



A GUIDE TO THE LONG-TERM CARE CLAIM PROCESS

Thrivent is committed to making your claim experience as smooth and stress-free as possible. Call our Customer Care Center to begin the claim process.



GETTING STARTED

A Thrivent customer care professional will answer your questions about the types of long-term care benefits that are included in your contract and explain the benefit eligibility criteria. Most contracts define this eligibility in terms of the assistance you need with **activities of daily living (ADLs)** due to a physical impairment, or assistance needed because of a cognitive impairment. Details about benefits and eligibility requirements can be found in your contract.

Relatives share responsibility with Durable Power of Attorney

If family members or friends will be helping you manage your claim, we will need your authorization to discuss the contract and claim details with them. This authorization might be a **Durable Power of Attorney for Finances**. Send a copy of your Durable Power of Attorney for Finances document to Thrivent.

NOTE: Your contract may have an elimination period. A claim does not need to be filed until the elimination period has been met.

Activities of daily living may include bathing, dressing, eating, transferring in and out of a bed or chair, toileting, continence and walking. These will be listed in your contract.

What's needed to file a claim on my behalf?

Anyone can initiate the claim process on behalf of the insured, as long as they have identifying information, including:

- Insured's name and date of birth.
- Thrivent member ID number or the long-term care contract number.

Need an extra copy of your contract?

If you need a copy of your long-term care contract, ask your claims coordinator to mail a duplicate contract to you or to the person you designate.

Customer Care Center: 800-847-4836

To initiate a claim, say "directory" and then say or enter 3166.

To check the status of a claim, say "directory" and then say or enter 6316.

Monday through Friday, 7 a.m. to 6 p.m., Central time.

WHAT YOU'LL NEED

In order to process a claim, your claims coordinator will need to gather the following:

- **Claimant Information**

We will ask you for the name, address and phone number of current and past facilities or agencies that have provided you care.

- **Provider Information**

We will request information from your provider(s) to determine benefit eligibility. This will include the type of care provided, start and end dates of care, and any time you may have been out of the facility.

To help expedite the process, there may be times when additional information is required. In these cases, Thrivent may order an onsite **Benefit Eligibility Assessment (BEA)**. This assessment will be conducted by a registered nurse and take place at no additional cost to you. We will make you aware if a BEA is necessary.

CLAIM REVIEW AND DECISION

Your claims coordinator will be responsible for obtaining the information needed to complete the claim review. If we are awaiting information needed to review your claim, your claims coordinator will follow up with both you and your providers. Once we have all of the information needed to determine benefit eligibility, your claims coordinator will call you with the decision and a letter will also be mailed to you.

How long will my claim take to process?

To expedite the handling of your claim, please be prepared to provide all required information when you speak with your claims coordinator. Claims are reviewed in the order they are received. A large portion of time is confirming the care you are receiving from your provider. Your claims coordinator will be able to provide you with a timeframe for review of your claim.

CLAIM MAINTENANCE

If your claim is approved, you will transition from working with your claims coordinator to working with a Thrivent staff member who is skilled in assisting with claim maintenance, such as care changes and ongoing payments.

Each time Thrivent processes a claim, we will mail a **Claim Payment Summary** to the contract owner. This will include the number of care days that have been applied toward the elimination period or qualifying days, the benefits paid to date, the dates of service, and the service type. The letter may also include additional notes to inform you of any claim adjustments or items that require action on your part.

Submit documents to:

Fax:

800-225-2264

Attn: LTC Claims

U.S. Mail:

Attn: LTC Claims

Thrivent

4321 N. Ballard Rd.

Appleton, WI 54919-0001

We require information from your care providers in order to apply all days of eligible care toward your contract's **Qualifying Days (QD)** or **Elimination Period (EP)**, if your claim is approved. Similar to a deductible on auto, home or health insurance, benefits will not be payable until you have met your contract's QD or EP.

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How are payments processed?

To process payments for a residential facility claim (nursing home or assisted living facility, for example), Thrivent may need monthly detailed billing statements, depending upon the contract you own. To process home health care claims, we may need both detailed billing statements and daily care notes.

Depending on the terms of your contract, we will periodically request a Care Review from your provider to verify that you are continuing to receive eligible long-term care services. If we do not receive this updated care information from the provider in a timely fashion, your claim benefit payments may be delayed. If there is a delay in receiving the Care Review from your provider, we will let you know so you can follow up with your care provider, if necessary.

Claim payments can be sent to you by check or direct deposit. If you so choose, payments can be sent directly to certain care providers. A claims coordinator can provide the instructions.

Can I change providers?

You have the option to change care providers at any time, for any reason. Thrivent will request information from your new provider to verify that you are continuing to receive eligible long-term care services. Please call Thrivent to report any change in providers.

How long will it take for my payment to go through?

After the elimination period or qualifying days requirement has been met, **indemnity contracts** (see below) pay 30 days of benefits every 30 days. Monthly billing statements are not required.

After the elimination period or qualifying days requirement has been met, **expense reimbursement contract payments** are made at the end of the month as long as we have received the detailed billing statement for that month if required.

How are payments determined?

If your claim is approved, our letter will:

- Advise you if we need ongoing care bills and daily care logs.
- Verify the mode of benefit payment you have elected (check, direct deposit, assignment to care provider).
- Explain that benefits are payable after the contract's elimination period or qualifying days requirement has been met.
- Explain the Premium Waiver benefit (see next page), if applicable.
- Advise you to contact Thrivent if you are out of the care facility for any reason, such as a visit with family or for hospitalization.

If your claim is denied, our letter will:

- Explain the benefit eligibility criteria in your contract and the information we reviewed regarding the care you are currently receiving.
- Explain that if your care needs change, we will review any updated written documentation submitted for review of benefit eligibility.

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Payments are based on the licensing of the facility, and the care received in that facility. Some contracts pay a different benefit amount for care received in a nursing home versus in an assisted living facility.

Expense reimbursement contracts pay the actual charge incurred (or appropriate percentage) for covered long-term care services, up to the daily maximum benefit.

Indemnity contracts pay the selected daily benefit amount regardless of the actual cost of care.

Call us in the event you:

- Are out of the care facility overnight for any reason, such as a visit with family or a hospitalization.
- Change care providers or stop receiving care.

Do you have a Premium Benefit Waiver?

If you are receiving care in a residential facility, such as a nursing home or assisted living facility, your contract may include the Premium Waiver benefit. This benefit waives premium payments after 90 consecutive days of care.

We advise that you continue to pay your premiums until you receive a letter from Thrivent verifying that the premium waiver has been established.

Depending on the terms of your contract, this letter may include a refund check for premiums due and paid while you were receiving eligible care.

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