The **Federal** Long Term Care Insurance Program™

Using Your FLTCIP Benefits: 2.0 and 3.0

The Federal Long Term Care Insurance Program

Thank you for your participation in the Federal Long Term Care Insurance Program (FLTCIP). For FLTCIP enrollees who have met the conditions for benefit eligibility, this brochure is intended to assist you at the time of claim by providing an overview of the process. Once you are eligible for benefits, you will receive the *Invoice Submission and Reimbursement Package*, which includes information about submitting requests for the reimbursement of approved care expenses.

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, under a group long term care insurance policy, and administered by FedPoint®. FedPoint is the trade name of Long Term Care Partners, LLC®.

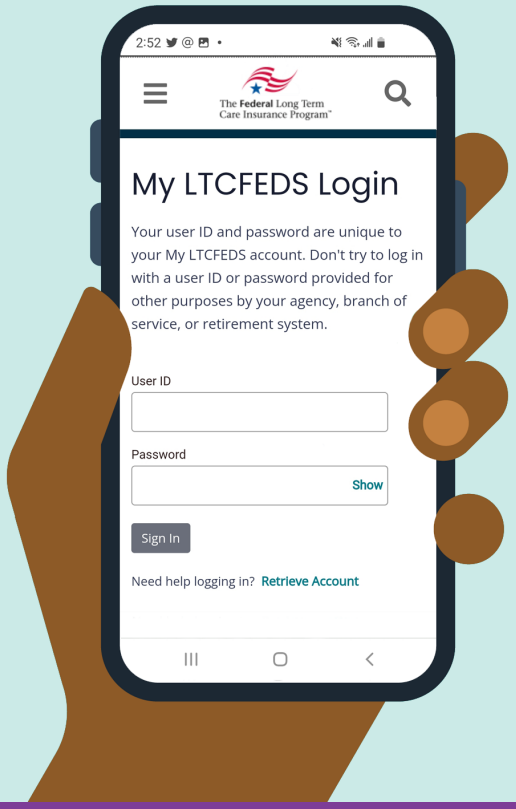
FEDPOINT®

This brochure refers to FedPoint as "us," "we," and "our." Definitions of capitalized words within this brochure can be found in your *FLTCIP 1.0 Benefit Booklet*.

Managing your FLTCIP claim is easier than ever.

To improve your benefits experience, FedPoint developed a Claims dashboard on **LTCFEDS.gov**, where reimbursement requests can be submitted online, at your convenience, in one secure location. Log into your **My LTCFEDS account** to:

- track time and upload proofs of payment for Informal Caregivers
- submit invoices for Formal Caregivers and facilities
- view your FLTCIP claims history and get your real-time invoice status
- go paperless and view your explanation of benefits online



Visit LTCFEDS.gov to log into or create an account today.

In addition to the features above, you'll find many valuable resources on **LTCFEDS.gov**, including downloadable FLTCIP materials and forms, webinars, videos, news articles, and frequently asked questions.

Access your FLTCIP plan information, including your:

- overview of your current coverage
- Benefit Booklet
- approved Plan of Care
- remaining waiting period days
- benefit amounts to date, including remaining Bed Reservation and Respite Service days

The **Federal** Long Term Care Insurance Program™

Table of Contents

Note: This brochure provides an overview of the claims process. It does not replace the most recent *FLTCIP 2.0* or *3.0 Benefit Booklet* we sent you. Only the Benefit Booklet contains governing contractual provisions. For more detailed information or if you have any questions about your FLTCIP coverage, refer to your current Schedule of Benefits and Benefit Booklet, or contact us at **claimsinfo@ltcfeds.gov** or **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 711.

1 Establish an approved Plan of Care

Once you are eligible for benefits, a FLTCIP care coordinator—a licensed Nurse or Social Worker experienced in long term care—will work with you to develop your Plan of Care (POC). Your POC is developed from your personal health information and care recommendations from your licensed health care practitioner and is approved by our care coordination staff.

Your POC is used to validate invoices we receive for reimbursement of qualified long term care services. It will include details such as approved providers, dates of service, facility charges, hourly rates for caregivers, and quantified time for specific care services.

Any requested change to your POC must be reviewed and approved by our care coordination staff to avoid reimbursement denials or delays. Changes to your POC can only be requested by you, the claimant, or your legal representative.

Decide where your care will take place

Our care coordination staff will work with you to help ensure that your long term care is provided in an appropriate setting to best meet your personal needs.

The chart below provides an overview of where your care may take place.

In your home	In a facility

Care may take place while you reside at home, which means your personal place of residence that is not a licensed facility.
Types of providers allowed:
▸ Informal Caregivers
  ▸ friends
  ▸ relatives (limited to 500 days in your lifetime)
  ▸ private caregivers
▸ Formal Caregivers
  ▸ Adult Day Care Centers
  ▸ Home Care Agencies
  ▸ visiting nurse associations
  ▸ Hospice agencies
  ▸ independent Nurses, Therapists, Social Workers, or registered dieticians
*Please note: These types of providers are referred to as **Home Care Agencies** throughout the brochure.*
	Care may also take place outside your home in a licensed facility.
	Types of providers allowed:
	▸ Assisted Living Facilities
	▸ Nursing Homes
	▸ Hospice facilities

Now that you have a better understanding about where long term care services can take place, your care coordinator will **help you**:

- determine what services you need
- identify care providers in your area
- determine the number of days and hours per day
- monitor your care needs
- adjust your Plan of Care as your needs or providers change

1 Establish an approved Plan of Care (continued)

Alternate Plan of Care

A care coordinator may approve alternative services to your POC that we deem to be both appropriate for you and cost-effective for the FLTCIP. For example, under an Alternate Plan of Care, we may consider a facility that is not otherwise covered under the FLTCIP. The expenses you intend to incur for these alternative services must be approved by your care coordinator before they are applied to a POC and submitted for reimbursement. For more information, visit our dedicated Learning Center at **LTCFEDS.gov/webinar**.

Coordinate benefits

Some enrollees may be eligible for benefits for long term care services under another insurance plan or through other programs. For this reason, the FLTCIP includes a coordination of benefits (COB) provision, which follows the guidelines set by the National Association of Insurance Commissioners.

This COB provision allows us to consider other plans—such as government programs (other than Medicaid), group medical benefits, and other employer-sponsored long term care insurance—when determining the amount of benefits we will pay.

If the FLTCIP is primary (meaning it pays first), we will pay benefits without coordinating with other plans. This means we will pay benefits to the maximum extent permitted by your coverage.

If another plan or program is primary, then it will pay first for the services they cover. In this case, we will require you to submit the explanation of benefits you received from that other plan or program showing that you submitted a claim to it and how that claim was decided. We may also request a copy of the other plan, program booklet, or terms of coverage. We will pay no more than the difference between the amount payable by your other coverage(s) and your actual covered expenses up to the daily benefit amount you selected.

Although we do not coordinate benefits with Medicaid, we may be required by state law to notify your state Medicaid office about your coverage under the FLTCIP. In addition, we reserve the right to notify your applicable state Medicaid office about your FLTCIP coverage, as may be appropriate.

Note: When Medicare or another government program is the primary plan, the services and durable medical equipment they cover are not eligible for reimbursement under the FLTCIP. However, Medicare-reimbursed long term care services may be used toward your waiting period. Please obtain and submit copies of Medicare's UB04 or explanation of benefits (EOB) documents for these services if you would like them to be applied.

2 Identify caregivers

Our care coordination staff has access to more than 200,000 providers of daily care, skilled nursing, Assisted Living Facilities, Home Care Agencies, and much more to help you maintain your independence as you age. Providers must meet the qualifications established in the *FLTCIP 2.0* and *3.0 Benefit Booklet* to be certified and included by us in an approved POC.

Care in your home

Informal Caregiver

An Informal Caregiver is a person providing maintenance or personal care whose services are not arranged or supervised by a Home Care Agency. Informal care may be provided by a friend, relative, or private caregiver if that person did not live in your home at the time you became eligible for benefits. Benefits for care provided by relatives are limited to 500 days in your lifetime. An employment agency may offer support in locating an Informal Caregiver, but it does not arrange for or provide supervision of care.

Required documentation

- A copy of a valid driver's license, U.S. passport, or government-issued ID, and a valid Social Security number are required for each Informal Caregiver.

Formal Caregiver

A Formal Caregiver is a caregiver whose services are arranged and supervised by a Home Care Agency (the caregiver is an employee of the agency). In addition, independent Nurses and Therapists may be used as Formal Caregivers. All Formal Caregivers must meet the laws of the jurisdiction in which they are located to be included in an approved plan of care.

Required documentation

- A copy of the state-issued license (if applicable) for the appropriate type of Home Care Agency or independent Formal Caregivers and a Federal Employer Identification number are required.
- We will make reasonable attempts to obtain this information directly from the Home Care Agency. However, we may ask for your assistance if we are unsuccessful in getting the information.

Care in a facility

A facility may be an Assisted Living Facility, a Nursing Home, or a Hospice facility. Facilities must meet the laws of the jurisdiction in which they are located in order to be included in an approved POC.

Required documentation

- A copy of the state-issued license for the appropriate facility and a Federal Employer Identification number are required. The facility must also complete the appropriate facility form, which we will send to them.
- We will make reasonable attempts to obtain this information directly from the appropriate facility form that outlines the services, staffing, and licensing requirements. However, if we are unsuccessful, we may ask for your assistance.

2 Identify caregivers (continued)

To avoid reimbursement denial or delays, all required documentation must be received and in good order before a provider can be added to an approved POC. Download forms at **LTCFEDS.gov** or refer to the *Invoice Submission and Reimbursement Package*.

Log into your **My LTCFEDS account** to review your POC. It provides a list of approved current and former caregivers as well as a list of providers who are not covered. A copy of your POC is mailed to you and available in your online account any time a care coordinator makes updates.

3 Meet the waiting period

Satisfy your plan's waiting period

Your waiting period is the number of calendar days during which you must be eligible for benefits before we will pay benefits. The length of your waiting period is shown on your current Schedule of Benefits and is **90 calendar days**. This means that 90 calendar days after your benefit eligibility date, you will be eligible for reimbursement of approved long term care expenses for services received after your waiting period if you continue to be eligible for benefits at that time. It is not necessary to submit invoices for care received during the waiting period.

Please refer to pages 11 and 12 for examples of the services covered and not covered for reimbursement by caregiver type.

You only have to satisfy your current plan's waiting period once in your lifetime.

Hospice Care, Respite Services, and the Stay-at-Home Benefit

The waiting period does not apply while you are receiving Hospice Care, Respite Services, or the Stay-at-Home Benefit. Please be aware that if you are contemplating using the Stay-at-Home Benefit, the charges you intend to incur must be preapproved before they are applied to a POC and submitted for reimbursement. Contact Customer Service to review the preapproval process. If, at any point, you are no longer approved by us for these services, benefits for other Covered Services will not be payable until the waiting period is satisfied.

Notification that the waiting period has been met

If your POC includes services that are subject to a waiting period, we will send you written confirmation once you have satisfied the waiting period indicating the date you are eligible for reimbursement of Covered Services and the date your waiver of premium will begin.

Waiver of premium

You will not have to pay your premium once you have satisfied your waiting period. We will also waive your premium if you are eligible for benefits and receiving Hospice Care. If you satisfy the requirements for the waiver of premium on the first day of a month, the waiver will take effect on that date. Otherwise, the waiver will take effect on the first day of the following month.

4 Explanation of claims topics

Assessment	Assessments are performed by a vendor Registered Nurse (RN), who is different from our care coordinators who manage your case. The vendor RN will contact you directly to schedule a time that is convenient for you, and they will observe your ability to perform Activities of Daily Living and administer a brief mental status exam.. We recommend that you have another person with you at the time of assessment. The assessment may be completed onsite at your place of residence or virtually, depending on the situation. The length of an assessment is about 1.5 hours. The vendor RN only has the information that you provide on the form. This vendor RN is objective and has no knowledge about your policy or your medical history. The information collected is provided to us for consideration in their decision. Your tax-qualified policy requires reassessment at a minimum of every 12 months.
Calling 1-800-LTC-FEDS	When you call the FLTCIP toll-free number, you will reach one of our Customer Service claim services consultants who are trained to support our care coordination and claims process. They are qualified and well-versed in answering your questions regarding your coverage and policy provisions, your invoice reimbursement, and the status of your claim. They do not provide support for clinical or medical information, or other Nurse-related issues that should be discussed with your care coordinator. If you need to speak with your care coordinator directly or if you are returning your care coordinator's call, the claim services consultant will provide you with instructions.
Care coordinator	Our FLTCIP care coordinators are licensed Nurses or Social Workers who are experienced in long term care. They will manage your claim and work with you to develop your Plan of Care. You may receive a claims satisfaction survey asking you about the service level of a care coordinator.
Claim payments	We reimburse for actual charges you incur for Covered Services received up to a specific dollar amount. We will only pay for invoices submitted directly to us. Invoices must be filled out completely, and we must receive all necessary certification requirements. Providers and services must match those on your POC. All services must have been rendered; we do not pay for care in advance.
Informal Caregivers	We require you to submit a photo ID of the Informal Caregiver, such as a valid U.S. driver's license or a government-issued ID, and a copy of their Social Security number.
Legal representative	If you have a legal representative (e.g., a power of attorney), we will review submitted documentation and inform you if the documents are in good order. If accepted, your legal representative will be able to make changes on your behalf as authorized in the legal representative documentation. If your condition involves the potential of a cognitive decline, you may want to consider establishing a legal representative.
Medical records	Medical records are requested from your health care provider. At times, the provider may not send us complete records, or send the records in a timely manner, which may cause a delay in the benefit eligibility decision or recertification. We may request additional medical records based on information we received that may help determine your eligibility for claims.

4 Explanation of claims topics

Plan of Care	The Plan of Care (POC) identifies ways of meeting your needs for qualified long term care services. It will include details such as approved providers, dates and hours of service, hourly rates for caregivers, and quantified time for specific care services. Your POC is also used to validate invoices we receive for reimbursement. It is different from a plan of care you see in a Hospital, Nursing Home, Assisted Living Facility, and other providers where the POC is medical in nature. All caregivers must meet the requirements stated in your benefit booklet to be approved and added to your POC. Any change to your POC must be submitted by you or your legal representative and approved by our care coordination staff prior to you making the actual change to avoid reimbursement denials or delays. It is important that you notify us of any changes to your care.
Submitting documents	All the required forms found in your Claims Information Kit must be completed and returned to us before we will open your claim. It's important to verify that all questions have been answered and that signatures are made by you, the insured, or by your legal representative. However, if you wish to authorize someone to make decisions on your behalf, the designated person must be so authorized in your durable financial power of attorney or guardianship papers. Once we process this legal documentation, your representative will then have the ability to complete forms related to your claim. When you send documents via mail, email or fax, please be sure to provide identification on every page. This may include your claims ID or unique ID, along with your name. We will confirm receipt within two to three business days after we receive a document.
Waiting period	The waiting period is the number of days during which you must be eligible for benefits before we will pay benefits for covered charges you incur for long term care services. The number and type of day is dependent on your FLTCIP coverage. Please refer to your Benefit Booklet and Schedule of Benefits for your specific requirements.

5 Services covered and not covered for reimbursement for FLTCIP 2.0 and 3.0

Note: The following is not a complete description of coverage. For detailed information about FLTCIP coverage, including exclusions and limitations, refer to your *FLTCIP 2.0* or *FLTCIP 3.0 Benefit Booklet*.

Care in a facility

Caregivers	Services Covered	Services Not Covered	Reimbursement
Types of providers covered: ▶ Assisted Living Facilities ▶ Nursing Homes ▶ Hospice facilities	We will pay for: ▶ room and board accommodations ▶ nursing care, maintenance, or personal care, and therapy services provided to you by a Formal Caregiver ▶ drugs, incontinence supplies, dietary supplements, personal medical equipment, and laundry services **Note:** We do not pay benefits for services you receive during your waiting period, except for Hospice Care, Respite Services, and the Stay-at-Home Benefit.	We will **not** pay for: ▶ medical services (e.g., X-rays, laboratory fees, physician charges) ▶ informal caregiver services while residing in a facility ▶ fees beyond usual and customary room and board charges (e.g., move-in or entry fees, security deposits, finance charges) ▶ room and board charges for independent living quarters in a continuing care retirement community, rest home, or similar entity ▶ services or items that are not related to the provision or support of long term care services (e.g., beauty or barber services, cable, furniture rentals, vacations, guest meals) ▶ second occupant fees for individuals not eligible for FLTCIP benefits ▶ no-show fees ▶ care or services that are not included in or are inconsistent with your Plan of Care (POC) **Note:** Please see the "Exclusions" section of the Benefit Booklet for additional services and supplies that are not covered.	You must submit an itemized invoice to us that includes the following: ▶ the complete name, address, and phone number of the facility ▶ the individual dates of service ▶ a description of services provided ▶ the total charge per type of service ▶ the total amount charged per invoice Reimbursement requirements: ▶ services have been rendered (e.g., reimbursement is processed after the last day that service has been provided) ▶ completed invoices and proof of payment have been received in good order (submitted by you or the facility) ▶ providers and services match the approved POC An assignment of benefits is available for facilities within the United States.

5 Services covered and not covered for reimbursement for FLTCIP 2.0 and 3.0

Note: The following is not a complete description of coverage. For detailed information about FLTCIP coverage, including exclusions and limitations, refer to your *FLTCIP 2.0* or *FLTCIP 3.0 Benefit Booklet*.

Care at home

Caregivers	Services Covered	Services Not Covered	Reimbursement
Types of Informal Caregiver providers covered: ▶ friends ▶ Family Members* *Benefits for Informal Caregivers who are Family Members are **limited to 500 days in your lifetime.** Any day during which you receive any amount of Informal Caregiver services from a Family Member counts toward the 500 days.	We will pay for services provided by an Informal Caregiver as long as the services are all of the following: ▶ provided to you at home or at a location other than a Nursing Home, Hospice facility, or Assisted Living Facility (such as the home of a friend or relative) ▶ approved by our care coordinator as part of your written POC ▶ provided by a person who did not live in your home at the time you became eligible for benefits **Note:** We will pay for Informal Caregiver services provided by a person who began living in your home after you became eligible for benefits.	We will **not** pay for: ▶ medical services (e.g., X-rays, laboratory fees, physician charges) ▶ transportation, mileage, or gasoline ▶ services or items that are not related to the provision or support of long term care services (e.g., beauty or barber services, cable, furniture rentals, vacations) ▶ any type of residential upkeep, construction, renovation, or home maintenance (e.g., painting, plumbing) except that which is covered as a home modification under the Stay-at-Home Benefit ▶ lawn care, snow removal, or vehicle or equipment upkeep ▶ services provided by someone who normally lived in your home at the time you became eligible for benefits **Note:** Please see the "Exclusions" section of the Benefit Booklet for additional services and supplies that are not covered.	You must submit a completed FLTCIP Informal Caregiver Invoice and proof of payment: ▶ proof of payment includes cancelled personal, business, substitute, or cashier's checks (front and back); eStatements; money orders; online bill pay; or payroll payments ▶ payments made by cash or checks made out to cash are not reimbursable Reimbursement requirements: ▶ services have been rendered ▶ complete invoices and proof of payment have been received in good order (submitted by you) ▶ providers and services match the approved POC We will honor an assignment of benefits for Home Care Agencies and facilities in the United States.
Types of Formal Caregivers and other providers covered: ▶ Home Care Agencies ▶ visiting nurse associations ▶ Hospice agencies ▶ independent Nurses, Therapists, Social Workers, or registered dieticians ▶ Adult Day Care Centers	We will pay for: ▶ nursing care, maintenance, or personal care ▶ therapy service (e.g., physical, respiratory, speech, and occupational services) ▶ certain attendance and activity fees (e.g., Adult Day Care Center) ▶ Hospice care at home **Note:** The waiting period does not apply to Hospice care received at home. A Formal Caregiver may include Family Members provided: ▶ the Family Member is one of the following professionals: a Nurse, Therapist, Social Worker, or registered dietician ▶ the Family Member is a regular employee of an Adult Day Care Center, an Assisted Living Facility, a Home Care Agency, or a Nursing Home ▶ the organization receives the payment for the services ▶ the Family Member receives no compensation other than the normal compensation for employees in their job category ▶ the Family Member did not normally live in your home at the time you became eligible for benefits	We will **not** pay for: ▶ medical services (e.g., X-rays, laboratory fees, physician charges) ▶ transportation, mileage, or gasoline ▶ services or items that are not related to the provision or support of long term care services (e.g., beauty or barber services, cable, furniture rentals, vacations) ▶ any type of residential upkeep, construction, renovation, or home maintenance (e.g., painting, plumbing) except that which is covered as a home modification under the Stay-at-Home Benefit ▶ lawn care, snow removal, or vehicle or equipment upkeep ▶ care or services that are not included in or are inconsistent with your POC **Note:** Please see the "Exclusions" section of the Benefit Booklet for additional services and supplies that are not covered.	You must submit an itemized invoice that includes the following: ▶ the complete name, address, and phone number of the agency or Adult Day Care Center ▶ the individual dates of service ▶ the total hours per day ▶ the total charged per day ▶ a description of services provided ▶ the total amount charged per invoice Reimbursement requirements: ▶ services have been rendered ▶ complete invoices and proof of payment have been received in good order (submitted by you or the agency) ▶ providers and services match the approved POC An assignment of benefits is available for Home Care Agencies within the United States.

6 Maintain the continuation of your claim

In addition to completing and submitting invoices following the processes outlined in the *Invoice Submission and Reimbursement Package* brochure, you can help us provide you with timely reimbursements by:

Keeping your Plan of Care (POC) up to date

- It's your responsibility to inform us of any anticipated or actual change in your condition, care, or caregivers, and/or anticipated stay-at-home needs (such as home modifications and durable medical equipment) as soon as you know about or need to make a change. Any requests for changes to your POC must be made by only you or your legal representative for our care coordinator staff to approve them and update your plan to avoid reimbursement denials or delays.
- You must inform us of any dates you were hospitalized or, if you are in a facility, any days you were out of the facility overnight.
- You may review your POC at any time by logging into your **My LTCFEDS account**.

A member of our care coordination team will contact you periodically to review your current needs and the existing POC.

Participating in the reassessment of your benefit eligibility

It is not uncommon for an enrollee to exit claim if they are no longer meeting the FLTCIP's benefit eligibility criteria. Enrollees may enter claim again in the future should their needs change. Because conditions can change with time, we regularly monitor each claimant's eligibility status throughout the claims process. While you are receiving care, we will review your eligibility for benefits at least once every 12 months and sometimes more frequently depending on your specific condition(s). It is your responsibility to notify us if your condition changes.

We may request additional information by contacting you, your physician, or other persons familiar with your condition; accessing your medical records; having you examined, at our expense, by a licensed health care professional; and/or conducting an onsite or virtual assessment.

If long term care eligibility criteria can no longer be documented, a claimant is determined to be recovered and, therefore, no longer eligible for reimbursement benefits for the current claim. If you wish to maintain your FLTCIP coverage, you must resume paying your premium on the first day of the month following the month in which you are no longer eligible for benefits, unless you selected the paid-up, limited benefit option during a premium increase.

If you recover during your waiting period, any waiting period days accumulated will be applied to any future instances of becoming benefit eligible.

Any person who knowingly and with intent to defraud any insurance company or other person makes a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Visit our Learning Center

We offer online educational resources for FLTCIP enrollees and their representatives to help you learn more about your coverage and the claims process. You can register in advance for our upcoming webinars or watch on-demand webinars and videos at your convenience. Visit **LTCFEDS.gov/webinar** today.

Contact us

If you have a question about your FLTCIP coverage, please log into your **My LTCFEDS account** on **LTCFEDS.gov**. There, you can review your coverage, your current claim, and any previous claim. If you need more assistance, email **claimsinfo@ltcfeds.gov** or call **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 711. Be aware that any time we speak to you or your legal representative about specific health information or coverage, we are required to verify your identity by asking for personally identifiable information through our security process.

Call FedPoint

When you call our toll-free number, you will reach one of our Customer Service claim services consultants (CSC), who are trained to support our care coordination and claims process.

Each time, the CSC will ask you to verify three facts:

- your claim ID, your unique ID, or your Social Security number (or last four digits)
- your date of birth
- your address

This security check is required to protect your health information. Without it, Customer Service will not be able to provide support or refer calls.

Once the security check is successfully completed, the CSC will ask how they may assist you. Many questions can be answered by the CSC. If you need to speak directly to your care coordinator or if you are returning your care coordinator's call, the CSC will provide you with instructions.

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