Glossary

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Activities of Daily Living (ADLs): Routine actions such as eating bathing, transferring (bed to chair), dressing, toileting and continence. The inability to perform 2 or 3 of these activities is generally used to determine level and kind of home health or nursing home care needed and to qualify for benefits under long-term care insurance.

Acute Care: Immediate, short-term, medical treatment for a serious illness or injury, usually in a hospital or skilled nursing facility. May be contrasted with chronic care.

Adult Day Care: Care inside or outside the home provided for adults who require assistance with the activities of daily living or other largely non-medical supervision. But possibly including minimal medical-related services such as supervising the taking of medicine. Often includes social and recreational programs and, sometimes, occupational and physical therapy. Primarily intended for care during the hours that family members or other informal caregivers are at work, rather than care on a 24-hour basis.

Adult Day Care Facilities: Community based centers that provide comprehensive services ranging from health assessment and care to social programs for older persons who need some supervision. They may be operated by hospitals, nursing homes, local governments or private groups. Out of pocket costs vary. Medicare does not cover adult day care.

Alternate Care: A plan mutually agreeable to you, the insurance company of your long-term care policy, and those individuals preparing the plan. The alternate care you receive can include special treatment at home or in other facilities. Benefit levels may differ from your usual coverage. Definitions used in insurance policies may vary from policy to policy. Insurers may use this term to extend coverage to care in facilities of the future not yet identified or in use.

Alzheimer's Disease: A progressive and irreversible organic disease, typically occurring in the elderly and characterized by degeneration of the brain cells, leading to dementia, of which *Alzheimer's* is the single most common cause. Progresses from forgetfulness to severe memory loss and disorientation, lack of concentration, loss of ability to calculate numbers and finally to increased severity of all symptoms and significant personality changes. *Alzheimer's* is now typically covered by name in newer policies. (More information on Alzheimer's)

Assisted Living Facility: A non-specific term referring to any setting that provides living arrangements and assistance for the elderly and/or disabled. Also called *Adult Foster Care*.

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Bed Reservation Benefit: In some long-term care policies, a benefit paid to maintain the insured's space in a *nursing home* facility when the insured must be hospitalized temporarily.

Benefit Amount or Limits: In general, the maximum amount payable by an insurer to an insured for the specific benefits contracted for under an insurance policy. In *long-term care insurance*, generally refers to the daily benefit amount for which the insured has contracted and which is payable for each day of long-term care the insured receives in accordance with the policy's provisions.

Benefit Period: In a long-term care insurance policy, the maximum length of time specified in the contract during which benefits will be paid. Periods available vary considerably from policy to policy and insurer to insurer, ranging from as short as one year to a lifetime. In some cases, especially for longer benefit periods, a maximum dollar limit may also apply. For example, the policy might provide for a lifetime benefit period capped at $500,000 maximum benefits. When $500,000 in benefits have been paid, benefits cease even if the insured is still living and receiving long-term care.

Benefit Cap: The lifetime dollar limitation of a long-term care policy.

Benefit Maximum: Either a certain number of days or a dollar amount expressing what a policy will pay for a given service. This is the "most" that the policy will pay. It may pay less due to other policy limitations.

Benefit Period: Also called "Spell of Illness". A period of time that begins on or with the first day of confinement in either a hospital or nursing home and ends at a specific point. As an example, *Medicare*'s first 60 days of hospitalization begins on the first day admitted to the hospital and ends when the beneficiary has gone 60 days without being re-admitted to the facility.

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Care Coordination Benefit: A benefit in newer long-term care policies that pays consultation fees for a professional, such as a registered visiting nurse or a medical social worker, to periodically assess and make recommendations about the insured's care program. For example, consultation might begin at a specified time after the insured has been confined to a *skilled nursing facility*. The purpose is to adjust services when and if the individual's care needs change. Also called *personal care advisor* and *personal care advocate benefit.*

Caregiver: A non-specific term describing either a skilled or nonskilled person who provides some type of care for another. In long-term care policies, types of care and types of caregivers are generally defined for purposes of identifying covered services.

Case Management: A professional service which arranges and coordinates health and/or social services through assessment, service plan development and modification, monitoring, and quality assurance.

Chronic Care: Continuous, long-term care for persons suffering from chronic conditions. May be contrasted with *acute care*.

Cognitive Impairment: A defect in or loss of all or part of an individual's memory, judgment, perception, reasoning or other intellectual functioning as medically diagnosed. Often one of the triggers for benefit payments under a long-term care insurance policy.

Cognitive Impairment Reinstatement Provision: A provision in some long-term care policies that allows a policy that has lapsed because the insured did not pay the premium to be reinstated for full benefits if the premiums are paid within six months after the lapse. Typically, the insured's physician must certify that the insured suffered a *cognitive impairment* that presumably caused the individual to fail to pay the premium on time.

Coinsurance: A cost-sharing requirement which provides that a *Medicare* beneficiary must assume a portion or percentage of the costs of covered services. Medicare coinsurance amounts are usually stated either in dollars or as a percentage of the reasonable charge for services.

Continuing Care Retirement Community (CCRC): A combination of residential and nursing home facilities that might also include a broad variety of recreational, social, medical and other services. Requires a significant entrance fee followed by monthly payments to retain residency and services. As one option for obtaining and paying for *long-term care*, CCRCs are currently considered affordable for fewer than 10% of retirees. Also called *life care community*.

Convalescent Care is another term often used for short-term *custodial care* and refers to a "recovery" period after an illness or injury when some assistance may be needed that does not require *skilled care*.

Co-Payment: Used interchangeably with *coinsurance*. Co-payment is usually a set dollar amount rather than a percentage.

Custodial Care: In the context of long-term care or *Medicare*, refers to assistance requiring the lowest level of skills, helping with *activities of daily living*, but not with medical care. Can be provided by people who have no medical training, sometimes by aides trained in caregiving skills and frequently provided informally by family members or other

unpaid volunteers. Custodial care services, which may be performed in a nursing home, the individual's home, or some other setting, are the most common type of services required by the elderly and the disabled.

Custodial Care Facility: A care facility providing the lowest skill level of care, primarily assistance with activities of daily living and minimal skilled nursing care, the latter usually limited to supervision of medicine-taking.

Custodial Nursing Care: Also called *Maintenance Nursing Care* or simply Maintenance Care; it is care which is primarily done for the purpose of meeting an individual's daily personal needs such as bathing, eating or taking medications. It may be provided by persons without special training or skills. If given in a hospital or nursing home, the care will usually be under the direction of a doctor. Also called custodial care.

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Daily Benefit Amount: In a long-term care policy the specific amount of insurance the policy pays for each covered day of long-term care as defined in the policy. The insured may choose from a wide range of daily benefit amounts and, under some policies, different amounts for different types of care, such as a higher daily benefit for nursing home care and a somewhat lower benefit for home care. Options available vary widely among insurers and policies.

Death Benefit: In some long-term care policies, a benefit payable to the insured's survivors or estate if the insured dies before a specified age. Often 65 or 70. The benefit amount is a refund of premiums the insured paid minus the amount of any benefits the insured received while living.

Deductible: The amount of health care expense that a Medicare beneficiary must first incur and pay out-of-pocket annually before Medicare will begin payment for covered services. Medicare deductibles include the Part A hospital deductible; the Part B deductible for all covered services under Part B; and the blood deductible.

Dementia: Deterioration of mental ability, generally caused by organic brain disease, less often by psychological factors. Characterized by disorientation and loss of memory and intellect. Also called *organic dementia*.

Diagnostic Related Group (DRG): A classification based upon an individual's medical diagnosis at the time the individual is admitted to a hospital for treatment that is funded by Medicare and which determines in advance how much Medicare will reimburse the hospital for treatment regardless of the length of the hospital stay. The DRG classification is part of Medicare's Prospective Payment System (PPS), designed to help contain costs. This has resulted in shorter hospital stays and an increase in nursing home admissions since its implementation in 1984. Also called *Diagnosis Related Groups*.

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Elimination Period: In insurance policies, a period after the onset of an illness or injury during which no benefits are paid, effectively providing for a deductible. Common in long-term care policies, although some insurers offer policies with no elimination period. Sometimes called a waiting period, which is technically incorrect from the viewpoint of the insurance industry, in which a waiting period is a different phenomenon.

Employer-Sponsored LTC Insurance: Long-term care insurance made available by an employer to its employees, similar to other types of group insurance. Many employer-sponsored LTC plans may also be offered to employee family members including spouses, parents, parents of spouses and children, depending on the particular plan and the insurer.

Excess Charge: Also called *Balance Billing*, it relates to Medicare Part B charges. It is the amount of the medical bill which is above the dollar figure allowed by Medicare.

Exclusion: A condition not covered under the policy.

Explanation of Medicare Benefits (EOMB): The statement of payment from Medicare; it shows the amount charged by the medical provider, the amount approved by Medicare and the amount actually paid by Medicare. It is this statement that is submitted to the insurance company for payment under the Medigap policy.

Extended Care Facility: An institutionalized setting outside of a hospital that provides 24-hour skilled nursing care as prescribed by a physician.

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Free Look Provision: An insurance policy provision required by most states, allowing the policy owner to inspect the policy for a specified period of time, often ten, 15, 20 or 30 days and to return the policy to the insurer, if desired, for a refund of the entire premium.

Fraud: The outright misrepresentation of facts with the direct intent to defraud either Medicare and/or an insurance company.

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Gatekeepers: In long-term care insurance, refers to policy provisions, restrictions or limitations that qualify the insured to begin receiving benefits, such as being referred for care by a physician, being unable to perform a specified number of activities of daily living, having a prior hospital confinement, or others. Technically, these are the coverage triggers in long-term care policies. Also called *safety nets*.

Guaranteed Renewable Policy: A policy that guarantees the insured may renew the policy up to a specified age, or for life, as long as the insured pays the premiums. The insurance company may increase the premiums on guaranteed renewable policies for all policies of that particular type, but may not increase the premium for any individual policy.

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Health Care Financing Administration (HCFA): The branch of the U.S. Department of Health and Human Services that administers the Medicare program and provides information about long-term care and other health services.

Health Insurance Association of America (HIAA): An insurance trade group, comprised primarily of private health insurers, that represents the U.S. health insurance industry on public policy and other issues related to health insurance. It also compiles and disseminates data reported by insurance companies, government agencies, and hospital and medical associations.

Health Insurance Claim Number: The number listed on the beneficiary's Medicare card; it will consist of nine digits followed by one or more letters. The nine digits represent the Social Security number of either the beneficiary or their spouse depending upon whose income it is based upon.

Health Maintenance Organization (HMO): A type of service provider that arranges for both health care services and payment for those services. Requires members to pay a pre-set monthly fee covering a broad range of services rather than payment for individual services. Members must use medical practitioners and facilities approved by the HMO, usually at a location the HMO owns and operates and using medical personnel employed by the HMO. HMOs may contract with Medicare to offer Medicare beneficiaries all services covered by fee-for-service Medicare. When a Medicare beneficiary joins an HMO, he or she must usually "sign over" their Medicare benefits to that HMO.

Home Health Care: A type of medical care that is gaining popularity as people attempt to stay out of nursing homes. It is growing rapidly as technology provides equipment that is more portable and personnel receive additional training. As the name implies, services are performed at an individual's home, as opposed to an outside facility. Generally may refer to any level of care and a wide range of skilled and non-skilled services, including part-time nursing care, various types of therapy, assistance with activities of daily living and homemaker services such as cleaning and meal preparation. For Medicare purposes, this term refers specifically to intermittent, physician-ordered medical services or treatment and should not be confused with definitions contained in long-term care policies.

Home Health Care Agency: Either a private commercial venture or a state-operated organization that is licensed to provide health care and/or homemaker services to

individuals who need assistance but need not be institutionalized. Those who actually provide the services are commonly referred to as home health aides who may or may not have to be specifically trained and licensed or certified in particular states. Newer long-term care policies often pay for such services performed in an insured's home.

Homemaker Services: A variety of non-skilled at-home services, including shopping, meal preparation, laundry services, housekeeping and similar activities provided either by employees of private home health agencies or state agencies. Some long-term care policies pay a benefit for such services.

Hospice: An organization which primarily provides pain relief, symptom management, and support services for terminally ill patients and their families.

Hospice Care: Care for the terminally ill. Includes some medical assistance primarily for pain control and making the ill person comfortable, as well as counseling services for the ill and their families. May occur at home or in an institutionalized setting. Medicare provides benefits under Part A for this type of care; there are restrictions and qualifications that apply.

Hospital Insurance (Part A): That part of the Medicare program which helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

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Inflation Protection is an option offered on some long-term care policies which can increase the maximum daily and lifetime benefits to combat inflation. The protection is generally 5% per year, but varies from policy to policy as to whether the increase is calculated at simple or compound interest.

Intermediate Care: In the context of long-term care and Medicare, refers to a level of nursing services performed intermittently, rather than around the clock, by professional medical personnel, usually a registered or licensed practical nurse or other medical practitioners such as licensed therapists.

Intermediate Care Facility (ICF): A care facility providing skilled nursing care on an as-needed basis rather than on a 24-hour basis, as well as custodial care associated with the intermediate level care. An Intermediate facility may not provide Skilled Care and, therefore, may not be certified by Medicare since that is the only level of care which they will pay for.

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Levels of Care can include these three levels of long-term care:

- **Skilled Care:** 24 hour a day prescribed care provided by licensed medical professionals who are under the direct supervision of a physician.
- **Intermediate Care:** Prescribed care that can be provided on an intermittent, rather than continuous basis - for example, physical therapy.
- **Custodial Care:** Care that assists people with daily living requirements, such as dressing, eating and personal hygiene.

Lifetime Maximum: A set benefit amount payable under a contract or policy. In some types of contracts, benefits that have been used are renewable, but usually only up to a specific figure. That specific figure is the lifetime maximum. It is the total amount of benefits payable during the lifetime of the policy.

Lifetime Reserve Days: Hospitalization (*Part A*) under *Medicare* from the 91st day of confinement through the 150th day. This period of consecutive hospitalization is not renewable; once used, the benefit is gone.

Limiting Charge: Also called Limiting Physician Charge. This refers to the OBRA 1989 and 1990 legislation which, among other things, attempts to put a cap or ceiling on the amount medical providers charge for their services under *Part B* of *Medicare*.

Long-Term Care (LTC): A wide range of medical and non-medical services ranging from *custodial help* with *activities of daily living* to occasional *nursing care* to *skilled nursing* services provided to people who are physically or mentally unable to provide independent care for themselves. Usually used to describe care for the elderly although younger disabled persons also utilize long-term care services. Care may be needed while recovering from an accident or illness, during an extended period of disability, or simply as a result of the normal aging process. *Home health care*, *adult day care*, *respite care* and *nursing home* stays fall into the category of long-term care.

Long-Term Care (LTC) Insurance: Insurance that covers expenses incurred when the insured receives specified services associated with extended care in a variety of settings including the individual's home, nursing homes and community-based facilities such as assisted living facilities and *adult day care centers*

Long-Term Care Partnerships: See *State/Private Insurer Long-Term Care Partnerships*.

Long-Term Care Rider: An attachment that may be added to some life insurance and other types of insurance policies to allow some or all of the death benefit or other primary benefit to be used to help pay for *long-term care* costs under situations defined in the policy.

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Maintenance Nursing Care: Also called simply *Maintenance Care* or Custodial Care; it is care which is primarily done for the purpose of meeting an individual's personal needs (activities of daily living) such as bathing, eating, dressing or taking medications. It may be provided by persons without professional training or skills. Even so, this type of care is usually given under a doctor's orders.

Maximum: A limit on the amount that a plan will pay. It may be expressed as a dollar amount or as a time limit.

Maximum Daily Benefit: The amount designated in a long-term care policy up to which it will pay benefits per day for nursing home care. It also determines the amount per visit payable for home health care.

Medicaid: A joint federal-state welfare program that pays for medical care for those with very low incomes. It will cover nursing home costs and some very limited home health care but only after most assets and income have been exhausted. Being on Medicaid may reduce or limit the choice of nursing homes. Called Medi-Cal in California.

Medical Insurance (Part B): That part of Medicare which helps pay for medically necessary physicians' services, outpatient hospital services, home health care services, and a number of other medical services and supplies that are not covered by Medicare Part A. Part B is also called *Supplementary Medical Insurance.*

Medicare: The Federal government-sponsored health care program funded and operated by the Social Security Administration, providing medical benefits for individuals over the age of 65, some disabled persons and those with end-stage renal disease. Automatically includes Part A Hospital Insurance. Part B Supplementary Medical Insurance covers physicians services and other outpatient care and is optionally available for a monthly charge. . There are some co-payments and deductibles on both Parts A and B. The dollar amounts of these may change each year (check with your local Social Security office for current details). Medicare does not provide benefits for custodial or intermediate nursing home care, or long-term care.

Medicare Supplement Insurance: Private insurance policies that "supplement" the benefits provided by Medicare. A Medicare supplement policy is sometimes called a "Medigap" policy supplement because it fills in the "gaps" left by Medicare benefits. Generally speaking, Medicare supplements will pay only if Medicare approves some portion of the services provided. The general rule of thumb is: Medicare supplements supplement Medicare. Therefore, if Medicare totally denies the claim, the supplement policy will deny the claim also. Medicare supplements do not provide long-term care benefits.

Model Policy (NAIC): Any insurance policy prototype, including a long-term care

policy, developed and recommended by the National Association of Insurance Commissioners (NAIC) and offered to insurance companies and to the individual states as a minimum standard for approval purposes. Neither insurers nor states are required to accept or adopt NAIC models, although many do. NAIC's model long-term care policy is more liberal than the first generation of private LTC policies, but less liberal than many private LTC policies currently available.

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National Association of Insurance Commissioners (NAIC): An organization of insurance commissioners and superintendents that promotes communication about insurance regulation and practices and recommends model laws related to insurance in all states for the purpose of helping standardize laws and practices, and promoting consumer protection.

Nonforfeiture Feature: A provision in some long-term care policies offering a guarantee that certain policy benefits will remain available even if the insured stops paying premiums. One type of nonforfeiture is a paid-up policy providing the same benefits for a shorter period or lower benefits for the same period as the original policy. Return of premium benefits are another form of nonforfeiture.

Nursing Home: A non-specific term that refers to any of several types of facilities designed to provide one or more levels of care for persons who need assistance. May include skilled, intermediate, and/or custodial care facilities.

Nursing Home Care is care provided in a skilled nursing facility where all three levels of care (skilled, intermediate and custodial) are provided. In order to be licensed, nursing homes must meet appropriate standards for the state in which they operate. They may or may not be Medicare approved.

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Organic Disorder: An alteration in the structure of an organ caused by disease as opposed to psychosomatic or functional disorders in which no evidence of organic problems exist even though some impairment exists. In long-term care policies, often referred to as demonstrable organic disease and should specifically include Alzheimer's and Parkinson's diseases, both of which have organic origins. Other associated terms are *dementia* and *organic dementia*.

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Paid-Up Policy: In long-term care insurance, it is generally the operation of a nonforfeiture feature under which the insured's coverage continues for some period based on the amount of premiums paid when the policy lapses. Methods for providing the

paid-up policy may include full benefits for a shorter benefit period or partial benefits for the full original benefit period. Some policies also have a provision which pays up the policy under specified conditions upon the death of an insured spouse. Some companies offer limited or single payment premium modes that result in paid up policies when a specified number of annual premiums have been paid.

Parkinson's Disease: An organic brain disease caused by degeneration of or damage to the basal nerve cells of the brain, usually in elderly people and characterized by tremors, muscle rigidity and a shuffling walk. About a third of diagnosed patients progress to dementia after ten or more years if untreated. Symptoms are less severe with drug treatment. It is often covered by name in newer policies.

Part A: That part of Medicare that covers inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Also called *Part A Hospital Insurance*.

Part B: That part of Medicare that covers physicians' services, the cost of medical equipment and supplies, outpatient hospital services, and a variety of other medical services not covered by Medicare Part A. Also called *Part B Medical Insurance*.

Participating Medical Provider: A Participating Physician is one who accepts as payment for his or her services, the portion of the bill that Medicare approves. Medicare will then pay 80 percent of that amount approved and either the patient or their insurance company must pay the other 20 percent remaining.

Peer Review Organization (PRO): A group of practicing doctors and other health care professionals under contract to the federal government to review the care provided to Medicare patients. Also known as a Quality Review Organization (QRO).

Personal Care Advisor: A benefit offered by some long-term care policies. Also called *Care Coordination Benefit*.

Pre-Existing Condition: Health conditions diagnosed or treated prior to the effective date of a health care or long-term care policy. Precise definitions differ widely among health insurers and policy types. Policies vary in whether or not they exclude coverage for these conditions and, if so, for how long.

Policy Form Number: Legal designation used by an insurance company when filing a specific policy form with the state insurance department.

Policy Summary: A summation of selected features of an insurance policy prepared and attached to the policy by the insurer for delivery to the policyowner/insured.

Primary Care Physician: Generally refers to HMOs or other types of member organizations; the doctor selected by the enrollee is called the Primary Care Physician since that doctor is in charge of managing that member's health care needs.

Primary Care Services: Under Medicare, they are designated to include consultation services, hospital in-patient services and psychiatric services. These services are often referred to as "Evaluation and Management Services."

Prospective Payment System (PPS): Federally mandated method intended to control Medicare costs under which Medicare pays a fixed reimbursement to hospitals based on the individual's diagnosis rather than on the actual cost of treatment. Costs are determined in advance—prospectively—rather than after the fact or retrospectively. Implemented by classifying patients into diagnostic related groups (DRGs) that dictate the amount Medicare pays for treatment.

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Registered Nurse (RN): An individual who provides nursing services after completing a course of study that results in a baccalaureate degree and who has been legally authorized or registered to practice as an RN and use the RN designation after passing examination by a state board of nurse examiners or similar state authority.

Rehabilitative (Restorative) Care is skilled care provided by a trained medical person (physical therapist, R.N., speech therapist). Its purpose is to restore health following an accident, injury or illness. Medicare pays for a limited amount of this type of care.

Reinstated Benefits: When a policy has lapsed due to nonpayment of premiums, benefits may be reinstated at the company's option. It is common for the company to determine proof of insurability before it will do so.

Renewable at the option of the Insurance Company: This refers to policy contract renewability. The insurance company can choose to cancel the policy on an individual basis.

Respite Care: A few hours to several days of assistance to give a temporary rest or break from caregiving for the individual's usual caretaker, often a family member or friend. The service can be provided at home or in a facility setting such as a nursing home. Benefits for respite care are included in most long-term care insurance policies. Medicare covers respite care only for the terminally ill under their hospice program.

Restoration of Benefits means once you are benefit-free (as defined in your particular policy) for a specified length of time, usually six months, those benefits already paid out are restored. Not all long-term care policies offer this benefit.

Return of Premium Benefit: A type of nonforfeiture benefit included in some long-term care policies that provides a cash value accumulation and return of premiums in the future

to insureds who receive no policy benefits or minimal benefits while the policy is in force. Exact provisions vary from policy to policy, but generally provide a greater return the longer the policy is in force and usually deduct the amount of any claims paid before returning premiums to the insured.

Rider: An attachment to an insurance policy that changes or adds provisions not included in the original policy There is an additional charge for riders added at the insured's option to provide additional benefits for the insured. Also called an *endorsement* .

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Safety Nets: See Gatekeepers

Senile Dementia: Outdated term referring to organic dementia associated with old age. Dementia was formerly divided by age of onset into senile (over age 65) and pre-senile (under age 65). But this division is now considered artificial since symptoms are identical regardless of age.

Skilled Nursing Care: In the context of long-term care or Medicare, refers to the highest level of professional medical care, characterized by 24-hour supervision by a registered or licensed practical nurse as ordered by a physician. For Medicare, must be performed in a skilled nursing facility as specifically defined by Medicare, a requirement that may or may not apply under a long-term care policy depending on the insurer.

Skilled Nursing Facility (SNF): A facility licensed by the individual state, and one that may be certified by Medicare, providing care that requires the highest level of medical skills with continuous, 24-hour attention from a registered or licensed practical nurse, under a physician's orders and/or supervision. May also provide Intermediate or Custodial care and makes care available from other medical practitioners and for emergency services.

Spousal Discount: A premium reduction, usually from 10% to 25% of the premium, that some insurers provide when both a wife and husband purchase long-term care policies. Insurers offering such discounts sometimes do so for two people who permanently reside together whether or not they are spouses.

State/Private Insurer Long-Term Care Partnerships: Arrangements between some states and certain private insurance companies to provide long-term care insurance. Subject to the specific legal requirements for each state, these partnerships help protect the assets of insureds who typically must become nearly impoverished before qualifying for Medicaid (Medi-Cal in California) assistance for long-term care costs. In general, the state approves the long-term care policies offered by insurers who agree to include state-mandated provisions. Insureds who purchase the approved policies may protect one dollar in assets for every one dollar in benefits paid by the private insurance coverage. The purpose of these plans is to shift some of the burden for long-term care from Medicaid

programs to private insurance while at the same time allowing insurance purchasers to keep assets they would otherwise have to spend in order to qualify for Medicaid when the private insurance benefits are exhausted.

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Therapeutic Devices may include hospital beds, crutches, wheelchairs, ramps, intravenous pumps and respirators.

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Underwriting: The process of examining and investigating an applicant for insurance to determine whether or not the insurance company is willing to provide insurance coverage and on what basis.

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Waiting Period: In some health insurance policies, a period during which no benefits are paid immediately after the policy goes into effect. Sometimes used incorrectly as a synonym for an insurance policy's *elimination period*.

Waiver of Premium Provision: Any provision included within or as a *rider* to an insurance policy providing that, when specified conditions exist, the policy will continue in force without further premium payment. When the specified conditions no longer exist. the insured person resumes paying premiums.

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