securian FINANCIAL®

SecureCare™ IV

**Long-term care and nonparticipating whole life insurance policy**

Insurance products issued by:
Minnesota Life Insurance Company

# SecureCare: How it works

## Claims process

The claims process described here applies to SecureCare IV. Please note: in many cases, the individual whose health determines their eligibility for a claim (the insured) is also the person to whom the claim is paid (the policyholder or legal representative, also known as the claimant; however, this is not always the case. For those situations in which the claimant and the insured are two different individuals, this document helps outline the requirements of each party during the claims process.

### Claim service and support

Our care management program is designed to provide all SecureCare policyholders with claims and care management support throughout the life of their policy.

If the insured is uncertain whether they meet the criteria to qualify as chronically ill and may be eligible for benefits, care management is here to help. They can clarify the policy's benefit-eligibility requirements, explain the claims process, and, when appropriate, assist the insured and/or policyholder in initiating a claim.

If the policyholder would like help finding care service options that are potentially available in their area, we can provide a list of local caregiving services and providers. It's important to note that this list is meant to help policyholders and/or their loved ones research available options and compare alternatives – it's not an exhaustive and/or exclusive list of all services/providers in their area. Additionally, as a cash indemnity policy, the policyholder may utilize any service provider they choose once they are eligible to receive benefits.

### How to start a claim

If the insured believes they may be eligible for benefits based on their medical condition, either the claimant or financial professional can call, mail or fax a request to initiate a Request for Benefits from care management and begin the claims process. At that time, the insured's name and policy number are required.

### Contact Information

**Call:**
1-888-405-5824

**Fax:**
952-833-5384

**Mail:**
P.O. Box 64935
St. Paul, MN 55164-0935

## Claim intake process

1. If the claimant calls in, we will conduct a claim intake interview immediately. If the claim is initiated by mail or fax, care management will attempt to make two outbound calls to the claimant within two business days of a Request for Benefits.

If the interview cannot be completed, we will mail a letter to the claimant to request a call to complete the intake process. The goal of the intake process is to:

a. Understand the basis for the claim.

b. Educate the claimant on the policy's benefits and eligibility requirements.

c. Reach a consensus on whether the claims process should move forward.

2. Within two business days of completing the claim intake call, a letter will be sent to the claimant.

This letter will either:

a. Confirm the claims process will not proceed, or

b. Acknowledge the claims process will proceed and request completion of all claims forms, including the proof of claim (more information below). All claims forms must be signed by the claimant.

i. When all required information is received in good order, we will make a decision within 10 business days.

ii. If care management has not received the requested proof of claim information within 30 days, we will follow up. Follow-ups continue at 60 and 90 days. At 90 days, the claim will be closed.

## Proof of claim and chronic illness certification

We utilize a network of licensed health care practitioners who review proof of claim to certify the insured as a chronically ill individual.

In order to make this determination, the insured's proof of claim needs to include detailed, written documentation that satisfactorily describes and confirms the insured is a chronically ill individual and is prescribed care covered by this policy. The insured's proof of claim may include, but is not limited to:

- confirmation of the certification of chronic illness by a licensed health care practitioner;
- copies of medical records;
- copies of the licensed health care practitioner's daily notes of care;
- copies of the insured's original and current plan of care.

If the insured does not have extensive medical documentation detailing their physical or cognitive abilities, or if the submitted proof of claim documentation is otherwise insufficient for care management to determine if the insured meets the definition of a chronically ill individual, then we will schedule a phone assessment or home visit to gather the information needed to complete our review.

**It is important to note that the insured can have a chronic illness but may not meet the definition of being chronically ill.**

Chronically ill means an individual who has been certified by a licensed health care practitioner within the preceding 12-month period as:

- being unable to perform, without substantial assistance from another person, at least two Activities of Daily Living (ADLs) due to a loss of functional capacity for a period of at least 90 days; or
- requiring substantial supervision to protect the insured from threats to health and safety due to severe cognitive impairment.

### Claim decision

1. Once a claim decision is made, care management will attempt to contact the claimant by phone.

   a. If the call is not answered, a voicemail will be left. No personal medical information will be included in the voicemail.

   b. Regardless if the claimant has returned the call, a letter detailing the decision and additional information will be mailed to the claimant within two business days.

2. **If the claim is denied,** a denial letter will be mailed to the claimant and will include an appeals process to follow if they disagree with the decision.

   a. Appeals must be received in writing within 30 days of receipt of the decision. This notification must state the reasons for disputing the decision as well as documentation to support the request. (No special form is required.)

   b. Generally, based on this information, a decision will be made within 10 business days of receiving an appeal request. If more time is required, a letter will be sent within seven business days to the claimant, acknowledging receipt of the request and advising that additional time is necessary.

3. **If the claim is approved,** an Episode of Benefit based on the likelihood for recovery will be established, and we will assign a care manager to the claim to serve as a constant point of contact for the claimant.

   a. A three-month Episode of Benefit will be established for conditions that have a high likelihood of recovery.
   - Examples: broken bone or joint replacement

   b. A six-month Episode of Benefit will be established when a disability is linked to a primary diagnosis or disease that has an unpredictable course. If there is no improvement by the end of six months, the Episode of Benefit period may be set to 12 months going forward.
   - Examples: Angina or Graves' disease

   c. A 12-month Episode of Benefit will be established when a disability is linked to one or more chronic, debilitating diagnoses or diseases as a result of which the claimant has a low likelihood of recovery.
   - Examples: Alzheimer's disease or other forms of dementia

   d. The care manager will work with the claimant to develop a Plan of Care that best fits the insured's needs. If the policyholder requests assistance finding services in their area, their care manager can give them a list of local providers (see "Claim service and support" on page 1 for more information).
   **Please note: while the Plan of Care will recommend levels of care and services for the insured based on our review of the claim, the type of care the insured actually receives is not enforced.**

## What are Activities of Daily Living (ADLs)?

Activities of Daily Living are essential and routine tasks of daily life that people do every day without receiving substantial assistance from another person. There are six ADLs:

- Eating
- Bathing
- Getting dressed
- Toileting (using the bathroom)
- Transferring (example: moving from a bed to a chair)
- Continence (controlling bladder and bowel)

## Recertification process

1. Recertification is required at the end of the insured's Episode of Benefit. The claimant's care manager will assist in gathering the necessary information (including scheduling a follow-up with our network of licensed health care practitioners, if needed) to verify the insured is still chronically ill.

   a. Information required will vary based on the insured's condition. For example, permanent conditions such as Alzheimer's disease or dementia may require less information compared to conditions with a higher likelihood of recovery.

      i. If we determine the insured is no longer chronically ill, benefit payments will stop. An appeals process, as previously described, will be available if the claimant disagrees with the decision.

   b. In the event that the insured's condition or care needs have changed, the care manager will review and update the insured's Plan of Care.

      i. The claimant should notify their care manager immediately if the insured's condition changes.

## Benefit payments

1. Benefit payments will be made once the insured has met all the benefit eligibility requirements.

2. The insured's first payment will be a lump sum equal to four months of long-term care benefits. This includes the first month of benefits plus retroactive payments for the 90-day elimination period. The regular monthly benefit will then continue each month while the insured is on claim.

The claimant may choose to decline retroactive benefit payments by selecting this option on the proof-of-claim form. If this option is elected, the claimant will receive only one month of benefits and will continue to receive ongoing benefits as long as eligibility requirements are met. Please note that once this election is made, the insured cannot request retroactive benefits at any later point during the claim. The benefits will remain as part of the total benefit pool received by the claimant.

3. The claimant may request a monthly benefit amount anywhere between the available minimum and maximum monthly benefit.

   a. This amount can be changed each month at the claimant's request. Notification of a change must be received 10 days before the next benefit payment is processed.

4. If included in the insured's Plan of Care, Caregiver Training and Home Modification benefits may be paid, if requested, prior to the satisfaction of the elimination period. After the elimination period, the claimant may use benefits as they see fit to meet the needs of the insured.

### The benefit payment eligibility requirements include the following:

- the insured must be certified as a chronically ill individual; and
- the insured must be prescribed qualified long-term care services covered under this agreement which are specified in a Plan of Care; and
- the Plan of Care must be submitted to us; and
- the long-term care 90-day elimination period must be satisfied (must only be satisfied once while the contract is in force);
- and the agreement must be in force.

5. If the insured goes on claim before the premium schedule has been completed, they may either choose to continue making their premium payments or stop paying and go into a reduced paid-up[1] status.

a. In the event the claimant decides to go into reduced paid-up status, new data pages will be mailed to the claimant detailing the new policy values.

i. A policy with the Long-Term Care Inflation Protection Agreement will continue to inflate based on the new maximum monthly benefit, even after going to reduced paid-up.

Please note: Loans are not available while the insured is on claim.

## Benefits outside of the United States

1. All qualified services, including informal care, are available for the entire long-term care benefit amount.

2. The maximum payable amount each month is 100 percent of the monthly maximum benefit. This amount will continue to increase if the inflation agreement is included.

3. The claim intake and decision process for claims outside the United States follows the same process as that listed above. If the claimant resides outside of the U.S., they are not required to return to the U.S. for certification; however, the licensed health care practitioner providing the certification must be licensed to practice in the U.S. The written notice of claim and proof of claim must be translated to English at no cost to Securian Financial.

All benefit payments will be paid in U.S. currency to U.S. banks.

## Upon the insured's death

1. If the insured dies before receiving any benefits, beneficiaries will receive the policy's death benefit.

2. If only a portion of the available long-term care benefits has been accelerated prior to the insured's death, the beneficiaries would receive the remainder of the death benefit.

3. If enough long-term care benefits have been paid and the death benefit is exhausted, the beneficiaries will receive the guaranteed minimum death benefit, which is the lesser of 10 percent of the base face amount or $10,000.

4. Once we are notified of an insured's death, we will send the owner a claim form and request a copy of the death certificate.

a. It is important to notify us of a death immediately in order to avoid overpayment of any long-term care benefits. Securian Financial has the right to recover any overpayment. Therefore, overpaid amounts must be returned.

b. Any claim (long-term care or death) within the first two years of the policy will be reviewed as a part of the normal contestability review process.

1. Reduced paid-up benefits refers to the reduced paid-up nonforfeiture benefit that purchases paid-up insurance in the event of premium lapse.

Please keep in mind that the primary reason to purchase a life insurance product is the death benefit.

Insurance policy guarantees are subject to the financial strength and claims-paying ability of the issuing insurance company.

Qualified long-term care services received outside the United States, its territories or possessions are limited to the non-United States monthly benefit limit. If the insured returns to the United States, the non-United States monthly benefit limit will no longer apply.

Agreements may be subject to additional costs and restrictions. Agreements may not be available in all states or may exist under a different name in various states and may not be available in combination with other agreements.

SecureCare refers to a line of hybrid life/long-term care insurance products issued by Minnesota Life Insurance Company, including SecureCare Universal Life, SecureCare III and SecureCare IV, which are non-participating whole life policies with long-term care. SecureCare (including SecureCare Universal Life and/or SecureCare III and/or SecureCare IV) may not be available in all states. Product features, including limitations and exclusions, may vary by state. SecureCare products contain qualified long-term care agreement(s) that cover care such as nursing care, home and community-based care, and informal care as defined in those agreements. These agreements provide for the payment of a monthly benefit for qualified long-term care services. These agreements are intended to provide federally tax qualified long-term care insurance benefits under Section 7702B of the Internal Revenue Code, as amended. However, due to uncertainty in the tax law, benefits paid under these agreements may be taxable. Additionally, SecureCare products may contain other additional agreements, which may be subject to additional costs and restrictions, and may not be available in all states or exist under a different name in various states.

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Policy form numbers: ICC20-20212, 20-20212 and any state variations; ICC21-20220, 21-20220 and any state variations; ICC21-20221, 21-20221 and any state variations; ICC21-20222, 21-20222 and any state variations; ICC21-20223, 21-20223 and any state variations.

Insurance products are issued by Minnesota Life Insurance Company in all states except New York. In New York, products are issued by Securian Life Insurance Company, a New York authorized insurer. Minnesota Life is not an authorized New York insurer and does not do insurance business in New York. Both companies are headquartered in St. Paul, MN. Product availability and features may vary by state. Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

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