RiverSource Long-Term Care Insurance – Michigan Guide

1. Overview and Scope

1.1 Who This Guide Is For

This guide is designed for **Michigan families** who already have a **RiverSource Life Insurance Company long-term care** (LTC) policy and want to use it for in-home care. It is written for **practical decision-making**: how to recognize when a claim is likely to qualify, how to start a claim, and how to keep benefits flowing with clean documentation. It assumes a private LTC insurance audience (not Medicaid) and focuses on home-care use because that is how most claims begin.

1.2 What This Guide Covers

You will find a Michigan-focused explanation of how long-term care insurance typically works when care happens at home, and how the process often looks under RiverSource **legacy policy** designs. RiverSource LTC policies are commonly part of a closed block and were discontinued for new sales decades ago, so definitions kf7cand benefits can vary meaningfully by issue year and form. The goal of this guide is to help you translate your policy language into **a workable home-care plan** and a claims file that is **easy for a reviewer to approve**.

This guide covers:

•**How RiverSource LTC policies are commonly structured**, including daily or **monthly limit**s, **benefit pool**s, and riders that affect home-care use.

•**How to identify whether your RiverSource coverage is** comprehensive (home/community care) or more facility-centric (nursing-home **indemnity**), and why that distinction changes planning.

•**What in-home services are typically covered under comprehensive LTC contracts**, and what **documentation** is usually required for **reimbursement**.

•**How eligibility is established through ADL limitations or cognitive impairment**, and what evaluators tend to review during assessments.

•**How benefit triggers and practitioner certification work in practice**, and why wording differences across older RiverSource forms matter.

•**How elimination periods are counted (calendar-day vs. service-day)** and what that means for early out-of-pocket costs in Michigan.

•**How to start and maintain a RiverSource claim in Michigan**, including a practical workflow for invoices, **visit logs**, and follow-up requests.

•**Common patterns that cause delays in legacy-policy claims**, and how to avoid them with clean, consistent records.

•**Practical habits that help Michigan families pace benefits** over time and reduce avoidable back-and-forth with the carrier.

1.3 How to Use This Guide

•**If you are deciding whether it is time to use the policy**, start with Section 5 (**Eligibility**) and Section 6 (**Benefit Triggers**).

•**If you are worried about early out-of-pocket costs**, read Section 7 (**Elimination Period**), then return to Section 2 (Michigan costs).

•**If you are ready to open a claim**, go to Section 8 (Starting a Claim) and keep Section 9 (Avoiding Delays) open as your checklist.

•**If you are about to call in a claim**, Section 8 (Starting A Claim) and Section 9 (Avoiding Delays) are the most relevant.

- **If you are not sure whether your RiverSource policy includes home-care benefits**, start with Section 3.1 and Section 4 before building a schedule.

Technical terms such as **Activities of Daily Living** (**ADLs**) and **elimination period** are explained in plain language. A short glossary near the end gathers these definitions in one place so you can refer back to them without searching through earlier sections.

This document is not a substitute for the policy itself. The contract you hold governs what is and is not covered. However, by working through the sections that apply to you, you should have a clearer sense of what questions to ask, what information to gather, and how to work with care providers so that your benefits are used effectively.

2. Michigan Home-Care Context (Private Pay)

Most long-term care insurance claims in Michigan begin at home, even when the policy ultimately supports other settings later. Your care schedule, the type of caregiver you hire, and the records you keep will influence both qualification and how quickly benefits begin. Michigan also has meaningful regional variation: metro areas may have more agency options, while rural areas can face staffing constraints that shape weekly scheduling.

2.1 Michigan Home Care Pattern in Practice

Michigan families often begin with **limited help**, such as a few visits each week, and then increase support as needs become more consistent. **This matters** because many LTC policies **pay up to a daily or monthly cap**, so a schedule that looks affordable at first can become costly as hours expand.

Operational constraints also shape real-world care: agency minimum shift lengths, weekend coverage, and caregiver turnover. If your RiverSource policy counts service days for the **elimination period**, those scheduling details can also affect how quickly the waiting period is satisfied.

A second trend is **documentation** discipline. Agencies increasingly use standardized visit notes and **itemized invoices**, while independent caregiver records remain highly variable. In **reimbursement** designs, that **documentation** difference can become the difference between routine payment and repeated requests for clarification

2.2 Typical In-Home Care Cost Ranges in Michigan (Private-Pay)

As a **planning baseline**, **non-medical in-home care in Michigan** is commonly priced in the low-$30s to low-$40s per hour range for many providers, with higher rates in some regions and for specialized schedules. When translated into a consistent weekly plan, full-time-equivalent home care can reach the tens of thousands of dollars per year, depending on the actual hours delivered.

Agency support typically costs **more than** an independent caregiver, but agencies often provide stronger scheduling reliability and more standardized invoices. Facility-based care in Michigan generally costs more than part-time home care, and many families use home care first to delay higher-intensity settings.

These figures are planning ranges rather than a quote, and your local market will vary. They are useful because they let you compare expected monthly spend against your policy's daily or monthly maximum and estimate how quickly a **benefit pool** will draw down.

2.3 Why These Cost Patterns Matter for RiverSource Policy Planning

Since RiverSource LTC coverage is **commonly issued under older forms**, it is important to confirm what your policy **actually pays for** before you assume "standard" home-care rules apply. Some RiverSource coverage is comprehensive and includes home and community care, while other RiverSource coverage is more facility-focused, which changes the value of early home-care spending.

The practical planning goal is to align three items from the start: care schedule, **documentation**, and your policy's benefit limits and elimination-period rules. If you align those early, you are less likely to experience claim delays that effectively extend your out-of-pocket time window.

3. Policy Structure: How These Policies Are Built

This section **tries to explain the policy features** that most directly affect claim payment and timing. The key RiverSource takeaway is that **many policies are legacy** and may differ significantly by issue year and form, so treat your own policy as the controlling document.

3.1 Policy Types: Comprehensive vs. Facility-Centric Designs

RiverSource has historically offered different long-term care designs, including comprehensive **reimbursement** coverage and nursing-home **indemnity** coverage. Comprehensive designs typically allow benefits across multiple settings (which may include home and community care), while nursing-home **indemnity** designs may focus more narrowly on facility care.

Practical implication: before you build a home-care plan, **confirm** whether your policy includes a home and community care benefit and whether that benefit has different limits than facility care. If you start paying for home care assuming it is covered and later discover the policy is facility-centric, you can lose time and money and still have to redesign the care plan.

3.2 Benefit Limits and Benefit Pools

Most long-term care policies define **a maximum benefit** that can be paid over time, often described as **a daily limit**, **a monthly limit**, or **a lifetime benefit pool**. Some policies also apply different maximums by setting, such as one cap for nursing facility care and a different cap for home care.

Your best starting point is the schedule page that lists: the maximum benefit, the **elimination period**, and any inflation or benefit increase feature. A simple planning method is to convert your benefit limit into an expected monthly cap, then compare it to your likely Michigan care budget range.

If your plan has inflation protection, the benefit may increase over time, but the practical question is still whether the monthly cap can keep pace with Michigan care costs. If your **benefit pool** is finite, track the pool as you begin care so you can

3.3 How Benefits Are Paid (Reimbursement vs. Indemnity)

Many comprehensive LTC policies are **reimbursement**-based, which means the insurer pays based on actual covered expenses up to the policy maximum. In practice, **reimbursement** designs require **itemized invoices** and **care logs** that show dates, hours, and services performed.

Indemnity (cash-benefit) designs pay a fixed amount once you qualify, even if actual expenses differ. Even then, the carrier typically still requires **eligibility documentation** and may require ongoing proof that the insured remains eligible.

Also note timing: **reimbursement** designs often pay after services are delivered, so families should plan for a cash-flow gap even after the **elimination period** is satisfied. For older RiverSource forms, confirm whether the policy has special rules for home care provider type or invoice format, because those details can drive delays.

3.4 RiverSource Variability: Legacy Forms, Riders, and Administration

RiverSource long-term care coverage is commonly part of a closed block, and new sales were discontinued years ago. As a result, claim forms, covered-service definitions, and provider rules can vary across policy versions.

Many policies also include riders or options that **materially change** home-care use, such as inflation features or alternative care provisions. Practical implication: when

a family says “my friend’s LTC policy paid for X,” your RiverSource policy may still require different provider credentials, **documentation** language, or benefit limits for the same service.

A common RiverSource pattern is a life insurance policy with an accelerated-benefit long-term care (LTC) rider. When the insured is certified as chronically ill under the rider definition, the policy can pay monthly accelerated benefits for qualified long-term care services. This is different from stand-alone LTC insurance because each payment typically reduces the remaining life insurance **death benefit**.

Why it matters in real life: families often have two “documents that govern the claim” — the base life policy and the rider pages. The rider controls **eligibility** language, how the **elimination period** is counted, and what proof of services is required. If you treat the coverage as one generic LTC contract, you can miss a rider-specific rule and end up re-submitting paperwork.

Before you start services, do a quick RiverSource-specific check:

- **Confirm whether your benefits are reimbursement-style payments or** accelerated monthly benefits tied to a rider.
- **Identify the rider’s maximum monthly benefit and whether** it is capped by a percentage of the **death benefit**.
- **Read the provider definition carefully (some riders limit** or exclude care provided by close family members).
- **Note the elimination period counting rule and any** “must be satisfied within” time window.
- **Save the claim contact instructions printed in your policy/certificate pages**; they are often more reliable than generic web search results.

4. Home Care Services Commonly Covered(Policy-Dependent)

Most in-home claims revolve around a small number of service categories, even if the paperwork uses different terms. The most important step is to align the services you purchase with your policy's covered-service definitions and document them consistently.

If your RiverSource policy is comprehensive and includes home and community care, common covered categories may include:

- **Personal care / ADL support such as bathing**, dressing, toileting, transferring, and mobility assistance.
- **Homemaker services such as meal preparation**, laundry, light housekeeping, and help maintaining a safe home environment.
- **Supervision / safety oversight when cognitive impairment creates** risk and the insured cannot safely self-direct care.
- **In some policy versions**, adult day services or other community-based supports may be covered when tied to an approved **plan of care**.

Transportation, general errands, and purely social companionship may be treated differently **by different policy forms**, so avoid assuming they are covered without checking definitions. If your policy is more facility-centric, home care may be limited or unavailable unless a rider expands benefits.

Practical RiverSource emphasis: confirm whether your policy includes an alternative care or **alternate plan of care** provision. When it applies, this feature can sometimes support coverage for non-standard supports if a written plan is developed with care professionals and approved under policy terms.

5. Eligibility (ADLs and Cognitive Impairment)

Long-term care insurance generally pays based on functional need, not based on diagnosis alone. Your RiverSource policy will define **eligibility**, but most claim approvals are grounded in ADL limitation and/or **cognitive impairment** with safety risk.

To reduce claim friction, document functional needs in practical terms: what the insured cannot do safely, what assistance is required, and how often it is required. **Eligibility** becomes easier to approve when your medical records, care plan, and caregiver notes all describe the same functional story.

5.1 ADL Eligibility (What Counts as Assistance)

ADLs are basic self-care tasks such as bathing, dressing, eating, toileting, transferring, and continence. **Eligibility** often requires inability to perform a minimum number of **ADLs** without help, and the help must be substantial rather than occasional convenience.

Assessors may distinguish between hands-on help, stand-by assistance, and cueing, so your **documentation** should describe the type of help being provided. For Michigan families, the practical question is whether the insured needs meaningful help most days, not whether they "struggle a bit."

If you use an agency, ask whether it can provide an initial functional assessment summary that aligns with ADL language, because it often strengthens the physician **documentation**.

5.2 Cognitive Eligibility (Supervision and Safety)

Cognitive impairment claims focus on whether the insured needs **substantial supervision** to protect health and safety. It is rarely enough to list a diagnosis alone;

reviewers look for concrete safety risks such as wandering, medication errors, unsafe cooking, or inability to respond appropriately in emergencies.

A strong file includes objective notes: a clinician's evaluation, examples of unsafe events, and a care plan that explains what supervision is being provided and when. If you hire home care in Michigan for cognitive supervision, make sure invoices and notes describe supervision and safety monitoring, not only "companion care."

5.3 What RiverSourceEvaluators Review

When a claim is filed, RiverSource (or its administrator/assessment nurses) reviews multiple sources of information together, rather than relying only on family reports. They typically examine:

- **ADL function** — Which **Activities of Daily Living** are limited, what kind of help is required (hands-on vs. stand-by), and how often assistance is needed.
- **Cognitive status and safety risk** — Diagnoses, screening results, and real-world safety concerns (wandering, medication errors, unsafe cooking, etc.).
- **Proof of services** — Physician or nurse notes, a current **plan of care**, and caregiver/agency logs plus invoices that match dates, hours, and tasks.

Long-term care benefits are typically approved only when need and **documentation** both align with the policy wording. For Michigan families, keeping these records organized and current makes follow-up questions easier to answer and reduces avoidable delays.

6. Benefit Triggers and Staying Eligible Over Time

A benefit trigger is the policy threshold for when RiverSource long-term care benefits can become payable **after the elimination period** is satisfied. In most policies, eligibility is built around **functional loss (ADLs)** and/or **cognitive impairment that creates a supervision/safety need**. The practical rule is simple: your file should make eligibility

clear to someone who does not live with the insured, using **consistent, dated documentation** rather than general statements.

6.1 Two Paths to Eligibility (ADLs vs. Cognitive/Safety)

An **ADL-based trigger** focuses on whether the insured needs substantial help with core daily tasks, and whether that help is needed in a reliable, ongoing way. A **cognitive/safety trigger** focuses on whether the insured needs **regular supervision** because memory or judgment problems create real-world risk (for example, wandering, medication mistakes, unsafe cooking, or inability to respond to emergencies).

In Michigan home care, eligibility usually shows up through patterns, not single events: repeated hands-on help with bathing and dressing, frequent transfer assistance, or daily supervision to prevent harm. The key is to describe **function**, not mood or intention—avoid vague phrases like "needs more help," and instead document **what cannot be done safely**, **what assistance is required**, and **how often** it is required.

6.2 Assessments and Documentation (What Reviewers Usually Compare Side-by-Side)

When a claim is opened, RiverSource (or its administrator/assessment vendor) typically reviews multiple sources together rather than relying only on family reports. They usually examine:

- **Clinical assessment findings** — how the person actually performs ADLs, whether the help is **hands-on vs. stand-by vs. cueing**, and what safety risks are observed.
- **Medical and cognitive records** — diagnoses and evaluations, plus recent clinician notes that describe limits or supervision needs in **concrete, day-to-day terms**.
- **Care plan and care proof** — a current **plan of care**, plus caregiver/agency logs showing **dates, hours, and tasks**, and invoices that clearly match those logs.

• **Provider and documentation fit** — whether the provider meets the policy's definition of a **qualified provider**, and whether the invoices contain the details needed for reimbursement review.

Long-term care benefits are usually approved only when there is **clear functional or cognitive impairment** and the documentation aligns with the **policy wording**. For Michigan families, keeping records organized and current reduces follow-up questions—and helps avoid delays that feel like an "extended waiting period."

6.3 Simple Instructions in Real Life (A Practical Workflow)

1. Read the **Eligibility** and **Benefit Triggers** sections in your RiverSource policy to confirm how ADL and cognitive triggers are defined and whether proof must be refreshed on a set schedule.

2. Ask the treating clinician to document **specific ADL limits** and/or **specific safety risks**, and to write a clear **plan of care** if ongoing support is needed.

3. Start a single claim folder and keep it "clean": clinician notes, assessments, the plan of care, and **care logs + itemized invoices** that match (same dates, same tasks).

4. Open the claim and confirm the process for assessments and **how elimination-period day counting works** under your contract.

5. Keep your documentation consistent month to month—**the same story** should appear in the plan of care, caregiver notes, and invoices, so the file reads as one coherent record.

7. Elimination Period (EP): When RiverSource Benefits Actually Start Paying

In long-term care insurance, the **elimination period (EP)** is the waiting time between meeting the benefit triggers and when the policy can start paying or reimbursing covered expenses. During this window, families typically pay **out of pocket**.

Think of the EP as a **time-based deductible**: instead of paying one lump sum, you must satisfy the EP's **day-count rule** before benefits become payable. Because RiverSource policies can differ by form, confirm your own EP clause before assuming how fast the clock moves.

7.1 EP Counting Styles (Calendar-Day vs. Service-Day)

Policies typically count the EP in one of two ways:

- **Calendar-Day EP** — once eligibility is established, **every calendar day** counts, even if no paid visit occurs on some days.
- **Service-Day EP — only days with covered, paid services** count. Days with no paid care—or care that does not meet the policy's provider rules—generally do **not** count.

Some legacy designs apply different rules by setting (home care vs. facility care) or require certain documentation before a day is credited. The exact rule should be stated in the policy schedule or EP clause.

7.2 What This Means for Michigan Home Care Planning

Many Michigan families start with **part-time home care** because it matches both budget and current need. If your EP is **service-day**, a part-time schedule can stretch a "90-day" EP across **many more calendar months**, increasing early out-of-pocket exposure.

If your EP is **calendar-day**, the waiting period can finish sooner on the calendar—but you still need **clean proof** that eligibility is met and the care plan is appropriate. Either way,

your best move is to choose a schedule you can sustain and document it consistently, rather than changing hours repeatedly and creating a messy record.

7.3 Why EPs Often Take Longer Than Families Expect

Even after triggers are met, EPs often finish later than expected for preventable reasons:

- **Irregular schedules** — with service-day counting, fewer paid visits means the EP completes more slowly in calendar time.
- **Provider doesn't qualify under the policy** — family, friends, or informal caregivers may not count as covered providers for EP credit.
- **Invoices/logs don't "line up"** — missing dates, unclear task descriptions, or mismatched logs can cause days to be questioned or not credited.
- **Gaps in care or stale plans of care** — hospital stays, pauses in services, or an outdated plan can trigger extra review steps.
- **Late claim setup** — waiting to open a claim can create administrative friction, especially in older/legacy workflows.

When you understand **which days count**, **who counts as a provider**, and **what proof is required**, you can plan the early phase of Michigan home-care spending with far fewer surprises.

8. Starting a RiverSource Claim in Michigan

The safest approach is to treat your policy statement and schedule pages as the "map" for intake. RiverSource stopped underwriting new stand-alone LTC after 2002, and Ameriprise reported outsourcing claims administration on the in-force block to a Genworth Financial insurer—so many policyholders will see an **administrator workflow** rather than a single, modern "carrier portal."

Start by locating the pages showing your **policy/certificate number**, **EP**, and the **claims contact instructions** listed on your statement.

8.1 Step-by-Step Claim Intake

1. **Find your schedule pages.** Confirm benefit limits, EP method, and the exact claim contact instructions.
2. **Create a one-page medical summary.** Use ADL language and include cognitive/safety risks if supervision is part of the claim.
3. **Draft a simple plan of care.** State what help is needed, how often, and who will provide it.
4. **Open the claim and confirm the workflow.** Ask what forms are required, how the assessment is scheduled, and how EP days are credited.
5. **Start services and keep records clean from day one.** Use **itemized invoices** plus a simple visit log that matches (dates, hours, tasks).
6. **If you need non-standard support, ask about "alternate care" options.** Some legacy policies allow variations, but only with a clear plan and approval.
7. **Set a monthly rhythm.** Submit consistently, keep copies, and track what you sent so follow-ups are easy.

8.2 Preparing for the Nurse/Care-Manager Assessment

Before the assessment:

- Write a short **"day in the life"** summary (one page).
- Use concrete examples: what fails, what risks happen, what help is required, and how often.
- Make sure your provider's notes and invoices reinforce the same story (**ADL help** or **supervision/safety monitoring**).

During the assessment, focus on typical function and safety. Don't minimize needs—assessors are evaluating real-world capability, not attitude.

9. Avoiding Claim Delays or Denials

Most LTC problems come from **mismatch**: the need is real, but the plan and paperwork don't clearly support the policy definition. With legacy RiverSource forms, this can matter even more because wording and administrator processes are often less forgiving.

9.1 Common Pitfalls

- **Thin medical notes:** clinician documentation doesn't clearly state ADL limits or safety risks.
- **Care that doesn't match the policy:** provider type or service category doesn't meet the contract definition.
- **Missing logs/invoices:** reimbursement and service-day EP counting navigation depends on a clean paper trail.
- **Fragmented submissions:** sending pieces over weeks increases back-and-forth.
- **Inconsistent wording:** doctor notes say one thing, invoices say another, family reports say a third.

9.2 Practical Habits to Keep Things Moving

·**Start a claim folder early.** Keep schedule pages, forms, plan of care, logs, and invoices in one place.
· **Use documentation-friendly providers.** You need invoices that show **dates, hours, tasks, and provider identity**.
· **Match invoice language to the plan.** If the plan says **ADL support** or **supervision**, don't let invoices downgrade it to vague "companionship."
· **Pick one family point person.** One organized contact reduces mixed messages and missed requests.

9.3 Two Michigan Examples

Case AHome-care assumptions collide with policy limits.

A family pays for home care assuming it will qualify, then learns the policy's home-care benefit is limited or rider-dependent. The fix is early verification: confirm covered settings and provider rules, then align the care model before you burn months in non-creditable spending.

Case B: Supervision is billed as "companionship.

A family hires daily oversight for wandering risk, but invoices label services as companionship without safety-monitoring language. The fix is documentation: update the plan of care and invoice descriptions so they reflect **supervision and safety**, and make clinician notes consistent.

10. Using Benefits Effectively Over Time

Once the claim is active, the objective is stable payment and fewer administrative interruptions. Your benefit maximum is not just a limit—it's a planning tool.

10.1 Tracking Hours and Limits

Track visits in a monthly view and compare your spend to the daily/monthly maximum. Avoid uneven schedules that cause frequent "over-the-cap" days.

If reimbursement is required, treat invoices like accounting: clean, consistent, and easy to review.

10.2 Reassessments and Recertification

Keep clinician notes current, especially when needs change (more ADL help, new falls, worsening confusion). When the administrator asks for updates, respond by mapping each request to a specific document, rather than resending everything.

10.3 Family Caregivers (If Payment Is Possible)

Payment to family caregivers is **policy-dependent**. Even when allowed, it often requires specific documentation, qualifications, and time records. If family care isn't payable, you can

still use it strategically to reduce paid hours while keeping paid services focused on the tasks that matter for coverage.

11. Michigan Resources (Private-Pay Relevant Only)

Long-term care insurance works best when it is paired with **local navigation and a stable care plan**, especially during the elimination period and early claim setup. These Michigan resources **do not replace** your RiverSource benefits, but they can help you choose providers, reduce caregiver burnout, and avoid last-minute plan changes that create documentation problems.

11.1 Dementia, Safety, and Caregiver Support (Education + Planning)

If your claim involves cognitive impairment, prioritize resources that help you define **real-world safety risks** (wandering, medication errors, unsafe cooking, falls) and build a supervision plan that can be documented.

· **Alzheimer's Association** – education, care planning tools, and **a 24/7 helpline** that families often use when they need guidance quickly.
· Use support resources to produce **clear, repeatable language** for your file (what happens, how often, why it is unsafe), then keep that wording consistent across clinician notes, care plans, and caregiver logs.

Key point: For cognition-based claims, **"supervision and safety monitoring"** should be explicit in the plan of care and in service documentation—not buried under vague labels like "companionship."

11.2 Area Agencies on Aging (AAA network): Local Help by County

Michigan's Area Agencies on Aging can help families understand local options, compare agencies, and find caregiver support programs. They are most useful when you need **structured guidance before a crisis**, or when you are trying to stabilize a plan during the elimination period.

· Michigan provides county-based AAA contact information—use it to find the correct office for your location.
· If you are not sure which local office applies, the **Eldercare Locator** is a national entry point that can route you to your local aging network.

Key point: AAAs typically help you **navigate and plan**—they are not the insurer and they do not approve claims. Their value is improving your care plan quality and reducing churn in providers and paperwork.

11.3 Finding Documentation-Friendly Providers

Your provider choice is not only about care quality—it is also about whether the paperwork will stand up to claim review. For reimbursement-style workflows and service-day elimination periods, documentation discipline matters.

When interviewing agencies or caregivers, ask for specifics:

· **Invoice format:** Can they issue **itemized invoices** showing **dates, hours, caregiver name, and task categories**?
· **Visit notes/logs:** Do they keep notes that match invoices (same dates/hours/tasks)?
· **Service language:** Will documentation clearly reflect **ADL support** (bathing, dressing, toileting, transfers) or **supervision/safety monitoring** when cognition is involved?
· **Provider status:** Are they licensed/qualified in the way your policy expects (and can they prove it if asked)?

Key point: Ask for a **sample invoice** (with personal info removed). If the invoice cannot clearly show **date + hours + tasks**, your claim will almost always move slower.

11.4 If You're Coordinating Care From Out of State

Many Michigan claims are managed by adult children who live elsewhere. Distance increases the risk of fragmented communication.

· Choose **one family point person** for the insurer/administrator, the agency, and clinicians.

· Use one shared folder (digital or binder) so every document has a home: **policy pages, care plan, assessments, logs, invoices, letters**.
· Keep a simple running timeline: **when care started, when the claim was opened, assessment dates, elimination period counting method, submission dates**.

Key point: A clean timeline reduces repeat requests because you can answer "what happened when?" in two minutes instead of two days.

11.5 A Practical "Claim Folder" Starter Kit

Keep these items together from day one:

· **Policy/certificate schedule pages** (benefit limits, EP type/length, contact instructions)
· **Clinician summary** (ADL limits and/or safety risks with concrete examples)
· **Plan of care** (who provides what help, how often, and why)
· **Care logs** (dates, hours, tasks)
· **Invoices** (matching the logs)
· Any letters/emails and a short "open issues" list (what the administrator asked for, what you sent, what is pending)

12.Key Terms (Glossary)

ADLs (Activities of Daily Living) — Basic self-care tasks used to measure functional need. Most policies focus on **bathing, dressing, eating, toileting, transferring**, and **continence** (definitions vary by contract).

Cognitive Impairment / Cognitive Trigger — Ongoing problems with memory, judgment, or orientation that create **documented safety risk** and require **substantial supervision**.

Benefit Trigger — The policy's threshold for eligibility (ADL impairment and/or cognitive supervision need) that must be met before benefits can be payable **after** the elimination period is satisfied.

Elimination Period (EP) / Waiting Period — A required period of days that must be satisfied after eligibility is established before benefits start paying. Think of it as a **time-based deductible**.

Calendar-Day EP — Each calendar day counts once eligibility is confirmed (even if no paid care occurs that day), depending on contract wording.

Service-Day EP — Only days with **covered, paid services from a qualified provider** count. Part-time schedules can stretch the EP across many months of calendar time.

Plan of Care — A written outline describing what help is needed, how often, and why. It is used to align services with policy definitions and supports smoother claim administration.

Qualified Provider — The policy's definition of who can provide covered services (agency, licensed provider, facility, etc.). If a provider does not meet this definition, **days may not count** and expenses may not be reimbursable.

Reimbursement — A benefit design where you pay for services and then submit invoices for repayment up to a daily/monthly maximum, subject to remaining benefits and policy rules.

Indemnity / Cash Benefit — A design that pays a set amount once eligible (still may require proof of ongoing eligibility). Payment is not necessarily tied dollar-for-dollar to actual expenses.

Daily/Monthly Maximum (Benefit Limit) — The cap on what the policy will pay per day or per month, even if actual costs are higher.

Benefit Pool (Total Available Benefits) — The total amount available over the life of the policy (or benefit period). Payments reduce the pool over time.

Assessment (Nurse/Care Manager Evaluation) — A structured review of ADL performance, cognition, and safety. The report often carries significant weight in eligibility decisions.

Care Log / Service Documentation — Notes/timesheets showing **what was done, when it was done, for how long, and by whom**. Strong logs match invoices and reflect policy language (ADL help, supervision, etc.).

Appeal — A formal request for reconsideration after a denial or reduction, typically strengthened by **updated clinician notes, clearer documentation, and policy-language references**.

13. Summary

This RiverSource Michigan guide is designed to help families use long-term care insurance for home care with fewer surprises and fewer avoidable delays. The practical reality is that most claim friction comes from **unclear policy form details, elimination period misunderstandings, and documentation gaps**, not from lack of need.

If you want the cleanest path through the process, focus on three priorities:

1. **Confirm your exact policy wording early** (benefit triggers, elimination period counting, qualified providers). RiverSource legacy forms can vary, so your schedule pages are the starting point.

2. **Build a stable plan of care that matches the trigger** (ADL help and/or supervision for safety) and keep clinician notes aligned with the same functional story.

3. **Run your claim like a simple recordkeeping system:** one folder, consistent invoices, matching logs, and one family point person who can respond quickly.

Done well, your documentation makes eligibility obvious to a reviewer who has never met your family—and that is what keeps a RiverSource home-care claim moving.

Care Plan Inc.
DBA
American Angels Home Care
The Concierge Standard in Care.
★★★★★

14. FAQ

Q1. **Are RiverSource long-term care policies mostly legacy policies?**
A. Yes. RiverSource long-term care coverage is generally part of an **older (legacy) block**, and wording can vary by **issue year and policy form**. The practical impact is that **home-care coverage, provider rules, and claim instructions can differ** across policies.

Q2. **Is RiverSource LTC often a rider on life insurance (instead of a stand-alone LTC policy)?**
A. Very often, yes. Many RiverSource designs provide LTC benefits through a **life insurance rider** that pays benefits as an **acceleration of the death benefit** (or related pool mechanics), meaning LTC payments can **change other policy values**. Your contract form controls the exact structure.

Q3. **What usually "triggers" RiverSource LTC benefits (ADLs vs. cognitive impairment)?**
A. In many RiverSource LTC rider forms, benefits are payable when the insured is certified as a **Chronically Ill Individual**—typically either: **unable to perform at least two ADLs without substantial assistance**, or requiring **substantial supervision due to severe cognitive impairment**.

Q4. **What documents does RiverSource usually require before paying benefits?**
A. Many forms require (1) a **current eligibility certification** from a **licensed health care practitioner**, (2) proof the insured is receiving **qualified long-term care services** under a **plan of care**, (3) proof the **elimination period** is satisfied, and (4) **claim notice/proof of loss** in the required format.

Q5. **How does the elimination period work under many RiverSource forms?**
A. A common structure is an elimination period defined as **90 days of receiving qualified services**. The days **do not have to be continuous**, but some forms require the EP to be satisfied within a **two-year lookback window**, and benefits are **not paid retroactively** for EP days. Always confirm your exact EP clause.

Q6. **Does home care count—what "kind" of home care provider usually qualifies?**
A. Many RiverSource forms recognize non-institutional services (home/community) and

define a **Home Health Care Provider** to include a **home health agency** or an **independent home health care provider**—but services typically must be delivered pursuant to a **plan of care**, and the provider must meet the policy's definition.

Q7. **Do I need a plan of care even if my family is doing most of the caregiving?**
A. Often, yes—because eligibility and payment commonly depend on proof that the insured is receiving **qualified services** pursuant to a **plan of care**, along with matching documentation (notes/logs/invoices as applicable). Even when family helps daily, the claim file usually needs **clinician-backed structure**.

Q8. **If my RiverSource LTC is an accelerated benefit rider, what should I watch for financially?**
A. The key point is that benefits may be paid as an **acceleration of the life policy's death benefit**, and rider benefits paid can **change other values** of the life insurance contract under the rider terms. Practically, treat it as a tradeoff: **cash flow for care now** in exchange for **reduced future life policy value** (depending on your form).