RiverSource

# Long Term Care Insurance Claim Process

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In this guide, you'll find important information related to the following topics:



Are you ready to file a claim under your RiverSource® long term care (LTC) insurance policy (these policy numbers begin with 9100 or 9800 and may also be referred to as a certificate)? Before you begin, we recommend you familiarize yourself with the claim process detailed in this guide. It includes everything you need to know about filing a claim to receive benefits from your LTC policy.

**This process typically takes 60 days from start to finish.**

## What to expect when you file a claim

**1** **Notification of claim**
When you're ready to file a claim, you or someone you trust can call **LTC Claims at the number below**.

**2** **Claim paperwork will be sent to you within 5 business days of your claim initiation**
Complete all required paperwork (including signatures and dates) included in your claim packet.

**3** **You will be contacted to schedule an initial functional assessment within 10 days of your claim initiation**
The initial functional assessment is conducted by an assessing nurse.

**4** **Your claim will be reviewed and the decision will be communicated**
A team will be assigned to evaluate your claim. After reaching a benefit eligibility determination, a member of the team will contact you, or your authorized representative, to discuss the decision.

**5** **Start receiving payments or reimbursements**
If your claim is approved and after any applicable elimination or deductible period has been met, you will start receiving benefit payments. You may need to submit proof of your loss, depending on your LTC plan.

**6** **Change in care**
Call **LTC Claims at the number below** as soon as it is known that a change in care level is expected. A full benefit eligibility review must be completed when your level of care changes.

**Questions?** Contact a LTC Claims service representative at 1-888-320-8741 (or 1-800-541-2251 for New York policyholders). Representatives are available Monday through Thursday, 7:30 a.m. to 5 p.m. Central time, or Friday 8 a.m. to 5 p.m. Central time.


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# Before you File a Claim

Gather all contact information for any care and medical providers.

Care providers may need to meet specific policy criteria; however, obtaining care before initiating a claim is not required.

- RiverSource Life offers a no-cost service to assist in locating providers in your area. For more information contact CareScout directly online at https://elderanswers.carescout.com. To log in, enter the LTC policy number (no dashes or spaces between numbers) and Insured Name, as it appears on your statement.
- Prior to receiving services, the LTC Claims team also offers a provider inquiry to assist in determining if the provider satisfies your policy requirements. For more information on this no-cost service, contact the LTC Claims team.

**When to file a claim**
Deciding when to file a claim varies by person and their unique situation. Generally, you may want to consider filing a claim to receive LTC benefits if you've recently received LTC services or expect to receive services within the next two weeks.

# Filing a Claim

When you're ready to file a claim, you or someone you trust can call **LTC Claims** (contact information is provided on page 1).

**Claim paperwork will be sent to you within 5 business days of your claim initiation**
After you've contacted **LTC Claims** and filed a claim, we will send you all required paperwork that must be completed in order for us to begin reviewing your claim for benefits. We request you complete all paperwork and return it as soon as possible.

An assessing nurse from CareScout or Long Term Solutions will contact you to complete the initial functional assessment (additional details can be found in the next section). After all required information is received in good order, the LTC Claims team will review your claim for benefits.

**Ensure all contact information is up to date**
Please ensure the LTC Claims team has complete and current information for you and/or your authorized representative for the claim (e.g., mailing address and phone number).

You or your authorized representative are the only individuals who have access to your personal claim information (health and financial). If you have a Power of Attorney, please ensure the required documentation is provided to the Claims team.

# Initial Functional Assessment

The initial functional assessment is conducted by an assessing nurse. The nurse will assess your functional abilities, cognitive status, personal needs and environment in order to assist us in determining your benefit eligibility. Please plan to have a family member or caregiver present during this assessment.

**To ensure the assessment moves smoothly, have the following documents and information readily available:**

- Two forms of photo identification (driver's license, ID card, passport);
- Names and phone numbers of all primary care and treating physicians;
- A list of all current medications, including dosages;
- Names and contact numbers for any current caregiver(s); and
- Medical history, such as hospital confinement dates, procedures and diagnoses.

Following the assessment, the information obtained during the assessment will be provided to a Care Coordinator who will then summarize it and forward the information to the LTC Claims team.

In some cases, where required by the policy, the Care Coordinator will develop a personalized Plan of Care (POC) for you. The POC is a written individualized plan for the services you may need, the hours of care needed per week, and what, if any, special equipment you may need. In developing the POC, the Care Coordinator focuses only on your health and well-being, and does not consider the benefits available in your policy. Therefore, it is important to understand the following:

- Because a service is included in a POC does not mean it is covered by your policy.
- Because something is included in a POC does not mean you are obligated to make use of the service or item.

The Care Coordinator can also help identify resources, such as home health agencies and assisted living facilities, and can make suggestions for your specific care needs. If required by the policy, the Care Coordinator may provide a Chronically Ill Certification.

**Please note:** If you reside in a nursing home or are receiving hospice services, a Care Coordinator may contact your care provider directly to obtain the information needed to assess your care needs.

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# Eligibility Review Process

After the initial functional assessment is complete, a team will be assigned to evaluate your claim.

During the eligibility review process, this team will do the following:

- Work with you, or your authorized representative, and care providers, to gather all required documentation.
- Review the documentation received and complete an evaluation of the LTC Benefits you wish to access and coverage limits.
- Contact you, or your authorized representative, to review their decision regarding your claim for benefits and help answer any related questions.

**Please note: Active claims may require additional ongoing eligibility evaluations. You and/or your provider may periodically be evaluated to ensure that the benefit eligibility requirements are still being met. These reevaluations are based on policy type, policy form and the state which issued the original policy.**

**Periodic reviews**
We will periodically review your claim to confirm your level of care and that you continue to satisfy the eligibility requirements of the policy.

# Reimbursement vs Indemnity Policies

**Do you have a Reimbursement or Indemnity policy?**
It is important to know the type of policy you have because the claim's evaluation and benefit payment process may differ. You can confirm which type of policy you have by referring to the section of your contract where we explain how benefits are paid.

**Reimbursement**
With a **reimbursement policy**, benefit payments are reviewed based on the billing invoices submitted for covered LTC expenses according to a Plan of Care (if applicable), and then reimbursed *up to* the policy's coverage limits.

Typically, benefit payments are made within 20 business days of receipt of in good order bills. Payments are made directly to you or a Provider designated by an acceptable Assignment of Benefits.

**Indemnity**
With an **indemnity policy**, benefit payments are paid in an amount *equal* to the applicable benefit upon confirmation that you received covered care and services. Please note, if you purchased a home care rider with your Indemnity policy, benefit payments subject to that rider are reviewed based on the reimbursement payment process previously described.

Benefit payments are typically made within the first 10 business days of the month, upon receipt of the Confinement Form that is completed by the facility. In the event we do not receive the Confinement Form within the first 10 business days of the month, we will contact the facility directly to verify continuous facility confinement.

**Before payment of covered expenses under your claim, it must be verified that your claim:**

- Meets all the benefit eligibility and LTC provider requirements set forth in the policy; and
- Satisfies any applicable elimination or deductible period.

# Benefit Payments

If your claim is approved and after any applicable elimination or deductible period, has been met, you will start receiving benefit payments or reimbursements (depending on your LTC plan). **It's important that you continue to pay your premiums until we inform you otherwise.**

- Reimbursement policy: You, your authorized representative, or your care provider must submit billing invoices to us for LTC services or items you received.
- Indemnity policy: A claim associate will contact your care provider to confirm that you received covered LTC services.

**Elimination or Deductible Period**
The elimination or deductible period is a period of time in which expenses for covered care and services will not be reimbursed. This period of time is referenced in the 'Schedule' section of your LTC contract that was chosen by you when you purchased your LTC policy.

When required by the policy, an elimination or deductible period *must* be met before benefit payments will begin. You will need to submit invoices to establish you have satisfied your elimination or deductible period. After any applicable elimination or deductible period, has been met, and while you remain benefit eligible, benefit payments will begin. The initial benefit payment is usually processed within 30 business days of meeting the elimination or deductible period.

For more information related to your elimination or deductible period, call **1-888-320-8741** (or **1-800-541-2251** for New York policyholders).

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**For reimbursement policies, you may submit billing invoices through email**

The fastest way to submit invoices is by emailing them to the following email address. Please include the claim number in the subject line of the email and ensure the updated document(s) are formatted as a PDF or TIF.

- For billing invoices: LTCInvoices@ltc-claims.com
- For other forms or documents: LTCDocuments@ltc-claims.com

**Benefit Payment Review**

- Reimbursement Policy: During each benefit payment review, the claim associate will consider the services or items submitted for reimbursement, as well as the available coverage and your Plan of Care. Covered expenses are then reimbursed up to the policy's coverage limits.
- Indemnity Policy: During each benefit payment review, the claim associate confirms the services received, as well as the policy's available coverage, then issues a benefit payment in an amount equal to the applicable benefit. Please note, if you purchased a home care rider, benefit payments subject to that rider are reviewed based on the reimbursement payment process as described on the previous page.

## Change in Care

When your level of care changes (e.g., move from a facility to home, home to a facility, or a change in care levels from skilled nursing to assisted living or vice-versa), a full benefit eligibility review must be completed to determine if you continue to satisfy the eligibility requirements of the LTC policy.

To avoid delays, you or your authorized representative should call LTC Claims at **1-888-320-8741** (or **1-800-541-2251** for New York policyholders), as soon as it is known that a change in care level is expected. This call will ensure that the LTC Claims team is made aware of the change in your care, which will initiate the eligibility review process.

Upon contacting the LTC Claims team at the number above, the Customer Service Representative will obtain the necessary information related to your new location and/or care needs. The claim associate will request any required information needed to complete the review, which may include:

- Onsite Functional Assessment Interview
- Provider information

The LTC Claims team *typically* makes a claim decision within 30 days of receiving all required information needed to complete the evaluation process. However, if the claim associate is unable to reach a decision, or if additional information is needed, you will receive periodic communications outlining the remaining information required to complete the review.

You can help the eligibility review by ensuring the LTC Claims team has complete and current information, and by being available for questions.

After reaching a benefit eligibility determination, the claim associate will contact you, or your authorized representative, by letter or telephone to discuss the decision made and to answer any related questions.

## Closing a Claim

Claims may be closed for various reasons, including your recovery, claim withdrawal, death, or exhaustion of benefits.

To discuss the claim closure process, you or your authorized representative should call LTC Claims at **1-888-320-8741** (or **1-800-541-2251** for New York policyholders). At the time of the call, the Customer Service Representative will discuss the claim closure process, and any impacts of closing the claim.

The LTC Claims team *typically* makes a final benefit payment, if applicable, within 30 days of receiving a request to close a claim. However, if a final benefit payment is not required, or if additional information is needed, the claim associate will send written communication outlining the claim's status.

**Recovery**

If you recover and no longer require covered LTC services, you should contact the LTC Claims team to discuss your care needs.

**Withdrawal**

If you are benefit eligible, but choose to no longer access your LTC benefits, you may contact the LTC Claims team to request a claim withdrawal.

**Benefits Exhausted**

While you remain benefit eligible, and continue to receive covered LTC services, benefit payments will continue to be processed until the policy's coverage limits have been reached.

**Death**

The loss of a loved one is a difficult time. Therefore, to avoid delays in processing any outstanding benefit payments, your authorized representative should mail or fax us a copy of your death certificate, if accessible, to:

RiverSource Long Term Care
70100 Ameriprise Financial Center
Minneapolis, MN 55474

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Fax: 612.547.0256

**Please note:** At the time of death, any remaining benefits that are due and owed for covered expenses are generally paid to the Insured's Estate. If no Estate is set up, please contact us to discuss payment options.

## Questions?

Contact a LTC Claims service representative at 1-888-320-8741 (or 800.541.2251 for New York policyholders). Representatives are available Monday through Thursday, 7:30 a.m. to 5 p.m. Central time or Friday, 8 a.m. to 5 p.m. Central time.



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