in an auto business

2) "Family members" ARE NOT automatically covered for Liability. They must be named in order for coverage to apply to them. [resident spouses are automatically covered]

3) Medical Payments and UM/UIM coverage may be provided to the named individual and "family members"

4) May extend liability, physical damage, medical payments and UM/UIM to the individual (and resident spouse) NAMED IN THE ENDORSEMENT



POLICY NUMBER: COMMERCIAL AUTO CA 99 10 09 02

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

DRIVE OTHER CAR COVERAGE – BROADENED COVERAGE FOR NAMED INDIVIDUALS

This endorsement modifies insurance provided under the following:

BUSINESS AUTO COVERAGE FORM
BUSINESS AUTO PHYSICAL DAMAGE COVERAGE FORM
GARAGE COVERAGE FORM
MOTOR CARRIER COVERAGE FORM
TRUCKERS COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by the endorsement.
This endorsement changes the policy effective on the inception date of the policy unless another date is indicated below.

Endorsement Effective:	Countersigned By: (Authorized Representative)
Named Insured:	

SCHEDULE

Name Of Individual	Liability		Auto Medical Payments	
	Limit	Premium	Limit	Premium

Name Of Individual	Uninsured Motorists		Underinsured Motorists		Physical Damage	
					Comp.	Coll.
	Limit	Premium	Limit	Premium		

SAMPLE

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Problems - Gaps

- All vehicles insured under XYZ Inc.’s Corporate policy – No PAP
- Dad is Furnished Company Car by XYZ Inc.
- Dad, Mom and Son all live in same household – no one has a PAP
- Employer has BAP with symbol 1 for liability, and symbol 2 for UM, Med Pay, and symbols 2 and 8 for Physical Damage
- CA 2054 added- Employee hired autos

Problems - Gaps

- Coverage WOULD be provided for XYZ, Inc and Dad, mom and son in the following circumstances:
  - Dad is driving company car on business and causes injury/damage to third party and company car
  - Mom and/or son are driving company auto with permission and cause injury/damage to third party and company car
  - Dad while away on a business trip rents a car in his personal name and damages the rental car and does third party damage/injury [CA 2054]
  - All covered because they involve a “covered auto”

Problems -Gaps

- Coverage would NOT be provided under the BAP in the following circumstances:
  - Dad rents a car while on vacation and damages/injures a third party
  - Mom travels out of town and rents a car for business for her employer (not xyz, inc.)
  - Son borrows a friends car and injures/damages a third party and is sued naming son, mom and dad
  - Dad, Mom or son are struck as a pedestrian by an uninsured motor vehicle
  - Not covered because none of the above are a “covered auto”

ISO Commercial Auto Policy

CA 00 01 (1013)

SECTION II – COVERED AUTOS LIABILITY COVERAGE

A. Coverage

- We will pay all sums an "insured" legally must pay as damages because of "bodily injury" or "property damage" to which this insurance applies, caused by an "accident" and resulting from the ownership, maintenance or use of a covered "auto".
- **We will also pay all sums an "insured" legally must pay as a "covered pollution cost or expense" to which this insurance applies, caused by an "accident"** and resulting from the ownership, maintenance or use of covered "autos". However, we will only pay for the "covered pollution cost or expense" if there is either "bodily injury" or "property damage" to which this insurance applies that is caused by the same "accident"

EXAMPLES OF POLLUTION LIABILITY LOSSES	
COVERED	EXCLUDED
1. Covered auto causes a train wreck resulting in the release of pollutants carried by the train.	1. A gasoline truck owned, hired, or borrowed by the insured overturns.
2. Covered auto runs into an storage tank, belonging to somebody else, causing release.	2. A shipment of batteries on an insured truck is damaged by fire, causing release of acid.
3. Covered auto is involved in an accident and leaks oil from its own crankcase.	3. While loading chemical wastes onto an insured vehicle, a barrel is dropped, causing escape of pollutants.
4. Hydraulic fluid from a garbage truck (covered auto) leaks onto the road.	4. An insured gasoline truck parked overnight leaks gasoline from its tanker trailer.
5. Exhaust fumes from a covered auto cause Bodily Injury.	5. Fuel oil stored on an insured truck at a job site is damaged by vandals and leaks into a local well
6. Leakage of gasoline from a vehicle's gas tank causes an explosion.	6. A dangerous chemical is released from a garbage truck when compacting the load.
7. Following the delivery of hazardous cargo, a covered auto backs into the shipment, causing release.	7. Following delivery of a shipment of solvents, the 55 gallon drums topple over causing a spill.
Note: Coverage provided for: **1. liability from pollutants not being transported or towed by, handled or handled for movement into, onto or from the covered "auto"; in the course of transit by or on behalf of the "insured"; or being stored, disposed of, treated or processed in or upon the covered "auto".** **2. liability from pollutants that are needed for or result from the normal electrical, hydraulic or mecha nical functioning of the covered "auto" or its parts.**	Note: CA 99 48 Pollution Liability Broadened Coverage "buys back" coverage for all above examples except #7 and liability assumed in a contract. Coverage provided for the discharge of pollutants that are being transported … in the course of transit by or on behalf of the "insured"; or being stored … in or upon the covered "auto". Deletes the CCC exclusion, which would have prevented the very coverage bought.

LOADING and UNLOADING

Exposure	Business Auto Coverage Form	Commercial General Liability Coverage Form
Losses during Loading and Unloading	**Covers.** Insuring agreement of the BAP generally covers claims arising out of the "use" of a covered auto, which under the common law "completed operations" doctrine, includes all loading and unloading operations, from the moment of pickup to the moment of final delivery.	**Excludes.** CGL policy's auto exclusion applies to claims "arising out of the ... handling of property: "a. *After* it is moved from the place where it is accepted for movement into or onto an ... 'auto' [i.e., during loading]; or ... "c. *While* it is being moved from an ... 'auto' to the place where it is finally delivered [i.e., during unloading]."
Losses before Loading or after Unloading	**Excludes.** The BAP's "handling of property" exclusion applies to claims "resulting from the handling of property: "a. *Before* it is moved from the place where it is accepted by the 'insured' for movement into or onto the covered 'auto' [i.e., before loading]; or "b. *After* it is moved from the covered 'auto' to the place where it is finally delivered by the 'insured' [i.e., after unloading]."	**Covers.** Claims resulting from the handling of property *before* it is moved from the point of acceptance and *after* being moved to the point of final delivery would not fall within the CGL policy's auto exclusion, and thus would be covered by the general terms of the CGL policy's insuring agreement.
Losses during Transit	**Covers.** The BAP's "handling of property" exclusion only applies before loading and after unloading. It does not apply in between, and therefore the BAP covers losses during transit.	**Excludes.** CGL policy's auto exclusion specifically applies to claims "arising out of the ... handling of property ... "b. While it is in or on an ... 'auto' [i.e., during transit]."

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Insurance Risk Management Institute

Exposure	Business Auto Coverage Form	Commercial General Liability Coverage Form
Losses during Transit	**Covers.** The BAP's "handling of property" exclusion only applies before loading and after unloading. It does not apply in between, and therefore the BAP covers losses during transit.	**Excludes.** CGL policy's auto exclusion specifically applies to claims "arising out of the ... handling of property ... "b. While it is in or on an ... 'auto' [i.e., during transit]."
Detached Mechanical Device	**Excludes.** The BAP has a separate "mechanical device" exclusion for claims "resulting from the movement of property by a mechanical device (other than a hand truck) unless the device is attached to the covered 'auto.'" If the device is not attached, the exception does not apply, and the BAP would not cover the loss.	**Covers.** CGL policy's auto exclusion excepts "the movement of property by means of a mechanical device, other than a hand truck, that is *not* attached to the ... 'auto.'" If the device is not attached, the exception applies, and the CGL policy would cover the loss.
Attached Mechanical Device	**Covers.** BAP's "mechanical device" exclusion has an exception for devices that are attached to the covered auto, meaning the BAP covers them.	**Excludes.** Any mechanical device that *is* attached to the auto would not fall within the exception and thus would be excluded under the CGL policy.
Hand Truck	**Covers.** BAP's "mechanical device" exclusion has a separate exception for hand trucks, meaning the BAP covers them.	**Excludes.** Auto exclusion has an exception to the exception for "hand trucks," meaning the CGL policy does not cover them.

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Insurance Risk Management Institute

CGL Exclusions

Aircraft, **Auto** Or Watercraft

- **"Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft <u>owned</u> or <u>operated by</u> or <u>rented</u> or <u>loaned</u> to any insured.** Use includes operation and "loading or unloading".
- This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involved the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft that is owned or operated by or rented or loaned to any insured.

- What's left ?
- *The named insured may have coverage for the hiring of an Independent Contractor that use their own auto, aircraft or watercraft*

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- A case in point is *Nick's Brick Oven Pizza, Inc. v. Excelsior Insurance Company, et al., No. 2008-03856 (Sup. Ct. N.Y. App. Div. 2009).* Both the pizza business and the person delivering pizzas were sued following an accident that injured another motorist. Claim was denied by the CGL carrier because of (1) the auto exclusion in the CGL policy and (2) the driver, as an employee, was an insured.
- The pizza company, however, maintained that the delivery person was a temporary employee because he was hired to meet seasonal or short-term workload conditions during the busy summer months prior to his return to college. Since the delivery person was not an insured, coverage applied.
- Ever since its introduction to the CGL policy, the definition of "temporary employee" has been a problem for insurers. It, therefore, should not be a surprise if a change were to be made with the definition of "temporary employee" and this CGL exclusion.

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CGL Automatic Insureds

Automatic Insureds - Includes Others:

"Employees" – while acting within the scope of their employment. [why? Coop]

Employee Definition

*"Employee" includes a "leased worker". "Employee" **does not** include a "temporary worker".*

Leased Workers Definition

"*Leased worker" means a person leased to you by a labor leasing firm under an agreement between you and the labor leasing firm, to perform duties related to the conduct of your business. "Leased worker" does not include a "temporary worker".*

Temporary Workers Definition

"Temporary worker" means a person who is furnished to you to substitute for a permanent "employee" on leave or to meet seasonal or short-term workload conditions.

Limitations or Exceptions to Coverage- except for BI/PI/AI to the Named insured, partners or members or other employees and for professional health care services.

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THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ABSOLUTE
AUTO, AIRCRAFT AND WATERCRAFT EXCLUSION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

A. **SECTION I – COVERAGES, COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY, 2. Exclusions**, paragraph **g.** is deleted and replaced with the following:

g. Aircraft, Auto Or Watercraft

"Bodily injury" or "property damage" arising directly or indirectly out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft. Use includes operation and "loading or unloading".

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involved the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft.

B. The following is deleted under **SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS, 4. Other Insurance,** paragraph **b. Excess Insurance**:

If the loss arises out of the maintenance or use of aircraft, "autos" or watercraft to the extent not subject to Exclusion **g.** of Section **I** – Coverage **A** – Bodily Injury and Property Damage Liability.

ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED.

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<u>However, none of these "employees" or "volunteer workers" are insureds for:</u>

(1) "Bodily injury" or "personal and advertising injury":

(a) To you, to your partners or members (if you are a partnership or joint venture),to your members (if you are a limited liability company), to a co-"employee" while in the course of his or her employment or performing duties related to the conduct of your business, or to your other "volunteer workers" while performing duties related to the conduct of your business;

(b) To the spouse, child, parent, brother or sister of that co-"employee" or "volunteer worker" as a consequence of Paragraph **(1)(a) above;**

(c) For which there is any obligation to share damages with or repay someone else who must pay damages because of the injury described in Paragraphs **(1)(a)** or **(b) above; or**

(d) Arising out of his or her providing or failing to provide professional health care services.

(2) "Property damage" to property:

(a) Owned, occupied or used by,

(b) Rented to, in the care, custody or control

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STATES ALLOWING FELLOW EMPLOYEE ACTIONS

The workers compensation statutes in the following states allow injured employees to sustain actions against responsible fellow employees in certain circumstances such as negligence, gross negligence, intoxication, or in the negligent operation of a motor vehicle.

State	Actionable Circumstances per Statute
Alabama	An officer's, director's, employee's, or agent's "willful conduct" or intoxication of another employee
Arizona	When employer or fellow employee acts knowingly and purposely to cause injury
Arkansas	Negligent coemployees are not protected against lawsuits
California	Employer's willful and unprovoked physical act of aggression or intoxication of a fellow employee
Connecticut	Willful or malicious wrong by a fellow employee or negligence of a fellow employee in the operation of a motor vehicle (Endorsement CA 01 07 provides coverage under the BAP for bodily injury caused by the named insured's employee to his fellow employee.)
Florida	Willful and wanton disregard or unprovoked physical aggression or gross negligence resulting in injury or death of the other employee. Also, coemployees working in unrelated business for the employer.
Hawaii	Fellow employees can be sued for injuries caused by their willful and wanton misconduct.
Idaho	When injury is proximately caused by willful or unprovoked physical aggression, the aggressor is not exempted from liability.
Iowa	When injury is caused by a fellow employee's gross negligence amounting to such lack of care as to amount to wanton neglect for the safety of another
Kentucky	Where injury is caused by the willful and unprovoked physical aggression of a fellow employee or of the employer
Louisiana	The WC Act does not affect the liability of the employer or an employee resulting from an intentional act.
Maine	Negligence of an employee in a superintending capacity
Minnesota	Injury intentionally inflicted by the fellow employee or injury resulting from the fellow employee's gross negligence

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Mississippi	Common law actions based on intentional torts or bad faith are not precluded by exclusive remedy provision.
Montana	Intentional and malicious act of a fellow employee
Nebraska	Injury proximately caused by the willful and unprovoked physical aggression of a fellow employee, officer, or director
New Hampshire	Intentional tort of any officer, director, agent, servant, or fellow employee
New Jersey	Intentional wrong by a fellow employee
Oregon	There is no exemption from liability for a person whose willful and unprovoked aggression is the proximate cause of the injury, where the worker and the otherwise exempt person are not engaged in furtherance of a common enterprise, or when the injury is proximately caused by the employer's failure to post a safety warning.
Pennsylvania	Intentional act by a fellow employee
South Dakota	Intentional act by employer or a fellow employee
West Virginia	Deliberately inflicted injuries
Wisconsin	When a coworker's assault is intended to cause bodily harm (excluded under BAP Exclusion B.1); or for negligent operation of a motor vehicle not owned or leased by the employer. (Endorsement CA 01 17 makes an exception to the fellow employee exclusion if the bodily injury results from the use of a covered auto that the named insured does not own or lease.)
Wyoming	Intentional injury by a fellow employee

IRMI publication date for this page: June 2010

Where might employee get coverage for a fellow employee suit if the BAP is not endorsed ?

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Fellow Employee Suits

- Based on judicial interpretation, 13 additional states allow a fellow employee to be sued:

- Alaska, Delaware, Illinois, Indiana, Michigan, New York, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Utah, and Washington.

- See Arthur Larson, Larson's Workers Compensation Law, Desk Edition, Vol. 3 (New York: Matthew Bender & Co., Inc., 2010) § 111.03.

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Fellow Employee Exclusion

- Contained in both CGL and BAP
- CGL has a give back for “executive officers”
- BAP does not
- At very least, you should equate the two policies to have coverage for “executive officers” by adding:
  - CA 20 56-Fellow Employee Coverage for Designated Employees/Positions or
  - CA 20 55-Fellow Employee Coverage, to delete the exclusion in its entirety.

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Commercial

General

Liability

CGL- Liquor Exclusion History

c. Liquor Liability

"Bodily injury" or "property damage" for which any insured may be held liable by reason of:

(1) Causing or contributing to the intoxication of any person;

(2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

(3) Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

This exclusion applies only if you are in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages.

Laconia Rod and Gun Club v. Hartford Accident and Indemnity Company, 459A 2nd 249 (N.H. 1983)

- **Court determined that the phrase *"in the business of"* was ambiguous**
- **Determined the word "business" to have a dual sense of usage**
- **A broad sense to mean any regular activity that occupies one's time and attention with or without a direct profit objective, OR can be used more narrowly to mean a direct profit objective.**
- **The fact that the club did not make a profit on the beverages it served – as would a tavern – was sufficient to create ambiguity.**
- **Result: The Court concluded that because the phrase *"in the business of"* was ambiguous, the exclusion would not apply.**

American Legion Post #49 v. Jefferson Insurance Co. of N.Y., 485A 2nd 293 (N.H. 1984)

- **Not-for-profit veterans association derived substantial profit revenues from sales of alcohol.**
- **Court concluded the insured was not *"in the business of"* because they used the proceeds to meet operating expenses to provide benefits to its members as well as community activities.**
- **Court reasoned the insured did not have same profit motive as an inn or tavern would have.**
- **Result: Exclusion does not apply in that insured was not *"in the business of"*.**

CG 2150 – Amendment of Liquor Liability Exclusion

CG 2151 – Amendment of Liquor Liability Exclusion – Exception for Scheduled Premises or Activities

c. "Bodily injury" or "property damage" for which any insured may be held liable by reason of:

(1) Causing or contributing to the intoxication of any person;

(2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

(3) Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

This exclusion applies only if you:

(1) Manufacture, sell or distribute alcoholic beverages;

(2) Serve or furnish alcoholic beverages for a charge whether or not such activity:

(a) Requires a license;

(b) Is for the purpose of financial gain or livelihood; or

(3) Serve or furnish alcoholic beverages without a charge, if a license is required for such activity.

B.Y.O.B.-Restaurants

- ABC Regulations
- Liquor Liability Exposure ?
- Catch-22 !
- Not for Profits- B & G Clubs/Fire Depts.

Important Cases

- **Penn-America Insurance Company v. Peccadillos, 27 A.3d 259 (Pa. Super.Ct. 2011)**
- **McGuire v. Curry, 766 N.W.2d 501 (S.D. 2009)**
- **Essex Insurance Company v. Café Dupont,LLC, 674 F.Supp.2d 166 (D.D.C. 2009)**
- **Simmons v. Homatas, 925 N.E.2d 1089 (Ill. 2010)**

BYO Alcohol

- The ISO now is facilitating the expansion of BYOB restaurants by adding an exception to the liquor liability exclusion for patrons who bring their own alcoholic beverages for consumption on the insured's premises, whether or not a fee is charged or a license is required.
- The ISO is also putting further restrictions on coverage regarding the failure to provide transportation or negligent hiring or supervision

c. Liquor Liability

"Bodily injury" or "property damage" for which any insured may be held liable by reason of:

(1) Causing or contributing to the intoxication of any person;

(2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

(3) Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in:

(a) The supervision, hiring, employment, training or monitoring of others by that insured; or

(b) Providing or failing to provide transportation with respect to any person that may be under the influence of alcohol;

if the "occurrence" which caused the "bodily injury" or "property damage", involved that which is described in Paragraph (1), (2) or (3) above.

However, this exclusion applies only if you are in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages. ***For the purposes of this exclusion, permitting a person to bring alcoholic beverages on your premises, for consumption on your premises, whether or not a fee is charged or a license is required for such activity, is not by itself considered the business of selling, serving or furnishing alcoholic beverages.***

CG 2150 – Amendment of Liquor CG 2151 Liability Exclusion

c. "Bodily injury" or "property damage" for which any insured may be held liable by reason of:

(1) Causing or contributing to the intoxication of any person, including causing or contributing to the intoxication of any person because alcoholic beverages were permitted to be brought on your premises, for consumption on your premises;

(2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

(3) Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in:

(a) The supervision, hiring, employment, training or monitoring of others by that insured; or

(b) Providing or failing to provide transportation with respect to any person that may be under the influence of alcohol; if the "occurrence" which caused the "bodily injury" or "property damage", involved that which is described in Paragraph (1), (2) or (3) above.

This exclusion applies only if you:

(1) Manufacture, sell or distribute alcoholic beverages……;

(2) Serve or furnish alcoholic beverages for a charge whether or not such activity:

(a) Requires a license;

(b) Is for the purpose of financial gain or livelihood; or

(3) Serve or furnish alcoholic beverages without a charge, if a license is required for such activity.

(4) Permit any person to bring any alcoholic beverages on your premises, for consumption on your premises

CG 2406 Liquor Liability BYO Alcohol Establishment

Serves two purposes:

- Attached to the Liquor Liability Policy to include “BYO” establishments within the category of businesses engaged in “selling, serving or furnishing alcoholic beverages”
- Used to negate the BYO exclusion found in CG 2150 or CG2151

Troublesome Endorsements

- Cross Suits / Cross Liability Endorsements
- CGL Look–A–Like Endorsements
- CG 21 42 – Explosion, Collapse and Underground PD Hazard (Specified Operations)
- CG 24 26 – Amendment of Insured Contract Definition
- CG 21 39 – Contractual Liability Limitation
- Manuscript Employers Liability and CGL endorsements
- CG 22 94- Exclusion – Damage to Your Work Performed by Subcontractors on Your Behalf
- CG 21 86 – Exclusion – Exterior Insulation and Finish Systems
- CG 21 01 – Exclusion – Athletics or Sports Participants

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXCLUSION – CROSS LIABILITY

This endorsement modified insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

This insurance does not apply to any actual or alleged "bodily injury", "property damage", "personal injury" or "advertising injury" to:

1. Any business enterprise in which any insured owns an interest, is a partner, or which is a parent, affiliate, subsidiary or sister company of any insured;
2. Any business enterprise directly or indirectly controlled, operated or managed by a business enterprise described in **1** above;
3. A present, former, future or prospective partner, officer, director, stockholder or employee of any insured;
4. Any insured; or
5. The spouse, child, parent or sibling of any of the above as a consequence of **1,2,3,** or **4** above.

Look-A-Like CGL Endorsements

- Watch wording at bottom- “contains” ISO

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Endorsement—Constricts Coverage

- Explosion, Collapse, Underground (XCU) Exclusion
  - A **property damage** exclusion eliminating coverage caused by one or more of the identified hazards.
  - Explosion exclusion applies to blasting or explosion
  - Collapse exclusion applies to structural losses caused by grading, excavating, tunneling, pile driving, operations involving structural support, etc.
  - Underground exclusion applies to specific property damaged by or in connection with the use of a mechanical device used in grading, drilling, filing, etc.
  - **Does not apply to bodily injury or completed operations**
    - CG 21 42 excludes operations listed on a schedule
    - CG 21 43 excludes operations *except* those listed on a schedule

CGL Exclusions

Employer's Liability

"Bodily injury" to:

(1) An "employee" of the insured arising out of and in the course of:

(a) Employment by the insured; or

(b) Performing duties related to the conduct of the insured's business; or

(2) The spouse, child, parent, brother or sister of that "employee" as a consequence of Paragraph (1) above.

This exclusion applies:

(1) Whether the insured may be liable as an employer or in any other capacity; and

(2) To any obligation to share damages with or repay someone else who must pay damages because of the injury.

This exclusion does not apply to liability assumed by the insured under an "insured contract". (watch CG 2139)

CG 2426 Amendment of Insured Contract Definition

9. "Insured contract" means:

f. That part of any other contract or agreement pertaining to your business (including an indemnification of a municipality in connection with work performed for a municipality) under which you assume the tort liability of another party to pay for "bodily injury" or "property damage" to a third person or organization, **provided the "bodily injury" or "property damage" is caused, in whole or in part, by you or by those acting on your behalf.** Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.

CG 2139 Contractual Limitation

CONTRACTUAL LIABILITY LIMITATION

This endorsement modifies insurance provided under the following:
COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

The definition of "insured contract" in the DEFINITIONS Section is replaced by the following:

"Insured contract" means:

a. A contract for a lease of premises. However, that portion of the contract for a lease of premises that indemnifies any person or organization for damage by fire to premises while rented to you or temporarily occupied by you with permission of the owner is not an "insured contract";

b. A sidetrack agreement;

c. Any easement or license agreement, except in connection with construction or demolition operations on or within 50 feet of a railroad;

d. An obligation, as required by ordinance, to indemnify a municipality, except in connection with work for a municipality;

e. An elevator maintenance agreement.

f. ?????

Watch Manuscript Endorsements

- Eliminating coverage for Contractual Liability assumed by insureds.

  – CG 2139

Unendorsed ISO CGL Language:

Employer's Liability
"Bodily injury" to:
(1) An "employee" of the insured arising out of and in the course of:
(a) Employment by ***the*** insured; or

This exclusion does not apply to liability assumed by the insured under an "insured contract".

Watch Manuscript Exclusions

- Modifying EL exclusion to exclude injuries sustained by employees of ***ANY*** insured

Unendorsed ISO CGL Language:

Employer's Liability
"Bodily injury" to:
(1) An "employee" of the insured arising out of and in the course of:
(a) Employment by ~~the~~ insured; or
(a) Employment by **ANY** Insured; or

Watch Manuscript Endorsements

- Add an Independent Contractors Exclusion-

  " No BI to an employee of a contractor for which any insured may be liable in any capacity"

- Add Exclusion for Scaffold, Gravity Related, or Fall from Height injuries

- Limits coverage only for those operations described within the listed class codes

Exclusions

I. Damage To Your Work

"Property damage" to "your work" arising out of it or any part of it ***and*** included in the "products-completed operations hazard".

(GC, Inc hired by State to construct new highway ramp. Project involves site preparation, excavation, grading compaction and laying down gravel base and covering with asphalt. Three weeks after GC, Inc. completes the project and the ramp is open to the public, the ramp caves in and crumbles due to faulty soil compaction. The State sues for faulty workmanship. No question ramp was GC's work, and since it was put to intended use it falls under products and completed operations. No Coverage.

This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor. (Watch for CG 2294)

GC, Inc. hired SUB, Inc to do site preparation work and GC was only responsible for asphalt. Therefore GC has coverage for damage to its work (asphalt) since damage arose out of work performed on its behalf by SUB, and also has coverage for improperly compacting soil. Exclusion does not reach GC, as the cause of damage was from SUB.

BEWARE THE CG 2294

Exclusion – Damage to Work Performed by Subcontractors On Your Behalf

- Nasty Exclusion
- Changes Your Work coverage
- Removes PD coverage for work done on your behalf by sub contractors

Example

- GC builds a warehouse
- Subs out 50% of the work
- A year later warehouse burns due to faulty electrical work
- Warehouse owner brings suit against GC for damage
- Any coverage under GC's policy?

- If electrical work was performed by a sub, the exclusion does not apply and GC's policy pays the claim up to its limits
- If GC did electrical work, the policy will exclude coverage for damage to the GC's work (50% of loss), but will cover the damage to the work by the subs.

Exception leaves coverage for…

(Paper GC-subs out all work)

- PD to the insureds work that results from the work of the the insured's subcontractor;
- PD to the work of the insured's subcontractor that results from that subcontractors work
- PD to the work of the insured's subcontractor that results from the insured's work
- PD to the work of the insured's subcontractor that results from the work of another contractor or subcontractor
- Not covered: PD to Insured's work caused by Insured

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIAL EXCLUSIONS AND LIMITATIONS ENDORSEMENT

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

A. In consideration of the premium charged this policy has been issued subject to the following exclusions being added to Coverages A & B:

This insurance does not apply to:

8. Failure To Maintain Secure or Safe Premises

Claims arising out of, caused by, resulting from, or alleging, in whole or in part, any insured or additional insured's failure to thwart, foil, avoid, hinder, stop, lessen or prevent any attack, fight, assault, theft, or crime. The company has no obligation to defend or indemnify any such claims.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXCLUSION - ASSAULT AND BATTERY

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

1. This insurance does not apply to "bodily injury", "property damage", "personal injury" or "advertising injury" arising out of or resulting from:
   - (a) any actual, threatened or alleged assault or battery;
   - (b) the failure of any insured or anyone else for whom any insured is or could be held legally liable to prevent or suppress any assault or battery;
   - (c) the failure of any insured or anyone else for whom any insured is or could be held legally liable to render or secure medical treatment necessitated by any assault or battery;
   - (d) the rendering of medical treatment by any insured or anyone else for whom any insured is or could be held legally liable that was necessitated by any assault or battery;
   - (e) the negligent:
     - (i) employment;
     - (ii) investigation;
     - (iii) supervision;
     - (iv) training;
     - (v) retention;

CG 2186 – Exclusion- Exterior Insulation and Finish Systems (EIFS)

- Problem: Building owners started making claims for moisture and water damage to floors, wood rot, and mold. Faulty application of EIFS allowed water to penetrate the exterior of building and become trapped.
- **Intent:** Exclude PD claims contributed to by EIFS to the CGL policies of contractors who install EIFS and other trade contractors who perform work on buildings with EIFS
- **Endorsement**: Excludes PD claims involving EIFS, but also excludes BI (mold), PI and AI (product disparagement) claims. Excludes injury or damage arising directly out of EIFS, but also any injury or damage arising out of work performed by the insured, or the insured's products used in connection with EIFS.
- **Ramifications:** Excludes BI and PD in connection with insureds work or product when that work of product is part of an EIFS clad exterior--- WHETHER OR NOT THE PRESENCE OF EIFS IS RELATED IN ANY WAY TO THE INJURY OR DAMAGE.
  - Contractor installing sign on the exterior of a store on which EIFS has been used. Contractor drops a hammer, injuring a pedestrian who in turn sues the Contractor. No Coverage.
  - Contractor installs sign, after installing a defect in the sign causes a fire that damages the building. No Coverage.
  - ***Insureds who are performing work on buildings with EIFS, or whose products are going to be incorporated into such buildings, should seek underwriting clarification on the breadth of this endorsement***

CGL Endorsements

- Athletic Participant/Sports Excl.- CG 2101
  - Already excluded from Med Pay
  - Real problem if attached to CGL

Helpful Endorsements

- CG 22 92 – Snow Plow Operations Coverage
- CG 22 64- Pesticide / Herbicide Applicator
- CG 2293- Lawn Care Coverage
- CG 2422 - Amendment of Coverage Territory – Worldwide Coverage
- Manuscript - Amendment of Limits of Insurance
- CG 25 03- Designated Construction Projects General Aggregate Limit

Snow Plow Operations

- CG 22 92 – Snow Plow Operations Coverage
- What does this endorsement really do ?

Snowplowing- Completed Operations

- Where is coverage afforded ?
  - CGL
  - Business Auto
- Business Auto Exclusion

  (10) BI or PD arising out of your work after that work has been completed or abandoned.
- CGL Exclusion

  (g) "Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and "loading or unloading".

  (excludes operation and loading/unloading-- coops?)

CG 2292

- Introduced in 2007 for use with CGL
- Mobile Equipment definition clarifies that self-propelled vehicles with equipment designed for snow removal are considered “autos”
- Adds completed operations for Snowplowing to CGL policy
- Lot’s of disagreement if coverage was previously included
- Assures client of coverage for Snow Plowing Completed Operations

COMMERCIAL GENERAL LIABILITY
CG 22 92 12 07

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SNOW PLOW OPERATIONS COVERAGE

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

Within the "products-completed operations hazard", Exclusion **g.** under Section **I – Coverage A – Bodily Injury And Property Damage Liability** does not apply to any "auto" used for snow plow operations.

CGL Endorsements

- Pesticide/Herbicide Applicator- CG 2264
  - Must be licensed with the State (# on truck)
  - Must be in compliance with all Fed, State and local laws / regulations
  - Golf Courses, Greenhouses, Farmers, Landscapers
- Lawn Care Service-CG 2293
  - Not required to be license by State
  - Use only OTC products

CGL Endorsements

- Amendment of Coverage Terr.- CG 2422
  - Unendorsed CGL provides “limited” world-wide coverage
  - This endorsement allows suit to be brought anywhere in the world
  - Except any country that is subject to a trade or economic sanction, or embargo by USA

Amendment of Limits for Designated Project

Manuscript

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

	Limits of Insurance
General Aggregate Limit	
Products-Completed Operations Aggregate Limit	
Personal & Advertising Injury Limit	
Each Occurrence Limit	
Damage To Premises Rented To You Limit	Any One Premises
Medical Expense Limit	Any One Person

Designation Of Project Or Premises:

Endorsement—Changes Condition

- Designated Limit of Insurance
  - Can apply exclusively to a specific project or location
    - CG 25 03—Applies a separate ***general aggregate*** per **project(s)** shown in the schedule
    - CG 25 04—Applies a separate ***general aggregate*** per **location(s)** shown in the schedule

➢ **Product-completed operations aggregate are not changed using either form shown above.**

CONTRACTUAL LIABILITY

Exhibit 5.2
Categories of Insured Contracts

- Lease of premises, except with respect to an obligation to indemnify for fire damage to the leased premises
- A sidetrack agreement
- Any easement or license agreement, except with respect to construction or demolition operations on or within 50 feet of a railroad
- An obligation under a city ordinance to indemnify a municipality, except in connection with work for a municipality
- An elevator maintenance agreement
- That part of any other contract related to the insured's business operations in which the insured assumes the tort liability of another party with respect to third-party "bodily injury" or "property damage" (This item is referred to herein as "part f." of the definition.

Contractual Liability Coverage

- CGL
  - Excluded Contractual Liabilities
    - Railroad indemnification agreements
      - Rail Road Protective Policy Form- CG 00 35
      - Where railroad protective liability limits are exhausted, this exclusion prevents recovery via contractual liability
      - CG 24 17- Contractual Liability – Railroads, modifies the CGL exclusion
      - CA 20 70 – Coverage for Certain Operations in Connections with Railroads, modifies the BAP exclusion
        - Truck runs over tracks and bends them causing derailment

- Be careful not to assume this type of liability without securing the proper coverage and endorsements

Limited Contractual PI/AI- CG 2274

- CGL
  - Excluded Contractual Liabilities
    - Personal and advertising liability
      - Does not meet definition requiring BI or PD
      - CG 22 74 provides limited contractual liability for specific personal injury offenses [false arrest, detention, imprisonment]

- PI used by attorneys in contracts and leases means something completely different than the Insurance PI we know – try to negotiate contract to terms we use in policy and provide coverage for. {eg: PI pollution claim}

Contractual Liability Coverage

- CGL
  - Excluded Contractual Liabilities
    - **Assumptions of professional design liability**
      - **Indemnification of design professionals for their *professional liability*, not non-professional liability, is excluded**

- Be careful not to assume this type of liability or modify contract if you hire professionals

Defense of Indemnittee

b. Contractual Liability

We exclude…."Bodily injury" or "property damage" for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement. ***This exclusion does not apply to*** liability for damages:

(1) That the insured would have in the absence of the contract or agreement; or

(2) Assumed in a contract or agreement that is an "insured contract", provided the "bodily injury" or "property damage" occurs subsequent to the execution of the contract or agreement. **Solely for the purposes of liability assumed in an "insured contract", reasonable attorney fees and necessary litigation expenses incurred by or *for a party other than an insured* are deemed to be damages because of "bodily injury" or "property damage", provided:**

(a) Liability to such party for, or for the cost of, that party's defense has also been assumed in the same "insured contract"; and

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Supplementary Payments

2. ***If we defend an insured against a "suit" and an indemnitee of the insured is also named as a party to the "suit", we will defend that indemnitee if all of the following conditions are met:***

a. The "suit" against the indemnitee seeks damages for which the insured has assumed the liability of the indemnitee in a contract or agreement that is an "insured contract";
b. This insurance applies to such liability assumed by the insured;
c. The obligation to defend, or the cost of the defense of, that indemnitee, has also been assumed by the insured in the same "insured contract";
d. The allegations in the "suit" and the information we know about the "occurrence" are such that no conflict appears to exist between the interests of the insured and the interests of the indemnitee;
e. The indemnitee and the insured ask us to conduct and control the defense of that indemnitee against such "suit" and agree that we can assign the same counsel to defend the insured and the indemnitee; and
f. The indemnitee:
(1) Agrees in writing to:
(a) Cooperate with us in the investigation, settlement or defense of the "suit";
(b) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the "suit";
(c) Notify any other insurer whose coverage is available to the indemnitee; and
(d) Cooperate with us with respect to coordinating other applicable insurance available to the indemnitee; and
(2) Provides us with written authorization to:
(a) Obtain records and other information related to the "suit"; and
(b) Conduct and control the defense of the indemnitee in such "suit".

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Other Requirements for Direct Defense under Supplemental Payments

- Both Named in Lawsuit
  - Problem with Third Party Over– Insured (employer) is not named - exclusive remedy doctrine
- No Conflict
  - No dispute of fact as to who did what to whom
- Request to Defend
  - Indemnitor and Indemnitee must both request indemnitors insurance carrier to conduct and control the defense, and both parties agree to the same legal counsel. [not right to chose your own counsel]
- Duty to Cooperate
  - Similar to those imposed on insured
  - **** Must notify insurer if any other coverage is available to indemnitee, and cooperate in coordinating the other insurance (trouble)**
- Continuing Duty
  - <u>These are ongoing continuous obligations</u>
  - If they stop, so does the defense
  - Duty to defend ends when limits have been exhausted by payment

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UMBRELLA CONCURRENCY

Understanding Concurrency

A. Underlying policy limits must be unimpaired as of the Umbrella/Excess policy renewal date
   1 Insured promises the Insurer that all underlying limits are in full force and effect as of the Umbrella/Excess policy renewal date
   2 The inception and expiration dates of most all underlying policies must be identical to those of the Umbrella/Excess policy dates
   3 Business Auto policies and other coverages without aggregate limits may be an exception to this rule

B Several reasons an Insured may not want concurrent policies
   1 All policies come up for renewal at same time
   2 Large deposit premium
   3 Seasonal business

C Problems of Non-Concurrency
   1 Impaired Aggregate Limits
   2 Continuous or Repeated exposure losses
   3 Examples

Concurrency Example #1

Example #1:
-- Underlying CGL policy period 1/1/08 to 1/1/09
-- Required Limits of $500,000 occurrence / $500,000 aggregate
-- Umbrella policy period 6/1/08 to 6/1/09
-- Limits of $1,000,000 occurrence / $1,000,000 aggregate

Policies

CGL POLICY 1/1/08– 1/1/09		UMBRELLA POLICY 6/1/08 – 6/1/09	
1/1/08 CGL Renewal	4/3/08 - Products $50,000 Claim	6/1/08 Umbrella Renewal	10/1/08 – Products $900,000 Claim

Claim Payments

CGL	$50,000 Paid		$450,000 Paid
INSURED			$ 50,000
UMBRELLA			$400,000

In the example shown above, the 4/3/08 Products claim reduces the underlying CGL aggregate to $450,000. When the Umbrella policy renews on 6/1/08, the insured promises all underlying limits are unimpaired. On 10/1/08 the insured suffers a $900,000 products claim which is reported to the underlying CGL and Umbrella carriers. The CGL carrier pays $450,000 (the balance of its aggregate), the Insured would then have to pay $50,000 out of pocket (it promised umbrella carrier unimpaired aggregates on renewal), only then would the Umbrella carrier would pay the remaining $400,000.

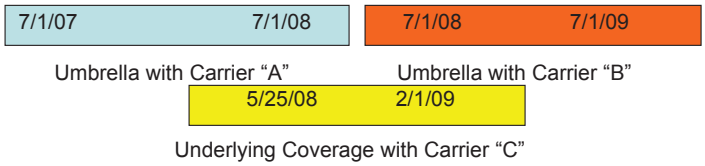
Strong Concurrency - Example #2

-- Underlying policy period 1/1/08 to 1/1/09
-- Limits of $1,000,000 occurrence / $1,000,000 aggregate
-- Umbrella policy period 6/1/08 to 6/1/09
-- Limits of $5,000,000 occurrence / $5,000,000 aggregate

Date of Loss	Amount of Loss	Underlying Aggregate Available after payment	Umbrella Retained Limit	Umbrella Payment
2/1/08	$ 50,000	$950,000	N/A	None
3/1/08	$100,000	$850,000	N/A	None
4/1/08	$200,000	$650,000	N/A	None
5/1/08	$ 50,000	$600,000	N/A	None
6/1/08	*$100,000*	*$500,000*	*$100,000*	*None*
7/1/08	$200,000	$300,000	$300,000	None
8/1/08	$300,000	$ -0-	$600,000	None
9/1/08	$200,000	$ -0-	$800,000	None
10/1/08	$300,000	$ -0-	$1,000,000	$100,000

Concurrency Example # 3

- **Example #3**



- OCCURRENCE LOSS
- Another gap may arise where an "occurrence" takes place over a period of time which overlaps the umbrella anniversary date, but not that of the underlying policy.
- If, in the above illustration, the occurrence loss exceeds the underlying limit, Umbrella carrier "A" may view is as occurring partially in the time frame of Umbrella carrier "B"; whereas carrier "B" may take the same position toward Umbrella carrier "A". If each umbrella carrier view the loss as occurring partially in the other's policy period, and therefore not exceeding the primary limit, there would be a void not filled by either policy. This situation creates an even stronger argument for having the primary and umbrella policies concurrent as to effective and expiration dates, and for like policy terms.

Possible Solutions

- Cancel / Rewrite specific underlying policy(ies) short-term to match umbrella policy dates
- Cancel / Rewrite umbrella short-term to match underlying
- Non-Concurrency endorsement
- Amend underlying aggregate requirements of umbrella, if possible
- Obtain a Buffer policy
- Request underlying carrier to reinstate Aggregate
- Self-Fund

Non-Concurrency Endt

UNIMPAIRED AGGREGATE LIMITS ENDORSEMENT
(NON-CONCURRENCY)

Umbrella/Excess Responsibilities

"Dovetailing the vital additional protection provided by Umbrella, excess and extended liability policies with the newer commercial general liability forms (both the "claims-made" and the "occurrence" versions) is a primary objective of underwriters and companies that issue overlying layers of coverage. They have a major stake in making certain that the language used in their policies carries out the intent without problems and uncertainties.

Agents, brokers, consultants, and risk managers most certainly have a responsibility to verify that the coverage issued fills their clients' coverage needs."

-PF&M-

Underlying Insurance Requirements

- Primary Layer or Working Layer
- Coverages
  - Commercial General Liability
  - Business Auto
  - Employers Liability
  - Other
- Limits / Aggregates
- Control U/L + Carrier's Rating
- Failure to Maintain Underlying Requirements
  - Underlying policy cancelled
  - Material change to underlying policies * must advise carrier
  - Bankrupt or Insolvency of underlying Insurer
  - Typical Umbrella/ Excess policy provision

Examples

- Example #1

  "The policy or policies referred to in the attached Schedule of Underlying Insurances, and renewals or replacement thereof not more restrictive shall be maintained by the Insured in full force and effect during the currency of this policy (including any Extended Reporting Period, if exercised) without alteration in their terms or conditions except for any reduction of the aggregate limits or limits contained therein solely by payment of claims."

  "Failure of the Insured to comply with the foregoing shall not invalidate this policy but in the event of such failure, we will only be liable to the same extent as we would have been had the Insured so maintained such policy or policies."

- You must notify us as soon as practicable when any Underlying Insurance is no longer in effect.

Examples

- Any "underlying insurance" must be maintained in full effect without reduction of **coverage** or **limits** except for the reduction of the aggregate limit in accordance with the provisions of such "underlying insurance" that results from payment of claims, settlement or judgments to which this insurance applies.
- Such exhaustion or reduction is not a failure to maintain "underlying insurance". Failure to maintain "underlying insurance" will not invalidate insurance provided under this Coverage Part, but insurance provided under this Coverage Part will apply as if the "underlying insurance" were in full effect.
- If there is an increase in the scope of coverage of any "underlying insurance" during the term of this policy, our liability will be no more than it would have been if there had been no such increase. You must notify us in writing, as soon as practicable, if any "underlying insurance" is cancelled, not renewed, replaced or otherwise terminated, or if the limits or scope of coverage of any "underlying insurance" is changed.

ISO CU 00 01 0413

Examples

- Example #2

  "Our liability under this policy shall in no way be increased or expanded as a result of the receivership, insolvency or inability to pay of any underlying insurer, with respect to both the duty to indemnify and the duty to defend."

- Example #3

  "In the event there is no recovery available to the insured as a result of the bankruptcy or insolvency of the underlying insurer, the coverage hereunder shall apply in excess of the applicable limit of liability specified in the underlying schedule of insurance."

The Lowest Bidder

It is unwise to pay too much, but it is worse to pay too little. When you pay too much, you lose a little money—that is all. When you pay too little, you sometimes lose everything, because the thing you bought is incapable of doing what it was bought to do. The common law of business balance prohibits paying a little and getting a lot—it can't be done. If you deal with the lowest bidder, it is well to add something extra for the risk you run. And if you do that, you will have enough to pay for something better"

John Ruskin (1819-1900)

James K. Ruble Seminar

a proud member of The National Alliance for Insurance Education & Research

Section 6

Understanding and Managing the 3 Big Government Benefits: Social Security, Medicare and Medicaid

Understanding (and Managing) the Three Big Government Benefits: Social Security, Medicare and Medicaid

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LEARNING OBJECTIVES

1. **To understand how, and when, Social Security provides various benefits to qualified beneficiaries.**

2. **To analyze when is the best time - and the various options - for an eligible person to select the Social Security Retirement Benefit.**

3. **To understand the role of various Life and Health insurance products that can assist at retirement time so an individual (or couple) does not have to rely simply on the Social Security Retirement Benefit.**

4. **An overview of the Medicare Program: Who are qualified beneficiaries; when to enroll; cost to the enrollee; various components, and options?**

5. **To understand the role of various Health insurance products that can assist with deductibles, co-pays, or excluded coverage areas found in Medicare.**

6. **An overview of Medicaid: Who qualifies for benefits; what are the major qualification rules; and, what are the primary benefits available?**

7. **The role played by the State and Federal Governments concerning Medicare and / or Medicaid, as it relates the funding of a Long-Term Care in a Skilled Nursing setting.**

8. **Understanding the various life and health insurance products available - including recent innovations - that can provide for the cost in a Long-Term Care setting so the beneficiary does not have to rely on the government.**

Notes	To Do

DISCLAIMER

Insurance policy forms, clauses, rules, court decisions, and laws change constantly. Policy forms and underwriting rules vary from company to company. This outline is intended as a general guideline and may not apply in each and every situation.

For any matters of legal and/or tax issues one should consult with competent counsel or advisor for the matter in question and in the jurisdiction in question.

This speaker, and any organization for whom this program is conducted shall have neither liability nor responsibility to any person or entity with respect to any loss or damage alleged to be caused directly or indirectly as a result of the information contained in this outline.

I. SOCIAL SECURITY

A. History and basic intent of the Social Security program

1. Current "key" numbers regarding Social Security

   a. Those currently contributing (funding) vs. those receiving a benefit

   b. FICA tax rules (see page 4)

      (1) Employee

      (2) Employers

      (3) Self-employed

2. *Who is covered and who is not covered under Social Security* - SSA.gov statistics show that @ 90% of U.S. wage earners are covered under Social Security. Not covered are some state, county and municipal employees, who are covered by their state-funded pension plans rather than Social Security. Also, not covered are employees of the U.S. government who were hired before 1984, the year federal agencies came under the Social Security umbrella. These longtime federal employees get pensions under the old Civil Service Retirement System. Railroad employees, who are covered by a separate pension system that came into being in the 1930s, around the same time as Social Security. Additionally, foreign nationals who work in the United States for their home governments or for some international organizations, such as the United Nations. Note: a U.S. citizens who works in the United States for foreign governments — say, an American employed by the French Embassy in Washington — do pay Social Security taxes and are covered.

Notes	To Do

Employee: 6.2% of income (up to $160,200, for 2023... in 2022 it was 147,000) is paid by an employee for Social Security, plus 1.45% of income (no maximum income limit) for Medicare, or 7.65% total. This 'tax' is called FICA (Federal Insurance Contributions Act).

Employer: 6.2% of income (up to $160,200) is paid by the employer for Social Security, plus 1.45% of income (no maximum income limit) for Medicare, or 7.65% total.

Self-Employed: A self-employed individual pays both parts of FICA (15.3%)

High Income: Individual/$200K, or married filing jointly/$250K pay an additional .09% - no income limit.

FICA (Federal Insurance Contributions Act) - The U.S. law that create a payroll tax requiring a deduction from the paychecks of employees as well as a contribution from employers to fund the Social Security and Medicare programs. For 2023, the Social Security tax is 6.2% on the first $160,200 of income. Additionally, 1.45%, is deducted for the Medicare Hospital Insurance - enacted in 1966. There is no income limit on this tax - this provision was enacted in 1994.

Primary Insurance Amount (PIA) - The benefit a person would receive if he/she elects to begin receiving retirement benefits at his/her normal retirement age. At this age, the benefit is neither reduced for early retirement nor increased for delayed retirement.

Full Retirement Age (FRA) - The age at which a Social Security Retiree can collect their full (100%) benefit. Their FRA is based on the year their birth. A covered person can begin benefits as early as age 62, but their benefits will be permanently reduced. They could wait as late as age 70, and receive an 8% increase annually, over their FRA elected benefit.

Cost-of-Living-Adjustments (COLAs) - Social Security and Supplemental Security Income (SSI) benefits for more than 67 million Americans will increase 8.7% in 2023... the biggest increase in 41 years.

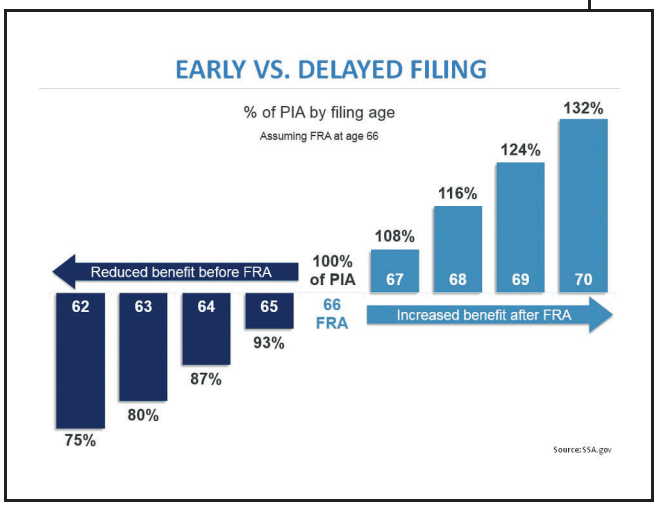
Average Indexed Monthly Earnings (AIME) - Social Security only uses the highest 35-years of earned income in its calculation. If the person worked over 35 years, the lowest income earning years are ignored. But, if they worked less than 35 years, then Social Security will use zeros in its calculation. For instance, if individual only worked 25 years, the AIME formula would include 10 years' worth of zeros. This is important to understand because it means that workers with shorter careers can wind up receiving less in Social Security income than workers with longer careers.

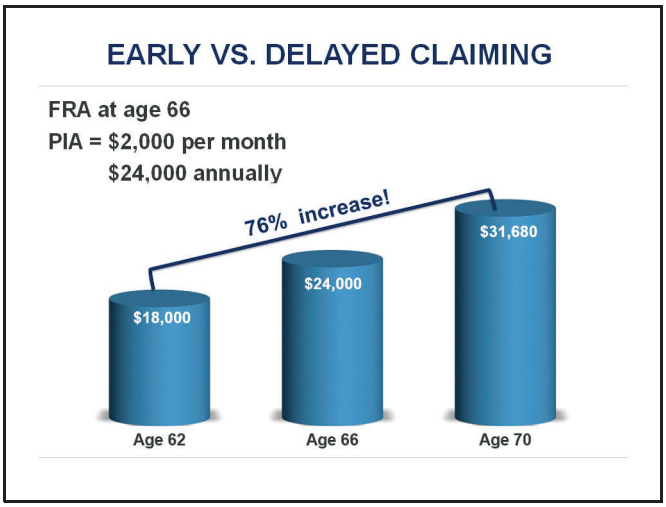
Delayed Retirement Credits (DRCs) - Should a Social Security retiree delay their retirement past their FRA, the benefit will increase (currently 8% annually) until their age 70. This is applicable for individuals born 1943 and later. There is no DRC increase past age 70, even if they do not elect their benefit.

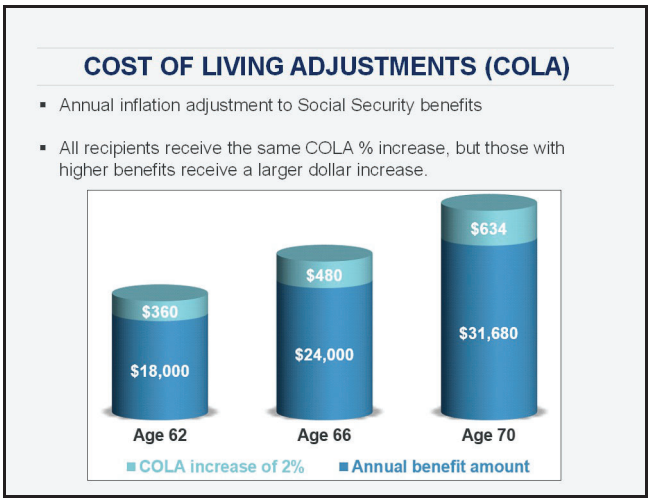
Windfall Elimination Provision (WEP) - This is applicable to persons that had a "non-covered pension" (typically a state, local or non-U.S. employers) and did not contribute to Social Security (through FICA). This provision closed a loophole that allowed these individuals to receive certain Social Security benefits. Numerous (and complicated) exceptions apply. This became law in 1983.

Government Pension Offset (GPO) - If a person received a pension from a government employer where Social Security taxes were not paid, some or all of the payment Social Security recipient's spouse(s), widow(s), or widower(s) benefit may be offset due to receipt of that pension. Numerous exception apply.

Notes	To Do







Full Retirement Age (FRA) for Social Security

Year of Birth	Full Retirement Age	Year of Birth	Full Retirement Age
Before 1938	Age 65	1955	Age 66 & 2 months
1938	Age 65 & 2 months	1956	Age 66 & 4 months
1939	Age 65 & 4 months	1957	Age 66 & 6 months
1940	Age 65 & 6 months	1958	Age 66 & 8 months
1941	Age 65 & 8 months	1959	Age 66 & 10 months
1942	Age 65 & 10 months	1960	Age 67
1943-1954	Age 66		

Notes	To Do

Social Security Cost of Living Adjustments (COLAs)

- July 1975 -- 8.0%
- July 1976 -- 6.4%
- July 1977 -- 5.9%
- July 1978 -- 6.5%
- July 1979 -- 9.9%
- July 1980 -- 14.3%
- July 1981 -- 11.2%
- July 1982 -- 7.4%
- January 1984 -- 3.5%
- January 1985 -- 3.5%
- January 1986 -- 3.1%
- January 1987 -- 1.3%
- January 1988 -- 4.2%
- January 1989 -- 4.0%
- January 1990 -- 4.7%
- January 1991 -- 5.4%
- January 1992 -- 3.7%
- January 1993 -- 3.0%
- January 1994 -- 2.6%
- January 1995 -- 2.8%
- January 1996 -- 2.6%
- January 1997 -- 2.9%
- January 1998 -- 2.1%
- January 1999 -- 1.3%
- January 2000 -- 2.5%
- January 2001 -- 3.5%
- January 2002 -- 2.6%
- January 2003 -- 1.4%
- January 2004 -- 2.1%
- January 2005 -- 2.7%
- January 2006 -- 4.1%
- January 2007 -- 3.3%
- January 2008 -- 2.3%
- January 2009 -- 5.8%
- January 2010 -- 0.0%
- January 2011 -- 0.0%
- January 2012 -- 3.6%
- January 2013 -- 1.7%
- January 2014 -- 1.5%
- January 2015 -- 1.7%
- January 2016 -- 0.0%
- January 2017 -- 0.3%
- January 2018 -- 2.0%
- January 2019 -- 2.8%

Social Security Cost of Living Adjustment will be 8.7% for 2023. This will affect more than 67 million American that receive Social Security retirement benefits and / or Supplemental Security Income (SSI) benefits.

COLA for 2020 was 1.6%; 2021 was 1.3%; 2022 was 5.9%; 2023 is 8.7%

Government Pension Offset

If you receive a pension from a government job in which you did not pay Social Security taxes, some or all of your Social Security spouse's, widow's, or widower's benefit may be offset due to receipt of that pension. This offset is referred to as the Government Pension Offset, or GPO.

The GPO reduces the amount of your Social Security spouse's, widow's, or widower's benefits by two-thirds of the amount of your government pension. For example, if you receive a monthly civil service pension of $600, two-thirds of that, or $400, must be used to offset your Social Security spouse's, widow's, or widower's benefits. If you are eligible for a $500 spouse's benefit, you will receive $100 per month from Social Security ($500 - $400 = $100). Some individuals are exempt from the offset.

B. The Retirement Benefit

1. The potential beneficiary(s) of this benefit

   a. Qualifying individual

   b. Spouse

   c. Divorced spouse

   d. Others

2. How and when to file for this benefit

   a. Options

   b. Various options for filing

   c. Documents needed for filing

3. Taxation of the Social Security benefit received by the recipient, spouse, ex-spouse or other family members (upon death - or disability - of the primary recipient)

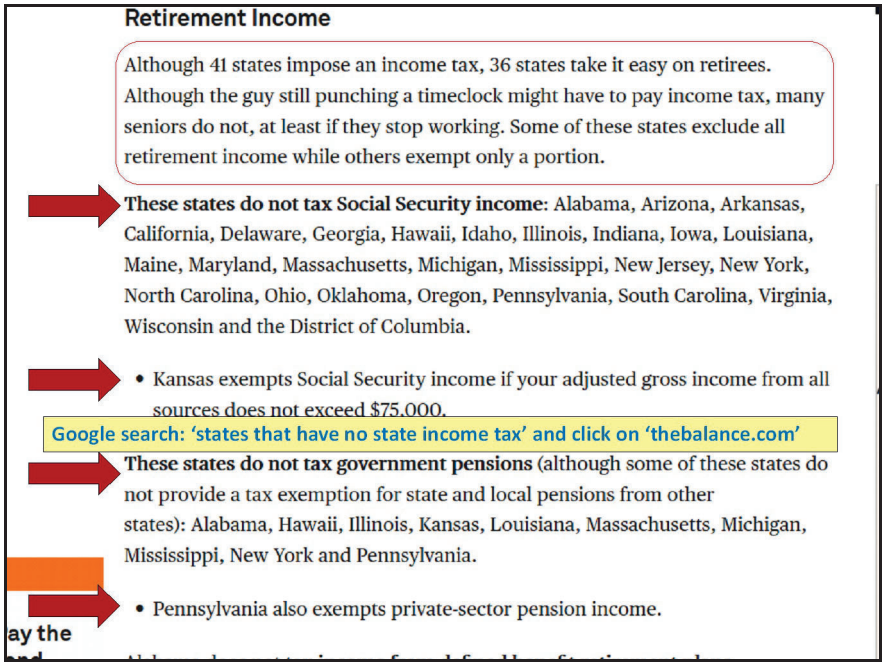
   a. Federal income tax: For some, the benefit is income tax-free. For others, they may pay income tax on up to 85% of the benefit. More on this later.

   b. State income tax

Notes	To Do

SPOUSE - To qualify, your spouse must have been married to you for at least one year, or be the parent of your child. A spouse who first becomes entitled to benefits at FRA, or later, may receive an amount equal to 50% of your PIA (not necessarily your benefit amount). At age 62, your spouse may receive permanently reduced benefits. As the FRA gradually increases to age 67, the percentage of the worker's PIA payable to the spouse at age 62 will gradually decrease to 31½% for people born in 1960 and later. This reduction does not affect the amount of a future widow(er) benefit.

EX-SPOUSE - Your unmarried divorced spouse may be entitled to benefits starting at age 62 if married to you for at least 10 years. You must be least age 62 (whether retired or not), or are receiving Social Security disability benefits. The benefit is not payable if your divorced spouse is remarried unless the marriage is to a person receiving benefits as a widow, widower, parent, or disabled child. If you are age 62, but not retired, then the divorced must have occurred at least two years prior before your ex-spouse can receive the benefit. If you were entitled before the divorce, there is no waiting period.



Retirement Income

Although 41 states impose an income tax, 36 states take it easy on retirees. Although the guy still punching a timeclock might have to pay income tax, many seniors do not, at least if they stop working. Some of these states exclude all retirement income while others exempt only a portion.

These states do not tax Social Security income: Alabama, Arizona, Arkansas, California, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Virginia, Wisconsin and the District of Columbia.

- Kansas exempts Social Security income if your adjusted gross income from all sources does not exceed $75,000.

Google search: 'states that have no state income tax' and click on 'thebalance.com'

These states do not tax government pensions (although some of these states do not provide a tax exemption for state and local pensions from other states): Alabama, Hawaii, Illinois, Kansas, Louisiana, Massachusetts, Michigan, Mississippi, New York and Pennsylvania.

- Pennsylvania also exempts private-sector pension income.

ay the

NOTE: the most convenient and hassle free- way to contact the SSA is to set up an on-line account.

SS Phone # - 800-722-1213

Documents Needed for Filing:

- Social Security number
- Birth Certificate
- W-2 form(s) or self-employment tax return for last year
- spouse's birth certificate and SS number (if applying for benefits on your work record)
- marriage certificate (if signing up on a spouse's record)
- military discharge papers if you had military service
- children's birth certificates and SS numbers (if they are applying)
- proof of U.S. citizenship or lawful alien status if you (or a family member is applying) were not born in the U.S.
- the name of your bank and your account number so your benefits can be directly deposited into your account

4. Retirement Benefit

a. Qualification rules and benefit calculations

b. The beneficiary (retiree) filing **BEFORE their FRA**

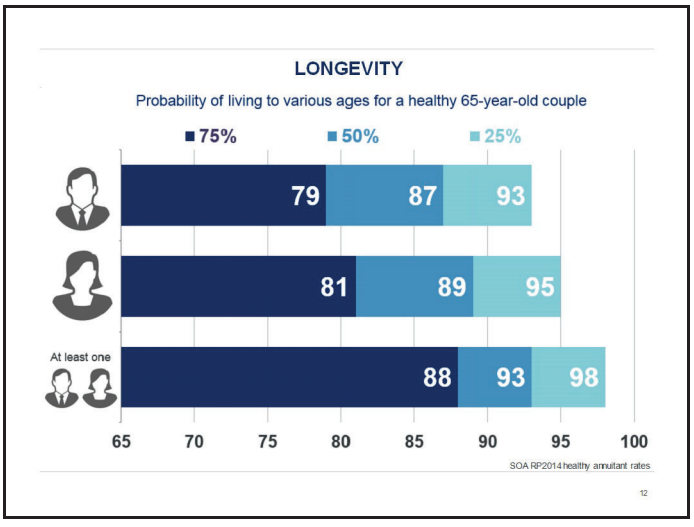
(1) Calculation of benefits

(a) Reduction in benefits

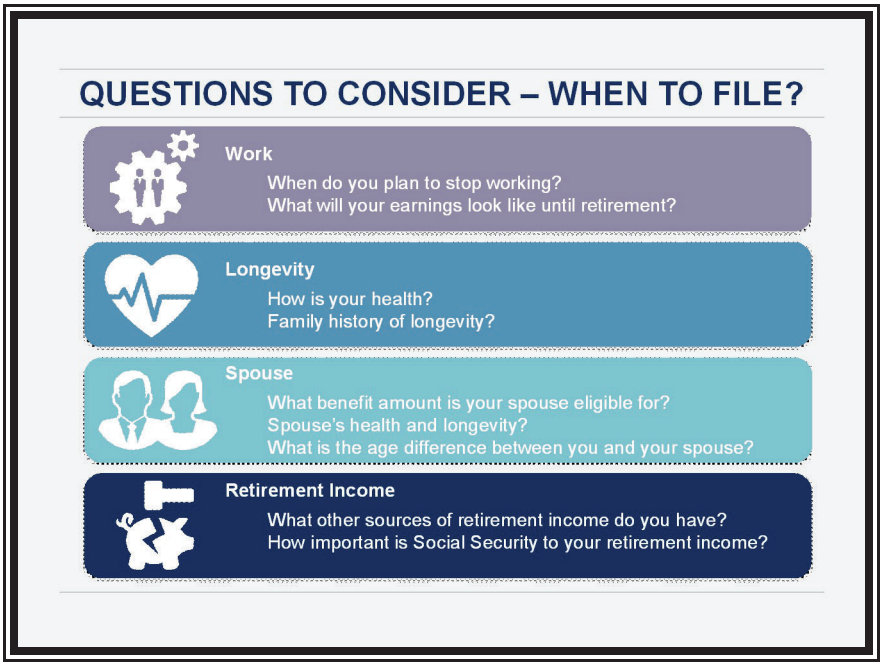
(2) Options

(3) Can the recipient still have an 'income', and if so, how much?

(a) The maximum annual income a pre-FRA retiree can have in 2023 is $21,240. Should the retiree exceed that amount, then $1 dollar in SS benefit will be withheld for every $2 in gross earning above that limit. In the year of their FRA (age 66 as an example), then the maximum gross income for 2023 is $56,520. Should they exceed that amount, then $1 dollar in benefit will be withheld for every $3 above that limit. This applies to all months prior to their birth month.



Notes	To Do



How Much Social Security Benefits You Receive Will Depend on Two Factors:

1) How much you earned over your working career, and,

2) the age at which you apply for benefits.

General Claiming Guidelines

BEFORE FRA	FRA or LATER
• Lower life expectancy • Lower earning & younger spouse • Strong need for income • Fully retired and no earnings • Survivor benefits • Disabled	• Generally a best practice • Longer life expectancy • Higher earning with lower earning younger spouse • Still working or access other sources of income to meet expenses • Maximize a large spousal benefit

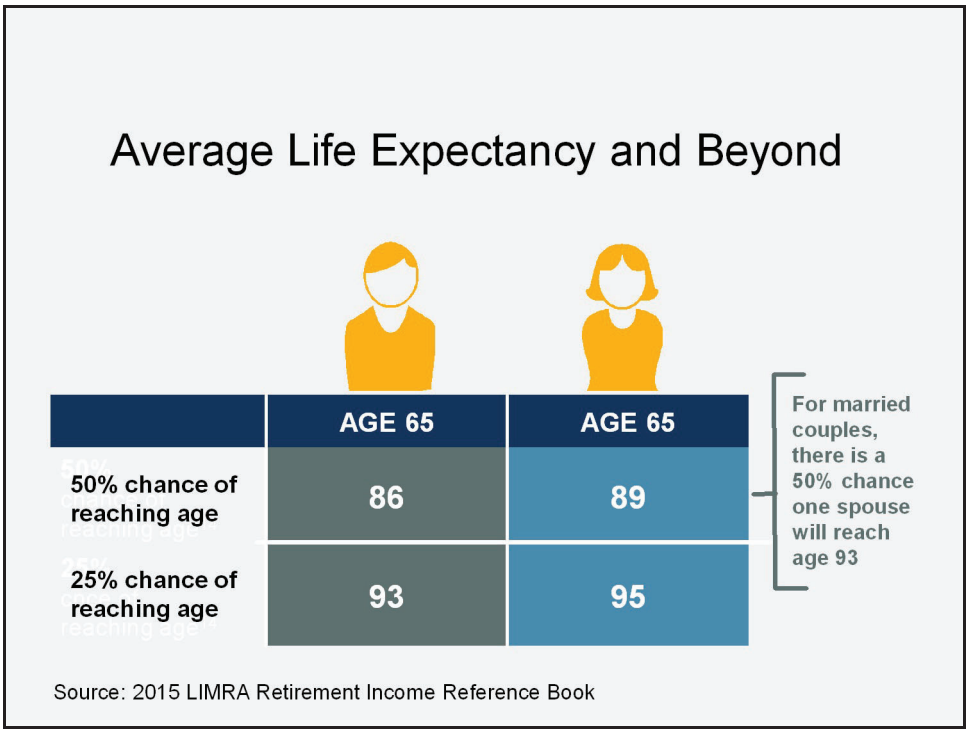
c. The beneficiary (retiree) filing **AT their FRA**

(1) Calculation of benefits

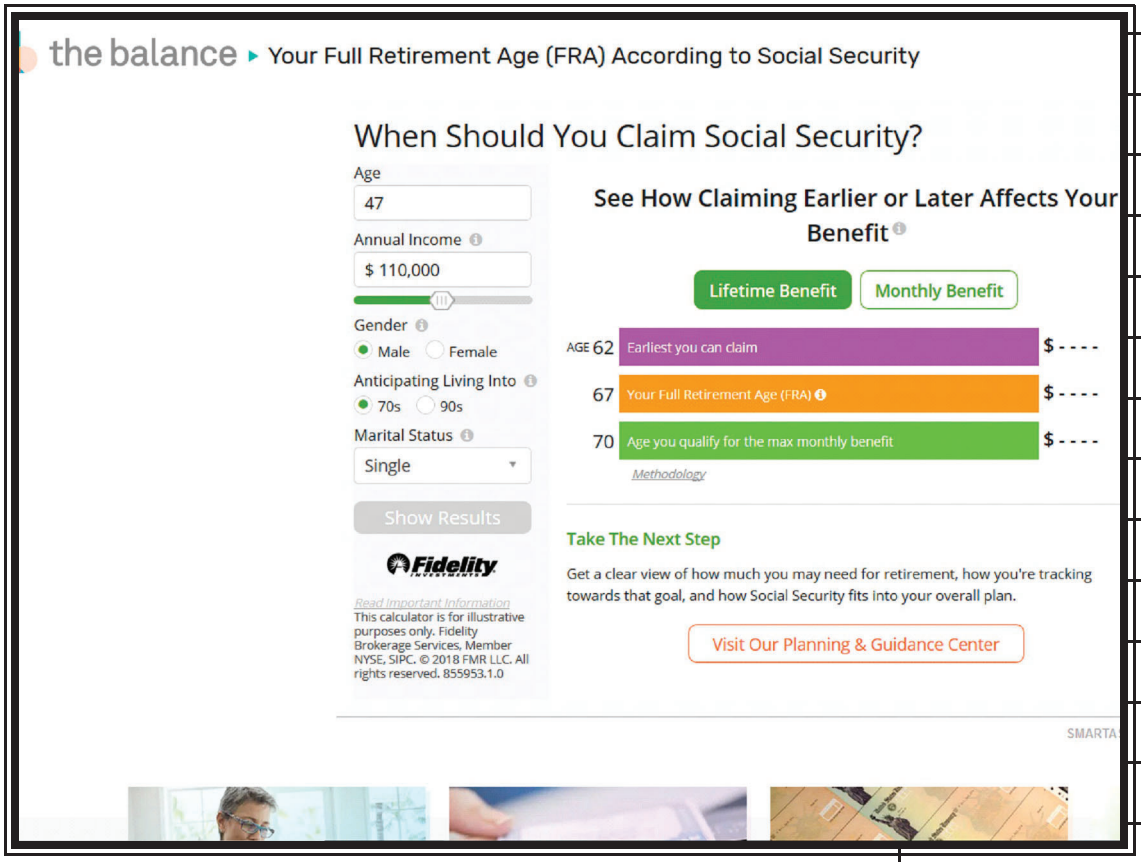
(2) Options

(3) Can the recipient still have an 'income', and if so, how much?

(a) The is no current (nor future) income limitation for a retiree should they wait to file at their FRA.



Notes	To Do
The **average monthly** Social Security benefit for all retired workers in **2023** is estimated to be $1,827, an increase of $146 from 2022 ($1,681). (Source: SSA.gov)	What is the Maximum Monthly SS Benefit in 2023 for a person that delayed their filing until their Full Retirement Age? **$3,627.**



d. The beneficiary (retiree) filing **AFTER their FRA**

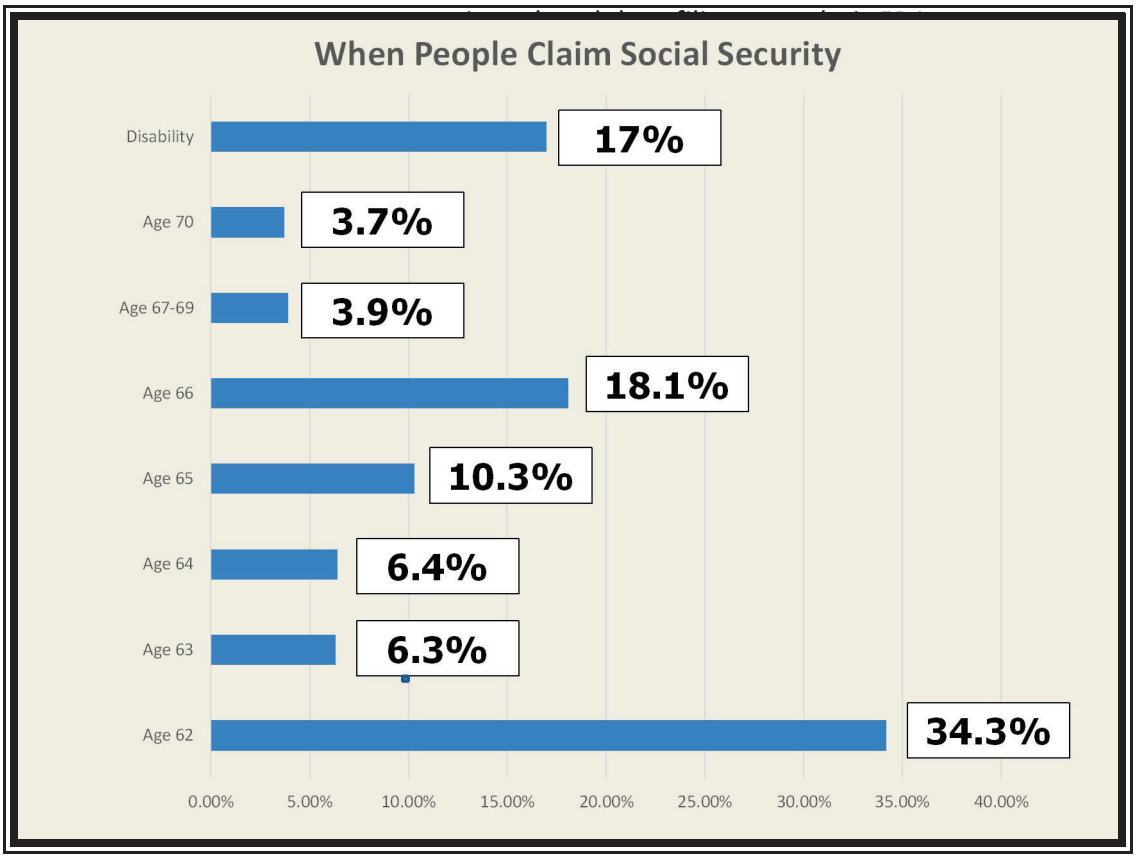
(1) Calculation of benefits

(a) Delayed Retirement Credits

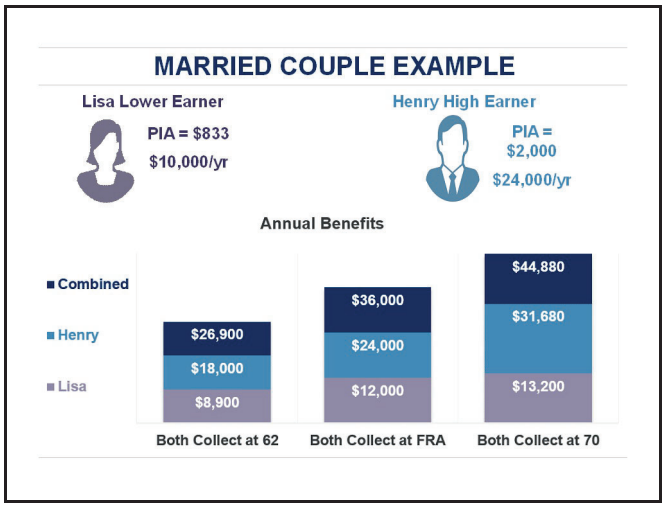
(2) Options

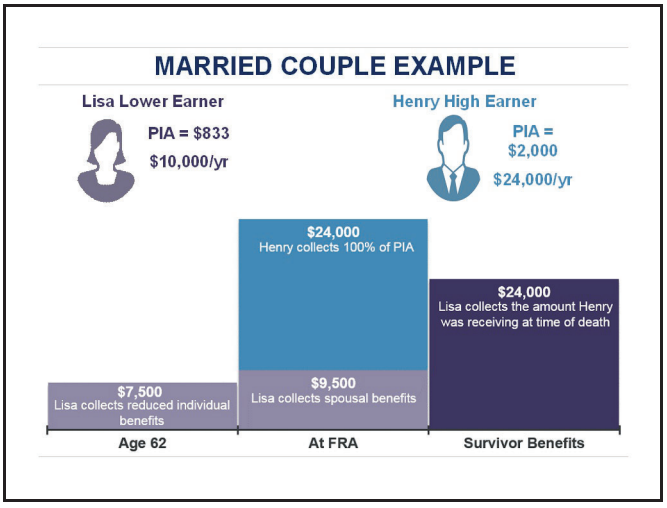
(3) Can the recipient still have an 'income', and if so, is there a limit?

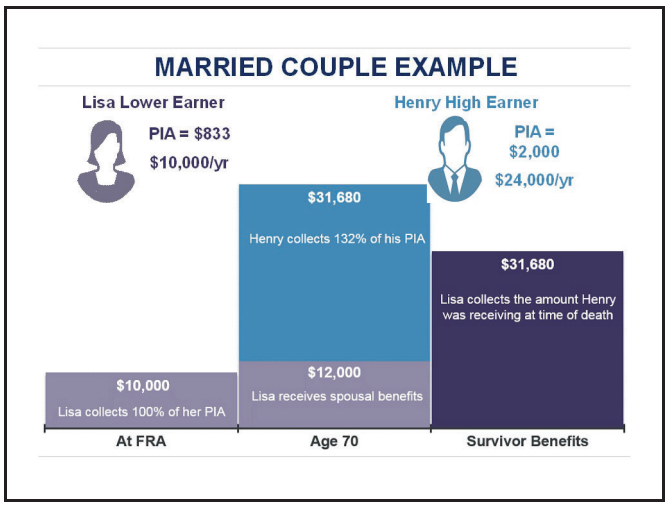
(a) As with filing at FRA, there is no income limitation for the

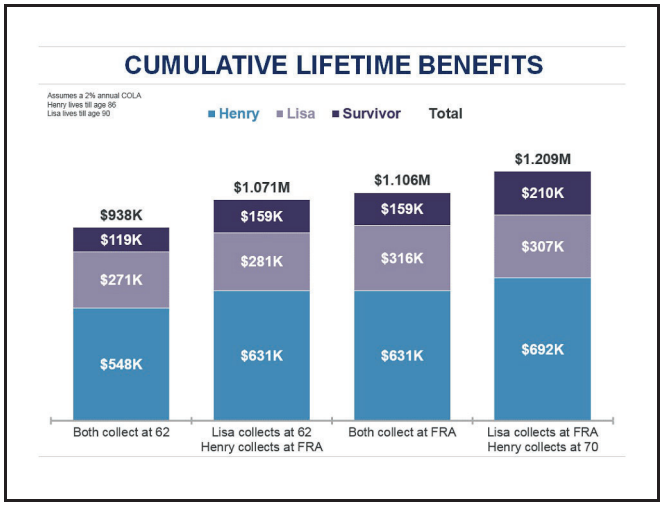


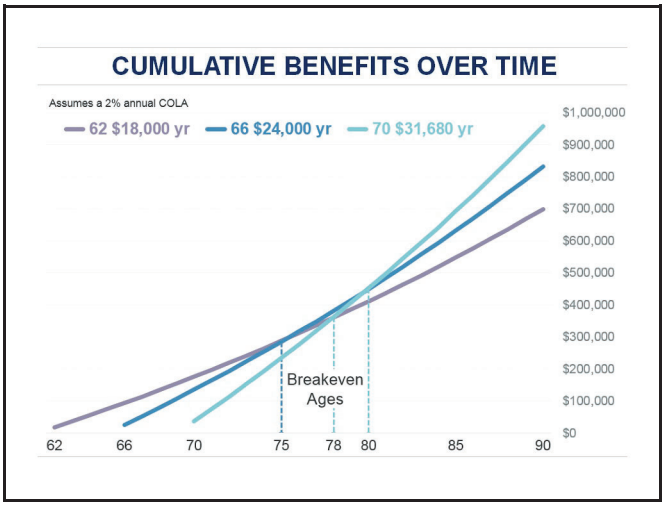
Source: Social Security Adm (2021)


MARRIED COUPLE EXAMPLE
Lisa Lower Earner
PIA = $833
$10,000/yr
Henry High Earner
PIA = $2,000
$24,000/yr
Annual Benefits
Combined
Henry
Lisa
$26,900
$18,000
$8,900
$36,000
$24,000
$12,000
$44,880
$31,680
$13,200
Both Collect at 62
Both Collect at FRA
Both Collect at 70


MARRIED COUPLE EXAMPLE
Lisa Lower Earner
PIA = $833
$10,000/yr
Henry High Earner
PIA = $2,000
$24,000/yr
$24,000
Henry collects 100% of PIA
$24,000
Lisa collects the amount Henry was receiving at time of death
$7,500
Lisa collects reduced individual benefits
$9,500
Lisa collects spousal benefits
Age 62
At FRA
Survivor Benefits


MARRIED COUPLE EXAMPLE
Lisa Lower Earner
PIA = $833
$10,000/yr
Henry High Earner
PIA = $2,000
$24,000/yr
$31,680
Henry collects 132% of his PIA
$31,680
Lisa collects the amount Henry was receiving at time of death
$10,000
Lisa collects 100% of her PIA
$12,000
Lisa receives spousal benefits
At FRA
Age 70
Survivor Benefits


CUMULATIVE LIFETIME BENEFITS
Assumes a 2% annual COLA
Henry lives till age 86
Lisa lives till age 90
Henry
Lisa
Survivor
Total
$938K
$119K
$271K
$548K
$1.071M
$159K
$281K
$631K
$1.106M
$159K
$316K
$631K
$1.209M
$210K
$307K
$692K
Both collect at 62
Lisa collects at 62
Henry collects at FRA
Both collect at FRA
Lisa collects at FRA
Henry collects at 70


CUMULATIVE BENEFITS OVER TIME
Assumes a 2% annual COLA
62 $18,000 yr
66 $24,000 yr
70 $31,680 yr
$1,000,000
$900,000
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
Breakeven Ages
62
66
70
75
78
80
85
90

e. Potential benefits for the spouse of a qualifying Social Security retirement beneficiary

(1) Key **'spouse'** rules, exceptions and definitions

(a) Must be married to the beneficiary / retiree at least one year, or be the parent of your child.

(b) Election can be made at 62, but if so, benefits will be ***permanently reduced***. If elected at FRA, then no reduction.

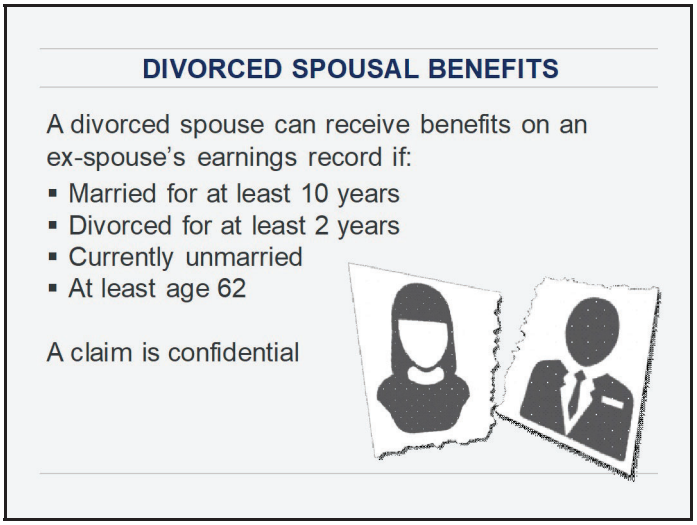
(c) If the spouse is also insured for a retirement benefit, that benefit will be paid, plus a spouse's benefit limited to the excess (if any) by which 50% of your PIA exceeds his or her own PIA. This excess is reduced if the spouse's benefit starts before the FRA. The spouse's benefit is then added to his or her own retirement benefit.

f. Potential benefits for the **'ex-spouse'** of a qualifying Social Security retirement beneficiary

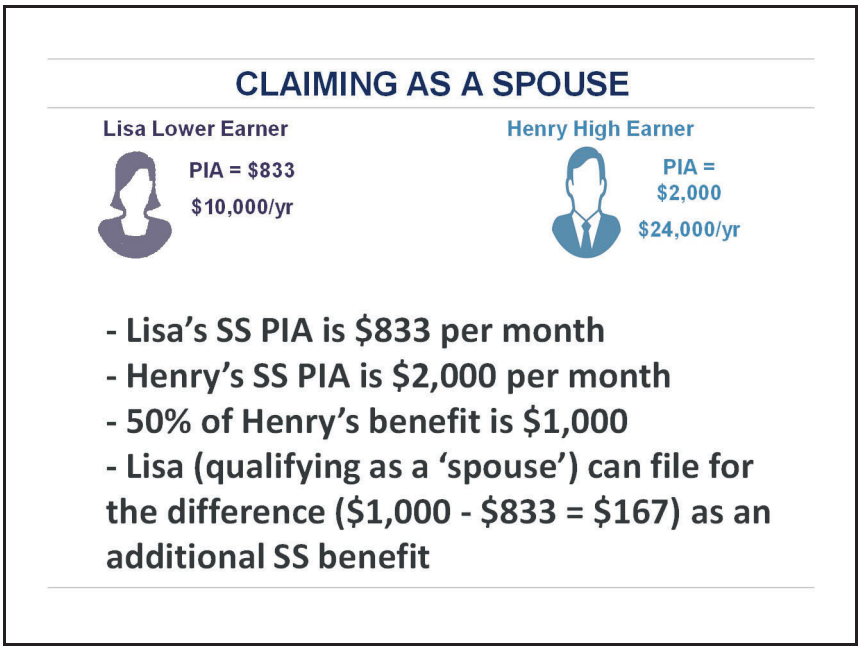
(1) Key 'ex-spouse' rules, exceptions and definitions

(a) Earliest eligibility filing is age 62 for the ex-spouse. The other spouse (beneficiary / retiree), must be at least age 62. It is not required that they be retired.

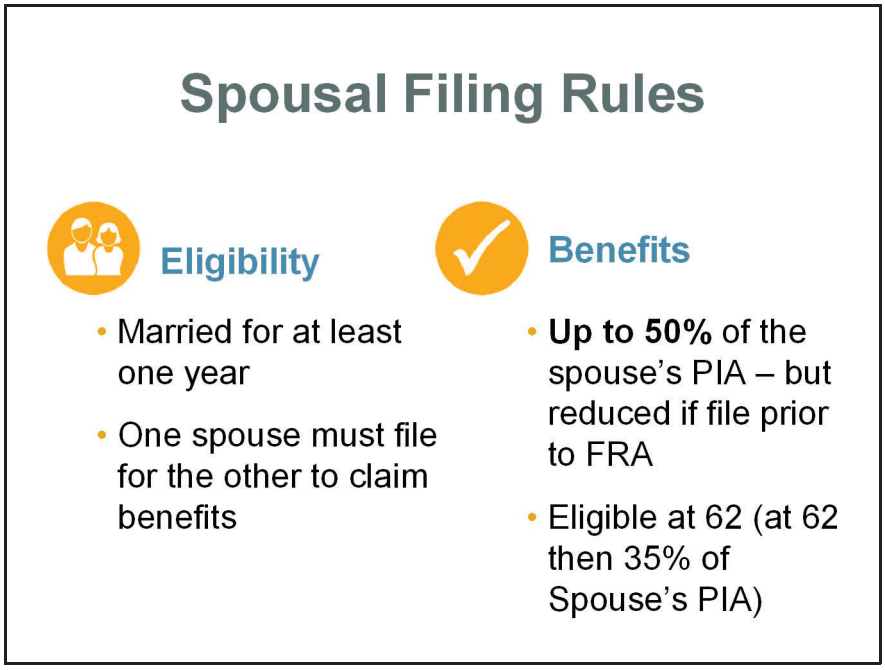
(b) They must have been married at least 10 years. Not payable if the ex-spouse is now remarried (exception exist).



Notes	To Do



A spouse who is caring for your eligible child is entitled to an amount equal to 50% of your PIA. The eligible child must be under age 16 (or any age, if disabled before age 22). In this case, no reduction is made because of the spouse's age.



Concerning Potential Benefits for the Ex-Spouse: If the ex-spouse is age 62 or older, but not retired, then the divorce must have occurred at least two years ago before the divorced spouse can receive the benefit. If they were entitled before the divorce, there is no waiting.

g. Potential benefits for dependent family members of a qualifying Social Security retirement beneficiary

(1) Key 'family member' rules, exceptions and definitions

C. Social Security's Death Benefit provision

(1) Definition of family member

(2) Who is eligible

(3) What is the potential payout and for how long

D. Social Security's Disability Benefit provision

(1) Definition of 'disability'

(2) Who is eligible

(3) What is the potential payout and for how long

Notes	To Do

SURVIVOR BENEFITS

A surviving spouse can receive the deceased spouse's benefit if:

- Married for at least 9 months
- At least 60 years old, unless disabled or caring for deceased spouses child

For Dependent Children

Eligibility

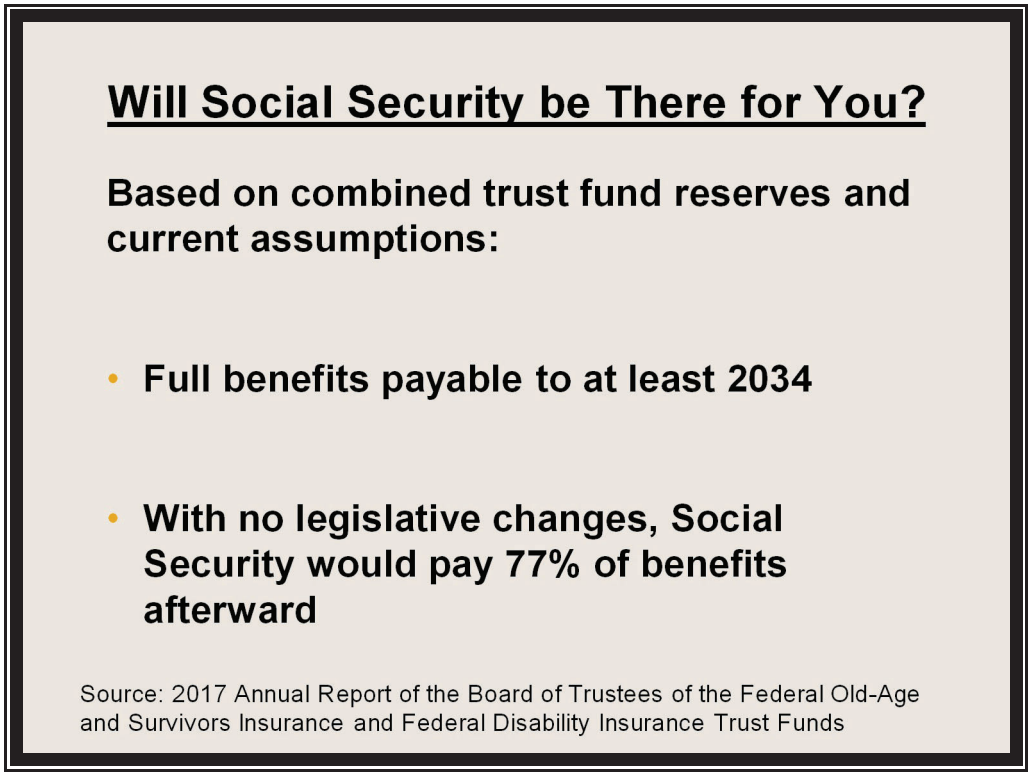
- Dependent under age 18
- Disabled dependents if disability occurred before age 22

Benefits

- 50% of parent's PIA
- 75% of deceased's PIA

E. Sustainability of the Social Security Retirement payout in the future

1. Data and facts



2. Are there potential solutions? If so, what are the options?

a. **Reduce benefits** to match income from payroll taxes.

b. **Increase payroll taxes** in order to pay the current level of benefits or higher. Currently, income is taxed at 12.4% (6.2% each for the employer and the employee) and income above $160,200 (2023) is not taxed at all. Options are: 1) increasing the tax; 2) remove the income ceiling on taxable income, or; 3) both.

c. **Change the retirement age** (and options) to delay when people can start collecting benefits.

d. **Reduce or eliminate benefits for wealthy retirees**.

e. **Privatize the program** and let workers invest their payroll taxes themselves.

Notes	To Do

INBLOG

Social Security finances worsen

New report predicts earlier exhaustion of trust fund in 2032

MARY BETH FRANKLIN

Two new reports from the University of Pennsylvania's Wharton School of Business document an increase in American retirees' reliance on Social Security income over the past 25 years as the program's long-term finances deteriorate at a faster pace than officially projected by the Social Security Administration.

The reports are based on simulations generated by the Penn Wharton Budget Model, a nonpartisan research initiative that provides economic analysis of the fiscal impact of public policies.

The Social Security program was introduced in the 1930s during the throes of the Great Depression to protect those who could no longer work, due to old age, from slipping into poverty. Social Security has evolved into a core pillar of retirement security, providing benefits to retirees and disabled workers, their dependent spouses, children and survivors.

But Social Security was never designed to be the sole source of retirement income. Retirees were expected to supplement their benefits with pension income and personal savings. Unfortunately, that plan hasn't worked out for many Americans.

RISE IN DEPENDENCY

The share of retirees who depended on Social Security for more than 90% of their income increased from 43.7% in 1991 to 46.6% by 2012, and the share of retirees depending on Social Security benefits for half or more of their income increased from 69% to 71% during the same period.

Now for the worse news.

Since major Social Security reforms were passed in 1983, the Social Security Trustees have slowly reduced their projected Social Security trust fund exhaustion date from 2058 to 2034 in the most recent report. The main reason for the changing projection was faster-than-expected increases in American life expectancy and reduced fertility rates that have resulted in fewer workers to support an increasing number of retirees.

But the trustees' estimates don't include some key economic variables, such as the nation's growing debt. A separate Penn Wharton report, Social Security's Worsening Financial Condition, projects that the Social Security trust fund will be depleted in 2032.

The two reports combined present an ominous picture of the future of retirement security for many Americans.

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mbfranklin@investmentnews.com
Twitter: @mbfretirepro

Observation: Conduct a **Google Search** for *'Sustainability of Social Security'* and you will find numerous articles by supposed "knowledgeable individuals". Some write that the program is "going broke and the younger generation will not collect a dime". Others state the program will be corrected by Congress in the near future and be around forever.

F. Insurance products and what they can provide in the way of Social Security replacement or coordination. And remember, when it come to your retirement 'money', it is **what you keep, not just what you make!** So don't forget about taxes.

1. Remember the comments about "federal income taxes and your Social Security benefit"? Please see the text concerning taxation on page 22.

   a. What is **NOT** counted as income? Income from your (or a spouse's): Roth IRA; Life Insurance Cash Value; Principle from an Annuity.

2. Annuities

   a. Advantages / Disadvantages

   b. Tax rules regarding annuities

      (1) Any money distributed from a Non-Qualified Annuity is considered **LIFO**. **Last-In** (the earned interest) is distributed **First-Out**. Thus, the earned interest will be the 1st dollars out of the contract and subject to ordinary income tax. The paid-premiums will be Last Out, and free of any taxation. This rule is the same whether it is paid to the annuitant, or a beneficiary after the death of the annuitant.

   c. Product options

3. Life insurance

   a. Advantages / Disadvantages

   b. Tax rules regarding life insurance

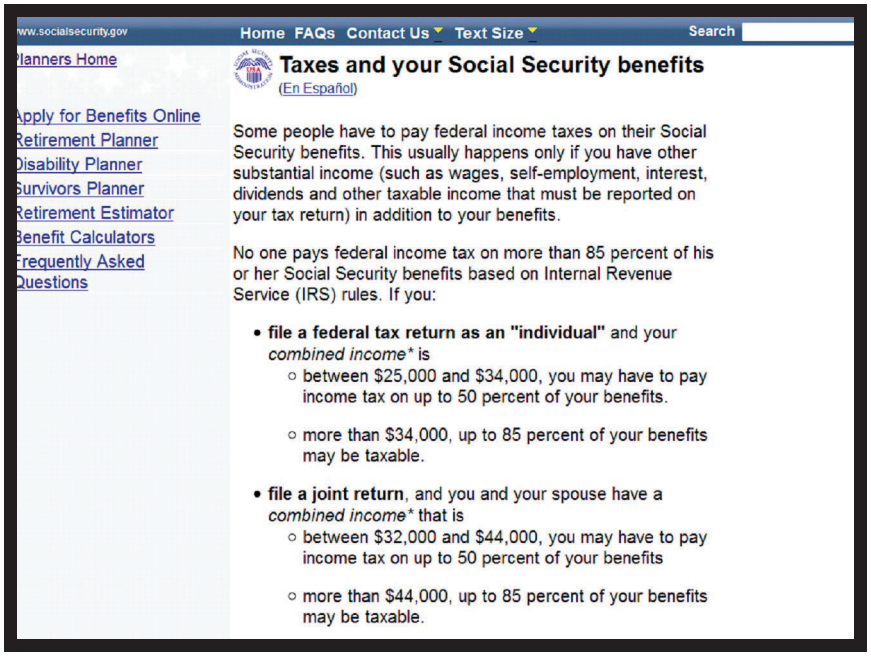
      (1) A paid **death benefit is income tax-free** to the beneficiary (minor exceptions apply)

      (2) Any money distributed from the contract's cash value is **FIFO**. First-In (paid premiums) are distributed first - thus the paid premiums (which are never tax deductible) are return first - and **income tax free**.

   c. Product options

4. Qualified retirement plans (401-k, IRA, SEP, ROTH, etc.)

Notes	To Do



- Social Security is the major source of income for **most** of the elderly.
- Among elderly Social Security beneficiaries, 48% of married couples and 69% of unmarried persons receive 50% or more of their income from Social Security.
- Among elderly Social Security beneficiaries, 21% of married couples and about 44% of unmarried persons rely on Social Security for 90% or more of their income.
- Nearly nine out of ten individuals age 65 and older receive Social Security benefits.

Source: https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf - (2018 data)

"66% of seniors believe that Social Security will be their primary source of income over the course of their retirement", according to a new Transamerica study[1]

"One thing many people fail to realize about Social Security is that it's not designed to sustain seniors in the absence of other income, nor is it meant to constitute the bulk of one's financial resources. In reality, those benefits will only replace about 40% of the average earner's pre-retirement income. Most folks, however, need roughly twice that amount to live comfortably once they retire. The fact that two-thirds of seniors are depending so heavily on Social Security therefore paints a rather ominous picture about their prospects, especially since future cuts in benefits aren't off the table."[2]

[1] https://www.transamericacenter.org/docs/default-source/retirees-survey/tcrs2018_sr_retirees_survey_financially_faring.pdf
[2] https://www.fool.com/retirement/2019/01/09/social-security-is-66-of-retirees-primary-source-o.aspx

Notes	To Do

Using an Annuity for Retirement Income and Long-Term Care Benefit (If Needed)

- **Action:** Transfer 401(k) (roll-over) assets into an individual IRA for future income ***plus*** Long-Term Care benefits, if needed.
- **Company:** American Equity Investment Life
- **Product:** Choice Series 10 MVA
- **Single Premium:** $250,000
- **Medically Underwritten:** No
- **Contract Value - 10 years:** $359,996
- **Annual Income:** $24,400
- **Strategy:** Volatility Control Annual Point-to-Point Spread Index Strategy - 10
- **Fee:** Spread Rate - 1.25%
- **Rider (Fee):** Lifetime Income Benefit - 1.00%

Historical Comparison / Rate of Return:

Worse 10 Years	Most Recent 10 Years	Best 10 Years
3.56%	4.66%	4.74%

Long-Term Care Benefit: If a single life contract is elected, and Jack cannot perform 2 of 6 Activities of Daily Living (ADL), or Cognitive Impairment, the income doubles. If a dual life contract is elected, and either Jack or Rebecca qualifies as above, the income increase by 1½ times.

Prepared For:
Type of Funds:

Gender, Age: Male, 62
Initial Premium: $250,000.00

Contract Values Projected on a Non-Guaranteed Basis

End of Year	Age	Premium	Contract Value Withdrawal	Lifetime Income Benefit Payment	Income Benefit Rider Fee	Interest Earned	Contract Value	Cash * Surrender Value	Death Benefit
1	62-63	250,000	0	0	0	0	250,000	227,250	250,000
2	63-64	0	0	0	2,500	13,765	261,265	239,711	261,265
3	64-65	0	0	0	2,613	14,433	273,086	253,287	273,086
4	65-66	0	0	0	2,731	0	270,355	252,782	270,355
5	66-67	0	0	0	2,704	12,365	280,016	264,615	280,016
6	67-68	0	0	0	2,800	32,926	310,142	296,185	310,142
7	68-69	0	0	0	3,101	12,041	319,081	307,913	319,081
8	69-70	0	0	0	3,191	0	315,890	307,993	315,890
9	70-71	0	0	0	3,159	6,855	319,586	314,792	319,586
10	71-72	0	0	0	3,196	43,606	359,996	358,196	359,996
11	72-73	0	0	24,400	3,600	0	331,996	331,996	331,996
12	73-74	0	0	24,400	3,320	16,923	321,199	321,199	321,199
13	74-75	0	0	24,400	3,212	16,382	309,969	309,969	309,969
14	75-76	0	0	24,400	3,100	0	282,469	282,469	282,469
15	76-77	0	0	24,400	2,825	11,792	267,035	267,035	267,035
16	77-78	0	0	48,801	2,670	25,603	241,167	241,167	241,167
17	78-79	0	0	48,801	2,412	7,449	197,404	197,404	197,404
18	79-80	0	0	48,801	1,974	0	146,630	146,630	146,630
19	80-81	0	0	48,801	1,466	2,112	98,475	98,475	98,475
20	81-82	0	0	48,801	985	6,711	55,400	55,400	55,400
21	82-83	0	0	24,400	554	0	30,446	30,446	30,446
22	83-84	0	0	24,400	304	319	6,060	6,060	6,060
23	84-85	0	0	24,400	61	0	0	0	0
24	85-86	0	0	24,400	0	0	0	0	0
25	86-87	0	0	24,400	0	0	0	0	0

Rider payments are based on the greater of your contract value or Income Account Value at each contract anniversary. Rider fees may apply depending on the options you choose.

The Lifetime Income Benefit Payment projected in years 16 to 20 assumes that at least two of the six Activities of Daily Living (ADLs) are unable to be performed.

Throughout this illustration any withdrawal amounts demonstrated do not reflect possible surrender charges that would occur on withdrawals greater than the penalty-free amount available.

* This value does not reflect the effect of any potential Market Value Adjustment (MVA). If an MVA is applicable see the page within this illustration describing the impact of any MVA calculation on the Cash Surrender Value.

Prepared on September 6, 2018
For

This illustration is not valid without all pages.

Page 6 of 17

ONEAMERICA®

Asset-Care®

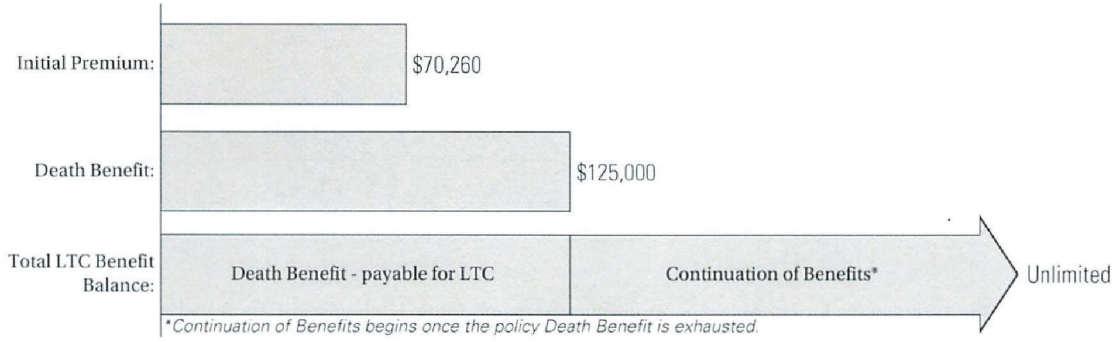
Product: Asset-Care I - Single Premium (cash)
State: TX

Presented by:
Charlie Matejowsky

Prepared for:

Emory Thomas	Sandy Thomas
Male, 61	Female, 62
Class: Non-Smoker	Class: Non-Smoker

Total Initial Premium:	
Death Benefit:	$125,000
Total LTC Benefit Balance / Benefit Period:	Unlimited / Lifetime



Initial LTC Benefit Limit, Per Individual:	$5,000 Monthly $60,000 Annually
Initial LTC Benefit Limit, For One or Both Individuals:**	$10,000 Monthly ($5,000 per person) $120,000 Annually ($60,000 per person)

***If both insureds receive long-term care benefits at the same time, the long-term care benefit will last for a shorter period of time than if only one insured receives long-term care benefits.*

Product Features:
Single Premium - $68,018
Guaranteed Return of Premium***
4% Acceleration Rate / 25 Months
Guaranteed Cash Value Accumulation
****Excludes cost of enhanced LTC monthly payout*

Continuation of Benefits Data:
Continuous Premium - $2,242
Benefit Balance - Unlimited
Benefit Period - Lifetime
Inflation Option - None

Not all features and benefits of the policy are shown here. For additional details of all benefits and features, please see the policy.

THE STATE LIFE INSURANCE COMPANY®

ONEAMERICA

Asset-Care®

Product: Asset-Care I - Single Premium (cash)
State: TX

Presented by:
Charlie Matejowsky

Prepared for:

Emory Thomas	Sandy Thomas
Male, 61	Female, 62
Class: Non-Smoker	Class: Non-Smoker

PREMIUM, CASH VALUE, AND LTC BENEFIT SUMMARY – GUARANTEED

Policy Year	Joint Equal Age	Total Annual Premium	Cash Surrender Value	Death Benefit	Total LTC Benefit Balance	Base Policy Annual Benefit Per Person	COB Rider Annual Benefit Per Person
1	63	$70,260	$68,018	$125,000	Unlimited	$60,000	$60,000
5	67	$2,242	$66,536	$125,000	Unlimited	$60,000	$60,000
10	72	$2,242	$66,165	$125,000	Unlimited	$60,000	$60,000
15	77	$2,242	$78,341	$125,000	Unlimited	$60,000	$60,000
20	82	$2,242	$89,268	$125,000	Unlimited	$60,000	$60,000
25	87	$2,242	$98,431	$125,000	Unlimited	$60,000	$60,000
30	92	$2,242	$105,168	$125,000	Unlimited	$60,000	$60,000
35	97	$2,242	$109,999	$125,000	Unlimited	$60,000	$60,000
38	100	$2,242	$112,119	$125,000	Unlimited	$60,000	$60,000

Table assumes policy and rider remain in force and no withdrawals have been made through given year.

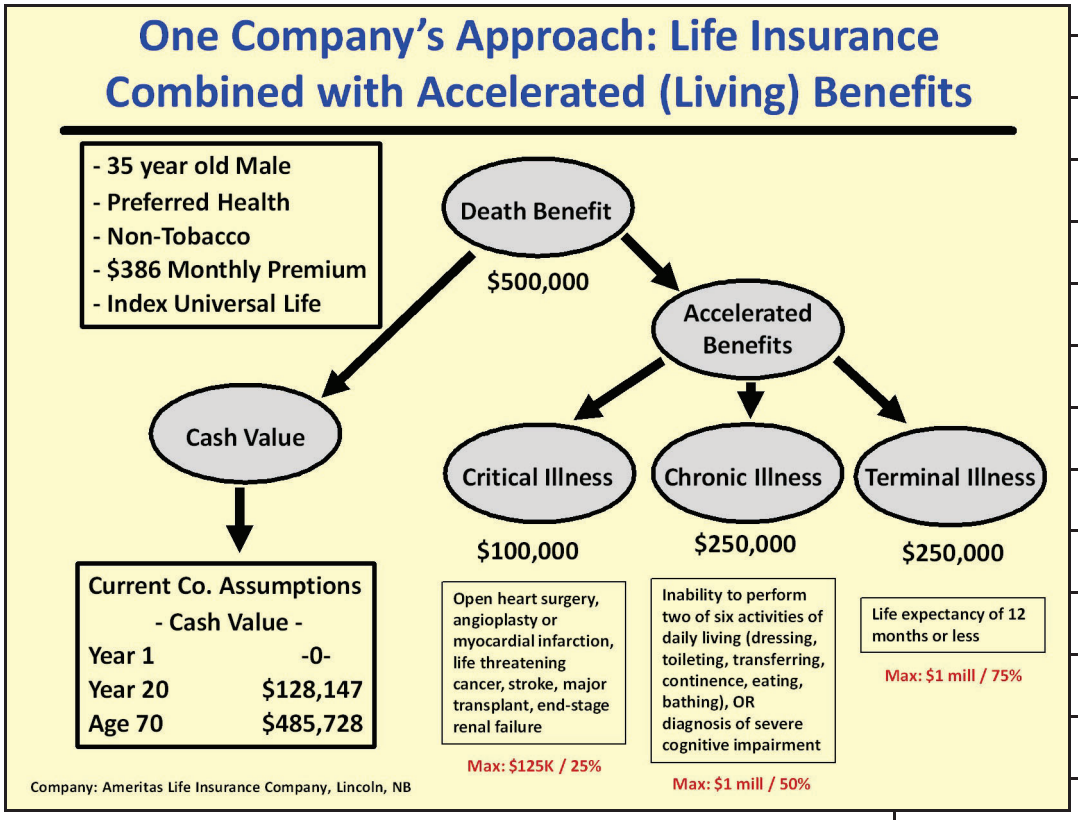
Client Disclosures

• OneAmerica is the marketing name for The State Life Insurance Company® (State Life). • Asset-Care is a whole life insurance or whole life and annuity combination that allows access to 100% of the life policy death benefit and/or annuity cash value for qualifying LTC expenses (paid monthly). • Asset-Care is subject to medical approval. Asset-Care is issued and medically underwritten by State Life. Policies and riders may not be available in all states and may vary by state. • Exclusions, restrictions, limitations, and reductions in benefits will, in certain situations, apply to this policy. For full details, please see your policy, discuss with your financial services professional or call us at 1-844-833-5520. • All guarantees are subject to the claims-paying ability of State Life. • Provided content is for overview and informational purposes only and is not intended as and should not be relied upon as individualized tax, legal, fiduciary, or investment advice. • The rates shown for Asset-Care are based on several factors including health factors of the proposed insured and optional riders chosen. Rates may change based on changes in the proposed insured's health status. • A minimum premium amount is required. Care Solutions premiums may be funded with a single premium or, depending on the product, paid annually, semi-annually, quarterly, or monthly. There are charges for all modes except annual. • Surrender charges apply, except as specifically stated in the contract. • Some optional riders, such as the LTC Benefits Continuation Rider, are available with this product for additional premium. • Not all ages and/or options are available on this calculator. • For additional options, please see your policy or financial services professional. • Premiums are not guaranteed until the policy is issued.

• NOT A DEPOSIT • NOT FDIC OR NCUA INSURED • NOT BANK OR CREDIT UNION GUARANTEED • NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY • NOT A CONDITION TO ANY BANKING SERVICE • MAY LOSE VALUE

Not all features and benefits of the policy are shown here. For additional details of all benefits and features, please see the policy.

Notes	To Do



What is an IRS Section 1035 Exchange?

A 1035 Exchange is a provision in the tax code which allows the policy owner of a life insurance contract, annuity (but only one that is non-qualified), or an endowment, to transfer funds from the old contract to a new contract, on a tax-favored basis.

How does a 1035 Exchange work? If all the surrender proceeds from the original policy are transferred into the new contract - and there are no outstanding loans on the original policy - there will be no tax on the gain in the original policy at the time of exchange. The tax on the gain is deferred to a later date. If the policy is surrendered without a 1035 Exchange, the gain from the original life insurance contract will be taxed as ordinary income (not capital gains).

Example #1: A life contract's cash value is $200,000 and $125,000 is the total premiums that have been paid. If it is surrendered, the owner would be looking at a $75,000 gain, subject to ordinary tax.

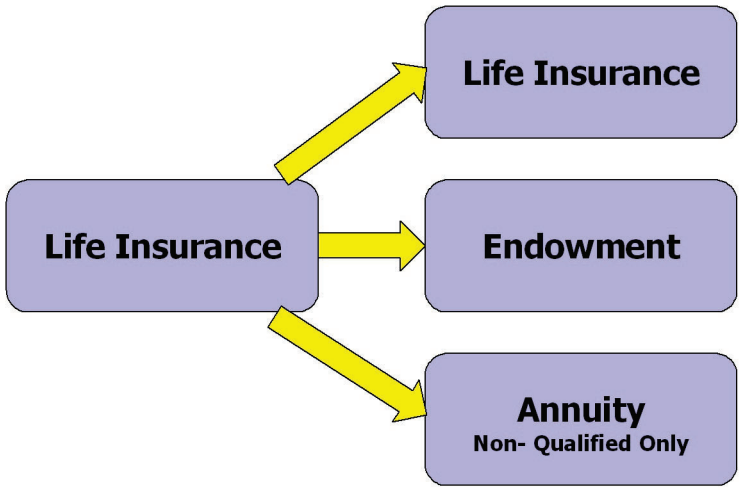
Example #2: Instead of surrendering the contract above, the owner conducted a 1035 Exchange from the life contract to a new annuity (or a new life contract). All gains from the old life contract would be *deferred* until funds are withdrawn from the new contract. If the new contract is an annuity, then distributions are taxed at **LIFO**. If the new contract is another life policy - then **FIFO**.

Notes	To Do

1035-a Exchange

- Your 'Old' Life Insurance cash values to your 'New" Life Insurance - **OK**
- Your 'Old' Annuity values to your 'New' Annuity - **OK**
- Your 'Old' Life Insurance cash values to your 'New' (or existing) Annuity - **OK**
- Your 'Old' Annuity values to your 'new' (or existing) Life Insurance - **NO**
- Your 'Old' Life Insurance cash values, or Your 'Old' Annuity values to a 'New' Annuity or Life Insurance contract on the life of a person that is not you - **NO**

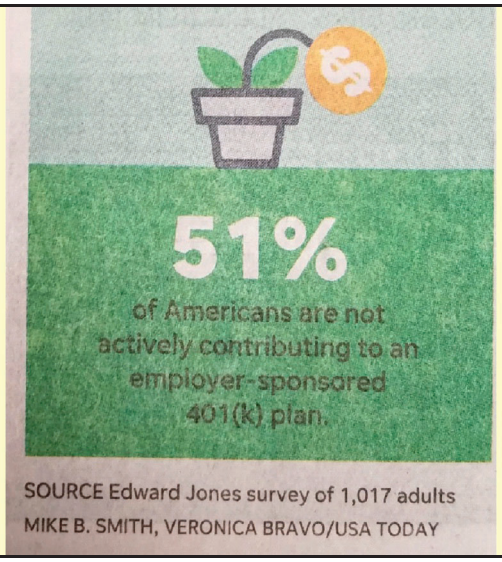
1035-a Exchange



Notes	To Do

401(k)

- **Eligibility and deferrals**
  - ✓ **Who is eligible?** any employee where a plan has been set up by the employer
  - ✓ **Deferrals (2023):** 100% of participant's income not to exceed $22,500 (and up to $7,500 'catch-up' limit for those age 50, and older)



The Tax Rules Regarding Your Qualified Money (401-k, IRA, etc.)

- Contributions are income tax-deductible when made to a qualified account
- The total account grows tax-deferred, until received
- 100% of withdrawals are subject to ordinary income when receive, plus penalty if taken prior to age 59½ (exceptions do exist)
- Some minimum amount must be taken at age 70½ (exceptions do exist)

II. MEDICARE

A. Overview

1. Basic intent

2. Qualified beneficiaries

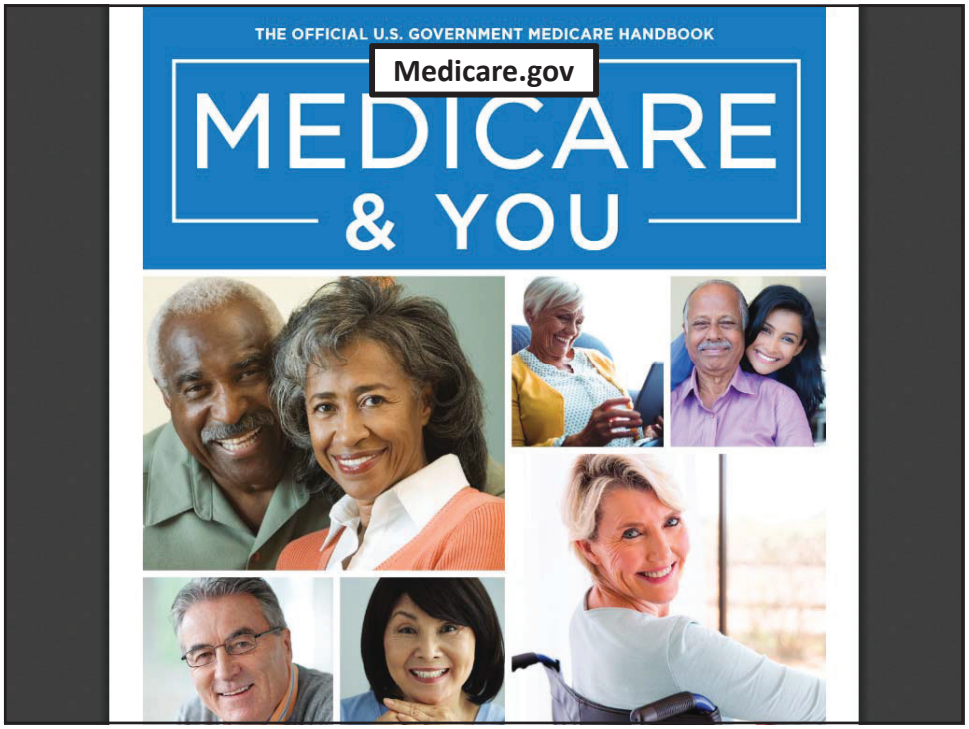
   a. Qualification rules

      (1) At Age 65

      (2) Other than at Age 65 - Lou Gehrig's Disease, end-stage renal, 24 months qualified as Social Security disabled.

3. How and when to file for Medicare

Notes	To Do
Medicare was created in 1965 when people age 65 and over found it virtually impossible to get private health insurance coverage. Medicare has made access to health care a universal right for Americans once they reach age 65. This has helped improve the health and longevity of older Americans. However, the program was created during an era when the big financial worry was that an illness might put someone in the hospital and generate huge bills. This was a period before the widespread use of prescription drugs to combat illness. The basic design of the Medicare program was modeled on the private insurance system in place in the 1960s.	



your Medicare coverage—see the next few pages to learn more.

- **Find out how and when you can sign up.** If you don't have Medicare Part A or Part B, see Section 1, which starts on page 15. If you don't have Medicare prescription drug coverage (Part D), see Section 6, which starts on page 73. There may be penalties if you don't sign up when you're first eligible.
- **If you have other health insurance**, see pages 20–21 to find out how it works with Medicare.

If you already have Medicare:

- **You don't need to sign up for Medicare each year.** However, you can **review your Medicare health and prescription drug coverage** and make changes each year.
- **Mark your calendar with these important dates!** This may be the only chance you have each year to make changes to your coverage.

October 1, 2018	**Start comparing your coverage with other options.** You may be able to save money. Visit Medicare.gov/find-a-plan.
October 15 to December 7, 2018	**Change your Medicare health or prescription drug coverage for 2019, if you decide to.** This includes returning to Original Medicare or joining a Medicare Advantage Plan.
January 1, 2019	**New coverage begins if you made a change.** If you kept your existing coverage and your plan's costs or benefits changed, those changes will also start on this date.
January 1 to March 31, 2019	**If you're in a Medicare Advantage Plan**, you can make one change to a different plan or switch back to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan) once during this time. Any changes you make will be effective the first of the month after the plan gets your request. See page 57.

Pages 4–8 provide an overview of your Medicare options.

What are the parts of Medicare?

Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

See pages 25–28.

Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment and supplies)
- Many preventive services (like screenings, shots, and yearly "Wellness" visits)

See pages 29–49.

Part D (Prescription drug coverage)

Helps cover:

- Cost of prescription drugs

Part D plans are run by private insurance companies that follow rules set by Medicare.

See pages 73–82.

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- If you want drug coverage, you can join a separate Part D plan.
- To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can also shop for and buy supplemental coverage.

☑ **Part A**

☑ **Part B**

You can add:

☐ **Part D**

You can also add:

☐ **Supplemental coverage**

(Some examples include coverage from a Medicare Supplement Insurance (Medigap) policy, or coverage from a former employer or union.)

Medicare Advantage (also known as Part C)

- Medicare Advantage is an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- Some plans may have lower out-of-pocket costs than Original Medicare.
- Some plans offer extra benefits that Original Medicare doesn't cover— like vision, hearing, or dental.

☑ **Part A**

☑ **Part B**

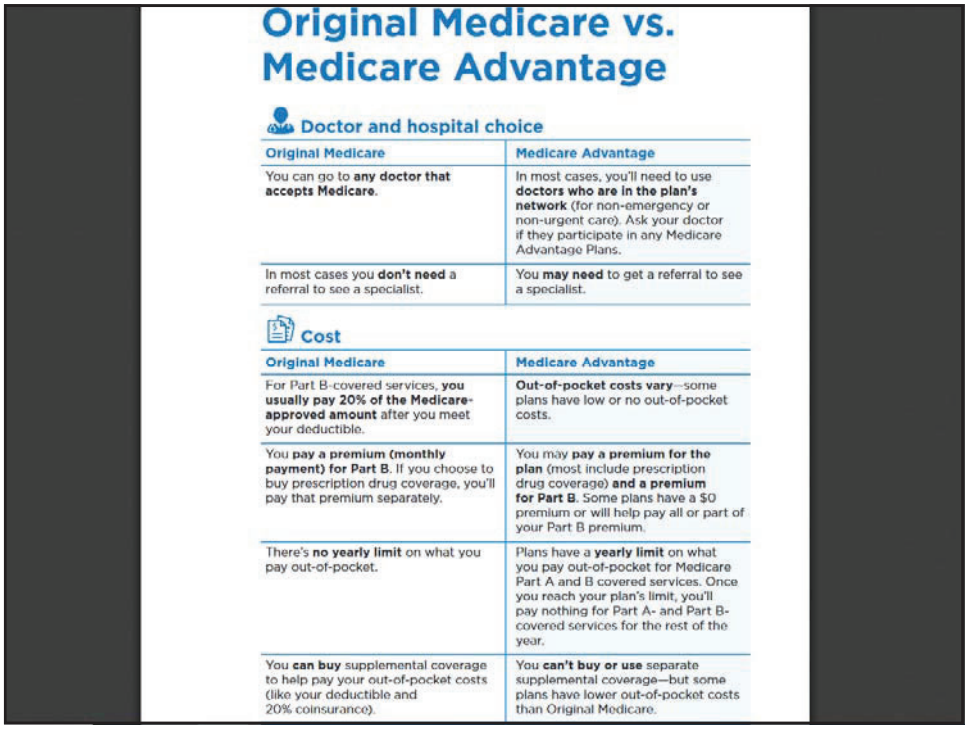
Most plans include:

☑ **Part D**

Some plans also include:

☐ **Lower out-of-pocket costs**

☐ **Extra benefits**



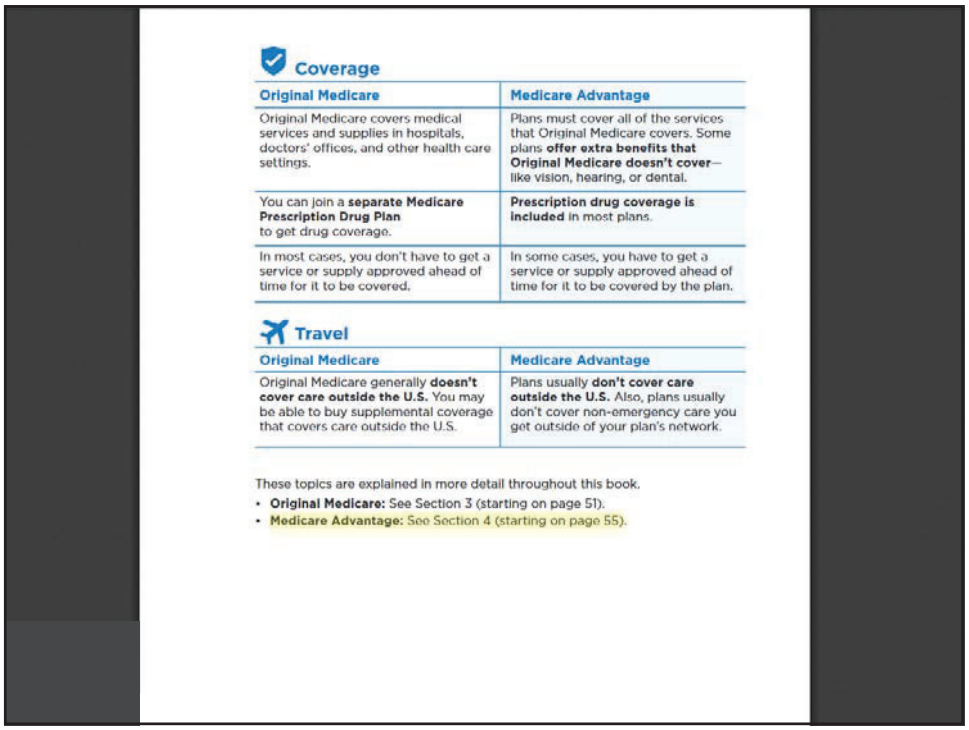
Original Medicare vs. Medicare Advantage

Doctor and hospital choice

Original Medicare	Medicare Advantage
You can go to **any doctor that accepts Medicare.**	In most cases, you'll need to use **doctors who are in the plan's network** (for non-emergency or non-urgent care). Ask your doctor if they participate in any Medicare Advantage Plans.
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

Cost

Original Medicare	Medicare Advantage
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible.	**Out-of-pocket costs vary**—some plans have low or no out-of-pocket costs.
You **pay a premium (monthly payment) for Part B.** If you choose to buy prescription drug coverage, you'll pay that premium separately.	You may **pay a premium for the plan** (most include prescription drug coverage) **and a premium for Part B.** Some plans have a $0 premium or will help pay all or part of your Part B premium.
There's **no yearly limit** on what you pay out-of-pocket.	Plans have a **yearly limit** on what you pay out-of-pocket for Medicare Part A and B covered services. Once you reach your plan's limit, you'll pay nothing for Part A- and Part B-covered services for the rest of the year.
You **can buy** supplemental coverage to help pay your out-of-pocket costs (like your deductible and 20% coinsurance).	You **can't buy or use** separate supplemental coverage—but some plans have lower out-of-pocket costs than Original Medicare.



Coverage

Original Medicare	Medicare Advantage
Original Medicare covers medical services and supplies in hospitals, doctors' offices, and other health care settings.	Plans must cover all of the services that Original Medicare covers. Some plans **offer extra benefits that Original Medicare doesn't cover**—like vision, hearing, or dental.
You can join a **separate Medicare Prescription Drug Plan** to get drug coverage.	**Prescription drug coverage is included** in most plans.
In most cases, you don't have to get a service or supply approved ahead of time for it to be covered.	In some cases, you have to get a service or supply approved ahead of time for it to be covered by the plan.

Travel

Original Medicare	Medicare Advantage
Original Medicare generally **doesn't cover care outside the U.S.** You may be able to buy supplemental coverage that covers care outside the U.S.	Plans usually **don't cover care outside the U.S.** Also, plans usually don't cover non-emergency care you get outside of your plan's network.

These topics are explained in more detail throughout this book.

- **Original Medicare:** See Section 3 (starting on page 51).
- **Medicare Advantage:** See Section 4 (starting on page 55).

Get the most out of Medicare

Get help choosing the coverage option that's right for you:

- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP)—see pages 109-112 for the phone number.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit the Medicare Plan Finder at Medicare.gov/find-a-plan.

Get free help with your Medicare questions

For general Medicare questions, visit Medicare.gov, or call 1-800-MEDICARE. See pages 101-104 to learn about other resources.

Get preventive services

Ask your doctor or other health care provider which preventive services (like screenings, shots, and tests) you need to get. Medicare covers many common preventive services at no cost to you. See pages 29-49 and look for the to learn more.

Get help paying for health care

Find out if you can get help paying your health and prescription drug costs. Go to Section 7, which starts on page 83, to see if you qualify.

Go paperless

Help save tax dollars by choosing to access future "Medicare & You" handbooks electronically. See page 103 to find out how. To access and manage your personalized Medicare information online, visit MyMedicare.gov. See page 103 for details.

Contents

Topics

Some people have to sign up for Part A and/or Part B

If you're close to 65, but not getting Social Security or Railroad Retirement Board (RRB) benefits, you'll need to sign up for Medicare. Contact Social Security 3 months before you turn 65. You can also apply for Part A and Part B at socialsecurity.gov/retirement. If you worked for a railroad, contact the RRB. **In most cases, if you don't sign up for Part B when you're first eligible, you may have a delay in getting Medicare coverage in the future, and you may have to pay a late enrollment penalty for as long as you have Part B.**

If you have End-Stage Renal Disease (ESRD) and you want Medicare, you'll need to sign up. Contact Social Security to find out when and how to sign up for Part A and Part B. For more information, visit Medicare.gov/publications to view the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

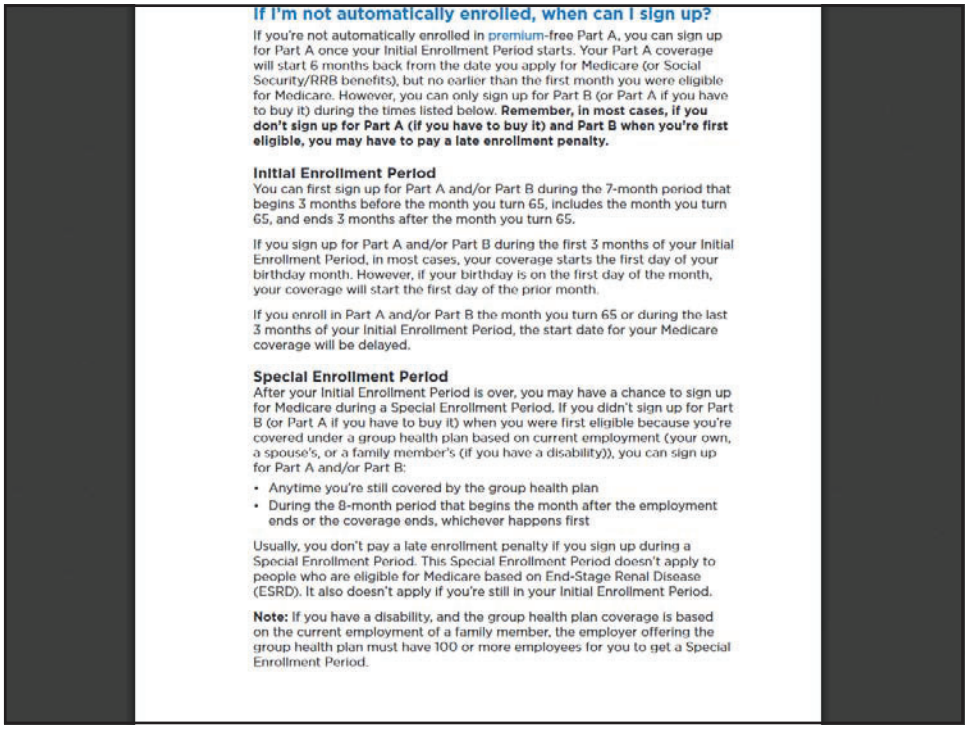
Important! **If you live in Puerto Rico and get benefits from Social Security or the RRB,** you'll automatically get Part A the first day of the month you turn 65 or after you get disability benefits for 24 months. **However, if you want Part B, you'll need to sign up for it by completing an "Application for Enrollment in Part B Form" (CMS-40B). If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B.** Visit CMS.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms017339.html to get Form CMS-40B in English or Spanish. Contact your local Social Security office or RRB for more information.

Where can I get more information?

Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility and to sign up for Part A and/or Part B. TTY users can call 1-800-325-0778. If you worked for a railroad or get RRB benefits, call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

You can also get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.

No matter how you enroll in Medicare, you'll need to decide how to get your Medicare coverage. You can choose between Original Medicare or a Medicare Advantage Plan. See pages 4–8 for more information.



If I'm not automatically enrolled, when can I sign up?

If you're not automatically enrolled in premium-free Part A, you can sign up for Part A once your Initial Enrollment Period starts. Your Part A coverage will start 6 months back from the date you apply for Medicare (or Social Security/RRB benefits), but no earlier than the first month you were eligible for Medicare. However, you can only sign up for Part B (or Part A if you have to buy it) during the times listed below. **Remember, in most cases, if you don't sign up for Part A (if you have to buy it) and Part B when you're first eligible, you may have to pay a late enrollment penalty.**

Initial Enrollment Period

You can first sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

If you sign up for Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage starts the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage will start the first day of the prior month.

If you enroll in Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, the start date for your Medicare coverage will be delayed.

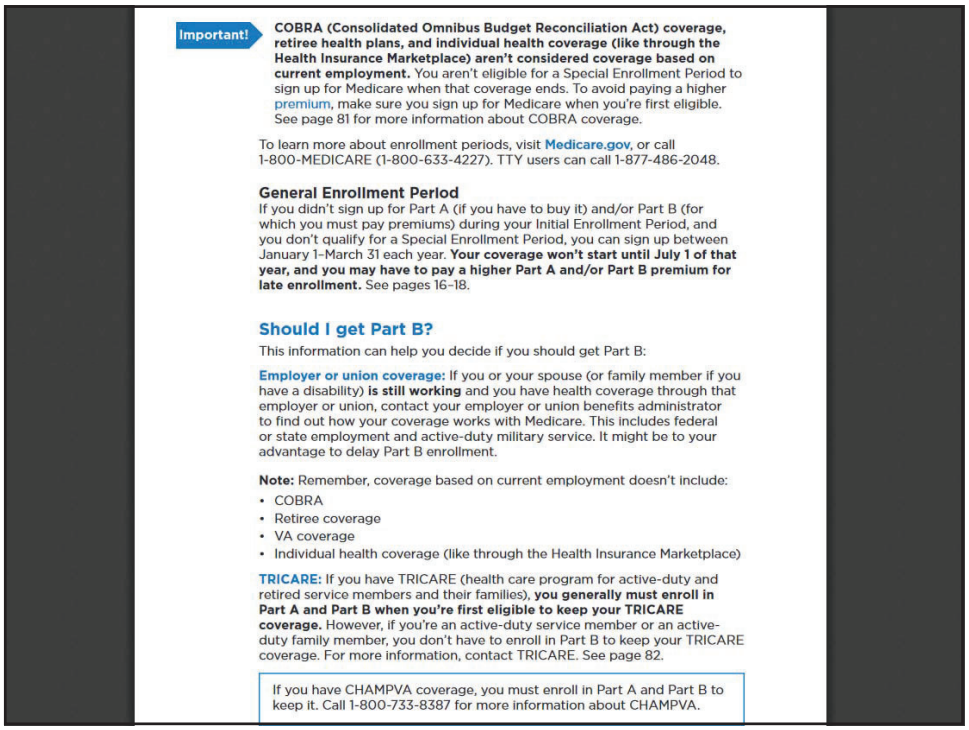
Special Enrollment Period

After your Initial Enrollment Period is over, you may have a chance to sign up for Medicare during a Special Enrollment Period. If you didn't sign up for Part B (or Part A if you have to buy it) when you were first eligible because you're covered under a group health plan based on current employment (your own, a spouse's, or a family member's (if you have a disability)), you can sign up for Part A and/or Part B:

- Anytime you're still covered by the group health plan
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first

Usually, you don't pay a late enrollment penalty if you sign up during a Special Enrollment Period. This Special Enrollment Period doesn't apply to people who are eligible for Medicare based on End-Stage Renal Disease (ESRD). It also doesn't apply if you're still in your Initial Enrollment Period.

Note: If you have a disability, and the group health plan coverage is based on the current employment of a family member, the employer offering the group health plan must have 100 or more employees for you to get a Special Enrollment Period.



Important! **COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, retiree health plans, and individual health coverage (like through the Health Insurance Marketplace) aren't considered coverage based on current employment.** You aren't eligible for a Special Enrollment Period to sign up for Medicare when that coverage ends. To avoid paying a higher premium, make sure you sign up for Medicare when you're first eligible. See page 81 for more information about COBRA coverage.

To learn more about enrollment periods, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

General Enrollment Period

If you didn't sign up for Part A (if you have to buy it) and/or Part B (for which you must pay premiums) during your Initial Enrollment Period, and you don't qualify for a Special Enrollment Period, you can sign up between January 1–March 31 each year. **Your coverage won't start until July 1 of that year, and you may have to pay a higher Part A and/or Part B premium for late enrollment.** See pages 16–18.

Should I get Part B?

This information can help you decide if you should get Part B:

Employer or union coverage: If you or your spouse (or family member if you have a disability) **is still working** and you have health coverage through that employer or union, contact your employer or union benefits administrator to find out how your coverage works with Medicare. This includes federal or state employment and active-duty military service. It might be to your advantage to delay Part B enrollment.

Note: Remember, coverage based on current employment doesn't include:

- COBRA
- Retiree coverage
- VA coverage
- Individual health coverage (like through the Health Insurance Marketplace)

TRICARE: If you have TRICARE (health care program for active-duty and retired service members and their families), **you generally must enroll in Part A and Part B when you're first eligible to keep your TRICARE coverage.** However, if you're an active-duty service member or an active-duty family member, you don't have to enroll in Part B to keep your TRICARE coverage. For more information, contact TRICARE. See page 82.

If you have CHAMPVA coverage, you must enroll in Part A and Part B to keep it. Call 1-800-733-8387 for more information about CHAMPVA.

Health Insurance Marketplace: If you have coverage through an individual Marketplace plan (not through an employer), you may want to end your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. It's important to terminate your Marketplace coverage in a timely manner to avoid an overlap in coverage. Once you're considered eligible for Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you may have to pay back the help you got when you file your taxes. Visit **HealthCare.gov** to connect to the Marketplace in your state and learn more. You can also find out how to terminate your Marketplace plan or Marketplace financial help when your Medicare enrollment begins. You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Health savings accounts (HSAs): You can't contribute to your HSA once your Medicare coverage begins. However, you may use money that's already in your HSA after you enroll in Medicare to help pay for deductibles, premiums, copayments, or coinsurance. If you contribute to your HSA after your Medicare coverage starts, you may have to pay a tax penalty. If you'd like to continue contributing to your HSA, you shouldn't apply for Medicare, Social Security, or Railroad Retirement Board (RRB) benefits.

Remember, premium-free Part A coverage begins 6 months back from the date you apply for Medicare (or Social Security/RRB benefits), but no earlier than the first month you were eligible for Medicare. To avoid a tax penalty, you should stop contributing to your HSA at least 6 months before you apply for Medicare.

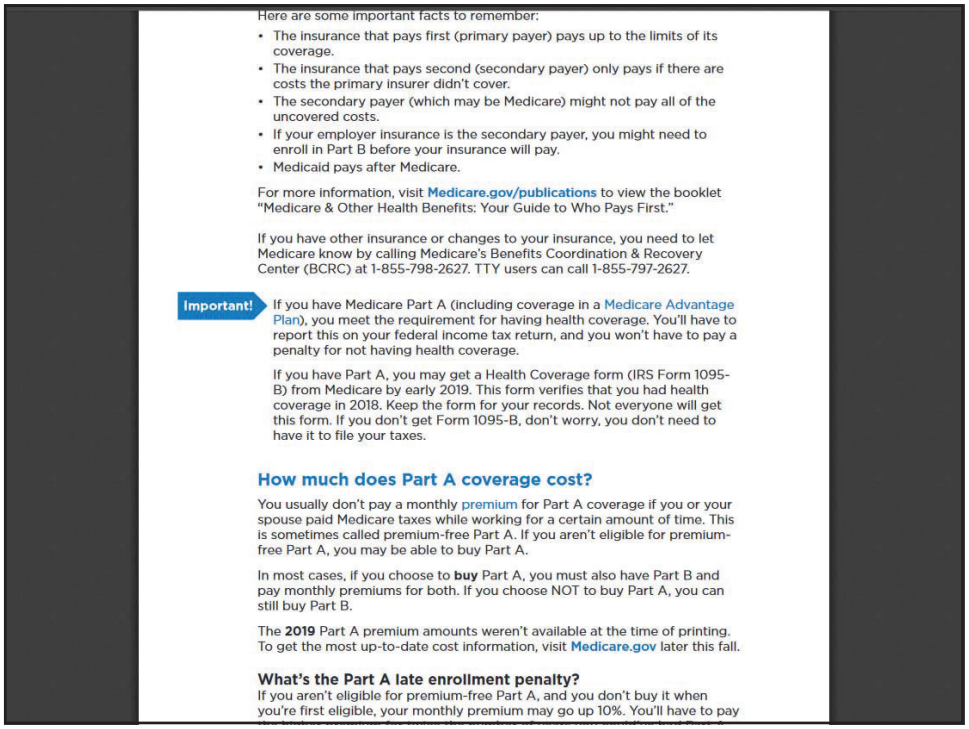
A Medicare Advantage Medical Savings Account (MSA) Plan might be an option if you'd like to continue to get health benefits through an HSA-like benefit structure. See page 55 for more information.

How does my other insurance work with Medicare?

When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

If you have **retiree** insurance (insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **20 or more employees**...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **fewer than 20 employees**...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your family member's **current** employment, and the employer has **100 or more employees**...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **fewer than 100 employees**...	Medicare pays first.
If you have Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.

Note: In some cases, your employer may join with other employers or unions to form or sponsor a multiple-employer plan. If this happens, the size of the largest employer/union determines whether Medicare pays first or second.



Here are some important facts to remember:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your employer insurance is the secondary payer, you might need to enroll in Part B before your insurance will pay.
- Medicaid pays after Medicare.

For more information, visit **Medicare.gov/publications** to view the booklet "Medicare & Other Health Benefits: Your Guide to Who Pays First."

If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare's Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627. TTY users can call 1-855-797-2627.

Important! If you have Medicare Part A (including coverage in a Medicare Advantage Plan), you meet the requirement for having health coverage. You'll have to report this on your federal income tax return, and you won't have to pay a penalty for not having health coverage.

If you have Part A, you may get a Health Coverage form (IRS Form 1095-B) from Medicare by early 2019. This form verifies that you had health coverage in 2018. Keep the form for your records. Not everyone will get this form. If you don't get Form 1095-B, don't worry, you don't need to have it to file your taxes.

How much does Part A coverage cost?

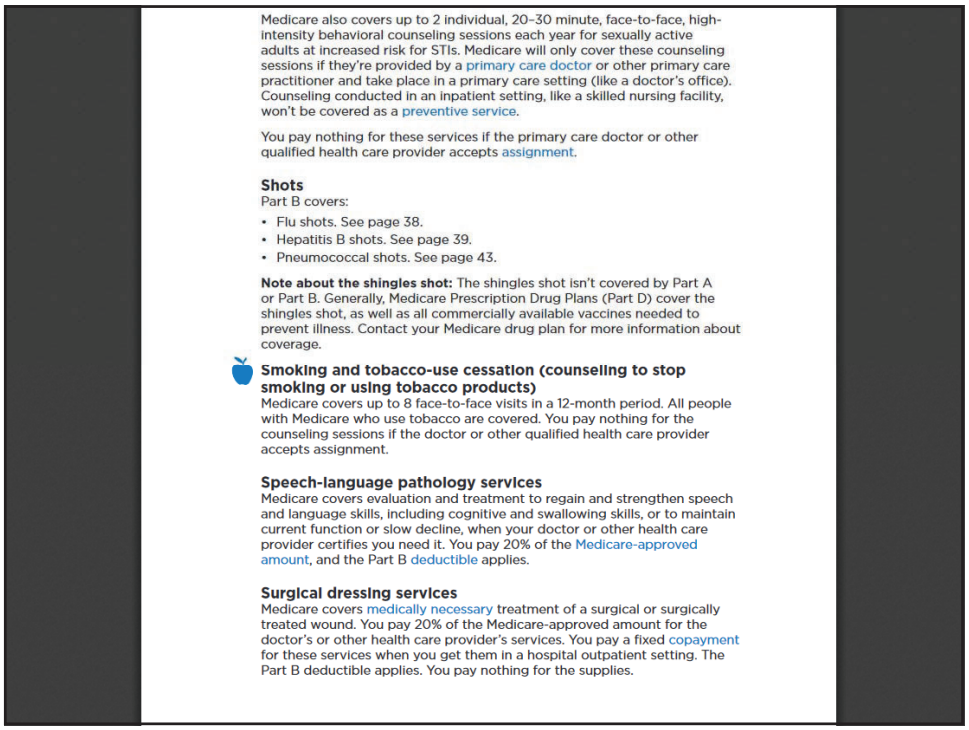
You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working for a certain amount of time. This is sometimes called premium-free Part A. If you aren't eligible for premium-free Part A, you may be able to buy Part A.

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. If you choose NOT to buy Part A, you can still buy Part B.

The **2019** Part A premium amounts weren't available at the time of printing. To get the most up-to-date cost information, visit **Medicare.gov** later this fall.

What's the Part A late enrollment penalty?

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay



Medicare also covers up to 2 individual, 20–30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other primary care practitioner and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

You pay nothing for these services if the primary care doctor or other qualified health care provider accepts assignment.

Shots

Part B covers:

- Flu shots. See page 38.
- Hepatitis B shots. See page 39.
- Pneumococcal shots. See page 43.

Note about the shingles shot: The shingles shot isn't covered by Part A or Part B. Generally, Medicare Prescription Drug Plans (Part D) cover the shingles shot, as well as all commercially available vaccines needed to prevent illness. Contact your Medicare drug plan for more information about coverage.

Smoking and tobacco-use cessation (counseling to stop smoking or using tobacco products)

Medicare covers up to 8 face-to-face visits in a 12-month period. All people with Medicare who use tobacco are covered. You pay nothing for the counseling sessions if the doctor or other qualified health care provider accepts assignment.

Speech-language pathology services

Medicare covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Surgical dressing services

Medicare covers medically necessary treatment of a surgical or surgically treated wound. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You pay a fixed copayment for these services when you get them in a hospital outpatient setting. The Part B deductible applies. You pay nothing for the supplies.

B. Coverage Parts and how they work

1. **Part A - Hospital Insurance**

a. Where is it available for a Medicare beneficiary

b. What if the beneficiary is still working

c. Cost of Part A to the Medicare beneficiary

(1) There is no cost for Part A if the beneficiary is qualified

(2) If you are not a 'qualified Medicare beneficiary', then there will be a monthly cost for Part A. See corresponding page for information.

d. Coverage / Deductibles and co-pays of Part A

e. What about care in a Skilled-Nursing Facility? Medicare only provides paid-care as per the "rehabilitation rules".

Medicare's payout facts concerning a Long-Term Care need:

1. The beneficiary must be confined to a hospital for 3 consecutive days.
2. Based on a 'medical treatment plan', the beneficiary must enter an approved Medicare facility (and receive SKILLED care) within 30 days of the original hospital discharge
3. Approved rehabilitation must be provided ... and accepted by the patient.
3. If approved, Medicare will pay 100% of the cost for the first 20 days.
4. For Medicare's payment to continue, the beneficiary must "continually be improving".
5. If the beneficiary continues to meet all requirements after the first 20 days, Medicare continues to pay, but there is then a $200.00 daily deductible (2023) until day 100, then Medicare pays nothing.

NOTE: The above are Federal numbers and Federal rules. They do no vary by state.

Notes	To Do

Most people do not pay a monthly premium for Part A (sometimes called "premium-free Part A"). If the person (or their spouse) paid Medicare taxes for at least 40 quarters of work (10 years), they qualify for no-cost Part A. If a person has to buy Part A, the cost is up to $506 each month. If they paid Medicare taxes for less than 30 quarters, the standard Part A premium is $506. If they paid Medicare taxes for 30-39 quarters, the standard Part A premium is $278. (Note: figures shown are 2023 cost)

❑ **Part A (Hospital Insurance)**

- **In-Patient Hospital Care:** In 2023, after a $1,600.00 deductible, Medicare pays all "reasonable and approved expenses" of a hospital stay for the first 60 days of each "benefit period". The following also applies per "benefit period" in 2022:

  * Days 1- 60, insured pays $0 coinsurance
  * Days 61-90, there is a $400 daily co-payment paid by the insured
  * Day 91 and beyond, there is a daily co-pay of $800 for each "lifetime reserve day." Lifetime reserve days are additional days that Medicare will pay beyond 90 days, with a maximum of 60 reserve days per lifetime.
  * The patient bears the expense of all costs beyond lifetime reserve days.

  * **NOTE: A "benefit period" begins the day the beneficiary is admitted as an inpatient to a hospital or skilled nursing facility. The benefit period ends when one has not received any inpatient care for 60 days in a row. A new admission as an inpatient begins a new benefit period. There is no limit to the number of benefit periods.**

- **Skilled Nursing Facility Care:** To qualify, the patient must have been hospitalized for at least 3 days. He/she must then enter the Medicare approved facility for medically-approved rehabilitation within 30 days after being discharged from the hospital.
  * Medicare pays 100% of approved charges for the first 20 days in a benefit period.
  * From day 21 through day 100 the patient pays $200.00 per day in a benefit period, as a co-payment (2023).
  * For Medicare to provide this care, the patient must be 'continually improving' from a medical / rehabilitation standpoint.

- **Home Health Care:** Primary in-home rehabilitation services and certain other medical test and observations as per a physician's treatment plan.

- **Hospice:** The physician for the hospice and patient's regular physician (if they have one) certify that the patient is terminally ill (with a life expectancy of 6 months or less). The patient accepts palliative care (for comfort) instead of care to cure your illness.

2. **Part B - Medical Insurance**

a. Where is it available for a Medicare beneficiary, and what does it cost

(1) Part B is optional. If elected, the monthly premium paid by the beneficiary varies, but generally will be $164.90 per month in 2023. Persons who fail to qualify for Part A can still receive Part B benefits. These benefits are generally provided as per a $226.00 annual deductible (2023 - only one per year).

b. What if the beneficiary is still working

(1) Coordinates with group insurance. Specific rules concerning a group with 20 or more employees, making that coverage primary.

c. Cost for Part B to the Medicare beneficiary

(1) Additional premium for higher income individual / and couples. Go to this site to see the income rules and additional Part B Premiums:

https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance

Notes	To Do

Part B (Medical Insurance)

* Services are provided on an 80/20 coinsurance basis, plus the annual deducible (only one deductible per calendar year). There is no "stop-loss" on the patient's 20% part of the co-insurance.
* Medical Expenses (Doctor's services)
* Home Health Care
* Out-patient Care

Medicare Part B covers 2 types of services:

- *Medically necessary services:* Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
- *Preventive services:* Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

You pay nothing for most preventive services if you get the services from a health care provider who accepts Assignment. Part B covers things like:

- Clinical research;
- Ambulance services;
- Durable medical equipment (DME);
- Mental health (inpatient, outpatient, partial hospitalization);
- Getting a second opinion before surgery;
- Limited outpatient prescription drugs

Source: Medicare Website

3. **Part C - Medicare Advantage Plans**

a. Enacted in to Federal law in 1985, Part C replaces original Medicare Part A and Part B, but will provide the came coverage. For most visits, only the Medicare Advantage Card is needed. Medicare **DOES NOT** pay for the medical service. The cost for the medical services are paid by the Part C carrier.

(1) Part C plans are sold by commercial insurance carriers, but regulated by the federal government

b. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, gym memberships, and/or health and wellness programs.

c. When is Part C generally better for a Medicare beneficiary than a Supplement? The key questions ... does the patient's physician's accept Part C ***and*** what is the over-all cost difference.

d. What if the beneficiary is still working?

e. Many Advantage Plans include Medicare prescription drug coverage (Part D). If so, there is no need to purchase a Part D. Additionally, there is no need to purchase a Medicare Supplement Plan.

f. Cost for Part C

(1) Some plans in certain locations are 'no cost'.

(2) The beneficiary still pays the Part B Medicare monthly cost ... generally $164.90 per month (2023).

g. If a beneficiary decides to sign up for a Medicare Advantage plan, they may enroll between Oct. 15 and Dec. 7 – the period known as Medicare Annual Election Period – in order for your coverage to start the first of the following year. (Original Medicare has separate enrollment periods for beneficiaries who aren't automatically enrolled.)

The Pros and Cons of Original Medicare vs. Medicare Advantage if ...

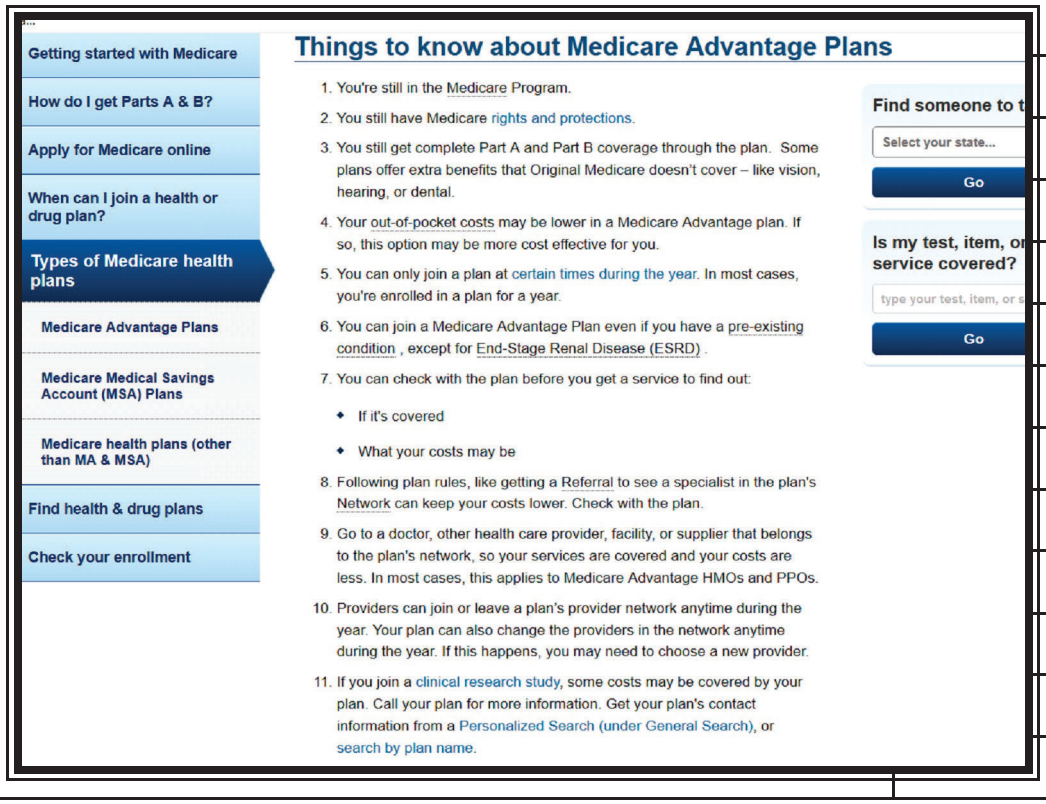
- **You take prescription drugs.** As stated, Original Medicare doesn't cover prescriptions unless you enroll in stand-alone Medicare. (The average monthly cost of Part D is @ $42 in 2023). By contrast, about 82 percent of Medicare Advantage plans include prescription drug coverage, according to the Kaiser Family Foundation, a nonprofit, nonpartisan research institute. In some cases your monthly premium will exceed the amount you'd pay for Medicare Part D.
- **You want a cap on your out-of-pocket health spending.** Original Medicare has no out-of-pocket maximum. You keep paying a portion of the cost of services as you use them. Medicare Advantage plans, by law, have an out-of-pocket maximum of no more than $6,700 per year (2023), although plans can choose to have a lower out-of-pocket maximum. Once you hit that limit, the plan pays for all covered expenses.
- **You want an alternative to enhancing your Medicare coverage with private "Medigap" (Medicare Supplement) insurance**. Medigap plans cover or help cover certain deductibles, coinsurance and out-of-pocket costs of Original Medicare. Some Medicare Advantage plans, but certainly not all, will be more cost-effective than adding Medigap coverage to Original Medicare. Scrutinize the plan details if this is your reason for considering Medicare Advantage.
- **You want an alternative to the 20 percent coinsurance charged by Original Medicare for most services.** Medicare Advantage plans structure costs differently and have an out-of-pocket maximum, which limits how much you're required to spend on your medical care each year.
- **You want coverage for vision and dental.** Original Medicare doesn't cover these services. Certain Medicare Advantage plans do.
- **You want the broadest possible choice in doctors and other medical providers**. More providers accept Original Medicare than private Medicare Advantage insurance. Private insurance plans tend to be restricted to a specific network, like a Health Maintenance Organization network. If you travel frequently, you may want to consider staying with Original Medicare for this reason.
- **You want maximum flexibility when seeking medical specialists.** Under Original Medicare, you don't need prior authorization from a primary care doctor to see a specialist, whereas Medicare Advantage plans that are designated HMOs could require you to see a primary care doctor first. Preferred Provider Organization plans may allow you to see a specialist without a referral, but seeing an out-of-network doctor or specialist would cost you more. Most Medicare Advantage plans are either HMOs or PPOs.
- **You're still employed and covered by your employer**. You might end up paying an unnecessary premium for Medicare Advantage or could lose your employer-provided coverage. Check with your human resources department and the Social Security Administration for specifics.
- **You have employer-sponsored retiree health benefits that supplement Original Medicare.** These benefits wouldn't help with Medicare Advantage, so check with your human resources department before signing up for a Medicare Advantage plan.
- **You qualify for Medicaid or a Medicare Savings Program.** Low-income Medicare beneficiaries have other options and should contact their state Medicaid office.

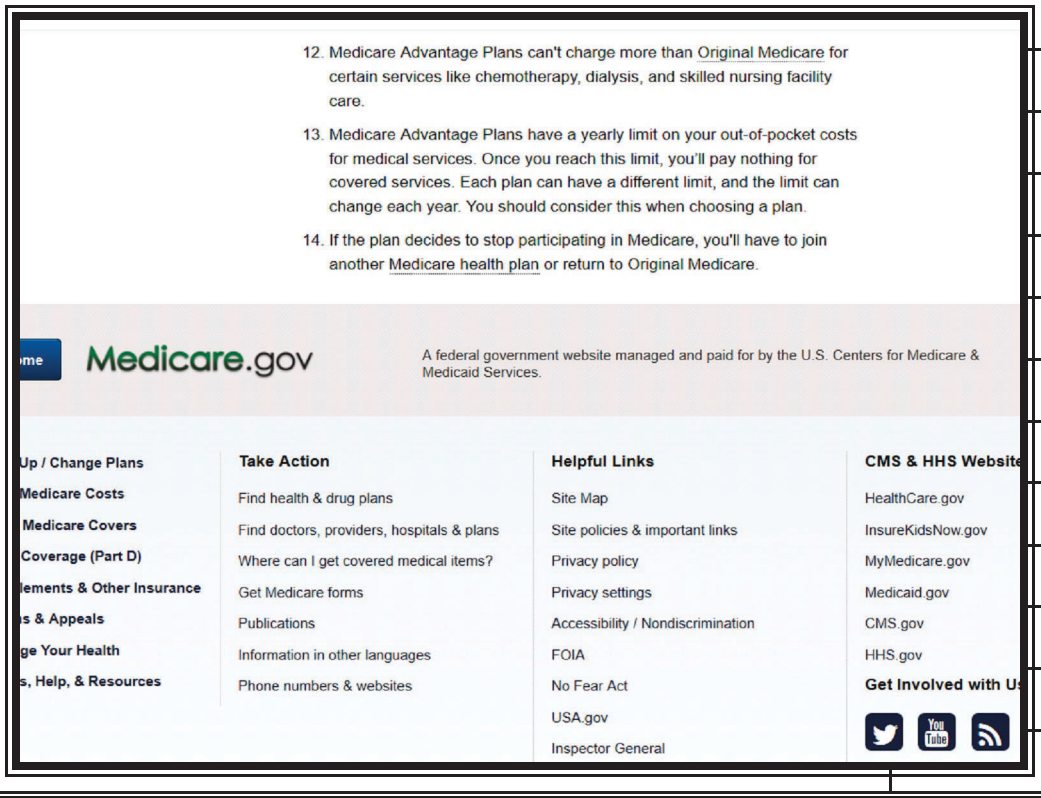
NOTE: Because of government regulation, Medicare Advantage premiums are not influenced by age, health status or the method by which a consumer signs up (through a licensed insurance agent, for example, or directly through an insurer). Monthly cost – and plan availability – varies from county to county.

Source: U.S. News and World Report

Notes	To Do

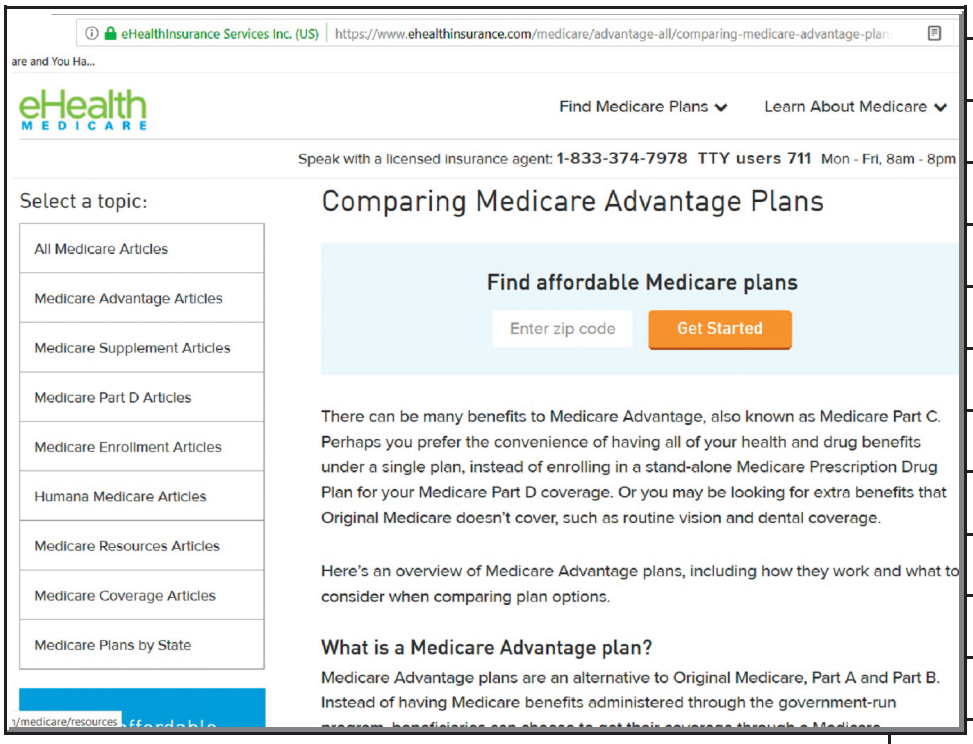
https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/things-to-know-about-medicare-advantage-plans





Notes	To Do


Talk to a Licensed Insurance Agent. 1-888-476-4947, TTY: 711
Mon. to Fri., 7 a.m. to 10 p.m., CST
Hablamos Español.
Learn About Medicare
Shop Medicare Plans
About HelloMedicare
Looking for a Medicare Advantage Plan? Let HelloMedicare Show You the Options!
Find cost savings by comparing plans available in your area with HelloMedicare.
Talk To An Agent
Shop Medicare Plans
aetna
Amerigroup
An Anthem Company
Anthem
Humana.
scan
HEALTH PLAN
UnitedHealthcare


eHealthInsurance Services Inc. (US)
https://www.ehealthinsurance.com/medicare/advantage-all/comparing-medicare-advantage-plan
eHealth
MEDICARE
Find Medicare Plans
Learn About Medicare
Speak with a licensed insurance agent: 1-833-374-7978 TTY users 711 Mon - Fri, 8am - 8pm
Select a topic:
All Medicare Articles
Medicare Advantage Articles
Medicare Supplement Articles
Medicare Part D Articles
Medicare Enrollment Articles
Humana Medicare Articles
Medicare Resources Articles
Medicare Coverage Articles
Medicare Plans by State
Comparing Medicare Advantage Plans
Find affordable Medicare plans
Enter zip code
Get Started
There can be many benefits to Medicare Advantage, also known as Medicare Part C. Perhaps you prefer the convenience of having all of your health and drug benefits under a single plan, instead of enrolling in a stand-alone Medicare Prescription Drug Plan for your Medicare Part D coverage. Or you may be looking for extra benefits that Original Medicare doesn't cover, such as routine vision and dental coverage.
Here's an overview of Medicare Advantage plans, including how they work and what to consider when comparing plan options.
What is a Medicare Advantage plan?
Medicare Advantage plans are an alternative to Original Medicare, Part A and Part B. Instead of having Medicare benefits administered through the government-run

4. **Part D - Outpatient Prescription Drug Plans**

a. A brief history and how it works

(1) The Medicare Prescription Drug, Improvement, and Modernization Act was passed on December 8, 2003. Also known as the Medical Reform Act, it established a **voluntary drug** benefit for Medicare beneficiaries and created a new Medicare Part D.

(2) Medicare Part D Prescription Drug plans are government sponsored insurance policies, but issued by commercial insurance companies. They are **designed to help protect the Medicare Beneficiary against the ever-rising costs of prescription drugs.** Anyone with Medicare Part A or Part B could purchase a prescription drug benefit plan through private insurance companies beginning on November 15, 2005.

b. What if the beneficiary is still working

c. Formulary

(1) A Medicare Part D drug list (Formulary) is a list of drugs covered by a plan. Formularies are developed to meet the needs of most members of that plan based on the most commonly prescribed drugs, including certain prescription drugs that Medicare requires to be covered. The Medicare Part D formulary is approved by Medicare and updated throughout the plan year, and may change if:

(a) The plan no longer covers a drug; a new drug is added; a drug is moved to a different cost-sharing tier; a Prior Authorization, Step Therapy restriction or Quantity Limit has been added, or changed for a drug; and, a drug is removed from the market.

d. Cost of Part D to the beneficiary

(1) The premium will vary by the prescription drug plan purchased and one's income as reported on your IRS tax return from 2 years ago and last year. Higher income consumers may pay more per month, similar in many respects to that of Part B Medicare. See the site shown on page 41 for potential additional premiums.

Notes	To Do
The national average monthly cost of Part D is @ $42.00	

C. Medicare Supplement Insurance

1. Overview: (from Medicare.gov website) Medigap policies are standardized. Every Medigap policy must follow federal and state laws designed to protect you, and it must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" policy identified in most states by letters. All policies offer the same basic Benefits but some offer additional benefits, so you can choose which one meets your needs. Note: In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. See Medicare.gov for details

2. Each insurance company decides which Medigap policies it wants to sell, although state laws might affect which ones they offer. Insurance companies that sell Medigap policies:

   a. Don't have to offer every Medigap plan

   b. Must offer Medigap Plan A if they offer any Medigap policy

   c. Must also offer Plan C or Plan F if they offer any plan

3. Cost - the monthly premiums vary by carrier and by state

4. Pros / cons for Medicare Supplement (see also pages 47 & 48)

Benefits Offered by Each Medigap Plan

Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K	L	M	N
Part A co-ins & hospital costs up to add'l 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B co-ins or copay	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care co-ins or copay	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes

Benefits Offered by Each Medigap Plan										
Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K	L	M	N
SNF co-ins	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A ded	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B ded	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess chg	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
OOP limit**	N/A	N/A	N/A	N/A	N/A	N/A	$5,240	$2,620	N/A	N/A

Benefits Offered by Each Medigap Plan

Table Key:

* Plan F also offers a high-deductible plan. If you choose this option, you must pay for Medicare-covered costs *up to the deductible amount of $2,300 in 2019* before Medigap pays anything. Plan F not available for new sales after 2019.

** After you meet the out-of-pocket (OOP) yearly limit and yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of *up to $20 for some office visits* and *up to $50 for emergency room visit*s that don't result in inpatient admission.

NOTE: *If you live in MA, MN, or WI, Medigap policies are standardized in a different way.*

Notes	To Do

Medicare supplement plans are changing: What you need to know

Gail Marks-Jarvis (September 19, 2018)

CHICAGO (Reuters) - If you are buying a Medicare supplemental policy in the United States, make sure you choose your insurance carefully over the next few months. At the end of 2019, the doors will close on Plan F, which is considered the Cadillac plan of supplemental insurance policies known as Medigap. Designed for people who do not like healthcare cost surprises, it is the most popular of supplemental plans used to pay for services that Medicare does not cover. But unless prices increase significantly, the existing Plan G may be a better deal. The government is cutting off access to Plan F for new Medicare enrollees to control costs.

Insurance experts expect Plan G to become the new draw for people wanting the most coverage without surprises. Although Plan F is the most expensive option, retirees pay top dollar because they can go to any doctor or hospital that accepts Medicare patients. There is no surprise bill afterward – no deductible, co-payments or coinsurance.

Participants already in Plan F when the doors close at the end of next year will be able to stick with the plan. But if you turn 65 any time after the beginning of 2020, you will not be able to buy Plan F. In addition, if you are in Medicare now and buy a Medicare Advantage plan or another Medigap insurance plan, switching after Jan. 1, 2020 could be difficult. Most states allow insurance companies to screen for conditions ranging from diabetes to heart attacks and cancer. On that basis, you could be turned away from Plan F or face high premiums. Plan G is currently identical to Plan F except for the $183 deductible participants must pay at the beginning of the year. Rates differ by state and insurance company, but the national average for Plan F premiums is $185.96 a month, compared with $155.70 for Plan G, said Kris Schneider, vice president of consumer and carrier engagement for AON Retiree Health Solutions.

"Buying G is a no-brainer," said Jeff Goldman, an insurance agent at G.M. Goldman & Associates in Skokie, Illinois. "You save about $350 a year on premiums, so it makes no sense to buy F to cover the $183 deductible." Lower costs have been drawing an increasing number of Medigap customers into Plan G in the last three years – about 37 percent of new enrollees versus 53 percent in Plan F, according to CSG Actuarial. Experts are not sure what will happen to costs once insurance companies see the effects of the 2020 changes. Some expect Plan G rates to jump because under Medicare rules, the plan must accept new enrollees regardless of health conditions. Others estimate Plan F premiums to soar because new healthy 65-year-olds will no longer come into the plan, resulting in an older, sicker pool of people to cover.

"I see no way around Plan F rates continually increasing, perhaps exponentially after 2026," said Adam Wasmund, chief marketing officer of Jack Schoeder & Associates, which advises health insurance brokers. There will be more clarity as state regulators approve rates and insurance companies examine the claims of participants in both Plan F and Plan G. But Wasmund is concerned that the federal government could raise Plan G deductibles in an attempt to curb more Medicare usage in the future. "Could the deductible be $200, $1,000 or $2,000?" said Wasmund. "Who's to say what the government will do?"

Medicare Advantage vs. Medicare Supplement Insurance Plans (eHealthInsurance.com)

While Original Medicare (Part A and Part B) covers many health-care expenses, it doesn't cover everything. Even with covered health-cares services, beneficiaries are still responsible for a number of co-payments and deductibles, which can easily add up. In addition, Medicare Part A and Part B also don't cover certain benefits, such as routine vision and dental, prescription drugs, or overseas emergency health coverage. If all you have is Original Medicare, you'll need to pay for these costs out-of-pocket. As a result, many people with Medicare enroll in two types of plans to cover these gaps in coverage. (Article continued on the next page)

There are two options commonly used to replace or supplement Original Medicare. One option, called Medicare Advantage plans, are an alternative way to get Original Medicare. The other option, Medicare Supplement (or Medigap) insurance plans work alongside your Original Medicare coverage. These plans have significant differences when it comes to costs, benefits, and how they work. It's important to understand these differences as you review your Medicare coverage options.

Advantages vs. Disadvatages: Medicare Supplement insurance plans work with Original Medicare, Part A and Part B, and may help pay for certain costs that Original Medicare doesn't cover. These plans don't provide stand-alone coverage; you need to remain enrolled in Part A and Part B for your hospital and medical coverage. If you need prescription drug coverage, you'd get it through a Medicare Prescription Drug Plan, not a Medicare Supplement insurance plan. When you buy a Medicare Supplement insurance plan, you are still enrolled in Original Medicare, Part A and Part B. Medicare pays for your health-care bills primarily, while the Medigap plan simply covers certain cost-sharing expenses required by Medicare, such as copayments or deductibles. In addition, Medigap insurance plans may help with other costs that Original Medicare doesn't cover, such as Medicare Part B excess charges or emergency medical coverage when you're traveling outside of the country. Keep in mind that Medicare Supplement insurance plans can only be used to pay for Original Medicare costs; they can't be used with Medicare Advantage plans.In contrast, Medicare Advantage plans are an alternative to Original Medicare. If you enroll in a Medicare Advantage plan, you're still in the Medicare program. However, you'll get your Medicare benefits through your Medicare Advantage plan, instead of through the federally administered program, and the Medicare Advantage plan replaces your Original Medicare coverage. To enroll in a Medicare Advantage plan, you must: A) have Original Medicare, Parts A and Part B; B)Live in the service area of the Medicare Advantage plan you're considering; C) Not have end-stage renal disease (with some exceptions). Medicare Advantage plans must provide the same level of coverage as Original Medicare, with the exception of hospice care (which is still covered by Part A). Some plans may also cover additional benefits that Original Medicare doesn't cover, such as routine vision and/or dental, health wellness programs, and prescription drugs.

Medicare Supplement insurance plan benefits: There are 10 Medigap insurance plans available in most states, and each plan type is designed by a different letter (for example, Plan A). Coverage is standardized across each plan letter, which means you'll get the same basic benefits for Medicare Supplement coverage within the same letter category, no matter which insurance company you purchase from. However, even if basic benefits are the same across plans of the same letter category, premium costs may vary by insurance company and location. If you live in Massachusetts, Minnesota, or Wisconsin, keep in mind that these three states standardize their Medigap plans differently from the rest of the country. Medigap plans cover out-of-pocket costs not covered by Original Medicare, such as copayments, coinsurance, and deductibles. Some plans may help pay for other benefits Original Medicare doesn't cover, such as emergency health coverage outside of the country or the first three pints of blood. Medigap plans don't include prescription drug benefits. If you don't already have creditable prescription drug coverage (coverage that is at least as good as the Part D benefit), you should consider buying a separate stand-alone Medicare Part D Prescription Drug Plan to cover the costs of your prescription medications. Also, Medicare Supplement insurance plans generally don't offer extra benefits like routine dental, vision, or hearing coverage beyond what's already covered by Medicare.

Medicare Advantage Plan Benefits: Private insurance companies have a bit more flexibility in designing Medicare Advantage plans, so you'll find more differences between plans. This means you need to be more careful comparing plan options to make sure you don't overlook anything. As mentioned, Medicare Advantage plans give you the opportunity to get coverage for benefits beyond Original Medicare. This may include routine vision and dental, hearing, and health wellness programs. Normally, under Original Medicare, you'd pay for these services out of pocket unless you have other insurance. Another benefit of Medicare Part C is that many of these plans also include Medicare Part D prescription drug coverage as part of the plan coverage. Also known as Medicare Advantage Prescription Drug plans, these plans give you the convenience of having all of your Medicare benefits administered through a single plan. If you enroll in a Medicare Advantage Prescription Drug plan, you will not need to enroll in an additional Medicare Prescription Drug Plan. In fact, if you are enrolled in a Medicare Advantage plan that includes prescription coverage and also enroll in a stand-alone Medicare Prescription Drug Plan, you could be automatically dis-enrolled from your Medicare Advantage plan.

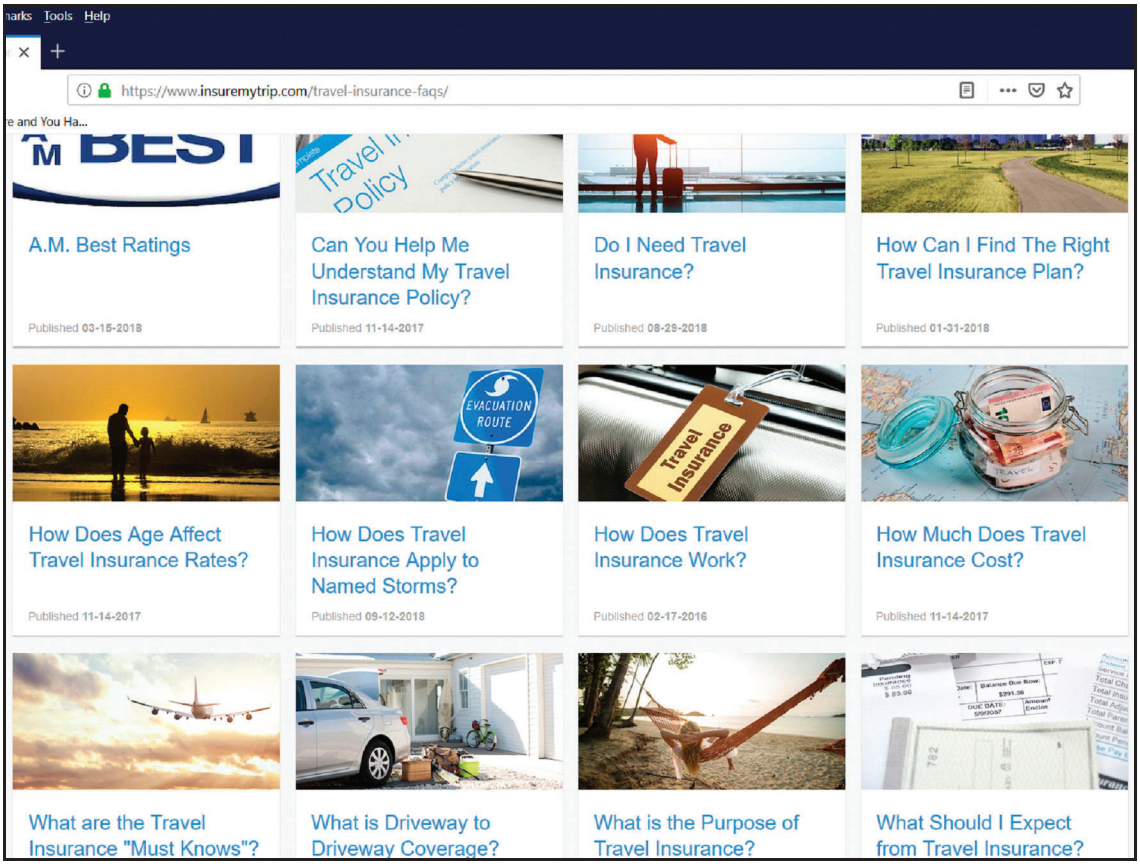
D. Enrollment periods and potential late-enrollment penalties

E. Insurance products and what they can coordinate with Medicare, or fill-in the gaps, or even provide coverage when an exclusion exist

1. Medicare Supplement Insurance

2. Medicare Advantage Plans (Part C)

3. Travel Insurance (Foreign Travel) - CAUTION: Medicare Parts A, B & D severely limits or EXCLUDES medical situations when traveling outside the U. S.



Notes	To Do
❑ Initial enrollment - Most people become eligible for Medicare when they turn age 65. They can enroll anytime between their age 64 years 8 months and 65 years 3 months, and no penalty will be incurred. ❑ Open Enrollment - Open enrollment generally runs from October 15 to December 7. During the annual enrollment period (AEP) a person can make changes to various aspects of their coverage. They can also switch from Original Medicare to Medicare Advantage, or vice versa. ❑ Late enrollees - A person eligible for Medicare Part B that did not sign up during their initial enrollment period may have a late-enrollment penalty, depending on their situation. The monthly premium may go up 10% for each full 12-month period that they went through without Part B coverage after their initial enrollment period ended. ❑ Penalties for Part D - Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" (@$42.00 in 2023) times the number of full, uncovered months the beneficiary did not have Part D, or creditable coverage. The monthly premium is rounded to the nearest $.10 and added to their monthly Part D premium. ❑ Exceptions for late enrollment - There are numerous exceptions to a 'late enrollment penalty' for either Part B, Part D, or both. There is a form concerning this process that can be found on the Medicare.gov site. There is also a form for an appeal.	
Please review the well written article concerning foreign travel issues and the Medicare covered individual. It's title - **A Medicare Enrollees Guide to Travel Coverage** - pretty much says it all: www.medicareresources.org/blog/2019/02/10/a-medicare-enrollees-guide-to-travel-coverage/	

III. MEDICAID

A. Overview

1. History and basic intent - Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965, alongside Medicare. All states, the District of Columbia, and the U.S. territories have Medicaid programs designed to provide health coverage for low-income people. Although the Federal government establishes certain parameters for all states to follow, each state administers their Medicaid program differently, resulting in variations in Medicaid coverage across the country.

2. Who it helps? - 74.5 million Americans in 2022 in the big three health areas for qualifying beneficiaries: 1) Medical care; 2) CHIP (Children Health Insurance Plan), and; 3) Skilled Nursing Care.

3. Medicaid Waivers - see a brief summary concerning the topic of “Medicaid Waivers” on page 52 and the latest map on page 53.

B. Medical

1. Cost to the beneficiary - it’s cost is based on income of the individual or family. Households with incomes up to 138% of the federal poverty level can generally qualify ($16,394 a year for an individual or $33,534 for a family of four).

C. Skilled Nursing Facilities

1. An Interesting statistic - 9% of all Medicaid beneficiaries are residents of a Skilled-Nursing facility. However, they accounted for 53% of all Medicaid expenditures in 2020. (Source: KFF.org)

2. Payments for a qualifying Medicaid beneficiary

    a. Cost to the beneficiary - based on income **and** assets

Notes	To Do

Medicaid - An Overview ... and Potential Changes

Medicaid, a federal/state partnership with shared authority and financing, is a health insurance program for low-income individuals, children, their parents, the elderly and people with disabilities. Medicaid pays for health care for more **than 74.5 million people nationally**. Although participation is optional, all 50 states participate in the Medicaid program. Primary, Medicaid provides health care (and its cost) for people that qualify - primarily low income. There are three broad groups: **1) Medical Care; 2) CHIP (Children Health Insurance Plan), and; 3) Skilled Nursing Care**. Other provisions also apply. While eligibility for Medicaid benefits varies widely among the states, all states must meet federal minimum requirements, but they have options for expanding Medicaid beyond the minimum federal guidelines.

States are considering the costs and benefits of expansion, and whether or not to pursue expansion through what is known as a costs, expanding coverage or improving care for certain target groups. With this waiver, a state can provide services to their residents **Section 1115 Waiver**. Recent changes may affect enhanced federal financing for expansion populations, conditions for eligibility, and enrollment and renewal procedure. A Medicaid waiver (Expansion) is a provision in the Medicaid law which allows the federal government to waive rules that usually apply to the Medicaid program.

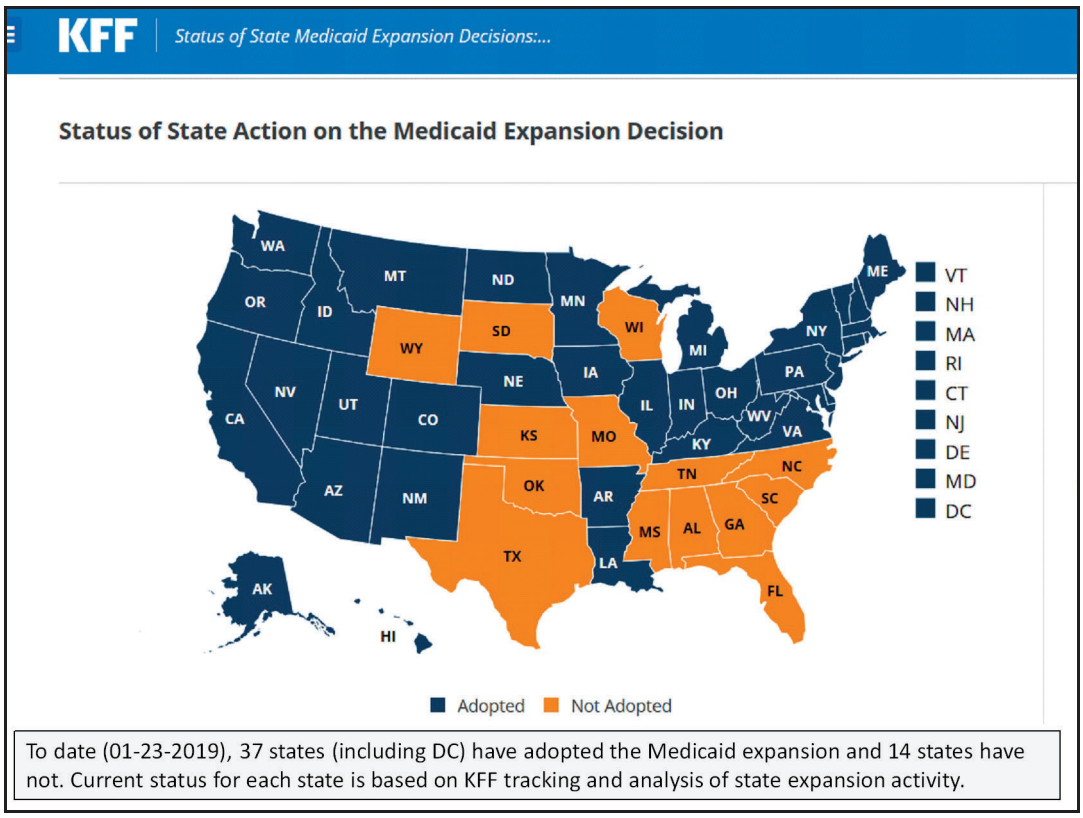
The intention is to allow individual states to accomplish certain goals, such as reducing costs, expanding coverage or improving care for certain target groups. With this waiver, a state can provide services to their residents that wouldn't usually be covered by Medicaid. For instance, in-home care for people who would otherwise have to go into long-term institutional care.

There are three types of Medicaid waiver, all of which have different purposes.

1. HCBS waiver: Also known as a Section 1915(c) waiver, this kind of waiver is designed to allow states to provide home and community-based services (HCBS) to people in need of long-term care. This means they can stay in their own home or a community setting (such as a relative's home or a supported living community) instead of going into a nursing facility.

2. Freedom of choice waiver: A Section 1915(b), or "freedom of choice," waiver lets states provide care via managed care delivery systems, thus limiting the individual's ability to choose their own providers.

3. Research and demonstration waiver: Otherwise referred to as a Section 1115 waiver, this lets states test out new approaches to delivering Medicaid care and financing.



To date (01-23-2019), 37 states (including DC) have adopted the Medicaid expansion and 14 states have not. Current status for each state is based on KFF tracking and analysis of state expansion activity.

D. Qualified beneficiaries regarding a stay / care in a Skilled-Nursing Home

1. Qualification rules

b. Income

c. Assets

(1) State rules

(a) Web-site - KFF.org

Notes	To Do

Medicaid - FL 2022	
Countable Assets	**Exempt Assets**
- Bank Accounts, CD's	- Home*
- Stocks, Bonds, Mutual Funds	- One Automobile
- Retirement Accounts, IRA's	- Household Goods
- Income or Vacation Property	- Personal Effects
- Revocable Living Trust	- Pre-Paid Burial Plots
- Boats, Motor home	- Certain Life Insurance*

Notes	To Do

Medicaid — FL 2023

Eligibility Qualifications Should the Applicant be Married and Leave Behind a Community Spouse (CS):

- **Value of Assets that may be kept by the CS - @$126,420 (certain exempt items - House, Auto, etc.)**
- **Any excess must be "Spent-down" to gain qualification.**

Life Insurance and Medicaid

- **Life Insurance and the Medicaid Qualification Rules (vary by state)**
  - **What about term life insurance?**
  - **What about a 'cash-value contract'? It better not exceed $1,500 in *death benefit* (in many states), or it will be required to count toward the 'spend-down'.**

How Can Life Insurance Affect My Medicaid Qualification

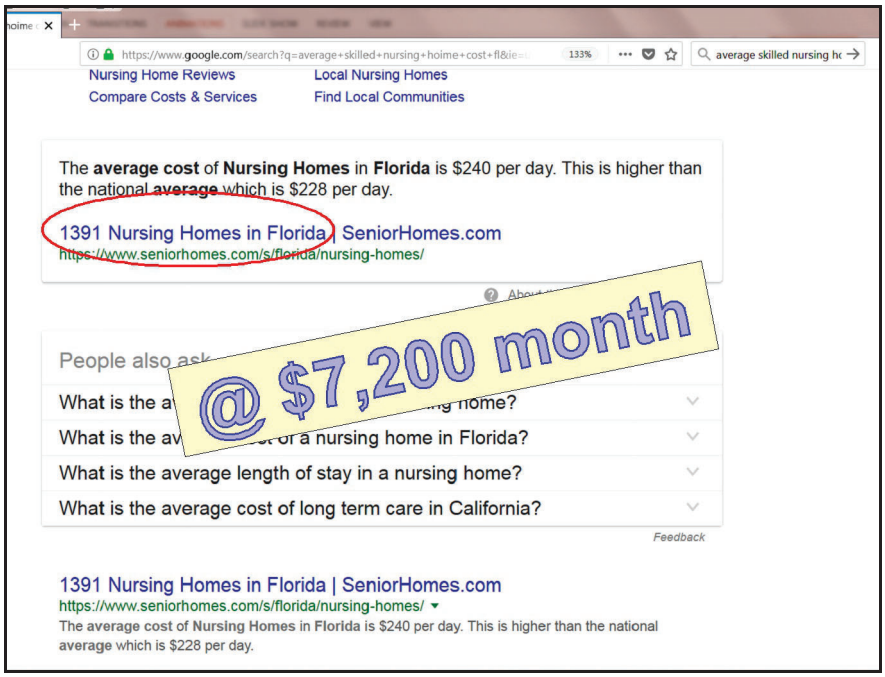
In order to qualify for Medicaid, you can't have more than $2,000 in assets (in most states). Many people forget about life insurance when calculating their assets, but depending on the type of life insurance and the value of the policy, it can count as an asset. Life insurance policies are usually either "term" life insurance or "whole" life insurance. If a Medicaid applicant has term life insurance, it doesn't count as an asset and won't affect Medicaid eligibility because this form of life insurance does not have an accumulated cash value. On the other hand, whole life insurance accumulates a cash value that the owner can access, so it can be counted as an asset. That said, Medicaid law exempts small whole life insurance policies from the calculation of assets. If the policy's face value is less than $1,500, then it won't count as an asset for Medicaid eligibility purposes. However, if the policy's face value is more than $1,500, the cash surrender value becomes an available asset. For example, suppose a Medicaid applicant has a whole life insurance policy with a $1,500 death benefit and a $700 cash surrender value (the amount you would get if you cash in the policy before death). The policy is exempt and won't be used to determine the applicant's eligibility for Medicaid. However, if the death benefit is $1,750 and the cash value is $700, the cash surrender value will be counted toward the $2,000 asset limit.

If you have a life insurance policy that may disqualify you from Medicaid, you have a few options:

- Surrender the policy and spend down the cash value.
- Transfer ownership of the policy to your spouse or to a special needs trust. If you transfer the policy to your spouse, the cash value would then be part of the spouse's community resource allowance.
- Transfer ownership of the policy to a funeral home. The policy can be used to pay for your funeral expenses, which is an exempt asset.
- Take out a loan on the cash value. This reduces the cash value and the death benefit, but keeps the policy in place.

Source: Elderlawanswers.com

Notes	To Do


Nursing Home Reviews
Compare Costs & Services
Local Nursing Homes
Find Local Communities
The average cost of Nursing Homes in Florida is $240 per day. This is higher than the national average which is $228 per day.
1391 Nursing Homes in Florida | SeniorHomes.com
@ $7,200 month
People also ask
What is the average length of stay in a nursing home?
What is the average cost of long term care in California?
Feedback
1391 Nursing Homes in Florida | SeniorHomes.com
https://www.seniorhomes.com/s/florida/nursing-homes/
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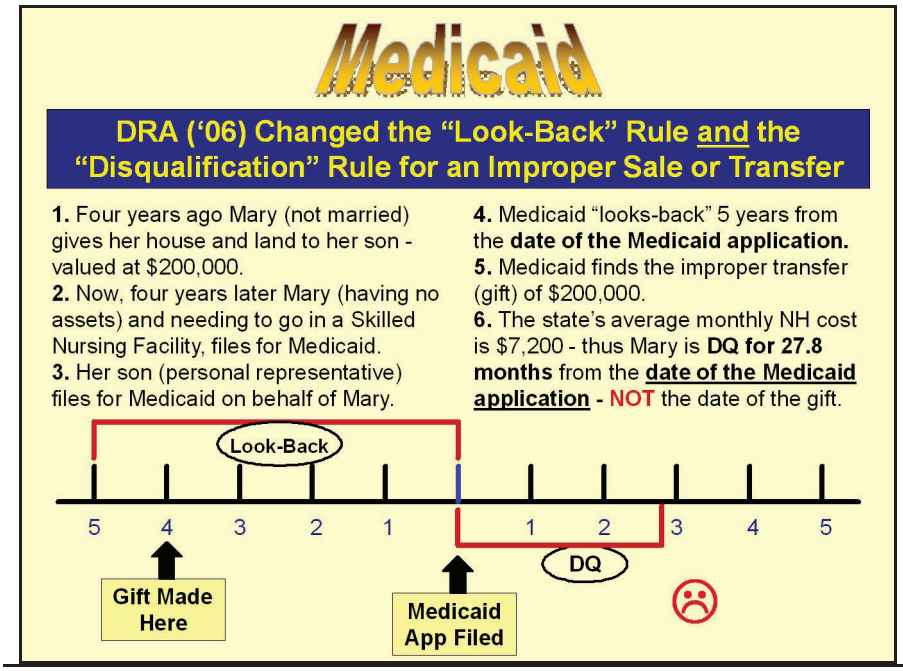

Medicaid
DRA ('06) Changed the "Look-Back" Rule and the "Disqualification" Rule for an Improper Sale or Transfer
1. Four years ago Mary (not married) gives her house and land to her son - valued at $200,000.
2. Now, four years later Mary (having no assets) and needing to go in a Skilled Nursing Facility, files for Medicaid.
3. Her son (personal representative) files for Medicaid on behalf of Mary.
4. Medicaid "looks-back" 5 years from the date of the Medicaid application.
5. Medicaid finds the improper transfer (gift) of $200,000.
6. The state's average monthly NH cost is $7,200 - thus Mary is DQ for 27.8 months from the date of the Medicaid application - NOT the date of the gift.
Look-Back
5 4 3 2 1 1 2 3 4 5
DQ
Gift Made Here
Medicaid App Filed

E. Can a state go after the adult children of Medicaid qualifying individual as it relates to a Skilled-Nursing Home stay? Possibly!

1. See information on the corresponding page

F. What are some insurance products that can provide protection for a person so Medicaid will not have to be applied for as it relates to a Skilled Nursing Home stay, or in-home care?

1. Traditional Long-Term Care Insurance

a. vantages / Disadvantages

(1) Cost / availability

2. Annuities or Life Insurance that has some form of LTCI linkage

a. New trends

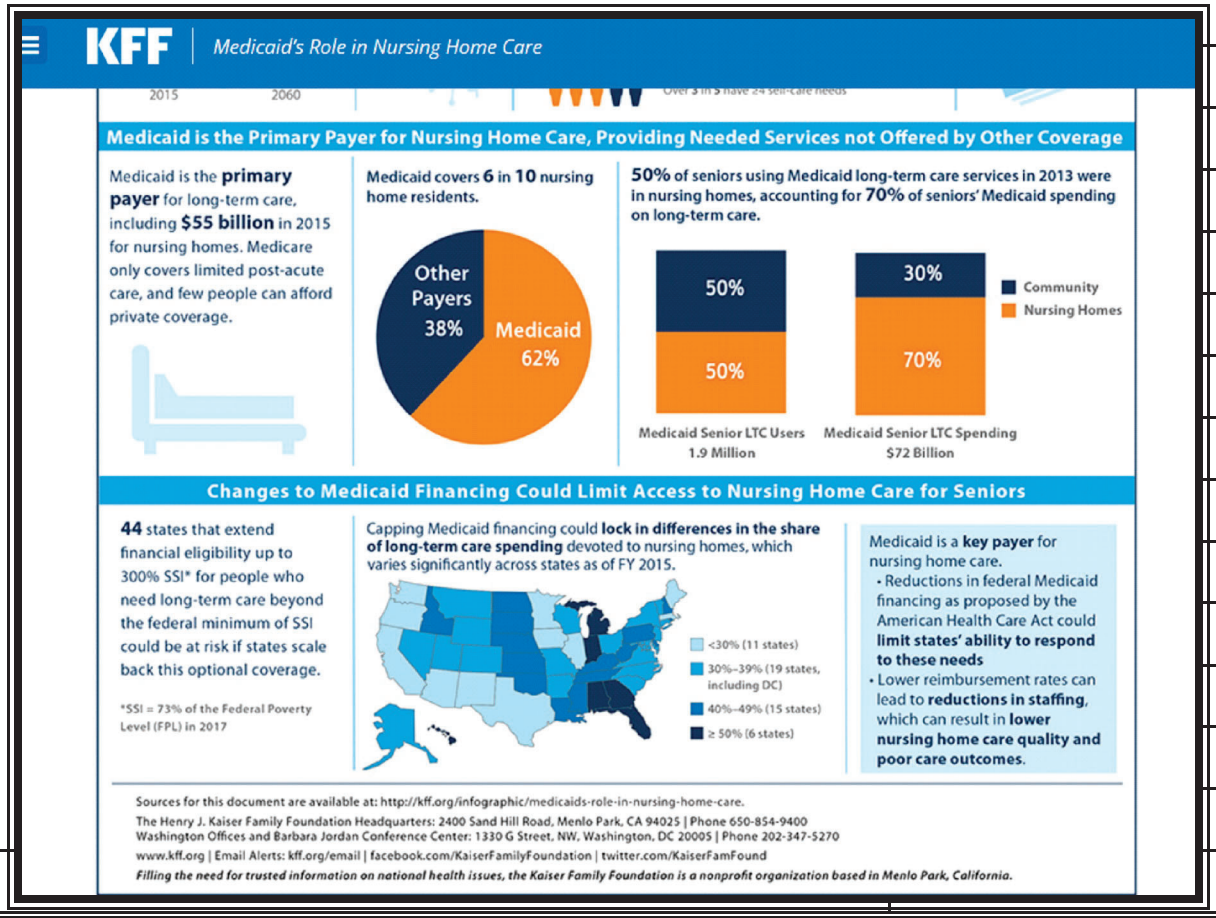
Notes	To Do

Where Do Your Parents Live? FILIAL

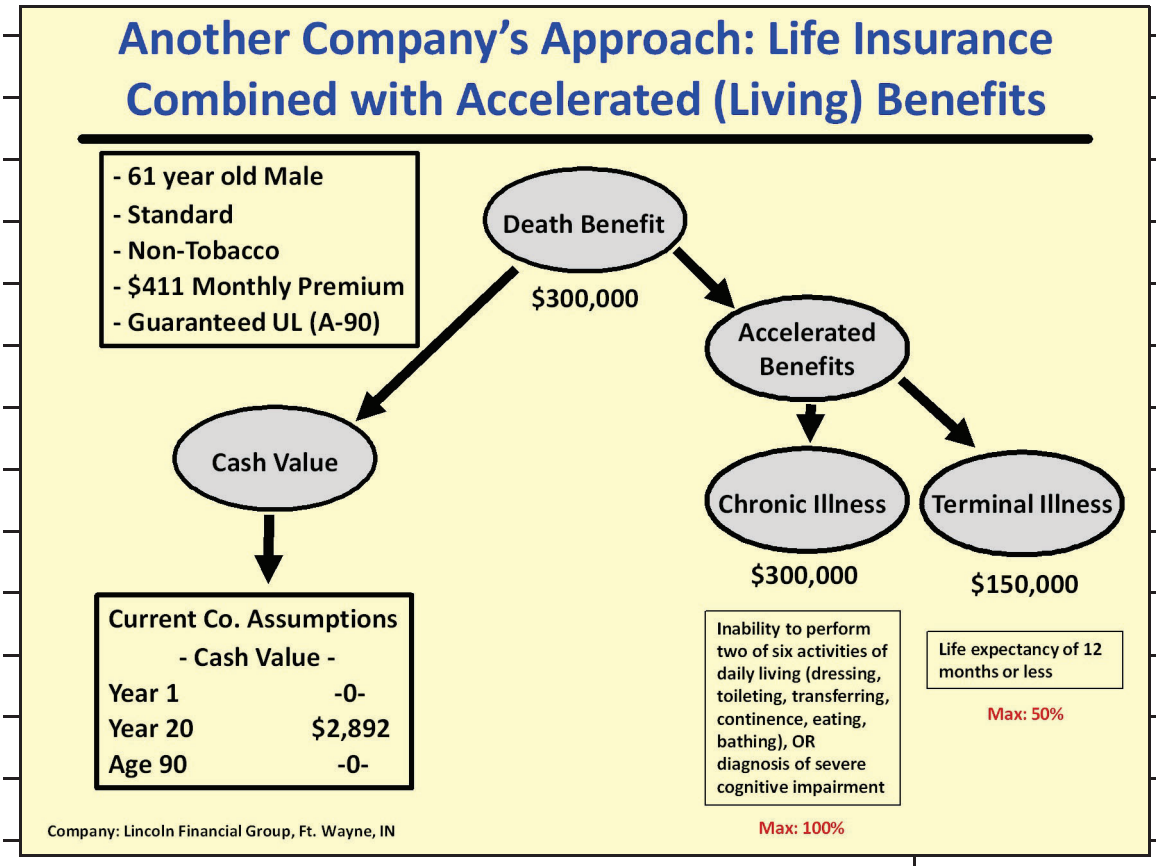
'Filial responsibility laws' in 29 states can potential force adult children to be financially responsible for their parent's care. Currently, 29 states have filial responsibility laws. In 2012, the state of PA made an adult child (son) responsible for his mother's $93,000 nursing home bill.

Alaska	Arkansas	California	Connecticut	Delaware
Georgia	Indiana	Iowa	Kentucky	Louisiana
Maryland	Massachusetts	Mississippi	Montana	Nevada
N. Hampshire	New Jersey	N. Carolina	N. Dakota	Ohio
Oregon	Pennsylvania	Rhode Island	S. Dakota	Tennessee
Utah	Vermont	Virginia	W. Virginia	

What is the definition of FILIAL? – 1) pertaining to, or befitting a son or daughter. 2) pertaining to the sequence of generations following the parental generation.



Notes	To Do



How Do Different Carriers Operate With This Coverage Form?

- Most carriers require the Chronic Illness benefit only be payable for 'Lifetime Certification'. Some will pay if the insured has the medical capacity to recover.

- Some companies 'waive' the premium when an insured goes on claim for a Chronic Illness. Those that do not, generally reduce the premium by the 'net actuarial amount at risk'. ***As an example:*** the insured is paying $5,000 per year for a $400,000 Death Benefit contract and takes a $200,000 lump-sum advance against the contract for a Chronic Illness benefit. The annual premium would be reduced to $2,500.

- Regarding the Chronic Illness benefit, some carriers only allow an insured to receive a monthly benefit, such as 2% of the net amount at risk. Others allow a lump sum, up to 100% of the net amount at risk. Many allow the insured to decide how its paid.

Many Long-Term Care insurance carriers are currently going through substantial changes in contract language, riders and pricing structure. The LTCI marketplace - which can provide long-term funding for those that experience various critical and chronic medical conditions - has seen many carriers abandon the sale of the product in the last 10 years or so. Of those that remain, many have increased the renewal premiums for their in-force contracts. Pricing for new sales have also see an increase. Increasing claims (far exceeding what was projected, by some carriers), and poor return-on-investment have triggered the erosion of the marketplace and pressure on increase pricing.

Notes	To Do

General Company Rules Regarding the Living Benefit Rider or Provision

(Rules varies by company)

- **Underwriting:** Specific underwriting rules will apply for this rider. This rider will generally not be available should the base life insurance coverage be approved at a higher rate class - maybe Table B or higher. It may not be available for certain hazardous activities (sports or occupations). Generally, the carriers will not approve the rider (or delete the provision) for foreign nationals.

- **Waiting Periods:** There may no waiting period for Critical Illness or Terminal Illness benefits to be payable. There is typically a 90 day waiting period for Chronic Illness benefit to be payable. Medical certification (and company approval) will be required in all cases for accessing this benefit. Some carriers may require the policy be in-force for a certain minimum time frame before accessing the Living Benefit is allowed.

- **Charges and Interest:** There will be an administration (or filing) charge to access a Living Benefit. A $150 fee is common. Additionally, there will be interest on any and all benefits received. This will be considered a ”lien” against the death benefit, and the rate will generally be @8% annually.

  Example: A $500,000 life insurance policy has been issued that contains the Living Benefit provision. A year later a $100,000 Chronic Illness benefit is filed, approved and taken.

  What is payable from the policy when the insured dies 10 years later?

  $320,000. Simple interest (annually) of 8% on the 100,000 for 10 years is $80,000. $500,000 less the $100,000 Chronic Benefit, less the $80,000 accrued interest.

Medicaid (called "Medi-Cal" in California and "MassHealth" in Massachusetts) is a joint federal-state program that provides health insurance coverage to low-income children, seniors and people with disabilities. In addition, it covers care in a nursing home for those who qualify. In the absence of any other public program covering long-term care, Medicaid has become the default nursing home insurance of the middle class.

As for home care, Medicaid offers very little except in New York, which provides home care to all Medicaid recipients who need it. Recognizing that home care costs far less than nursing home care, more and more states are providing Medicaid-covered services to those who remain in their homes.

While Congress and the federal Centers for Medicare and Medicaid Services (CMS) set out the main rules under which Medicaid operates, each state runs its own program. As a result, the rules are somewhat different in every state, although the framework is the same throughout the country.

Resource (Asset) Rules

These are general federal guidelines. The specific rules in your state may differ somewhat. In order to be eligible for Medicaid benefits a nursing home resident may have no more than $2,000 in "countable" assets (the figure may be somewhat higher in some states).

The spouse of a nursing home resident--called the "community spouse" -- is limited to one half of the couple's joint assets up to $119,220 (in 2016) in "countable" assets (see Medicaid, Protections for the Healthy Spouse). This figure changes each year to reflect inflation. In addition, the community spouse may keep the first $25,000 (this is the approximate amount in 2016 since it varies substantially by state), even if that is more than half of the couple's assets. This figure is higher in some states, even up to the full maximum of $119,220 (in 2016). All assets are counted against these limits unless the assets fall within the short list of "noncountable" assets. These include the following:

- Personal possessions, such as clothing, furniture, and jewelry
- One motor vehicle is excluded, regardless of value, as long as it is used for transportation of the applicant or a household member. The value of an additional automobile may be excluded if needed for health or self-support reasons. (Check your state's rules.)
- The applicant's principal residence, provided it is in the same state in which the individual is applying for coverage (the states vary in whether the Medicaid applicant must prove a reasonable likelihood of being able to return home). Under the Deficit Reduction Act of 2005 (DRA), principal residences may be deemed noncountable only to the extent their equity is less than $552,000, with the states having the option of raising this limit to $828,000 (in 2016). In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there
- Prepaid funeral plans and a small amount of life insurance
- Assets that are considered "inaccessible" for one reason or another

The Home

Depending on the state, nursing home residents do not have to sell their homes in order to qualify for Medicaid. But as noted above, under the DRA principal residences may be deemed noncountable only to the extent their equity is less than $552,000, with the states having the option of raising this limit to $786,000. In some states, the home will not be considered a countable asset for Medicaid eligibility purposes as long as the nursing home resident intends to return home; in other states, the nursing home resident must prove a likelihood of returning home. In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there.

The Transfer Penalty

The second major rule of Medicaid eligibility is the penalty for transferring assets. Congress does not want you to move into a nursing home on Monday, give all your money to your children (or whomever) on Tuesday, and qualify for Medicaid on Wednesday. So it has imposed a penalty on people who transfer assets without receiving fair value in return. These restrictions,

already severe, have been made even harsher by enactment of the DRA. This penalty is a period of time during which the person transferring the assets will be ineligible for Medicaid. The penalty period is determined by dividing the amount transferred by what Medicaid determines to be the average private pay cost of a nursing home in your state.

Example: For example, if you live in a state where the average monthly cost of care has been determined to be $5,000, and you give away property worth $100,000, you will be ineligible for benefits for 20 months ($100,000 / $5,000 = 20).

Another way to look at the above example is that for every $5,000 transferred, an applicant would be ineligible for Medicaid nursing home benefits for one month. In theory, there is no limit on the number of months a person can be ineligible.

Example: The period of ineligibility for the transfer of property worth $400,000 would be 80 months ($400,000 / $5,000 = 80).

However, for transfers made prior to enactment of the DRA on February 8, 2006, state Medicaid officials will look only at transfers made within the 36 months prior to the Medicaid application (or 60 months if the transfer was made to or from certain kinds of trusts). But for transfers made after passage of the DRA the so-called “look-back period” for all transfers is 60 months.

The second and more significant major change in the treatment of transfers made by the DRA has to do with when the penalty period created by the transfer begins. Under the prior law, the 20-month penalty period created by a transfer of $100,000 in the example described above would begin either on the first day of the month during which the transfer occurred, or on the first day of the following month, depending on the state. Under the DRA, the 20-month period will not begin until (1) the person making the transfer has moved to a nursing home, (2) he has spent down to the asset limit for Medicaid eligibility, (3) has applied for Medicaid coverage, and (4) has been approved for coverage but for the transfer.

For instance, if an individual transfers $100,000 on April 1, 2015, moves to a nursing home on April 1, 2016, and spends down to Medicaid eligibility on April 1, 2017, that is when the 20-month penalty period will begin, and it will not end until December 1, 2018.

Exceptions to the Transfer Penalty

Transferring assets to certain recipients will not trigger a period of Medicaid ineligibility. These exempt recipients include the following:

- A spouse (or a transfer to anyone else as long as it is for the spouse's benefit)
- A blind or disabled child
- A trust for the benefit of a blind or disabled child
- A trust for the sole benefit of a disabled individual under age 65 (even if the trust is for the benefit of the Medicaid applicant, under certain circumstances).

In addition, special exceptions apply to the transfer of a home. The Medicaid applicant may freely transfer his or her home to the following individuals without incurring a transfer penalty:

- The applicant's spouse
- A child who is under age 21 or who is blind or disabled
- Into a trust for the sole benefit of a disabled individual under age 65 (even if the trust is for the benefit of the Medicaid applicant, under certain circumstances)
- A sibling who has lived in the home during the year preceding the applicant's institutionalization and who already holds an equity interest in the home
- A "caretaker child," who is defined as a child of the applicant who lived in the house for at least two years prior to the applicant's institutionalization and who during that period provided care that allowed the applicant to avoid a nursing home stay.

Congress has created a very important escape hatch from the transfer penalty: the penalty will be "cured" if the transferred asset is returned in its entirety, or it will be reduced if the transferred asset is partially returned. However, some states are not permitting partial returns. Check with your attorney.

Is Transferring Assets Against the Law?

You may have heard that transferring assets, or helping someone to transfer assets, to achieve Medicaid eligibility is a crime. Is this true? The short answer is that for a brief period it was, and it's possible, although unlikely under current law, that it will be in the future.

As part of a 1996 health care bill, Congress made it a crime to transfer assets for purposes of achieving Medicaid eligibility. Congress repealed the law in 1997, but replaced it with a statute that made it a crime to advise or counsel someone for a fee regarding transferring assets for purposes of obtaining Medicaid. This meant that although transferring assets was again legal, explaining the law to clients could have been a criminal act.

In 1998, Attorney General Janet Reno determined that the law was unconstitutional because it violated the 1st Amendment protection of free speech, and she told Congress that the Justice Department would not enforce the law. Around the same time, a U.S. District Court judge in New York said that the law could not be enforced for the same reason. Accordingly, the law remains on the books, but it will not be enforced. Since it is possible that these rulings may change, you should contact your elder law attorney before filing a Medicaid application.

Treatment of Income

The basic Medicaid rule for nursing home residents is that they must pay all of their income, minus certain deductions, to the nursing home. The deductions include a $60-a-month personal needs allowance (this amount may be somewhat higher or lower in particular states), a deduction for any uncovered medical costs (including medical insurance premiums), and, in the case of a married applicant, an allowance for the spouse who continues to live at home if he or she needs income support. A deduction may also be allowed for a dependent child living at home.

In some states, known as "income cap" states, eligibility for Medicaid benefits is barred if the nursing home resident's income exceeds $2,199 a month (for 2016), unless the excess above this amount is paid into a "(d)(4)(B)" or "Miller" trust. If you live in an income cap state and require more information on such trusts, consult an elder law specialist in your state.

For Medicaid applicants who are married, the income of the community spouse is not counted in determining the Medicaid applicant's eligibility. Only income in the applicant's name is counted in determining his or her eligibility. Thus, even if the community spouse is still working and earning $5,000 a month, she will not have to contribute to the cost of caring for her spouse in a nursing home if he is covered by Medicaid.

Protections for the Healthy Spouse

The Medicaid law provides special protections for the spouse of a nursing home resident to make sure she has the minimum support needed to continue to live in the community.

The so-called "spousal protections" work this way: if the Medicaid applicant is married, the countable assets of both the community spouse and the institutionalized spouse are totaled as of the date of "institutionalization," the day on which the ill spouse enters either a hospital or a long-term care facility in which he or she then stays for at least 30 days. (This is sometimes called the "snapshot" date because Medicaid is taking a picture of the couple's assets as of this date.)

In general, the community spouse may keep one half of the couple's total "countable" assets up to a maximum of @118,000 (in 2016 - varies by state). Called the "community spouse resource allowance," this is the most that a state may allow a community spouse to retain without a hearing or a court order. The least that a state may allow a community spouse to retain is @$25,000 (in 2016).

Example: If a couple has $100,000 in countable assets on the date the applicant enters a nursing home, he or she will be eligible for Medicaid once the couple's assets have been reduced to a combined figure of $52,000 -- $2,000 for the applicant and $50,000 for the community spouse.

Some states, however, are more generous toward the community spouse. In these states, the community spouse may keep up to @$118,000 (in 2016), regardless of whether or not this represents half the couple's assets. Example: If the couple had $100,000 in countable assets on the "snapshot" date, the community spouse could keep the entire amount, instead of being limited to half.

In all circumstances, the income of the community spouse will continue undisturbed; he or she will not have to use his or her income to support the nursing home spouse receiving Medicaid benefits. But what if most of the couple's income is in the name of the institutionalized spouse, and the community spouse's income is not enough to live on? In such cases, the community spouse is entitled to some or all of the monthly income of the institutionalized spouse. How much the community spouse is entitled to depends on what the Medicaid agency determines to be a minimum

income level for the community spouse. This figure, known as the minimum monthly maintenance needs allowance or MMMNA, is calculated for each community spouse according to a complicated formula based on his or her housing costs. The MMMNA may range from a low of @$2,000 to a high of @$3,000 a month (in 2016). If the community spouse's own income falls below his or her MMMNA, the shortfall is made up from the nursing home spouse's income.

Example: Mr. and Mrs. Smith have a joint income of $3,000 a month, $1,700 of which is in Mr. Smith's name and $700 is in Mrs. Smith's name. Mr. Smith enters a nursing home and applies for Medicaid. The Medicaid agency determines that Mrs. Smith's MMMNA is $2,000 (based on her housing costs). Since Mrs. Smith's own income is only $700 a month, the Medicaid agency allocates $1,300 of Mr. Smith's income to her support. Since Mr. Smith also may keep a $60 a month personal needs allowance, his obligation to pay the nursing home is only $340 a month ($1,700 - $1,300 - $60 = $340).

In exceptional circumstances, community spouses may seek an increase in their MMMNAs either by appealing to the state Medicaid agency or by obtaining a court order of spousal support.

Estate Recovery and Liens

Under Medicaid law, following the death of the Medicaid recipient a state must attempt to recover from his or her estate whatever benefits it paid for the recipient's care. However, no recovery can take place until the death of the recipient's spouse, or as long as there is a child of the deceased who is under age 21 or who is blind or disabled.

While states must attempt to recover funds from the Medicaid recipient's probate estate, meaning property that is held in the beneficiary's name only, they have the option of seeking recovery against property in which the recipient had an interest but which passes outside of probate. This includes jointly held assets, assets in a living trust, or life estates. Given the rules for Medicaid eligibility, the only probate property of substantial value that a Medicaid recipient is likely to own at death is his or her home. However, states that have not opted to broaden their estate recovery to include non-probate assets may not make a claim against the Medicaid recipient's home if it is not in his or her probate estate.

In addition to the right to recover from the estate of the Medicaid beneficiary, state Medicaid agencies must place a lien on real estate owned by a Medicaid beneficiary during her life unless certain dependent relatives are living in the property. If the property is sold while the Medicaid beneficiary is living, not only will she cease to be eligible for Medicaid due to the cash she would net from the sale, but she would have to satisfy the lien by paying back the state for its coverage of her care to date. The exceptions to this rule are cases where a spouse, a disabled or blind child, a child under age 21, or a sibling with an equity interest in the house is living there.

Whether or not a lien is placed on the house, the lien's purpose should only be for recovery of Medicaid expenses if the house is sold during the beneficiary's life. The lien should be removed upon the beneficiary's death. However, check with an elder law specialist in your state to see how your local agency applies this federal rule.

Summary of the New Medicaid Rules (the DRA)

On February 8, 2006 President Bush signed into law the Deficit Reduction Act of 2005 (DRA), which cuts nearly $40 billion over five years from Medicare, Medicaid, and other programs. Of greatest interest to the elderly and their families, the law placed severe new restrictions on the ability of the elderly to transfer assets before qualifying for Medicaid coverage of nursing home care.

The DRA made significant changes to Medicaid's long-term care rules, including the look-back period; the transfer penalty start date; the undue hardship exception; the treatment of annuities; community spouse income rules; home equity limits; the treatment of investments in continuing care retirement communities (CCRCs); promissory notes and life estates; and state long-term care partnership programs.

Following is a brief summary of the Medicaid laws before and after enactment of the DRA in these areas. Also, bear in mind that states are gradually coming into compliance with the new transfer rules. For the status of the rules in your state, check with a qualified elder law attorney there.

The Look-Back Period

A person applying for Medicaid coverage of long-term care must disclose all financial transactions he or she was involved in during a set period of time--frequently called the "look-back period." The state Medicaid agency then

determines whether the Medicaid applicant transferred any assets for less than fair market value during this period. Congress does not want a person to be able to give away all of their assets one day and then qualify for public benefits the next.

The DRA extends Medicaid's "look-back" period for all asset transfers from three to five years. Previously, the agency reviewed transfers made within 36 months of the Medicaid application (60 if the transfer was to or from certain kinds of trusts). Now, the look back period for all transfers is 60 months. The extension of the look-back period will make the application process more difficult and could result in more applicants being denied for lack of documentation, given that they will need to produce five years worth of records instead of three.

The Penalty Period Start Date

The penalty period is the period during which a Medicaid applicant is ineligible for Medicaid payment for long term care services because the applicant transferred assets for less than fair market value during the look-back period.

Before the DRA, the penalty period began either when the transfer was made or on the first day of the following month. It was possible for the penalty period to expire before the individual actually needed nursing home care. The DRA changes the start of the penalty period to the date when the individual transferring the assets enters a nursing home and would otherwise be eligible for Medicaid coverage but for the transfer. In other words, the penalty period does not begin until the nursing home resident is out of funds and has no money to pay the nursing home for however long the penalty period lasts.

This change could have negative consequences for both nursing homes and residents. Nursing homes would be on the hook for the care of residents waiting out extended penalty periods. If nursing homes end up flooded with residents who need care but have no way to pay for it, they will begin looking for alternatives. In states that have so-called "filial responsibility laws," nursing homes may seek reimbursement from the residents' children. These rarely-enforced laws, which are on the books in 30 states, hold adult children responsible for financial support of indigent parents and, in some cases, medical and nursing home costs.

In addition, some states have passed laws providing that if a transfer occurs within 5 years of a Medicaid application, the state can assume the transfer was made to establish Medicaid eligibility and can retrieve the value of the Medicaid care services from the person who received the property.

Home Equity Limits

Before the DRA's enactment an individual could still qualify for long-term care services even if he or she had substantial assets in his or her home. Under the DRA, states will not cover long-term care services for an individual whose home equity exceeds $552,000, although states have the option of increasing this equity limit to $828,000. In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there.

Change in Community Spouse Income Rules

The DRA requires all states to follow the "income-first" rule for supplementing a community spouse's income. For more on this, click here.

The Treatment of Annuities

The DRA added requirements for disclosing immediate annuities, which have been useful long-term care planning tools. In its simplest form, an immediate annuity is a contract with an insurance company under which the consumer pays a certain amount of money to the company and the company sends the consumer a monthly check for the rest of his or her life or a prescribed time period.

An immediate annuity can be used to convert assets into an income stream for the benefit of an institutionalized Medicaid applicant or the applicant's spouse. The state will not treat the annuity as an asset countable toward Medicaid's asset limit ($2,000 in most states plus up to @$118,000 for the healthy spouse) as long as the annuity complies with certain requirements. The annuity must be: (1) irrevocable the annuitant cannot take funds out of the annuity except for the monthly payments, (2) non-transferable the annuitant cannot be able to transfer the annuity to another beneficiary, and (3) actuarially sound - the payment term cannot be longer than the annuitant's life expectancy and the total of the anticipated payments have to equal the cost of the annuity.

To these requirements, the DRA added an additional requirement. The state must be named the remainder beneficiary of any annuities up to the amount of Medicaid benefits paid on the nursing home resident's behalf. If the Medicaid recipient is married or has a minor or disabled child, the state must be named as a secondary beneficiary. The Medicaid application must now also inform the applicant that if he or she obtains Medicaid benefits, the state automatically becomes a beneficiary of the annuity.

In addition, all annuities must be disclosed by an applicant for Medicaid regardless of whether the annuity is irrevocable or treated as a countable asset. If an individual, spouse, or representative refuses to disclose sufficient information related to any annuity, the state must either deny or terminate coverage for long-term care services or else deny or terminate Medicaid eligibility.

Promissory Notes and Life Estates

Prior to the DRA's enactment, a Medicaid applicant could show that a transaction was an (uncountable) loan to another person rather than (countable) gift by presenting promissory notes, loans, or mortgages at the time of the Medicaid application. A promissory note is normally given in return for a loan and it is simply a promise to repay the amount. Classifying transfers as loans rather than gifts is useful because it allows parents to "lend" assets to their children and still maintain Medicaid eligibility.

Congress considered this to be an abusive planning strategy, so the DRA imposes restrictions on the use of promissory notes, loans, and mortgages. In order for a loan to not be treated as a transfer for less than fair market value it must satisfy three standards: (1) the term of the loan must not last longer than the anticipated life of the lender, (2) payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments, (3) and the debt cannot be cancelled at the death of the lender. If these three standards are not met, the outstanding balance on the promissory note, loan, or mortgage will be considered a transfer and used to assess a Medicaid penalty period.

Prior to the DRA's passage, another common estate planning technique was for an individual to purchase a life estate (a legal right to live in and possess a property) in the home of another person, such as a child. By doing this, the individual was able to pass assets to his or her children without triggering a transfer penalty. The DRA still allows the purchase of a life estate in another person's home, but to avoid a transfer penalty the individual purchasing the life estate must actually reside in the home for at least one year after the purchase.

Innovations in Long-Term Care Funding with Life Insurance

By: Jerry Rhinehart, CIC, CLU, ChFC, RHU – Panama City, FL (Fall – 2016)

As most of us are aware a prolonged nursing home stay can easily deplete a person's savings, liquidate their assets, and possibly erode their retirement money. And modern medicine – which is keeping us alive longer – is only making this possibility a bit more likely for most. If Long-Term Care (LTC) is needed, most people would like to remain in their home, rather than residing in a Skilled Nursing Facility (SNF). And they probably think the cost will be substantially less at their home than the expense at a SNF. That is possible if the individual has a friend or relative that can provide the hands-on care. But what if no such person is available? Consider this: A certified in-home care-giver runs a minimum of $20 per hour in most parts of the country. Do the math… three 8-hour shifts will be approaching $500 per day! That may be twice the cost of a SNF in the same general area.

According to the 2016 study by Genworth Insurance the national average cost for care is staggering:

The Average Monthly / Annual Cost (Nationally):

- Assisted Living Facility - $3,628 / $43,536
- Skilled Nursing Facility (Semi-Private) - $6,844 / $82,128
- Skilled Nursing Facility (Private) - $7,698 / $92,376

Site: genworth.com/about-us/industry-expertise/cost-of-care.html

With this site, it is very easy to search for your state's averages as well as most major cities in your state.

Ok, so what are the LTC funding options should the need arise? There are really only three options: **1) Be Rich**, **2) Be Poor**, or **3) Be Insured**.

The 1st option (**Be Rich**) eliminates the vast majority of people.

The 2nd option (**Be Poor** … meaning Medicaid). What usually happens is the person needing cares uses their money and assets FIRST and they become destitute, and then meet Medicaid eligibly rules. Every state has specific rules regarding Medicaid qualification: 1) the applicant must spend down their assets to a mandated amount – generally $2,000, and 2) their income can't exceed a certain level ($2,199 per month in Florida in 2016, as an example).

The 3rd option (**Be Insured**) usually meets with resistance due to, 1) the perceived high cost of the premium of Long Term Care insurance (LTCI), and, 2) many people simply do not think this issue will affect them. No question about it… a traditional LTCI contract is pricy! And, there is rarely any benefit payable should the person die before using the coverage. What is the "trigger" for a covered claim with a LTCI? Typically, it mean they can't perform any 2 of 6 Activities of Daily Living (ADLs). ADLs are defined as eating, dressing, bathing, toileting, transferring or continence. The second "claims-trigger" is the insured must have a medical diagnoses of Severe Cognitive Impairment. A person with a dementia impairment (maybe Alzheimer's disease) might be able to perform all 6 ADLs, but obviously should not be left without someone to look after them. So, how is a claim approved? The insured individual meets **either of the two defined claims-triggers** – any 2 of 6 ADLS **OR** Severe Cognitive Impairment. Once an individual claim's qualification is met, benefits are payable until they recover from the medical issue, or the "insurance bucket of money" is empty. What is meant by the term "… until they recover"? Well, most think of this coverage for older people with severe (and irreversible) medical situations. But what about a person of any age that has a serious medical event (heart, cancer, accident, etc.) and is in need of care for several months and then recovers? The benefit would be payable for that period of time if the claims-trigger and the elimination period are met.

We have discussed the dilemma, various options and the traditional LTCI approaches. **What about**

recent innovation and trends for this issue? A few years ago, we started seeing some life insurance carriers include a novel approach regarding the LTC benefit. Many refer to it as a Living Benefit (LB). Some call it an Accelerated Benefit. Now, keep in mind not all carriers include this coverage. For those that do, some make it a rider (with a published additional cost) while most make it a policy provision or contract feature, thus no published additional cost. Additionally, the LB contract language and pay-out provisions vary greatly with the companies that participate in this benefit. It is even available in varying degrees with some annuity contracts.

How does the LB provision generally work? First, the life insurance contract obviously has the death benefit. But as part of the death benefit, the contract will generally provide three "buckets" of money that can be accessed by the owner if the insured has a qualifying event or meets a "claims-trigger" provision. Note that just because a company's life policy is approved in a particular state, this rider may not. Always check with your company.

The first coverage "bucket" is generally referred to as "**Critical Illness**". Here the claimant can file for up to some maximum amount against the contract – meaning, the life insurance death benefit amount – should they have a defined medical procedure. A physician's certification will be required. One company's language defines it as: **"open heart surgery, angioplasty or myocardial infarction, life threatening cancer, stroke, major transplant or end-stage renal failure."** The limit may be a flat maximum amount (such as $25,000) or some maximum percent of the death benefit (such as 25%), but not to exceed some specified dollar amount (one company's maximum is $125,000). *An example:* John (who is self-employed) has a $500,000 life insurance policy that contains the LB provision. He becomes ill and ultimately receives a kidney transplant. He is responsible for a sizable medical insurance deductible and can't work for 4 months – so he sustains a significant loss of income. He decides to take an advance against his policy of $100,000. He still has $400,000 of death benefit coverage, since this is considered a lien against the contract. Most companies will charge an administrative fee when such a claim is made. A one-time fee of $150 is common.

The second "bucket" is generally defined as "**Chronic Illness**". Here the claimant will be required to provide a physician's certification that shows the individual is unable to perform any 2 of 6 ADLs (eating, dressing, bathing, toileting, transferring or continence), **OR**, has been diagnosed as having Severe Cognitive Impairment. You will note this is the exact language we discussed with a traditional LTCI contract. Carriers may require the "coverage-trigger" to be for a minimum and continuous time frame – perhaps 90 days. As with Critical Illness, there will be some maximum limit. With many life insurance companies, it will generally be up to 50% of the death benefit, with some overall maximum total. One company's maximum benefit payout is $1,000,000. One company's language states: ***"The sum of all accelerated benefits may not exceed either 50% of the specified amount (the death benefit) at the time of the first acceleration, or $1,000,000".*** Additionally, the company may limit how benefits are paid under this provision. Some may pay annual installments, but not to exceed the maximum LTC benefit as defined under HIPAA. Some may pay a maximum monthly benefit (such as 2% installments over 50 months). *An example:* Sharon is 45 years old and has a $400,000 life policy that contains the LB provision. She has developed a degenerative muscle disorder and is no longer able to care for herself. She and her husband take an advance of $200,000 from her policy to modify their home and help pay for a home health aide. She will still have $200,000 death benefit protection.

The final "bucket" is defined as "**Terminal Illness**". Most contract's LB language states the owner can access this benefit if the insured individual's life expectancy is 12 months or less. Generally, the maximum benefit will be 50% to 75% of the death benefit, not to exceed some specified amount,

perhaps $1,000,000. *An example:* Patrick has a $300,000 life policy that contains the LB provision. He has an inoperable tumor and his physician has given him 5 months to live. He requests a $50,000 advance against his contract - so he, his wife, and adult kids can take a cruise they have discussed for years. Upon Patrick's death, his wife receives the remaining $250,000 death benefit.

Note that a number of life insurance carriers have the LB provision as part of their Whole Life, Universal Life and even Variable Life contracts. A few carriers even have this part of selected Term Life contracts. **An important point:** when the LB benefit is received, it is considered a lien against the life insurance policy. The company will have some fee associated with each transaction ($150 as an example), *plus*, they will charge interest against the lien as specified in the contract. The company will always state the maximum interest – such as 8%. With a lien, the interest is charged against the ultimate remaining death benefit payout. By doing this, the amount received from the LB, should be free of taxation. Always recommend your clients check with their tax specialist for their advice and interpretation.

As mentioned, variation of this benefit is available with some annuity carriers. One such enhancement is the Waiver of Surrender Charge Provisions with many carriers. This provision has been around with most carriers for a number of years. ***How does this work?*** Should the annuitant have a terminal illness, or be confined to a nursing home (many define confinement as 12 months or longer), the individual can access the annuity account value without a surrender charge. Another variation is the ADL trigger provision (or rider). ***How does this work?*** Should the annuitant meet the LTC "claims-trigger" (2 of 6 ADLs, or Severe Cognitive Impairment), they can access a greater percentage of their annuity account value on an annual basis without a surrender charge. A 10% annual withdrawal with no surrender charge is common without this provision. This LB provision will increase this percentage to a higher amount – perhaps 20% annually – without a surrender charge. Currently, very few annuity carriers have this last provision available. Either of these annuity variations are a benefit to a person or family that has the long term care funding need. But neither will be as attractive as the life insurance with LB unless the annuity is very sizable.

What are the major advantages of an insured LTC funding program? With either a good quality LTC insurance contract or a somewhat sizable life insurance policy with the LB, the unpleasant thought of 1) running out of money, 2) having to liquidate their assets, or 3) trying to qualify for Medicaid, can be eliminated or greatly postponed. Most of us will work 30 or 40 years to amass a sizable amount of money in our qualified plans (401-k, IRA, SEP, ROTH, etc.) so our retirement years can be financially low-stress. As stated previously, to qualify for Medicaid, you must spend-down your assets to a certain threshold. Are you aware that Medicaid rules require you to spend down your qualified money (401-k, IRA, SEP, ROTH, etc.) in additional to all your other assets?

Think of a quality insured LTC funding program as a FIRE-WALL around all your qualified money!

Numerous questions might arise concerning this innovative LB provision. Others may come up about LTC funding options with an annuity. The questions may include: What are the tax rules, limitations on the use of the funds, coverage territory issues, and waiver of premium concerns … just to list a few. The comparison table found with this article should address most of the issues and questions that might come up for agents and their prospects. Since coverage language and benefit options vary greatly with life and annuity contracts that offer one or more of these funding choices, it is highly recommended that agents thoroughly research what is available with their carriers. Another alternative is to discuss these contracts and options with a knowledgeable life insurance brokerage agency that works in this area, and has a good relationship with numerous quality life insurance companies.


Thank
You!