



A guide to the long-term care claims process

Thrivent is dedicated to helping clients through life's most difficult moments. To guide you on this part of the journey, you'll have a Thrivent claims coordinator by your side.

Your claims coordinator will ask you for some information about the care you or your loved one has received. Then we'll gather information from your providers and put all this information to work to review your claim efficiently and effectively.

Getting started

When you're facing changes in your health needs, you'll have questions about your long-term care insurance coverage. The Thrivent claims coordinator team can get you answers. They'll discuss with you the benefits included in your contract and explain eligibility criteria.

Most contracts define eligibility in terms of the assistance you are receiving with **activities of daily living (ADLs)** due to a physical impairment, or the assistance you are receiving due to a cognitive impairment. Details about benefits and eligibility requirements can be found in your contract.

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.

Sharing responsibility for making claims

Anyone can initiate the claims process on your behalf, as long as the person has your identifying information, including:

- Name and date of birth.
- Thrivent ID or the long-term care insurance contract number.

If family members or friends will be helping you manage your claims, we will need your authorization to discuss with them the contract and claim details. One way to provide authorization is to use a **Durable Power of Attorney for Finances form**. If you have one, please send us a copy.

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.

How the claims process works

Your claims coordinator will obtain the information needed to complete the claim review.

In addition to gathering information from you about your claim, we'll need the names, addresses and phone numbers for your providers.

We'll request information from your providers too, including the type of care they provided, start and end dates, and a list of times you were out of the facility.

To help streamline the process, we may need to conduct a Benefit Eligibility Assessment (BEA). This assessment will be conducted by a registered nurse and at no additional cost to you. We'll contact you if a BEA is necessary.

Alerting you to claim decisions

Your claims coordinator will be pulling all the information together and will call you when a decision is made. We'll mail you a letter, too.

It's hard to say exactly how long the process will take to gather the needed information. Your claims coordinator will be able to provide you with a time frame.

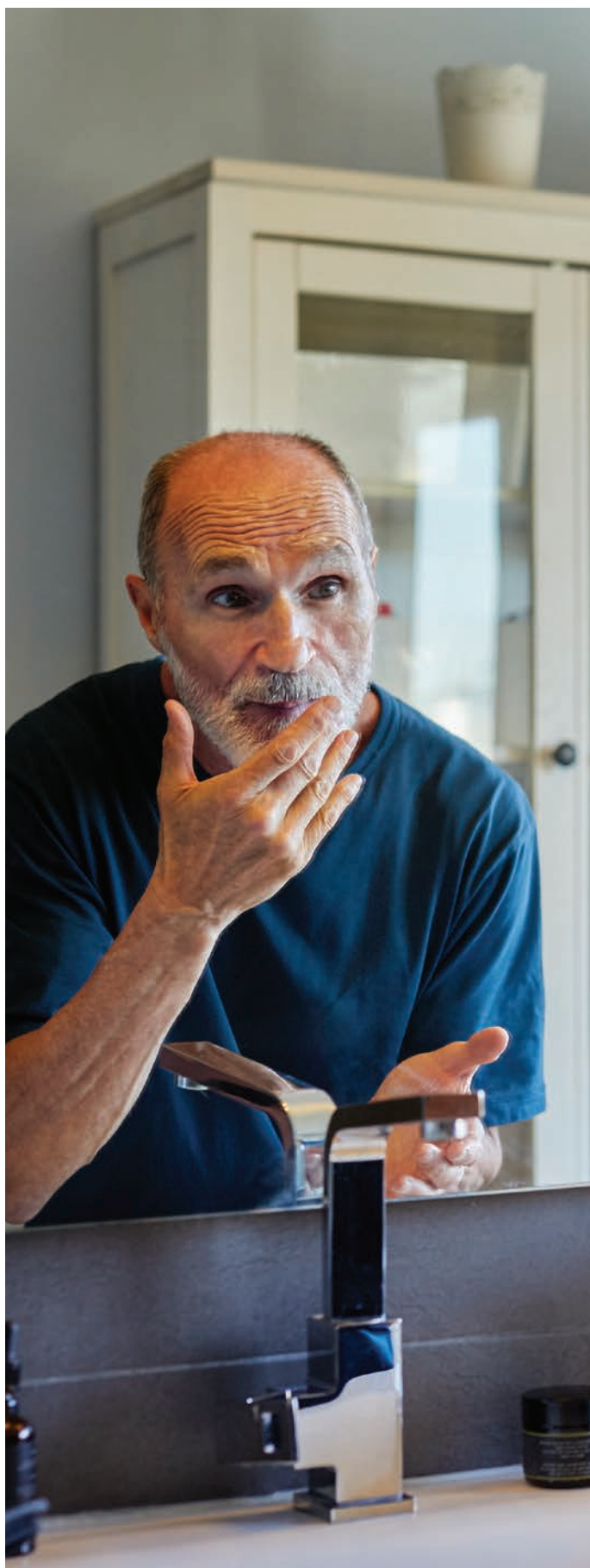
Ongoing support

If your claim is approved, you will start working with a Thrivent professional skilled in assisting you with ongoing payments and care changes.

Each time we process a claim for you, you'll receive a Claim Payment Summary that includes:

- Number of care days applied toward the elimination period or qualifying days.
- Benefits paid to date.
- Dates of service.
- Service type.

The letter may also include a note about claims adjustments or items that require action from you.



Answers to your questions

How are payments determined?

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. Benefits for home health care are also paid at a different rate.

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.

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. To process home health care claims, we may need both detailed billing statements and daily care notes.

We may periodically request a Care Review from your provider to verify you are continuing to receive eligible long-term care services. If we do not receive this information in a timely fashion, your claim benefit payments may be delayed. We'll let you know about delays 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 like, payments can be sent directly to certain care providers. A claims coordinator can provide instructions.

How long will it take for my payment to be processed?

After the elimination period or qualifying days requirement has been met, indemnity contracts 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.

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 you are continuing to receive eligible long-term care services. Please call Thrivent to report any change in providers.

What changes should I alert Thrivent to?

Call us when 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.

If your claim is approved, our letter will:

- Advise you if we need ongoing care bills and daily care logs.
- Verify the benefit payment method you've chosen (i.e., 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, 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 not eligible for approval, 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 changes, we will review your updated written documentation.

Do you have a Premium Waiver benefit?

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.

Thrivent Client Care Team

Remember, you have a team on your side to guide you through the long-term care claims process.

800-847-4836

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

To initiate a claim, say “Health insurance,” “Claim,” and then “Initiate a claim.” Or you can call the Long-Term Care claims initiation line directly at 920-628-6715.

To check the status of a claim, say “Health insurance,” “General policy questions,” and then enter 2. Or you can call the Long-Term Care claims status line directly at 920-628-6716.

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 so we can 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 health, home or auto insurance, benefits will not be payable until you have met your contract's QD or EP.

