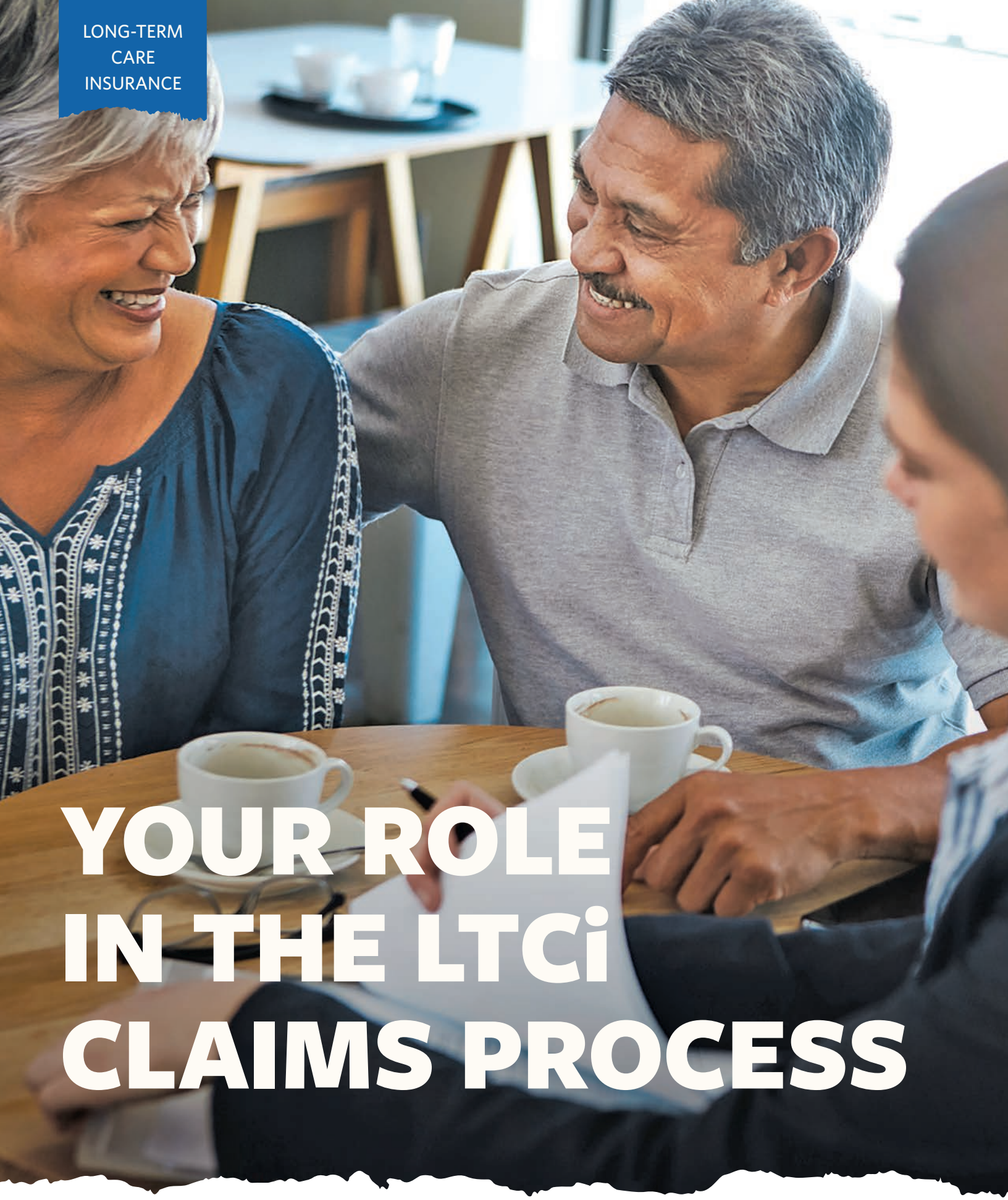
LONG-TERM CARE INSURANCE



YOUR ROLE IN THE LTCi CLAIMS PROCESS

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Mutual of Omaha

Underwritten by
Mutual of Omaha Insurance Company

When the need for long-term care services arises, the agent is often the first person the policyholder contacts. That's why it's important for you to know how the claims process works in order to understand your role.

Step 1: Making initial contact

Mutual of Omaha's claims department wants to be notified as soon as possible when it's believed there may be a need for long-term care services. There are two ways the initial contact can be made:

- ☑ The insured may contact you. If you are the first point of contact, please notify the claims department as soon as possible to let us know a claim is coming.
- ☑ The insured can contact Mutual of Omaha's claims department directly during normal business hours. The appropriate phone number is listed in the policy.

Step 2: Gathering information

Once we receive the initial notification, a representative from Mutual of Omaha's claims department will talk with the insured to gather more information. We'll send the insured a claims packet that includes the claim form and a list of documentation needed to evaluate the claim and determine eligibility. This may include things like medical records and provider bills.

Medical Records

We may need to contact medical providers to collect additional information that can help us determine the need for long-term care services and eligibility for benefits under the policy.

Provider Bills

We'll ask the insured to submit bills for any expenses they may have already incurred to determine if those services are covered under the policy.

Step 3: Explaining how the policy works

Not all long-term care insurance policies are the same, so a claims representative will explain the benefits of the policy to the insured. This may include:

- ☑ Elimination period
- ☑ Care coordination services
- ☑ Payment of benefits
- ☑ Waiver of premium

Elimination Period

There are two different types of elimination periods – calendar day and service day. A claims representative will explain which type of elimination period the policy contains. For example:

- ☑ 90 calendar days means the waiting period begins the first day covered services are received and ends 90 days later.
- ☑ 90 service days means the waiting period begins the first day covered services are received and ends after services are received for 90 days (not necessarily consecutive days).

Care Coordination Services

If the policy includes the services of a care coordinator, the claims representative will explain how this provision works. A care coordinator is a licensed health care professional — typically a registered nurse — who becomes the insured's point of contact with Mutual of Omaha. The care coordinator will work with the insured to develop an individualized plan of care, help to arrange for long-term care services and monitor the care the insured receives.

Payment of Benefits

Some policies may contain an option that allows insureds to choose how they prefer to receive policy benefits. If the policy contains this option, the insured can elect to receive either a cash benefit or a reimbursement benefit.

- ☑ A cash benefit is a percentage of the policy's maximum monthly benefit amount and is payable each month the insured is eligible for benefits. There's no elimination period to satisfy, and the cash can be used to pay any long-term care related expense
- ☑ A reimbursement benefit simply reimburses the insured for actual long-term care expenses incurred, up to the maximum daily or monthly benefit provided by the policy

Waiver of Premium

The policy may contain a waiver of premium benefit, which means the insured won't have to make premium payments while receiving benefits. However, it's important for the insured to continue paying premiums until notified that no further premium is due.

Step 4: Determining benefit eligibility

Each policy states how the insured is eligible for benefits. For example, the policy may state that a licensed health care practitioner must submit a plan of care certifying the insured is chronically ill. That means for a period of at least 90 days, he or she needs help with two or more activities of daily living (bathing, dressing, eating, transferring, toileting and continence) or requires continual supervision due to a severe cognitive impairment.

Typically, it takes approximately 10 business days to determine eligibility, providing we have access to all the information we need. Once eligibility has been confirmed, we'll notify the insured or their representative/ power of attorney.

If it's determined the insured is not eligible for benefits at this time, we'll send a letter explaining the decision and detailing the options. Keep in mind that the insured's health situation and need for care may change quickly, which means that even if they're not eligible for benefits initially, they may become eligible at a later date. If their condition worsens, we ask that they contact the claims department to re-evaluate their claim.

Step 5: Paying the claim

After satisfying the policy's elimination period,* the insured will become eligible to receive benefit payments. Once an eligible expense is received, it takes approximately 10 business days to approve it and issue a payment.

Payment can be sent directly to the insured, to his or her representative/power of attorney or to any long-term care service provider designated by the insured (i.e., a nursing home).

Each time a bill is submitted for reimbursement and a claim is paid, the insured will receive an explanation of benefits (EOB) statement showing the amount of the maximum lifetime benefit paid to date. This allows the insured to track benefits that have been paid and to calculate the remaining benefit amount.

**Remember if a policy includes a cash benefit and that option is elected, there is no elimination period to satisfy.*

The Role of the Agent

If you become aware of a potential claim, be sure to notify us as soon as possible. Please use this checklist to provide the following information about your client:

- ☑ Name ☑ Phone number ☑ Mailing address (so we can send a claims packet)
- ☑ Email address ☑ Policy number ☑ Policyholder's representative/power of attorney
- ☑ Type of claim (i.e., home health care, assisted living, nursing home)

Remember that as an insurance agent, **you may not act on behalf of your client** unless you are authorized to do so. HIPAA regulations require that all claims dealings must be between Mutual of Omaha and the insured or his or her representative/power of attorney.

Claims Department Contact Information

There are different phone numbers based on the type of policy the insured owns. Please be sure to use the correct number.

Policy Forms LT50, NH50, HCA, HCAQ, NHA, NHAQ, LTA, LTAQ
(Policies sold from 1987 to 2004)
Phone: 888-232-4597
Hours: Monday-Thursday: 7 a.m. – 5:30 p.m. CST
Friday: 7 a.m. – 5 p.m. CST

Policies Sold After 2004
(LTC04 and later; modern policies have 33-XXXXXX numbers)
Phone: 877-894-2478
Hours: Monday-Friday: 7 a.m. – 5 p.m. CST

LTCi Claims by the Numbers

- Mutual of Omaha Insurance Company sold its first long-term care insurance policy in 1987.
- Since then, we've paid over [$1.1 billion] in benefits to long-term care policyholders.
- In [2017] alone, we pay over [$10 million] per month in long-term care benefits.
- Currently, we provide long-term care coverage to over [200,000] individuals.

Why Mutual of Omaha

We're invested in your success. We're committed to giving you the products your customers want plus the tools, resources and support you need.

MutualofOmaha.com/sales-professionals