**Activities of Daily Living (ADLs):** These are the basic activities that enable you to take care of yourself. Each policy will include what that insurance company defines as activities of daily living (ADL's), and the list will include some or all the following: bathing, dressing, transferring, eating, toileting, continence, and mobility. People who need help from someone else in doing one or more of these are said to have an "ADL limitation" or "ADLs" for short. Insurance policies usually specify how many "ADL's" you must have before they pay benefits. Persons needing help performing ADLs are further classified as requiring "hands-on assistance" or "standby assistance" (see).

**Adult Day Care Facility** A facility that is:

1. licensed by the state in which it is located
2. has a full-time director and nurse present at least four hours per day
3. is not an overnight facility
4. maintains a written record of services rendered
5. is open a minimum number of hours per day at least five days per week
6. has established procedures for handling medical emergencies

It does not include care received at home or in a hospital or a convalescent care facility. Not all policies cover adult day care, and those that do cover it pay for the service at different rates.

**Alternate Plan of Care** This is an option offered by some LTC policies. The plan of care must be developed by a health professional and is an alternative to going into a nursing home or other care facility. The alternate plan of care may be initiated by you or the insurance company. Services that might be covered by such a plan include remodeling, ramps, home health care, an adult care center, or an alternate care facility. The services covered under an alternate plan of care are part of the nursing home portion of the policy and do not include services covered by a home health rider or policy.

**Assisted Living Facility** A residential living arrangement providing personal care and health services for people who need assistance with activities of daily living. Facilities can range from small homes to large apartment complexes. They also vary in the levels of care and services that can be provided. Assisted living facilities provide a way for people to retain a relatively independent lifestyle, and they are for individuals who do not need the level of care provided by nursing homes. Most LTC policies provide benefits for assisted living, usually up to the same daily maximum as the nursing home

**Bathing** One of the Activities of Daily Living used to determine the need for long-term care. Bathing is the ability to wash yourself, either in the tub, shower, or with a sponge (See also Activities of Daily Living.)

**Bed Reservations** If you are in a nursing home and need to go to a hospital, some policies will pay to reserve your nursing home bed so you can return when your hospital stay is over. There is a limit on how many days your bed will be reserved, often 14 to 21 days.

**Benefit Period** The benefit period begins on the first day that the insurance company begins to pay for your care and ends when you no longer require care or have reached the maximum benefits allowed by your policy. A new benefit period begins after you have been care free for a set period, usually 180 days. Any waiting period required by your insurance policy will have to be satisfied or each new benefit period unless the policy has a specific provision to credit you for previous waiting periods.

**Benefit Triggers** These are the conditions you must meet before the policy pays benefits. The 3 most common triggers are:

1. a specified number of ADL limitations (usually 2)
2. cognitive impairment
3. need medically necessary care

Tax qualified LTC plans do not generally allow medical necessity as a benefit trigger since the criteria for tax qualification prohibit it.

**Case Management/Care Management** Some policies may require or offer case management if you need care. A case manager is chosen either by you, your family, your doctor, or by the insurance company. The manager evaluates your need for care and determines the best type of care for your situation. Although insurers may use case management to control costs, it can also be a benefit to you, since managers know what care resources are available in the community and can identify options that others may be unaware of.

**Cash Benefit** Policies paying a Cash Benefit pay a fixed amount while the insured qualifies as disabled, regardless of whether the insured actually receives care. The fixed daily or monthly amount may differ depending on whether the insured is in a facility or in the community. See also Indemnity.

**Chronically Ill** Tax-qualified LTC policies require that an insured be certified as "Chronically ill" by a licensed health care practitioner. This means the insured is unable to perform without substantial assistance at least 2 ADLs for a period of at least 90 days due to a loss of functional capacity. The 90-day requirement does not imply a waiting period for payment of benefits or a period during which services are not considered qualified long-term care services. Tax-qualified policies may therefore pay benefits from the beginning of services, provided the services are expected to be needed for at least 90 days.

**Cognitive Impairment** The deterioration or loss in your mental capacity which requires continual supervision to protect yourself or others. It refers to your impairment in the following areas:

1. your short term or long term memory,
2. your orientation as to person (who you are), place (where you are), time (day, date and year), and
3. your deductive or abstract reasoning.

Tax qualified policies must specify "severe cognitive impairment" as a benefit trigger (see Severe Cognitive Impairment).

**Continence** The ability to control one's urination or bowel movements.

**Contingent Nonforfeiture** Provides nonforfeiture benefits in the event the policy issuer increases premiums on inforce policies. The provisions are triggered by a cumulative percentage increase in premium exceeding a threshold that depends on issue age. For issue age below 30 the trigger is a 200% increase over the initial premium, at age 65 it is 50%, and at age 75 it is 30%. This benefit has been defined by the National Associated of Insurance Commissioners (NAIC) and applies to insured's who choose not to purchase a standard nonforfeiture rider. Once the contingent nonforfeiture benefit trigger occurs, the NAIC Model Regulation provides 3 options to the policyholder:

1. Pay the higher premium for the same coverage
2. Pay the same premium for decreased benefit levels
3. Convert to a paid-up policy with a shortened benefit period.

Contingent nonforfeiture will be required in states that adopt these Model Regulations. Insurers may also offer it where not required by state law.

**Convalescent Care Facility** A skilled nursing facility or an intermediate care facility. Most insurance companies require such facilities to be state licensed or Medicare approved. The facility has to provide the following services:

1. A doctor available in case of emergency,
2. At least one nurse who is always employed full time and a nurse on duty,
3. Methods and procedures for handling and administering drugs and other treatments,

4. Keeping medical records for all patients.

**Coordination of Benefits** If you policy has coordination of benefits then it will pay benefits only after any other insurance policy or government agency has made payment. It will not make payments in addition to other benefits you receive.

**Criminalization** Under the provisions of the Health Insurance Portability and Accountability Act which became law January 1, 1997, persons who knowingly and willfully dispose of assets in order to become eligible for Medicaid payment of long term care expenses are subject to criminal penalties, if doing so results in a period of ineligibility for Medicaid benefits. As modified by the Deficit Reduction Act (DRA) of 2005, the period of ineligibility is now 5 years. Thus, asset transfers during this period could be subject to such penalties. However, subsequent Federal Court Decisions have ruled that the law is unconstitutional and cannot be enforced.

**Custodial Care** Custodial care helps you with the activities of daily living. It is given by people without medical training. Custodial care may involve preparation of meals, help with taking medicines, and other routine activities. Custodial care can be given in nursing homes, adult day centers, or at home. Most LTC policies pay for custodial care in an approved nursing home, and those with home care benefits pay for custodial care at home. Usually, you must meet the policy's disability conditions (such as 2 out of 5 ADL limitation) to get paid custodial care. Policies do not usually cover custodial care given in rest homes, residence homes, or similar living arrangements. Custodial care is usually the costliest LTC, because it is required for longer periods of time.

**Daily Benefit** The amount a policy will pay for a day of care. Often the daily benefit is higher for facility care than for home care. See also Per Diem.

**Deficit Reduction Act (DRA)** This is a law passed in 2005 that significantly tightens the eligibility for Medicaid payment of long-term care services. The law changed the look-back period for asset transfers from 3 years to 5 years. It also changed the calculation of the penalty period for asset transfers with the look-back period. Additional provisions prevent applicants with more than $500,000 in home equity from receiving Medicaid benefits, and allow states not having LTC Partnership programs to create them. The intent of the law was to eliminate or greatly reduce the use of asset transfers such as gifts to children, as a way to become eligible for Medicaid benefits, and to encourage the use of private long-term care insurance instead of Medicaid to pay for long-term care services. Other provisions of the law require that agents receive 8 hours of training before selling the new Partnership loans (or in some states, before selling any LTC policy), that they receive 4 hours of follow-up training every 2 years.

**Dementia** Deterioration of intellectual function due to a disorder of the brain.

**Elimination Period** The time between when you begin receiving care and the policy begins paying benefits. Most policies give you a choice of periods, for example 20, 60, or 100 days. The shorter the elimination period, the sooner the policy begins paying benefits and the more expensive the policy. The period may be different from nursing home care and home care. An elimination or waiting period is like a "deductible" in health or car insurance; it's the part you pay before the insurer starts to pay.

**Exceptions/Exclusions** All policies specify certain situations in which they will not pay benefits. These usually include care: required by war, for intentionally self-inflicted injury, paid by the government, for which no charge is made in the absence of insurance, required by mental illness or nervous disorders, due to alcoholism or drug addiction. Other exclusions frequently used are care received outside the United State and care provided by a family member.

**Extension of Benefits** If you cancel the policy or stop paying premiums while receiving care, the policy will continue to pay benefits for the current care period, up to the lifetime maximum of the policy. This feature usually applies only to nursing home care. Since most policies have a waiver of premium (see) for policy holders receiving nursing home care, it is not necessary to cancel the policy to avoid paying premiums. Extension of benefits is thus of limited value for policies with a premium waiver.

**Free-Look Period** Most states allow you to return a policy within 30 days if you change your mind after buying it, and to get your money back. The process for doing this is described in the policy. To make sure you have this option, get written evidence of when you received the policy. If you decide not to keep the policy, send it back to the insurer with a letter asking for a refund, by certified mail. Keep the mailing receipt.

**Functionally Disabled** You are considered functionally disabled when you have cognitive impairment or are unable to perform a prescribed number of the Activities of Daily Living (ADL) outlined in your insurance policy. For example, your policy may require that you be unable to perform two of these five ADLs to receive benefits: eating, transferring, toileting, bathing and dressing. Some insurance policies require that your treatment must also be medically necessary before they will pay any benefits when you are functionally disabled.

**Future Purchased Option (FPO)** A form of inflation protection where the insured has the right to increase benefits periodically (e.g., annually or every 3 years) to reflect increases in the cost of care. These increases can be elected without providing evidence of insurability as long as the insured is not receiving benefits at the time. In most plans if the insured declines 2 or 3 successive offers of additional coverage, no further chances to increase are available. If additional coverage is purchased, the additional premium is based on attained age, i.e., the insured then-current age.

**Guaranteed Renewable** The insurance company cannot cancel your policy for any reason except you're not paying the premiums. If a policy is guaranteed renewable, it will say so in those exact words. Almost all LTC policies are not guaranteed renewable. If not, the company is not obligated to continue insuring you.

**Hands-on Assistance** This is the physical assistance of another person, without which the disabled individual would be unable to perform an ADL.

**HIPAA** The Health Insurance Portability and Accountability Act of 1996 became law on January 1, 1997. The Act specifies requirements that a long-term care insurance policy must meet in order that premiums paid may be deducted as medical expenses, and benefits paid not be considered taxable income.

**Home Health Aide** A health worker employed by a Home Health Agency, other than a doctor, nurse, or therapist, who provides help at home with activities of daily living, and in some cases homemaker or companion services.

**Home Health Care** This is care provided by a state licensed agency and includes services provided by a nurse, home health aide, nutritionist, or occupational, speech, respiratory, or physical therapist. It does not usually cover services provided by members of your family, special companies, or homemakers. Home health care is not covered by all insurance companies. When it is offered, the services may be covered as part of the long-term care policy, an option or rider available with the policy, or a separate policy.

**Hospice Care** Short-term, supportive care for the terminally ill which focuses on pain management, emotional, physical, and spiritual support for the patient and family. It can be provided at home, in a hospital, nursing home, or a hospice facility. A person is considered terminally ill when their life expectancy is six months or less.

**Incontinence** One of the Activities of Daily Living used to determine the need for tong-term care. Incontinence is the ability to control one's urination or bowel movements (See also Activities of Daily Living).

**Instrumental Activities of Daily Living (IADL's)** These are activities such as using a telephone, shopping, traveling outside the home, taking medications, managing money, preparing meals, doing housekeeping and laundry. Persons unable to perform one or more of these without assistance are said to have an IADL limitation. These limitations may be early warnings of disability requiring long-term care, and evidence of IADL limitations may be used in the underwriting process to deny insurance to an applicant. Some LTC policies include IADL limitation as a benefit trigger for providing home health care benefits.

**Indemnity Benefit** An indemnity benefit is a fixed amount paid when care is received, regardless of the cost of care. A policy with a $100 nursing home indemnity benefit will pay $100 for each covered day in a nursing home, no matter what the nursing home charges. Indemnity benefits require that care be received. See also Cash Benefit.

**Inflation Protection** Because long-term costs can be expected to rise in the future, policies provide Inflation Protection or Benefit Increase Options that increase the maximum daily benefit and the total lifetime benefit each year. Usually, the buyer can choose between Simple and Compound increases. Simple increases add the same dollar amount to the daily benefit each year, typically 5% of the original benefit. Compound inflation protection increases the benefit by a percentage of the current benefit, again usually 5%. Because price inflation is a compound effect, compound protection is more likely to keep up with the cost of care in the long run. Guaranteed Purchase Options allow the insured to increase the benefit in future years for an additional premium. Often the option expires if it is not used for 2 or 3 successive years. Capped increases may also be offered, such as compound inflation with a 2X cap. This means that increases stop when the benefit reaches twice the original benefit. Alternatively, increase may stop after 10 years, 20 years, or some other period.

**Informal Care** Care provided by family or friends is referred to as Informal Care. Some LTC policies provide benefits for informal care. Whether benefits are available may depend on the relationship of the caregiver to the insured, and on whether the caregiver lives with the insured.

**Intermediate Nursing Care** This is care for stable conditions requiring daily but not 24-hour nursing supervision. The care is ordered by a doctor and supervised by registered nurses. Intermediate care is less intensive than skilled care, and usually needed for a longer period of time than skilled care. Virtually all LTC policies pay for intermediate care in an approved nursing home. Policies with home care or Alternative Plan of Care benefits will pay for intermediate care given at home.

**Lifetime Limits** Most insurance companies set a limit on the amount of benefits that a policy will pay. These limits are set in terms of either years or dollars, but not both. You will usually be given a choice of lifetime limits. For dollar limits, the higher the dollar amount that you choose, the more expensive the policy. If the limit is given in terms of years (for example 2, 3, 5, or lifetime) then you choose whether you want coverage for a set number of years or for your lifetime. The longer the period, the more expensive the policy.

**Limited Payment Options** A premium payment option in which the person pays premiums for a set time period, most commonly for 10 years or to age 65. Some plans offer other periods such as 20 years, 5 years, or single payment.

**Long-Term Care (LTC)** LTC is care is needed due to illness or disability, if one is unable to care for oneself, LTC can be given in a nursing home, an assisted living facility, at home, in an adult day-care center, or elsewhere. Formal long-term care is care provided by paid caregivers such as nurses or home health aides. Care provided by family or friends is referred to as Informal Care. Some LTC policies provide benefits for informal care. Not all LTC is long-term; some people may stay in a nursing home for only a month or require home care for a few weeks while recovering from acute illness or surgery.

**Medicaid** Medicaid is the joint federal and state government program to pay medical costs for the poor. Medicaid will pay nursing home and some home care costs if you are disabled, provided that your financial assets and monthly income are below certain allowed levels. If your assets are above the allowed level, you will have to “spend down” your assets to the allowed level before Medicaid will pay for your care. Medicaid pays for about half of all long term care for which payment is made.

**Medically Necessary Care** This is usually defined as care provided in accord with “accepted standards of medical practice” which is required by the patient’s condition, is specified by a “plan of care” written by a doctor or other health professional, and which is not solely for the convenience of the patient or care provider. An insurer requiring that care be “medically necessary” can refuse to pay benefits if you are disabled and need custodial care. Some insurers accept your doctor’s statement that care is medically necessary, while others may review your claim and make their own decision as to whether the care is medically necessary. Medical necessity is a benefit trigger only on non-tax-qualified plans. Thus, it may be more difficult to qualify for benefits under a tax-qualified plan. See also: Benefit Triggers.

**Medicare** The federal government program to provide health insurance for people over 65. While everyone over 65 is eligible for Medicare, it pays for very little long-term care. If you need daily skilled nursing or rehabilitative care in a

nursing home after a hospitalization, Medicare will pay for up to 100 days, but you must bay $148.00 of the daily charge between days 21 and 100 (in 2013). Some private Medicare Supplement (Medigap) policies will pay the copayment for you. Similarly, Medicare will pay for home health care if you are receiving skilled or rehabilitative care, but not for "maintenance" care or help with activities of daily living. Neither Medicare nor Medigap pays for this custodial care, the most common and costly form of long-term care.

**Medigap** Medigap or Medicare Supplement policies are private insurance policies that pay for care that is approved but not paid by Medicare. Typically, Medigap policies pay part or all of the coinsurance and deductibles associated with Medicare coverage. Medigap policies will not pay for services not covered by Medicare.

**Mental and Nervous Disorders** Refers to a mental or emotional disease or disorder of any kind that does not have an organic origin. Both Alzheimer's Disease and senile dementia are considered organic in origin: most insurance companies cover these, and it should say clearly that "Alzheimer's Disease, senile dementia and other organic" brain disorders are covered by the policy. Most insurance policies will not cover "nonorganic" mental and nervous disorders and disorders due to alcohol or drug related problems.

**Nonforfeiture** If you stop paying the premiums on a policy (lapse), it is cancelled. Nonforfeiture is an optional rider providing a residual benefit in case of lapse. Often this is a paid-up policy providing your regular daily benefit for a shortened period (see Shortened Benefit Period). Another form of Nonforfeiture is a return of some part of the money you have paid, called "return of premium" (see Return of Premium). The amount of nonforfeiture benefit depends on how long you have held and paid premiums on the policy. A benefit may also be paid if the policyholder dies while the policy is in force. Contingent Nonforfeiture (see) is a built-in feature giving the insured options in the event of a premium increase. NAIC Model Regulations require this on new policies, so in states that have adopted these regulations, any new policy must have Contingent Nonforfeiture.

**Partnership Policies** The LTCI Partnership program originated in the 1980's and at that time was implemented in 4 states: New York, California, Connecticut and Indiana. The partners were the carriers who wrote policies in those states and the state Medicaid departments. Policies that met the requirements of one of these states allowed buyers to shelter assets from Medicaid, in case they exhausted their LTCI benefits and then became Medicaid beneficiaries. Two forms of asset sheltering are used:

1. Dollar for Dollar allows insureds to keep assets equal to the total dollar benefit paid by the policy they purchased, rather than having to spend down to $2,000 in order to become Medicaid eligible.
2. Total asset protection allows insureds to keep all their assets if they buy a qualifying policy.

Neither choice allows the insured to shelter income from assets, which must be used to pay for long term care expenses, subject to certain Medicaid exclusions. The OBRA 1993 Federal legislation eliminated the Medicaid waiver, stopping any additional states from developing Partnership plans. The Deficit Reduction Act (DRA) of 2005 ended the restriction on Medicaid waivers and allowed states to again develop Partnership plans allowing dollar for dollar sheltering of assets. Qualified plans must meet Federal standards including compliance with the NAIC 2000 Model Act, requirement for inflation protection, and a requirement that policies be Tax Qualified. The inflation protection requirements for new Partnership plans are:

1. Under age 61 – Compound inflation, percentage not specified
2. 61 to 75 – Some form of inflation protection
3. Over 75 – Inflation protection must be offered but need not be purchased.

**Per Diem** The daily benefit a policy will pay. If you buy a LTC policy, you choose the daily benefit. In most cases, the policy will pay charges for care up to the daily benefit. Charges above that amount are your responsibility. A few policies require a "copayment"; that is, they pay a percentage of charges up to the daily maximum, and you pay the rest. A typical copayment is 20%.

**Pre-existing Conditions** Any illness or disorder for which you received treatment before the policy became effective. The "look back period" (how far back in your medical history the insurance company will go prior to the policy's purchase) varies from insurance policy to insurance policy. The shorter the look back period, the fewer conditions in your past will be considered pre-existing. This is important because many insurance policies have a waiting period for treatment of pre-existing conditions.

**Reimbursement** Reimbursement is the standard way that policies pay for long-term care. The insured or a care provider submits a claim for the charges for care delivered, and the claim is paid up to the daily or monthly maximum specified in the policy. A policy might pay "Usual and Customary Charges" for care services rather than actual charges. In this case reimbursement is likely to be lower than actual charges incurred. See also Indemnity and Cash Benefit.

**Residual** If 2 spouses or partners buy policies with a Shared Care rider, each can access the unused benefits of the other person, up to a residual amount, which is reserved for use only by the insured who owns the benefits. Example: a couple buys policies with a 3-year benefit and a shared care rider with a 1 year residual. Either insured can then use up to 2 years of the other insured benefits. i.e., 3 years minus the residual.

**Respite Care** This is care provided by a paid caregiver as a replacement to care you usually receive at home from a relative or friend. Respite care is provided to give relief to the person who normally cares for you without charge at home.

**Restoration of Benefits** A policy may reinstate benefits you have used, after you have not needed care for a prescribed period, usually 180 days. Example: you have a 3-year policy, receive benefits for 1 year, and then need no care for 6 months. The policy then gives you back the year, and you again have 3 years of coverage to use. Restoration of benefits may apply to facility care only, may be included in the base policy, or may be an optional rider. In some cases, only a percentage of the benefit amount you have used is restored.

**Return of Premium** Some policies offer riders that return some or all the premiums you have paid, if you cancel the policy (for example, by not paying) or at your death. The amount they give back is often based on the total you have paid in; minus any claims they have paid you. The amount returned may be a percentage of the net amount you have paid, and the percentage may be higher the longer you have held the policy. Return of Premium is almost always an optional rider. Its cost is usually high.

**Shared Care** Shared care is typically a rider available when spouses or domestic partners both buy policies. With this option, either partner can use the unused benefits of the other partner, up to a Residual amount that is reserved for use only by the partner whose benefit it is. Some carriers offer Joint Policies for which all the policy benefits can be used by either spouse or partner. In this case a Shared Care rider is not needed since the sharing is built in.

**Severe Cognitive Impairment** This is a loss or deterioration in mental capacity that is comparable to Alzheimer's Disease and similar forms of irreversible dementia and is documented by clinical evidence and standardized tests of memory, orientation as to people, places, and time, and deductive or abstract reasoning. Tax-qualified policies must require that cognitive impairment be "severe" in accord with this definition.

**Shared Benefit** Some policies provide a benefit that can be drawn upon by either of two spouses if both spouses hold policies. The benefit is triggered when one spouse uses all the benefits under his/her plan while the other spouse's plan has benefits remaining. This benefit is offered as an optional rider or in some cases as a joint policy covering both spouses. This benefit may also be available to unmarried domestic partners, depending on the insurer.

**Shortened Benefit Period** A Shortened Benefit Period is a benefit provided by a Nonforfeiture rider or by a Contingent Nonforfeiture provision in the base policy. Typically, the benefit creates a paid-up policy with a daily benefit equal to the benefit at the time the policy lapsed or was cancelled. The benefit is provided for a shortened period which is determined by the amount of premium paid before lapse or the number of years in force before lapse. Any claims paid before lapse may be subtracted from premiums paid in determining the maximum amount available under the

Shortened Benefit rider. Usually, the policy must be held at least 3 years before lapse to receive this benefit, and many policies provide that the benefit must be at least 30 times the facility daily benefit.

**Skilled Nursing Care** This is for medical conditions requiring care by skilled medical personnel, such as registered nurses and professional therapists. The care must be available 24 hours a day and is ordered by a doctor, usually in accord with a care plan. Skilled care is often needed only for short periods, such as when recovering from acute illness or surgery. All LTC policies cover skilled care in an approved nursing home. Sometimes skilled care can be given at home by visiting nurses. A policy with home care benefits or Alternative Plan of Care benefits would pay for skilled home care.

**Spend Down** This is a process of spending your savings on long-term care, to qualify for Medicaid benefits. Unmarried people must use up all but $2,000 (not including a primary home, a car, personal effects, and burial expenses) before Medicaid will pay. For couples, the spouse not receiving care can keep some of the joint assets. The amount varies from state to state.

**Standby Assistance** Standby Assistance means the presence of another person within arm's reach of the individual that is necessary to prevent injury while the individual is performing an ADL. It is sometimes referred to as Supervisory Assistance. An example is being ready to catch an individual who may fall getting into or out of a bath or shower.

**Substantial Assistance** Tax-qualified LTC policies must require that a disabled policyholder must need "substantial assistance" in performing at least 2 ADLs in order to receive benefits. "Substantial Assistance" is defined as either "hands-on assistance" or "standby assistance".

**Substantial Supervision** Under a tax qualified LTC policy, an insured with cognitive impairment may receive benefits if he or she requires "substantial supervision." This is defined as continual supervision (such as cuing by verbal prompting, gestures, or other demonstrations) that is needed to protect the cognitively impaired individual from threats to his or her health or safety. An example is the need for someone to be present to prevent the individual from wandering.

**Survivor Benefits** If both spouses have policies, some policies will, on the death of one spouse, convert the policy of the surviving spouse to paid-up status. That is, the surviving spouse need pay no further premiums.

**Tax-Qualified Policies** Beginning January 1, 1997, long-term care policies meeting certain requirements qualify for favorable tax treatment. Buyers of Tax-Qualified (TQ) plans can deduct the premiums if they itemize deductions on their federal tax return. The maximum deductible amount depends on age and is adjusted annually for inflation. Premiums are treated like other health insurance and medical expenses and must total more than 7.5% of adjusted gross income. If total health expenses are less than this amount, premium deductibility will not reduce your tax. Also, benefits received from a TQ plan are not taxed, up to $320 a day (in 2013) for a per diem benefit, while benefits received from a no-TQ plan may be taxable. TQ plans may provide more restricted benefits. Buyers should weigh these restrictions against the tax savings for their situation.

**Toileting** One of the Activities of Daily Living used to determine the need for long-term care. Toileting is the activity of using a toilet to relieve bowels or bladder, with or without assistance (See also Activities of Daily Living.)

**Transferring** One of the Activities of Daily Living used to determine the need for long-term care. Transferring is the activity of getting into and out of bed or a chair. (See also Activities of Daily Living.)

**Waiver of Premium** A provision that you will not have to pay your insurance premiums after a prescribed number of days while you are receiving care. The waiting period for waiver of premium is often 90 days, but the insurer can start counting days with the day you first receive care or the day you first receive benefits. For instance, if you have a 90-day waiver of premium that begins with payment of benefits and you have a 60-day elimination period before benefits are paid, then you will be receiving care for 15- days before the premium is waived. Also, a policy may have different waiver of premium rules for nursing home care and home care or may waive the premium only for nursing home care.