"No-Fault" Insurance

Aside from specifying required liability limits, some states also have what is known as a "no-fault" liability law. In such states, each person in an accident is covered by their own insurance company, regardless of who caused the accident. Although you may feel such a system is unfair if you are not the one who caused the accident, you will undoubtedly appreciate the ease with which you can file a claim since you're only dealing with your own insurance company. Plus, this system helps to lower insurance costs and keep policy costs down by eliminating most small court claims and limiting lawsuits to only those involving serious injuries.

Twelve states currently require all auto policies to be no-fault policies:

- Florida
- Hawaii
- Kansas
- Kentucky
- Massachusetts
- Michigan
- Minnesota
- New Jersey
- New York
- North Dakota
- Pennsylvania
- Utah

In these states, if you choose no-fault insurance, you are immune from being sued and from suing other drivers for non-economic damages like pain and suffering. However, if you choose traditional liability coverage, you can sue and be sued if the other driver also has traditional coverage. Because the "no-fault" choice provides immunity from being sued, it tends to be the choice of bad drivers. Even so, these same limits on lawsuits also tend to make no-fault coverage the cheaper option. Consequently, this system is often charged with unfairly punishing good drivers.

Eleven states allow you to add a no-fault provision to your auto insurance policy in order to facilitate claims, but do not restrict your ability to sue the other party in an accident.

These states, known as "Add-On" states, are:

- Arkansas
- Delaware
- D.C.
- Maryland
- New Hampshire
- Oregon
- South Dakota
- Texas
- Virginia
- Washington
- Wisconsin

In addition, drivers in the District of Columbia can choose no-fault or a traditional liability policy, but if they choose no-fault, they have 60 days after an accident to decide if they want the no-fault benefits or wish to pursue a claim against the other person in the accident.

The remaining 27 states have regular liability policies with no specific limitations on your ability to sue for damages.

Things Your Policy Won't Cover

In addition to stating the types of injury or damage that are covered, your auto insurance policy will also have a list of things that are not covered, called "exclusions." The most common exclusions are:

- **Intentional injury -** Your policy will not pay for damages if you intentionally hit another vehicle or piece of property.

- **Property owned or transported -** This refers to personal items carried in your vehicle. For example, if you are carrying golf clubs in your car and they are damaged during an accident, your auto policy will not pay to repair or replace them. However, your homeowners policy may provide such coverage.

Assisted Living Facility

No one looks forward to the day they may lose their independence. But we all know the day is bound to come sooner or later. Despite all our efforts, we'll be too strained or exhausted to complete all daily activities on our own. When that happens to us, we definitely don't want to be without the help we'll need.

Even if a Continuing Care Retirement Community is your first choice, for comparison purposes, you may also want to look into Assisted Living Facilities. In these kinds of facilities, you can still be relatively independent, but the worry and stress of performing certain daily tasks can be mostly removed. These facilities have all kinds of titles and names, such as:

- Residential care
- Personal care
- Adult congregate living care
- Board and care
- Domiciliary care
- Adult living facilities
- Supported care
- Enhanced care
- Community-based retirement facilities
- Adult foster care
- Adult homes
- Sheltered housing
- Retirement residences

But don't let the different names fool you. They're all basically Assisted Living Facilities. Typically, the services they give you include assistance with meals, medications, bathing, dressing, laundry, shopping and transportation.The place could be a high rise or single story. They may have one- or two-bedroom units or double-occupancy rooms, more or less like a hotel. Naturally, costs will be all over the lot, depending upon the amenities, the room size, and the geographic location, but the national average, private pay monthly rate is $4,051 or $48,612 per year. [5]

[5] Genworth June 2019

But remember: These facilities are not nursing homes. They are not intended for around-the-clock nursing. Instead, they cater to seniors who are more or less independent and just need occasional assistance with certain tasks.

Typically, when you're being admitted to an Assisted Living Facility, they'll evaluate the level of care you need. Then, about one month later, they'll do a second evaluation to get a more precise idea of what level of assistance you need. From that point forward, they'll do periodic re-assessments if you, the staff, or your family think it's necessary or if your health status changes. Ultimately, if your health deteriorates beyond the abilities of the facility, you may have to move to a nursing home.

However, Assisted Living Facilities have several clear advantages:

- They let you keep your independence without the strain of daily chores.
- Double check yourself, but as a rule, it should cost you less than some of your other options, such as staying at home with professional daily assistance.
- You'll have friends and social activities right there. That's probably going to be a lot more convenient than traveling or moving around to see friends. If you stay at home and you or your friends can't or don't want to drive around or take transportation, you'll start losing touch with each other, becoming more isolated, fixated on TV or talking mostly on the phone. Don't let that happen to you.

The main disadvantage of an Assisted Living Facility is the *limit* to the kind of assistance they can give you. Assisted living is just that - living on your own with support for a few tasks. It is **not** an alternative to a nursing home. That's why many facilities will not accept residents who need respirators or catheters. If you find yourself in this situation, a nursing home is usually the best alternative.

If you're in relatively good health and can handle the majority of day-to-day living, with the exception of a few tasks, then an Assisted Living Facility is a good option to consider.

They usually deliver meals three times a day with housekeeping and laundry done on a scheduled basis. The care providers may *remind* you when to take medications, but they're usually not allowed to

HSA Contributions

You can make the maximum pre-tax contribution to an HSA on the first day it's established. Your contribution is based on your expected coverage on the first day of the last month of your taxable year. The first thing to consider as soon as you become eligible might be how much to contribute. Contributions for the tax year can be made in one or more payments, at any time before you're required to file your federal income tax return for the prior year. This is usually April 15, and extensions are excluded. Neither your tax filing status nor the HDHP deductible affects your contribution level.

There are, however, limits to the maximum you can contribute. They depend on whether you have an individual or a family high-deductible health plan.

For 2019, the most you can contribute to an HSA and deduct from your taxes is $3,500 for individual HDHP coverage and $7,000 if you take family coverage. These amounts are indexed annually.

Contributions to an HSA can be made by you, your employer, or both. If your employer makes them, they are not taxable to you (excluded from income and wages). If you contribute, you can deduct those contributions from your taxable income on your tax return.

There is a lot of flexibility on the source of the contributions to your HSA. For instance, your spouse or partner can make them on your behalf. Additionally, you can make one-time transfers from your IRA to an HSA.

The key is that you must keep track of how much goes into your account and make sure it doesn't go over the limit. Your account administrator, trustee, or custodian will not notify you if you exceed your allowable contribution amount. **The management of your deposits and withdrawals is your responsibility**.

You can also make contributions to your HSA in a lump sum or in any amounts or frequency you wish under HSA rules; however, your administrator, who is your account trustee or custodian, may impose requirements. These can include a minimum deposit and minimum balance requirements.

You can make a full year's contribution plus the catch-up, if applicable, to an HSA anytime during the first year you become eligible, as long as you follow two rules:

Rule #1 - You must be eligible by December 1. In other words, you must have established an HDHP and meet all the other eligibility requirements.

If you are at least 55-years old, you can make additional catch-up contributions of up to $1,000 per year. And if you and your spouse are 55 or older, both of you can take advantage of the $1,000 catch-up contribution limit whether you have an individual or a family HDHP. Remember though, contributions must stop once you are enrolled in Medicare.

Rule #2 - If you contribute a full year's contribution, but are eligible only part of the year, you will be subject to taxes and penalties if you don't remain eligible for 12 months after the year in which you first become eligible.

For example, if you become eligible on December 1, 2017 and make a full year's contributions, you will need to remain eligible through all of 2018 to avoid tax and penalties. You can also make a full year's worth of catch-up contributions no matter when your birthday falls during the year.

Sometimes families have multiple HDHP coverage or additional non-HDHP coverage. If you have family coverage, you can contribute the maximum HSA limit for a family. Other coverage of dependent children or your spouse does not affect your contribution limit, except that if your spouse is not eligible, he or she cannot have an HSA.

If one of you has family coverage and the other individual coverage, or even if you both have family coverage, this does not affect your ability to make the maximum family contribution. In these cases, assuming you both have an HSA, you must allocate by agreement between you what amount of the contribution goes towards each HSA.

Things Your Policy Won't Cover

Although the homeowners policy is considered an all-risk policy and will cover you for any loss you incur, there are some exclusions or causes that it won't cover.

Property Exclusions

Coverage A and B

- **Collapse -** The collapse of your house is excluded unless the cause of loss is listed in the additional coverages section of your policy.
- **Freezing -** Freezing of plumbing, heating, or air conditioning systems is excluded if the heat has not been maintained while the building is vacant, unoccupied, or under construction.
- **Flood -** The most important thing to know is that your policy does NOT cover flood. You must purchase a separate policy to cover damage from a flood. Flood has been an excluded peril since 1968 when the government started the National Flood Insurance Program. Even if you don't live in a designated flood zone, it is important to have flood insurance in the event of hurricanes or heavy rains. Also, premiums for flood insurance can be inexpensive depending upon your flood risk. You can purchase a flood policy through your homeowners insurer or find an agent through the flood program.

  Visit www.FloodSmart.gov to learn how the National Flood Insurance Program defines a flood and learn how much your annual flood insurance premium can cost.

- **Foundations, Retaining Walls, and Nonbuilding Structures -** Loss to these items (including fences, swimming pools, and docks) by freezing, thawing, pressure or weight of water or ice is not covered.
- **Dwelling under Construction -** Theft from a dwelling under construction is excluded. Theft of material is also excluded until the dwelling is finished.
- **Vandalism and Malicious Mischief -** This exclusion only applies if the building has been vacant for more than 30 consecutive days before the loss. (Vacant being empty and unfurnished and unoccupied being a furnished home where the residents are on vacation.)

- **Mold, Fungus or Wet Rot -** Loss caused by Mold, Fungus or Wet Rot is not covered if caused by a sump, sump pump or related equipment or a roof drain, gutter, downspout or similar fixture or equipment. Please review your individual policy carefully in order to comprehend exactly what is covered.
- **Risks of Direct Physical Loss Exclusion -** The homeowners form insures your property against any loss as long as it isn't excluded. This section lists some of the other specific causes that aren't covered. Examples are: wear and tear, smog, birds, rodents, animals owned or kept by an insured, and settling.
- **Concurrent Causation Exclusions -** This section deals with more than one event causing a loss. The policy details how losses are handled when one cause is covered and another isn't.

Coverage A, B, C and D

- **Ordinance or Law -** Loss from the enforcement of any law relating to the construction,repair, or demolition of a building. An endorsement can be added to the policy to add back this coverage.
- **Earth Movement -** This is to exclude damage from earthquakes and landslides. Earthquake coverage can be added back to the policy as an endorsement if you live in an area that may be prone to earthquakes.
- **Water Damage -** This is to exclude flood (which can be purchased separately) as well as sewer backup.
- **Power Failure -** This is to exclude claims for damaged food from power outages.
- **Neglect -** This encourages the insured to take reasonable steps to save endangered property.
- **War -** Damage to your home from war, declared or not is excluded.

Liability Exclusions

Coverage E and F

- **Expected or intended injury or damage -** This section excludes intentional acts.
- **Insured's business -** Any damage or injury that arises out of your business is excluded.

What are the Types of Long-Term Care Needs and Services?

Custodial care, or supportive care, is by far the most common type of care in the U.S. Someone without medical training helps you with activities such as getting out of bed, walking, eating, and bathing. Homemaker services can provide companionship and assist with activities such as shopping, transportation, light housekeeping, or similar tasks.

Intermediate care is more serious and includes occasional nursing and rehabilitative care supervised by skilled medical personnel. It also includes basic medical procedures that are required sporadically and not on a 24-hour basis.

Skilled care is the highest level of care and the most expensive. A doctor prescribes care by a skilled nurse or therapist on a 24-hour per day basis.

You can receive these three levels of care in many forms, including:

- **At Home.** Most people prefer to stay at home as long as possible. If you have the financial resources, you can receive custodial, intermediate, and skilled care at home.
- **In An Adult Day Care Center.** The concept of adult day services is similar to that of child day care. Seniors are dropped off at the facility in the morning where they participate in activities and needed therapeutic services so their adult children can keep their full-time jobs.
- **In Assisted Living Facilities.** The philosophy of assisted living is to allow you the right to make choices about your health and safety. These facilities emphasize supervision and assistance as needed rather than on a scheduled basis. They typically provide help with activities of daily living, and if private nursing duty is needed, you can arrange and pay for it yourself.
- **In Nursing Homes.** Nursing homes can be either skilled nursing facilities or intermediate care facilities. Skilled nursing facilities, in which registered nurses provide 24-hour nursing services, emphasize medical care with restorative, physical and occupational therapy. Intermediate care facilities provide less intensive nursing care by registered and practical nurses along with social and rehabilitative services. In a long-term care facility, patients receive

assistance with activities of daily living such as bathing, dressing, eating, toileting, transferring in and out of chairs and beds, and/or have cognitive limitations.

- **Through Hospice Care.** This type of care is provided in your home or in a hospice facility and is exclusively to manage pain and symptoms of terminally ill patients. Medicare covers hospice care provided in your home only.
- **In Continuing Care Retirement Communities.** These types of communities combine housing, healthcare, and social services across a continuum of independent living to nursing home care. Three types - all inclusive, modified, and fee-for-service - provide various levels of care at varying costs.

WARNING: Among the 50 states, no consistent definition exists for adult day care centers, assisted living facilities, or other community-based facilities. When you're shopping for a long-term care policy, get the definitions of the various facilities from the insurer whose policy you are considering. Then visit the facilities in your area to make sure they meet the definitions.

Ask Yourself the Following When Considering Long-Term Care Insurance

1. **Do you want to leave an inheritance?**

   If not, allocate your savings or assets to cover long-term care expenses and then, if necessary, purchase a long-term care policy for remaining needs. If so, a long-term care policy will help prevent your assets from being depleted by the costs.

2. **Do you have family who can take care of you?**

   If you have an adult child or other family member that could act as a caregiver, you may not need the coverage of a long-term care policy or can purchase one with fewer benefits at a cheaper price.

What is Medicare Prescription Drug Coverage?

Medicare Primer: The new Medicare prescription drug benefit is available to all Medicare beneficiaries. You cannot be denied coverage for health or income reasons. It is a voluntary benefit.

You are probably familiar with Medicare's hospitalization benefits (Part A) and medical services benefits (Part B). While the federal Medicare program offers decent benefits, it is not designed to be comprehensive. As a result, seniors are responsible for substantial out-of-pocket costs. These costs include deductibles, premiums and significant co-payments to access covered benefits. Until 2006, Medicare did not include coverage for outpatient prescription drug costs.

You can access the benefits of Medicare Part A and Part B one of two ways: Original Medicare or Medicare Advantage.

Original Medicare: Most seniors get program benefits under Original Medicare, also known as traditional fee-for-service Medicare. You sign up directly with the Medicare program, with benefits provided by the federal government. Under Original Medicare, you can visit any physician or hospital that accepts Medicare payment and the government will reimburse the health care provider or yourself. You are responsible for paying the amounts not covered by the Medicare program. You can get additional hospitalization and medical coverage by purchasing a private insurance policy, called Medicare Supplement Insurance or 'Medigap.' Some beneficiaries have retiree health benefits from a former employer that helps to fill Medicare's coverage gaps.

Medicare Advantage: The other way to receive Medicare benefits is through private insurers that operate health plans, known as Medicare Advantage plans. These private insurers receive funding from the government to provide you Medicare Parts A and B, and some additional coverage. These offerings come in different designs, with the "Advantage" being that the insurer provides you additional hospitalization and medical coverage above what Medicare mandates at little or no extra cost. (Medicare Advantage plans are Part C of the Medicare program.) Medicare Advantage represents one-stop shopping.

That was the Medicare program in a nutshell up until 2006 when the Medicare program was expanded to include coverage for prescription drugs. This benefit is referred to as Medicare Part D. Just like Part A and Part B, the government has specified the coverage that it will pay for. What is different with Part D, however, is that you CANNOT access this coverage directly through Original Medicare. Keep reading to find out more abouthow the Medicare prescription drug coverage program works.

PLAN A

If you stay in the hospital for longer than 60 days, but less than 90 days, Plan A covers Medicare Part A coinsurance amount of $371 per day (in 2021) for each benefit period.

For each Medicare "hospital reserve day" you use, Plan A pays the $742 (in 2021) per day Medicare Part A coinsurance amount. "Hospital reserve days" are 60 nonrenewable hospital days that Medicare provides which can only be used once in a lifetime. After all Medicare hospital benefits are exhausted, Plan A will cover 100% of Medicare Part A eligible hospital expenses.

If the need arises, Plan A covers costs for the first three pints of blood or equivalent quantities of packed red blood cells received each year in connection with Medicare Parts A and B covered services. Once you have met this 3-pint blood deductible under Medicare Part A, it does not have to be met again under Part B.

After your $203 annual Medicare Part B deductible is met Plan A will cover the coinsurance amount for Medicare-approved medical services, which is generally 20% of the approved amount.

Plan A now includes coverage of cost sharing for all Part A Medicare-eligible hospice care and respite care expenses.

If you feel that Plan A fits your needs, take a look at the two tables below to find out what price you should expect to be charged for this plan. The tables outline the typical annual premiums charged for Plan A depending on age and gender. These rates are based on our 2021 nationwide collection of insurance premiums.

Plan A

Female

Age	Average Premium	Lowest Premium	Highest Premium	Median Premium
65	$1,772	$606	$19,061	$1,590
70	$1,966	$763	$21,686	$1,749
75	$2,257	$883	$23,385	$2,011
80	$2,537	$993	$27,513	$2,272
85	$2,798	$1,035	$29,972	$2,535
90	$3,017	$1,035	$31,814	$2,769
95	$3,196	$1,035	$31,814	$2,976

Male

Age	Average Premium	Lowest Premium	Highest Premium	Median Premium
65	$1,956	$656	$20,304	$1,778
70	$2,172	$827	$23,100	$1,950
75	$2,501	$958	$24,910	$2,247
80	$2,816	$1,076	$29,527	$2,550
85	$3,113	$239	$33,407	$2,850
90	$3,358	$1,122	$35,460	$3,120
95	$3,561	$1,122	$35,460	$3,356

Life Insurance Policy Types

As discussed previously, life insurance policies generally fall into one of two broad categories: permanent life or term life. Within these categories, however, there are a multitude of options that allow you to customize the policy to meet your specific needs - at either higher or reduced premium costs depending on the type of policy. This report does not (and could not possibly) provide premium rates for each of these policy variations, so if you see a policy type that appeals to you, be sure to inquire if it is available when you begin working with an insurer or agent.

Term Life Policy Types

- **Level Term Insurance** provides life insurance coverage for a specified number of years, typically a 5, 10, 15, or 20-year term. Both the death benefit and the annual premium remain the same over the course of the term you can cancel the policy at any time during the term. Parts 2 through 5 of this report provide premium rates for level term policies available to you.

Level Term

	Annual Premium	Death Benefit
Year 1	$400	$300,000
Year 2	$400	$300,000
Year 3	$400	$300,000
Year 4	$400	$300,000
Year 5	$400	$300,000

The benefit of a level term policy is that you can lock in your premium without having to worry about a yearly rate increase. That means you will typically pay more in the early years for a level term policy compared to a yearly renewable term policy, but pay less in the later years of the term.

- **Yearly Renewable Term (YRT) Insurance**, also called Annually Renewable Term (ART), provides life insurance coverage for only one year. At the end of that year, the policy expires but may be renewed for an additional year at a slightly higher premium rate. This allows you to pay as little as possible in the early years of coverage while paying more in the later years.

Yearly Renewable Term

	Annual Premium	Death Benefit
Year 1	$380	$300,000
Year 2	$395	$300,000
Year 3	$410	$300,000
Year 4	$425	$300,000
Year 5	$475	$300,000

This type of policy is most appealing to individuals who can't afford the higher premiums of a level term policy, only require coverage for a few years, or want to remain flexible with their coverage term.

- **Decreasing Term Insurance**, also called Annually Renewable Term (ART), is just the opposite of yearly renewable term. Here the annual premiums remain the same throughout the term of the policy, but the death benefit declines annually due to the higher mortality rate as you get older.

Decreasing Term

	Annual Premium	Death Benefit
Year 1	$400	$400,000
Year 2	$400	$305,000
Year 3	$400	$300,000
Year 4	$400	$280,000
Year 5	$400	$240,000

This type of policy is most appealing to individuals who expect their savings and investments to grow each year, effectively lessening the amount of life insurance coverage they need.

Two common types of decreasing term policies are **Mortgage Redemption** and **Credit Life** insurance. With mortgage redemption insurance, the death benefit equals and declines in tandem with the decreasing balance of your mortgage loan. Credit life is similar although it is typically tied to other types of loans like automobile or credit card loans.

Selecting a Variable Annuity

Are Variable Annuities Right For You?

Now that you are familiar with how variable annuities work, including their inherent advantages, disadvantages, tax considerations, and mutual fund considerations, you are in a much better position to determine whether or not they're right for you. Keep in mind though, it is usually a good idea to consult a professional such as a Certified Financial Planner before making any major moves in retirement planning.

You Should Consider Variable Annuities If:

1. You can make a long-term financial commitment for retirement, and you are confident that you won't need access to your money before you retire.
2. You have already fully funded any company-sponsored retirement plans or IRAs for which you are eligible.
3. You can take full advantage of tax-deferred growth of your investments. This is especially appropriate if you are in - or entering - a high marginal tax bracket and are at least six years away from retirement.
4. You need to shelter your savings from potential lawsuits and make it less accessible to the courts.
5. You feel up to making your own investment decisions, or alternatively, you have a financial advisor you can rely on.
6. You have already established a source of liquid assets that you could tap in case of an emergency. Remember, it will be costly if you ever need to withdraw money from an annuity before retirement.

You Will Probably Want To Avoid Variable Annuities If:

1. You have not yet fully funded any company-sponsored retirement plans or IRAs available to you.
2. The ups-and-downs of the stock market make you nervous and you are averse to the risks associated with mutual fund investing.
3. You know little or nothing about mutual fund investing and are not interested in learning.
4. There is a good chance you will need the money before retirement for living expenses, emergencies, long-term care or other investment opportunities you may want to pursue.

Ten Steps in Evaluating a Variable Annuity Policy

Once you decide that investing in variable annuities is the correct choice for you, you should follow these steps before buying:

1. Shop around. There are so many variable annuity products on the market today that it pays to take the time you need to find the one that best suits your needs.
2. Avoid all variable annuities that charge a front-end load. The up-front cost just cannot be justified.
3. Favor annuities with no or low back-end loads (surrender charges) unless guaranteed withdrawal benefits are one of your requirements. Most, although not all, variable annuities with guaranteed withdrawal benefits charge a surrender fee for a certain number of years.
4. Focus first on those insurance companies with a Weiss Safety Rating of A (excellent) or B (good). Since the variable annuity will be maintained as a "separate account," you may also decide to consider companies with a C (fair) rating, although you will want to periodically monitor them more closely.
5. Avoid variable annuities that do not offer a choice of at least seven mutual fund subaccounts - an aggressive growth fund; a growth fund or S&P 500 index fund; a growth and income fund or balanced fund; a small cap fund; an international or global fund; a bond fund; and a money market fund.
6. Compare the performance of the funds available through the variable annuity to the averages for those types of funds. You should look for variable annuities with funds that have achieved at least average performance for the last one-year, three-year, and five-year time horizons. It is a good idea to look at long-term results to get a sense of how well the subaccounts have performed over time.
7. Compare the variable annuities' total expense costs. (Total expense = mutual fund annual expense + insurance expense). Look for variable annuities that have total expenses at or below the industry average of 2.18%.
8. Make sure the variable annuity allows you to switch between the mutual fund subaccounts by telephone, preferably at no additional cost.
9. Favor a variable annuity policy that gives you the right to withdraw up to 10% of your money annually with no surrender charge or other penalty. You may never take advantage of this feature, but it is good to have in case of emergency.
10. Look for variable annuities offering a periodic step-up of the insurance amount as the value of the mutual fund subaccount grows through the years.