Frequently Asked Questions for Long-Term Care Claims

Initiating a Long-Term Care Claim

How does a claim for long-term care benefits get initiated?

The claimant or a close family member familiar with the claimant's medical and care information can start a claim online through their MyNYL account or contact a New York Life Long-Term Care Claim Benefit Specialist once long-term care services are needed.

Go online to your MyNYL account and proceed to the Long-Term Care Center page under your Long-Term Care Policy. From there, click on the Starting a Claim tab.

or

Call us at **(800) 224-4582** Choose option 1 then option 3
Office Hours are 8:00 am - 5:00 pm (CST)

The Claim Benefit Specialist conducts a 30-40 minute phone interview to obtain the following information:

- Claimant's care need
- Whether current care is in place
- Names & addresses of physicians and care providers
- Any other pertinent information

What forms need to be completed?

After the claim has been filed, a Claim Acknowledgment Letter is sent to the claimant with the following forms that need to be completed and returned by the claimant or their legal representative:

- Claims Medical Authorization
- HIPAA Compliant Authorization to Release Information if the claimant would like their information to be shared with their agent or a close family member
- IRS Form W-9: Request for Taxpayer Identification Number and Certification

Additional information from physicians and care providers will be obtained by the Claim Benefit Specialist.

Does the claimant require a Power of Attorney? If so, what kind?

A Power of Attorney is only required if the claimant wishes New York Life to discuss detailed financial or medical information with a third party – even a spouse, adult child, or agent. A copy of the relevant Power of Attorney must be in the claim file before information can be disclosed to anyone other than the claimant.

- To discuss **financial matters,** the third party must hold a Power of Attorney that permits the disclosure of financial information
- To discuss **health matters**, the third party must hold a Power of Attorney that permits the disclosure of personal health information

A HIPAA Compliant Authorization to Release Information provided by us and completed by the claimant may be used in lieu of a Power of Attorney to provide personal health information to a designated third party.

What occurs during the claims review process?

The entire process, from initial call to claim determination, can take approximately 6 weeks. This process can include:

- On-site independent RN interview with the claimant
- Obtaining information/ documentation from physician(s) and any care providers

Once all of the requested information is received, the claim is reviewed for benefit eligibility.

Can you make a determination based on a letter from the claimant's physician?

An assessment is required by the policy. The assessment provides information about:

- The claimant's care needs
- The claimant's care environment
- Other areas where New York Life Long-Term Care Insurance could offer assistance.

Additional information such as documents from the care provider and information from the claimant's physician may also be used to make the claim determination.

If a claimant is receiving hospice care do they automatically qualify for benefits? What if they have a specific diagnosis such as Alzheimer's disease or cancer?

Benefit eligibility is determined by the policy contract and is based on the need for assistance with one's Activities of Daily Living or a need for supervision for safety due to cognitive impairment. A specific diagnosis or certification, even if terminally ill, does not automatically qualify one for benefits.

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Benefit Eligibility Process

How can I check the status of my Claim?

The claimant can view the status of their claim online and proceed to the Long-Term Care Center site under the Eligibility tab.

What happens if a claim is approved?

The claimant or legal representative will receive written notification that the claim has been approved and instructions on the next steps needed for benefit reimbursement.

What is a Chronically Ill Individual Certification and why does a claimant need one?

The Chronically Ill Individual Certification is required for benefit eligibility for policies that are Tax Qualified Long-Term Care Insurance Contracts under Internal Revenue Code Section 7702B(c)(2). The Chronically Ill Individual Certification is a specific, defined requirement of the policy: A Licensed Health Care Practitioner certifies that a person is expected to require eligible care with at least 2 Activities of Daily Living for at least 90 days or suffers from a severe cognitive impairment requiring substantial supervision. The certification that the care requirement is going to last at least 90 days guarantees the policy will only pay for long-term care needs, not short-term disability. Without this certification, benefits under a Federally Tax Qualified Policy cannot be paid.

What happens if a claim is denied?

The claimant or legal representative will receive written notification and a detailed explanation of why the claim has been denied. If the claimant desires to file an appeal, instructions are also provided. Any state specific requirements and remedies will be noted in the denial letter along with the contact information to reach a claims representative should there be any questions. Denials, like many other aspects of the claims process, can only be discussed in detail with the claimant or their appropriate legal representative since personal health information will be revealed.

Some policies have a Care Coordination Benefit. Who is the Care Coordinator for the claimant's area? When does the claimant meet the Care Coordinator?

There is no individual Care Coordinator. Care Coordination is managed by a series of care professionals including the on-site RN that completes the assessment, the RN Care Manager that reviews the assessment, and the Case Manager (RN or LMSW) that reviews the claim. These individuals work in tandem to provide Care Coordination for the claimant.

Waiting Period

What is the Waiting Period?

The Waiting Period is similar to a deductible on other insurance types. Care charges are not reimbursed during the Waiting Period.

When does the Waiting Period begin? Can the Waiting Period be waived?

It begins once eligible care services begin. The Waiting Period is considered met and benefits become payable once the claimant has received a number of days of eligible care equal to the Waiting Period as detailed in the policy. Please note that only days during which eligible care is received can count toward satisfying the Waiting Period. The Waiting Period cannot be waived.

Benefit Reimbursement

What is required to receive benefit reimbursement on an approved claim?

Care invoices and if applicable daily visit notes should be promptly submitted to New York Life Long-Term Care Insurance at:

New York Life Insurance Co.
Long-Term Care Division
P.O. Box 64670
St. Paul, MN 55164-0670

Care invoices may also be faxed to:
(908) 840-3043

or sent via email to:
claimsfax@newyorklifeltc.com

Why does the claimant have to provide invoices?

The policy requires Proof of Loss to apply benefit eligible days to the Waiting Period and for benefit reimbursement. Detailed Proofs of Loss for eligible services consists of an invoice from the provider and, in the case of Home-Based claims, daily visit notes that document the care provided.

Invoices must be submitted within 30 days of a new claim approval or within 90 days for an ongoing claim. The claim will be closed and additional information may be required to reopen the claim for late invoices.

When will the claimant be reimbursed?

Once eligible invoices and any required supporting documentation such as care notes are received the claim is processed. The Claims Department makes every effort to pay all claims within 15 business days of receipt.

If utilizing **The Helper Bees** for invoicing, you will receive a bi-monthly email asking you to approve the invoice unless otherwise specified. Once reviewed and approved by the appropriate person, invoices will be sent to New York Life to be reviewed for claims processing.

Can you pay the facility or home care agency directly?

We can pay benefits to a facility as a convenience to the claimant as long as the facility will accept the payments. This payment is only a convenience and in no way constitutes a contract between the facility and New York Life Long-Term Care Insurance for payment. We do not pay benefits directly to home care agencies.

Why isn't housekeeping, transportation, meal preparation, etc. covered under the policy?

Most policies only cover assistance with the Activities of Daily Living defined in the policy or for supervision due to a cognitive impairment. Activities of Daily Living cover assistance with bathing, dressing, toileting, continence management, etc and are specifically defined in the policy.

Can Informal Care be paid for a caregiver that stays with the claimant temporarily?

Yes, if the claimant and the eligible informal caregiver have separate legal addresses, overnight care can be provided in the claimant's home temporarily.

Now that the claimant is on claim does he/she have to pay premium?

If the policy has a Waiver of Premium Benefit, premiums can only be waived once the Waiting Period has been met. Additional policy provisions may apply and the exact date the waiver of premium begins once the Waiting Period is met depends on the specific policy and any riders that may affect the waiver date. There is no Waiver of Premium Benefit for some benefits such as Informal Care or Hospice Care, and some older policies do not waive premiums for Home Care benefits. Please review the specific policy language regarding the Waiver of Premium Benefit.

Do you have a preferred care providers list?

New York Life Long-Term Care Insurance does not use preferred care providers. Any eligible care provider properly licensed by the state where care is received or that is otherwise eligible in accordance with the policy requirements may provide care. We can assist in locating eligible care providers in the claimant's area, but these lists are not recommendations.

The claimant on claim received a 1099 Tax Statement in the mail. Does he/she have to pay taxes on the benefits?

We are required by law to send 1099 Tax Statements to any claimant that has had benefits paid during the year. How the 1099 Tax Statement affects the claimant's federal and, if applicable, state taxes can only be answered by a qualified tax specialist. Claims representatives cannot provide any tax information or advice.

Contact Information

(800) 224-4582
Office Hours are 8:00 am - 6:00 pm (CST)

Preferred Address:

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