Securian FINANCIAL®

SecureCare™ III
Long-term care and nonparticipating whole life insurance

Insurance products issued by:
Minnesota Life Insurance Company

SecureCare III: How it works

Claims Process

Please note: in many cases, the person whose health determines their eligibility for a claim (the insured) and the person to whom the claim is paid (the policyholder or legal representative, also known as the claimant) are the same individual, but not all. For those situations in which the claimant and the insured are 2 different individuals, this document helps outline the requirements of each party during the claims process.

Claim service and support

Securian Financial's Care Management Program™ (Care Management) is designed to provide all SecureCare III policyholders with claims and care management support throughout the life of their policy.

If the insured is unsure if they qualify as chronically ill and may be eligible for benefits, Care Management can help explain the policy's benefit eligibility and claims process and, if appropriate, help the insured and/or policyholder initiate the claims process.

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 (RFB) 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 2 outbound calls to the claimant within 2 business days of an RFB.

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 2 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 chronically ill 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 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 2 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 2 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 7 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 (EOB) 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 3-month EOB will be established for conditions that have a high likelihood of recovery.
   - Examples: broken bone or joint replacement

   b. A 6-month EOB 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 6 months, the EOB period may be set to 12 months going forward.
   - Examples: Angina or Graves' disease

   c. A 12-month EOB 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 (POC) 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 POC 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 6 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 EOB. 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 POC.

      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 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.

3. If included in the insured's POC, 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.

4. 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 (RPU)[1] status.

   a. In the event the claimant decides to go into RPU 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 RPU.

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

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 POC; and
- the POC must be submitted to us; and
- the long-term care elimination period must be satisfied (must only be satisfied once while the contract is in force);
- and the agreement must be in force.

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

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 50 percent of the monthly maximum benefit. This amount will continue to increase if the inflation agreement is included.

   a. Example: if the insured has a 4-year long-term care benefit period (2-year acceleration and 2-year extension of benefits agreement), the total benefits will be paid out over 8 years.

3. The claim intake and decision process for claims outside the United States follows the same process as claims made within the United States with one exception: all proof-of-claim documentation must be in English or must be translated by a professional translation service, at the claimant's expense.

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 have 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 (LTC or death) within the first 2 years of the policy will be reviewed as a part of the normal contestability review process.

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 III may not be available in all states. Product features, including limitations and exclusions, may vary by state.

SecureCare III may not cover all of the costs associated with long-term care or terminal illness that the insured incurs. This product is generally not subject to health insurance requirements. This product is not a state-approved Partnership for Long Term Care Program product, and is not a Medicare Supplement policy. Receipt of a long-term care or terminal illness benefit payment under this product may adversely affect eligibility for Medicaid or other government benefits or entitlements.

The death proceeds will be reduced by a long-term care or terminal illness benefit payment under this policy. Please consult a tax advisor regarding long-term care benefit payments, terminal illness benefit payments, or when taking a loan or withdrawal from a life insurance contract.

SecureCare III includes the Acceleration for Long-Term Care Agreement and Extension of Long-Term Care Agreement. These two agreements are tax qualified long-term care agreements that cover care such as nursing care, home and community-based care, and informal care as defined in the agreement. 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. Please ensure that your clients consult a tax advisor regarding long-term care benefit payments, or when taking a loan or withdrawal from a life insurance contract.

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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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