

Volume

1

DISABILITY CLAIMS SOLUTIONS

Learning Group LTD 101

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A GUIDE TO LEARNING GROUP LTD POLICY PROVISION

Group LTD 101

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Introduction – What is A Group LTD Policy?

“Knowledge and understanding of policy provisions, in advance of a disability, is the key to the process of fair and objective review.”

Hello, and welcome to Group LTD 101. The purpose of this book is to provide you with information about your group long-term disability benefit plan. I recommend all employees who have been provided with a group LTD policy as an employee benefit, obtain an official copy (not a certificate booklet) before sickness or injury begins. The knowledge and understanding you have of your policy provisions can prevent a claim denial when monthly financial assistance is needed most.

Although designed primarily for employees participating in employer sponsored plans, this manual also provides information and insight to attorneys as well as employers. Many of the eligibility issues associated with group LTD policies are often overlooked in ERISA cases. Employers will also find this book useful as a reference when your group LTD policy is revisited during your annual employee enrollment period.

This book will take you from the first page of your group LTD policy to the last, explaining its provisions in language you can understand. I strongly encourage you to contact your employer or other trusted resource if, after completing this workbook, you still do not understand what you are entitled to under your covered plan.

You and your family may have to depend on the financial income of a group disability policy during periods of injury or sickness, which are almost always sudden and unexpected. This book is intended as a valuable resource to help you “connect the dots” your employer may or may not have explained to you while you are still on the job.

Group LTD 101 is in workbook format. It provides you with pages of definition and self-test questions to help you understand common provisions most often written in “group employee benefit plans” such as your LTD policy. I hope you enjoy working through LTD 101, and feel you have gained valuable information and experience helpful to you in a time of medical and family crisis.

If you have any questions, please feel free to email me at lindanee@metrocast.net I am ready to assist you with your disability claim by providing the knowledge and assistance you need.

As part of your purchase of this book, you are also entitled to receive any updates, resources, or priority issue announcements relating to group LTD insurance. I will send them to you via email as the issues are made known.

Good luck and enjoy the group LTD workbook.

What Is a Group Policy?

Before we begin the technical study of the specific provisions in your group policy, it is necessary to explain what a group long-term disability policy is, and how these policies are distinguished from Individual Disability Income policies purchased from an agent or broker. If you have been provided with a long-term disability policy by your employer, you have what is called a “group plan.” Group disability plans are not underwritten separately, but are sold to employers covering all employees. The insured “risk” of paying a disability claim is therefore spread out among all members of the employer’s group. These plans have typically lower premiums than individual policies which are normally not affordable for most of the American working middle class.

Since “group” policies are sold directly to your employer, your employer is called the “policyholder.” Your employer enters into a contract with the disability insurer and receives an official copy of the policy. The employees are referred to as “certificate holders” or “beneficiaries” of the policy, but are not the owners of the policy. This is why employees who apply for benefits are only provided with a “Certificate Booklet” describing benefits rather than an official copy of the actual policy.

Premiums for disability group plans may be contributory or non-contributory. A non-contributory policy means 100% of the premiums are paid by your employer. For a contributory policy, the premiums are paid both by the employer AND the employee in accordance with some percentage usually deducted directly from the employee’s paycheck. Disability benefits received are taxable only to the extent to which premiums are paid for by the employer. For example, if your employer pays 60% of the premium and you pay 40%, then your monthly gross disability benefits are only 60% taxable. If you are paying part or all of the premium through payroll deduction on a before-tax basis, your benefits are again taxable. Deferred payroll deductions may save you money in the short-run, but generally not over time for disability.

Most group disability policies are regulated by the Employment Retirement Income Security Act of 1974. (ERISA) These laws are enforced by the U.S. Department of Labor. Individual Disability Income policies are not subject to ERISA. There are some group STD and LTD policies not regulated by ERISA, but these are policies issued to employers of governmental agencies of the state or federal government. The governmental agency must have the authority to exercise control over the business activities of your employer, and provide financial monies to the operations in order to be pre-empted by the ERISA statutes.

The first page of a group LTD policy is called the “Title Page” and contains important information concerning the effective date of the policy, the policyholder’s name, and the state which holds the governing jurisdiction for the issuance of the policy. A typical title page might look like this:

**PRICED RIGHT INSURANCE COMPANY, INC. GROUP LTD POLICY
NON-PARTICIPATING**

POLICYHOLDER: Disability Claims Solutions, Inc.

POLICY NUMBER: 513266 001

POLICY EFFECTIVE DATE: January 1, 1997

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Maine

PRICED RIGHT Insurance Company of Maine (referred to as “Priced Right”) will provide benefits under this policy. Priced Right makes this promise subject to all of this policy’s provisions.

The policyholder should read this policy carefully and contact Priced Right promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees’ signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Priced Right can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Priced Right in Belfast, Maine on the Policy Effective Date.

Notice the policyholder is an employer and that the policy does not name each individual employee. This is because employees are not a party to the disability contract. The effective date is the date the policy is placed “in force”, usually the first of the year following an annual enrollment period. Disability policies are generally renewable only on the anniversary of the effective date indicated on the title page. In addition, any amendments or changes made to the policy can only be made once a year on the anniversary of the effective date.

A group “policy” governed by ERISA is referred to as “the plan”, and the accumulation of documents resulting from any claim you file is called “the administrative record.” An employee who submits a claim for benefits is called “a claimant.” For individual disability income claims the person filing for a claim is referred to as “the insured”, and the records are referred to as the “claim file.”

Insurance policies in general may be either “participating” or “non-participating.” “Participating”, means the policyholder will share in any dividend distribution the insurer makes to owners of insurance policies. This type of “dividend share” is most often seen in Individual Disability and Life Insurance policies. Group disability policies are always “non-participating” which means the neither the policyholders nor the certificate holders will receive any distribution of dividends from the insurer.

Your question in looking at the title page of your policy should be: “Is this the policy that was in force as of the date of my disability?” Always check the title page to make sure you have been provided with the policy “in force” as of your date of disability, and that you have been provided with copies of any added amendments.

Located at the bottom of each page is a number designation which describes the provisions, page number, and effective date. For example, a typical page number might be “LTD-BEN-3 (1/1/97)”. This means the page contains long-term disability provisions, benefit descriptions, page 3, effective 1/1/1997. If information has been amended, the date the date of change is so indicated.

All group policies under ERISA are required to have a “Plan Summary” page called the “SPD”. Some insurers call this page “Benefits At a Glance”, or just “LTD Summary.” All plan summaries must provide the holder with basic information about the policy eligibility requirements. All items listed on the summary page can be found in other provisions of the policy in more detail. The “SPD” is a disclosure requirement of ERISA. Here is a typical “Plan Summary” page. But first, let’s review.

SELF TEST QUESTIONS

Obtain a copy of your employer’s group plan and write in the information below from the Title Page and Summary Plan Description.

Am I a full-time or a part-time employee? FT PT

How many hours do I work per week? _____

**When was my group LTD policy effective? Do I need to enroll every year with my employer?
Yes No _____**

**Is my policy contributory or noncontributory? (Circle which one.) If contributory, I pay
_____ % of the premium.**

Is my policy an integrated STD/LTD plan? Yes No

If yes, does my employer self-insure my short-term benefits? Yes No (Circle)

I am considered a Class _____ employee.

LTD DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: January 1, 1997

POLICY NUMBER: 513266 001

ELIGIBLE GROUPS:

All Employees in active employment

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before January 1, 1997: None

For employees entering an eligible group after January 1, 1997: None

ELIMINATION PERIOD:

90 DAYS

Benefits begin the day after the elimination period is satisfied.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of \$6,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability

Maximum Period of Payment

Less than age 60

To age 65, but not less than 5 years

Age 60

60 months

Age 61

48 months

Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

No premium payments are required for your coverage while you are receiving payments under this plan.

OTHER FEATURES:

Disability Plus

Minimum Benefit

Noncontributory

Pre-Existing 6/12/24

Survivor Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

PARTS OF THE PLAN

ELIGIBLE GROUP(S) In order to be covered under a disability policy, you must be in what is called an “eligible group.” In the above example, all employees of Priced Right, Inc. are eligible for LTD coverage. This is not always the case. Your employer may have decided to provide coverage for some employee groups and not others. This section could have read, for example:

Group 1

All full time and part-time employees earning \$170,000 or less per year in active employment.

Group 2

All full-time and part-time employees earning more than \$170,000 per year in active employment.

As soon as you obtain a copy of your policy, you should always check to be sure you are in an eligible group of covered employees. You may hear through the employee grapevine you have LTD insurance, but if you are not in a covered eligible group listed in the plan, you are not eligible and will be turned down, if you apply for benefits. Eligible groups may also be referred to as “Class 1, or Class 2”.

In addition, there may be different classes of employees at different locations of the same employer. For example, you may be paid by the Pennsylvania Health Care Partners Association, but this employer has 35 different locations with very different classes of eligible employees at each location. Always check the policy to determine if you are included in an Eligible Class at the location in which you are actively working.

MINIMUM HOURS REQUIREMENT This is an eligibility requirement which sets a minimum number of hours an employee must be working just prior to disability in order to be eligible for benefits. For example, let's say you went out for a period of disability, were paid, but then your benefits were denied. If you never go back to work, and are still sick and file another claim, you won't be eligible because you were not working the required number of hours just prior to your date of disability. The minimum hours requirement may significantly affect your eligibility for benefits if you are working part-time, for example, and the provision requires you to work 40 hours. You must be working the minimum number of hours stated in the disability policy just prior to your date of disability in order to be eligible for benefits.

WAITING PERIOD this is the period of time a new employee must wait in order to be eligible for benefits and/or annual enrollment. In the above example for Priced Right, Inc., if you were hired on, before or after January 1, 1997, you are covered as of your first day of employment. This is not always the case.

Another example of a waiting period description might say:

“Employees entering an eligible class after the policy effective date: First of the month coinciding with or next following the date of active employment.”

Let's say you were hired on January 15, 2000. Your EFFECTIVE DATE OF COVERAGE will be February 1, 2000 which is the first of the month following your date of hire. The “effective date of coverage” is extremely important since pre-existing periods (we'll cover this a little later) are determined from the effective date of coverage. What if you were hired on January 1? Your effective date of coverage would be January 1. (Not a trick question, honest!)

ELIMINATION PERIOD is the period of time for which benefits are NOT paid after you file a claim. The elimination period begins the day after your last day worked (LDW) and stops on the last day indicated in your policy. This means if your plan has a 90 day elimination period, benefits would begin on the 91st day after your last day worked. Many people often confuse a “waiting period” and an “elimination period.”

Remember, a waiting period is the period of time you must wait in order to be ELIGIBLE for benefits, while an “elimination period” is the period of time after you file a claim for which you will not receive benefits. For LTD benefits, requiring you to satisfy an elimination period “eliminates” short term sickness and injuries which do not last long, and enable the claimant to return to work.. LTD really does mean long-term. STD elimination periods are typically short – 0-5 days.

MONTHLY BENEFIT For LTD, monthly benefits are always determined by a certain percentage of your pre-disability monthly earnings, most often 50%, 60% or 70%. “Monthly earnings” has a very specific definition described in more detail later on in your policy, and it is important for you to be able to verify your monthly earnings reported to the disability insurer so that you know you are being paid accurately. The insurance company will request either the previous year's W-2 or current payroll records from your employer. A calculation will be made in accordance with the “monthly earnings” definition in your policy. Always inquire what your “monthly earnings” calculation is, and verify the

number given to the insurance company from your employer. I have reviewed numerous claims where upon examination, the claimant has either been underpaid, and on occasion, overpaid. Neither situation is accurate, and requires correction as soon as the error is discovered. Always check and recheck the calculations involved when determining the amount or amounts you are to be paid.

MAXIMUM PERIOD OF PAYMENT OR MAXIMUM BENEFIT PERIOD Depending on your age at the time of disability, this is the maximum period your benefits may be paid. If you are under the age of 60 at the time of your disability, according to the example plan summary above, your benefits will be paid to age 65. If you are over the age of 60, your benefits are limited. Group plans do not insure for lifetime benefits.

A GOOD CASE IN POINT—Cecil’s Missed LTD Enrollment Period

Cecil Doolin is a 45-year-old warehouseman, employed by a local home supply chain. His employer offers all employees the opportunity to sign-up for group LTD insurance after one year of continual employment. On January 1, 2004, Cecil became eligible for his employer’s annual enrollment, but forgot to go and sign-up on the date his notice told him to report to the cafeteria. In fact, Cecil was so busy moving boxes for the annual inventory, he misplaced his enrollment card, and didn’t remember it until June 2005.

Cecil happened to meet an HR benefits representative in the hall sometime in the later part of June, and inquired about the LTD coverage. Marci told him to stop by and she would give him a form to complete called “Evidence of Insurability”.

“Since you missed the annual enrollment period”, she told him, you need to submit this form. “Do you have any medical conditions?”

Cecil shrugged. He didn’t know if he really wanted to answer that question since he did have some back trouble and had planned on having surgery sometime in the near future. His doctor recommended “as soon as possible”, but in addition to his 12 weeks of short term disability, he may need another two months of LTD benefits to keep his family going. He put off the surgery because of his blunder in not signing up for LTD when he had a chance. Cecil decided to wait until the next annual employee enrollment period.

On January 1, 2005 Cecil filled out his LTD enrollment card and became effective on his employer’s group sponsored plan. “Just in the nick of time”, he thought, “my back is killing me.” Cecil did not ask Marci for a copy of the LTD booklet.

On February 19th Cecil had his back surgery and after receiving 12 weeks of STD, applied for LTD since his Orthopedic Surgeon had not released him to return to work. Cecil’s occupation as a warehouseman requires lifting of up to 50 lbs. Cecil’s claim for LTD was denied due to the existence of a pre-existing condition.

Since Cecil’s date of disability occurred within 12 months of his effective date of coverage (January 1, 2005), the insurance company investigated the three months prior to the January 1st date to determine if he had received any treatment, consultation, or took prescribed medications for this time period.

There are quite a few lessons we can learn from this scenario. Generally, it is always a good idea to be “on the lookout for your annual” LTD enrollment period” and make a special effort to sign the enrollment card at that time. If Cecil had turned in his enrollment card on January 1, 2004 when he

originally became effective, his LTD disability in February 2005 would not have been subject to a pre-existing condition investigation. In fact, Cecil had an additional 31 day grace period to turn in his enrollment card.

In addition, Cecil should have obtained a copy of his LTD booklet from Marci in January 2005, at the time of his enrollment. Had he read through the complete policy he may have noticed the pre-existing condition provision, and put off his surgery as long as he medically could.

Unfortunately, Cecil was compelled to return to work, prematurely, in order to continue to receive his salary and support his family.

EVIDENCE OF INSURABILITY OR EOI If you miss your annual enrollment period by 31 days after you became eligible as a covered person you must file a form called “Evidence of Insurability” with the insurance company. This is an underwriting form which is used by the disability insurer to determine if you can be covered as part of the employee group, or due to medical conditions, whether your policy needs to be separately underwritten and a greater premium charged to the employer.

In general, there are three occasions when you must complete the EOI: 1) if you apply for coverage as a late enrollee; 2) your coverage under the Policy stopped and you need to apply for reinstatement; or, 3) you were eligible, but not covered under a prior plan.

The purpose of EOI is to prevent the possibility of “adverse selection” by preventing employees who previously declined coverage to decide after the fact to sign on when a serious disease is discovered.

Another good example of the EOI requirement is that employee who declines coverage because the plan is contributory (perhaps too expensive) and then decides to accept coverage because of pending surgery, or the diagnosis of a serious disease. Remember, group insurance can be said to be guaranteed since there is no “adverse selection” because the risk is spread out among all members of the insured group. This is true only if the individual employee accepts coverage at first annual enrollment period when eligible for coverage.

Long-Term Policy Provisions

The next several pages of your policy describe provisional requirements your employer has agreed to. Issues such as: the payment of premium, changes in premium rates for the group, and cancellation guidelines are written for the benefit of your employer who is the policyholder. The certificate section of the Plan Document (your policy) also describes plan summary definitions in more detail. These definitions are mostly self explanatory, but should be reviewed.

Several of the more important provisions in the certificate section include information as to when your insurance begins, what happens if you are temporarily laid off, or on leave, when your coverage ends, statute of limitations on legal actions and how the insurance company intends to handle cases of insurance fraud. These topics are briefly discussed below.

After your waiting period is satisfied, most employers will give you an opportunity to sign up for LTD insurance right away, and then ask you to re-enroll annually just before the anniversary date. This gives you the opportunity to choose various options if available.

You must apply for LTD insurance within 31 days of becoming eligible. (31 days after you satisfy the waiting period.) If you do not enroll, you must submit evidence of insurability (a disclosure form) which asks you specific health questions. The disability insurer then performs an underwriting analysis on your application instead of including you in the risk pool of the entire employee group. You may or may not receive LTD insurance at that point if you have one or more health problems, and may only enroll at the next yearly employee sign-up. When you are given the enrollment card, it is always best to sign-up right away and not wait. You must also provide evidence of insurability if you voluntarily cancelled your coverage and are reapplying.

If you are temporarily laid off and the premiums are paid by your employer, LTD coverage “remains in effect through the end of the month that immediately follows the month in which your temporary layoff begins.” For example, if you are laid off on April 10th, your LTD insurance remains in effect until May 31st. Family Medical Leave (FMLA) generally follows the same coverage extension.

A typical provision describing the end of your coverage might say the following:

“Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;

- the last day of the period for which you make any required contributions;
- the last day you are in active employment except as provided under the covered layoff or leave of absence provisions.

If you were a full-time employee and were in an eligible group, but reduced your hours to part-time, you may not be covered.”

THE DEFINITION OF DISABILITY

Each LTD policy has a provision defining under what conditions you will, or will not be awarded benefits. This provision is called “the definition of disability”, and it is the most important writing in your policy. Nearly all claim denials result from in-house interpretations of facts and how they relate to the definition of disability. Having a complete and thorough understanding of this provision is essential in managing and staying in control of any future claim process. The provision itself may seem very concise and understandable, but do not be misled. Words used in this provision have specific meaning, and it is equally important to have a grasp of the insurance vocabulary.

There are four basic types of definitions of disability written into group policies:

- ↳ 2-year own occupation with partial;
- ↳ 2-year own occupation with residual;
- ↳ LTIP (long-term income protection); and
- ↳ LTOC (long-term own occupation).

A detailed discussion of each one of these follows:

Here is an example of a **2-year own occupation with residual** policy:

You are disabled when Priced Right determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness or injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

*After 24 months of payment, you are disabled when Priced Right determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful** occupation for which you are reasonably fitted by education, training or experience.*

First of all, notice this two-part definition says “and”, not “or”. This means that you must meet BOTH conditions in order to qualify for benefits. **Limited** means you must not be able to do all of the important tasks normally identified with your occupation.

Material and Substantial duties are those required for the performance of your regular occupation, and cannot be reasonably omitted or modified. For example, if we removed “typing” from the occupational description of Secretary, in most instances, the occupation is no longer “Secretarial”.

“**Material duties**” are those which are characteristic to specific occupational tasks without which the occupation could not be distinguishable into any specific category or job specification. These duties are qualitative in nature and are those duties, which if eliminated, indicate the occupation, as defined, would not exist.

“**Substantial duties**” are job tasks which represent the largest proportion of total tasks performed in an 8-hour work day. Substantial duties are also recognizable as those which if eliminated, prevent the occupation from existing. These duties are quantitative, and suggest the performance of specific occupational duties for the majority of an 8-hour workday. Four hours per day is considered to be part-time.

“**Material duties**” refer to specific job-related tasks and is generally a qualitative measurement, while “**substantial duties**” refers to proportionate time spent and is an identifiable quantitative determination.

In general, those duties requiring more than 20% of your work day are considered to be material and substantial in nature.

Regular occupation means the occupation you are routinely performing when your disability begins. All group LTD policies require the insurance company to “**look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location, or job.**”

Most employees are very surprised to learn their group LTD policies do not insure actual **JOBS!** There is a big difference between what you do for a **JOB**, and what your **OCCUPATION** is. Group LTD policies only insure you to the extent you are unable to perform your **OCCUPATION** as it is normally performed by the majority of people who do the same occupation in the United States. Occupations are defined by using the standards used by the Department of Transportation, referred to as the DOT.

Here is an actual example of the job versus occupation issue, as it relates to claim situations. (The name of the claimant has been changed to protect his privacy.)

A GOOD CASE IN POINT – Stan’s job vs. occupation issue

Stan Whitmore is a 42 year-old retail manager for the Eckerd chain of discount stores. He has worked for Eckerd Drugs for the last 10 years, and supervises 15 employees. His job with Eckerd requires him to assist drivers in unloading inventory which can weigh as much as 40-50 pounds. He is required to be on his feet the majority of a 10 hour workday, and spends a great deal of his time stacking shelves and moving store fixtures. Last year, he began to have difficulties with his back which required surgery. His disability insurer paid a short-term disability claim, and later about 8 weeks of long-term benefits.

Shortly after the 8 weeks of LTD benefits, he was notified by the insurance company the occupation of “Retail Manager” as described in the DOT did not require lifting and stacking shelves, therefore, his claim was denied. Stan’s restrictions and limitations precluded him from lifting anything greater than 10 pounds. Could Stan return to his present job? NO. Will he receive LTD benefits? NO. Since the insurance company only insures his occupation as it is performed in the national economy (which does not require lifting), in this case defined as most supervisory and administrative, he will not receive benefits if the insurance company can show he is physically able to perform his “material and substantial” duties as they are performed in the national economy, namely the DOT.

You may ask the question, “What is Stan supposed to do now?” The response to Stan from the insurance company is, “Find another job because we can’t pay your claim under your current disability definition.”

It is extremely important for all individuals covered under a group LTD policy to understand the difference between your JOB, and your OCCUPATION. You can write to the U.S. Department of Transportation and ask for a DOT for your occupational category. O*NET online can give you a summary of most occupations.

Remember, your policy does not insure what you actually do on the job, but only what you are supposed to be doing as defined by the U.S. Department of Transportation for your occupation. It is extremely important you understand this basic concept when covered by a group LTD policy. There are a few court precedents requiring disability insurers to use a more liberal interpretation of the definition of “occupation”, (such as in the state of California). but in most incidents, the definition is applied as described above. (California, for example, requires the occupation to be defined a certain way regardless of policy provisions.)

Sickness means an illness or a disease while **Injury** mean a bodily injury that is the direct result of an accident and not related to any other cause. Most injuries or accidents on the job can be referred to Worker’s Compensation and if paid, will be an offset to any disability benefits you may receive. An “Accident” is covered by Accidental Death and Dismemberment insurance which is a separate policy from LTD.

The first part of the definition of disability defines the criteria which must be met for the first 24 months of your disability, namely that you cannot perform the duties of your occupation, AND you must have at least a 20% earnings loss. The second part of the definition tells you what criteria you must meet if you continue to be disabled starting on the 25th month.

On the 25th month, your definition of disability changes from an “**own occupation**” definition to an “**any occupation**” definition. This is a pivotal point in your claim and represents a “lost opportunity” for the insurance company if they are unable to deny benefits at this point in time. In fact, many disability insurers “target” claims for “any occupation” investigations and plan on achieving financial projections from denying LTD claims at this point. These investigations take place anywhere between 9 to 18 months of paid benefits.

Insurance companies are well aware of the fact that if they cannot deny your claim at this point in time, it is likely they will have to pay the claim to duration, usually age 65. To the insurance company, this is an unprofitable situation, not a profitable one, and an involved investigation is undertaken. This investigation is referred to as an “any occupation investigation.”

Nevertheless, the contractual agreement between your employer and the disability insurer provides for a change of the definition of disability after the 24th month, and therefore, the insurance company is entitled to an investigation of your ability to work in *any* occupation for which you have training, education, or experience.

At this point the burden of proof rests with the insurance company to show you can perform occupations other than your own. To do that, follow-ups are scheduled by the claims specialist to begin the any occupation investigation sometime between the 9th and 18th month of paid benefits. The purpose of the any occupation investigation is to document alternative gainful occupations based on your training, education and experience.”

I'm going to describe the "any occupation" investigation the way it should be performed by the disability insurer, not the way it IS performed by some insurance companies. Due to ill-trained employees, and the sudden "rush" to prematurely deny claims, I have observed any occupation investigations are quite often "bungled". **The claim is denied, but the any occupation investigation is not credible.**

This particular procedure, unfortunately, results in the GIGO, garbage-in, garbage-out principle. If inaccurate information is used in the transferable skills analysis, for example, inaccurate information is communicated in the conclusion. It takes a trained eye to identify whether these investigations are valid and in accordance with the provisions of the policy, which is a good argument for having an experienced consultant to advise you.

The claims specialist will begin the any occupation investigation some where between the 9th and 18th month of paid benefits. I've have noticed the investigations are beginning earlier and earlier in the claims process.

The insurance company will send you a letter notifying you they are beginning to "investigate your claim beyond the 24th month." Generally, this letter will quote your definition of disability from your policy. (Please verify this quoted definition of disability directly from your copy of the policy.) Within a short period of time you will receive a second letter requesting updated medical information, and a completed "Training, Education, and Experience" form. (TE&E)

It is important for you to consider this particular medical request seriously and obtain as much medical certification concerning your impairment as you can. It is also important to send this updated information to the insurance company in a timely manner. Remember what I said about the GIGO principle? If the insurance company has incomplete or late information they will deny your claim without having the basis of all relevant medical information. We don't want this to happen.

The claims representative will call you to conduct a detailed phone interview with management approved questions. The purpose of this interview is to document your claim file with any statements you make which can later be determined to be inconsistent with previously reported, and observed or medical data. Be careful.

When all the medical documentation requested has been received (or the deadline given in the letter has passed), the insurance company refers your claim for an in-house medical review to "clarify restrictions and limitations." In other words, the insurance company will not accept the restrictions given by your primary care physicians, but will examine your records and document R&L's of their own which they call "reasonable." Once these restrictions and limitations are clearly documented by in-house RN's, your claim file is referred to an outside vocational/rehabilitation agency for a "transferable skills analysis". (TSA) A common agency used for this purpose, among others, is GENEX Services (UNUM), or MATRIX. (Reliance Standard)

The vocational agency examines the restrictions and limitations determined by the insurance company, your completed TE&E (Training, Experience and Education form), and using various data base software programs, locates "alternative occupations" which you *should be able* to perform. In order for the results to be credible more than one occupation will need to be identified. The software programs used will also provide the agency with expected hourly and yearly salaried amounts. For example, if the insurance company determines sedentary work capacity is "reasonable", then all occupations considered "gainful", and sedentary, will be located, and documented.

Therefore, the first test, or burden of proof, if you will, is to locate alternative occupations the insurance company feels you can perform. The next task is to determine which of the occupations identified are gainful. LTD policies require alternative occupations identified after the 24th month to be “gainful”. A typical definition of “gainful” might be:

“GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment within 12 months of your return to work.”

If your policy is silent as to the definition of “gainful”, AND your policy has a 20% earning loss requirement, “gainful” is assumed to be 80% of your pre-disability earnings. Some policies require “indexing” in order to determine whether or not the alternative occupation is “gainful” or not. (I will explain indexing a little later.) What does all this mean for you?

Basically, the insurance company may not claim you can work in occupations which will not provide you with commensurate wages. If you were earning, let’s say, \$50,000 the year before you became disabled, the insurance company may not claim you can work at McDonalds. Or, if your monthly LTD benefit is \$3,500 per month, McDonald’s wouldn’t be considered “gainful” either.

The Transferable Skills Analysis, then, must show two things:

1) alternative occupations and 2) gainful occupations. And, there must be more than one “gainful” occupation given. If the occupations identified are complex, or, you live in a remote geographical area, the agency may perform what is called a Labor Market Survey to determine the availability of jobs within a 50-60 mile radius of your residence. A Labor Market Survey is not required in all cases, but it will document specific employers, job requirements and salary within the areas indicated. The LMS is intended to resolve the question: “ These identified occupations are not available in my area.” Therefore, the LMS is generally only performed when the claimant resides long distances from major urban or employment areas.

Once the completed TSA is received by the claims specialist, it is reviewed to determine the conclusion. If the TSA has identified “gainful” alternative occupations you can do, given your training, education, and experience, your claim is then denied for benefits beyond the 24th month. Nothing you say or do will stop this process.

Let’s step back a moment and take a look at this. First of all, the restrictions and limitations given by your own qualified medical providers are not used in the TSA to determine your realistic physical work capacity. Only those determined to be reasonable by in-house medical personnel are used. Second, if inaccurate information is given to the vocational agency conducting the TSA, their conclusions will also be invalid.

Insurance companies make monumental errors in this change of definition investigation, but deny claims nonetheless. Here are the most common errors:

- ↳ Inaccurate, outdated or incomplete medical information is forwarded to the TSA agency. Garbage in, garbage out.
- ↳ Identified occupations are not reviewed to determine if they meet the definition of “gainful” in your policy. There is no documentation in your claim file that the issue of “gainful” was even addressed by the insurance company.

- ↪ The test of “reasonableness” is not applied. For example, if the TE&E of an RN indicates she has only worked in patient care, it would not be reasonable to suggest she could later work in the ER, or in a clinical setting. Or, if an individual has been with their current employer for 15 years, it is not reasonable to suggest he/she could change occupations easily. Another example is if a claimant is 55 years old, does it really make sense that they are easily employable? What if a person has a third grade education and cannot read? Is it reasonable to assume they can be retrained and employed in a new occupation? Many insurance companies fail to employ the “common sense” test and as a result large numbers of claims are denied.
- ↪ Similar to above, gainful is not determined using “indexed” earnings if that definition applies. Claims specialists often are not trained to perform “indexing” and therefore this step is often omitted.
- ↪ Insurance companies abuse the “broad definition” of certain occupations such as RN’s, attorneys, and physicians.
- ↪ Complex or dual occupations are not investigated and documented by a qualified vocational/rehabilitation resource.
- ↪ Inaccurate and/or outdated DOT’s are used by the disability insurer when defining the functional capacity of your “occupation.” An Executive Director’s job listed as sedentary in physical capacity in 1977 may not be sedentary work in 2006.

All group LTD claims with a change in definition of disability undergo an any occupation investigation at some point in the claim history. Again, insurance companies consider the any occupation investigation to be “a last ditch opportunity” to terminate benefits legitimately in accordance with the “change in definition.”

A GOOD CASE IN POINT.... A case of laundry????

Let’s meet Betty M. Betty is a Registered Nurse who works at the local Memorial Hospital. Betty’s job involved routine patient care with some supervisory duties, daily reports and chart review. One day while she was handing out medications, Betty slipped on a wet floor and sprained her back which was very painful. After several weeks of trying to work, Betty’s doctor placed her on temporary leave and sent her home. Since she met all of the eligibility requirements of her employer, Betty qualified for STD benefits and was in the 25th week of an approved 26 weeks of leave.

Betty got a call from her insurance claims handler. She was asked questions such as “How do you do your laundry? Do you carry your laundry up the stairs from your basement? How many times a week do you DO your laundry?” In fact, Betty had been doing her laundry in the basement of her house and carried the laundry basket up 20 steps to the kitchen. Of course, Betty admitted she did do her own laundry several times a week, but that her back hurt continually especially when carrying the basket up all of those stairs.

A week later Betty received a denial letter from her disability insurer. According to the claims specialist, carrying a laundry basket up a flight of stairs several times a week equates to 2.5 METS which is equal to a “light physical capacity.” Since the occupation of a Registered Nurse is considered to be “light”, Betty was now able to perform her own occupation and her claim was denied.

Incredible!

What's a MET? A "metabolic equivalent" (MET) is the amount of oxygen used by an average seated person. METs increase with the intensity of exercise. METs are usually measured during cardiac stress tests. Consider the following:

Lying or sleeping	1 MET
Desk Work	1.5 MET or Sedentary Work Capacity
Driving	1.6 MET
Fishing	1.8 MET
Sitting	1.4 MET Sedentary Capacity
Standing	2 MET
Housework	1.5 MET
Bicycling	3-9 MET or Light Capacity
Boating	3-4 MET
Bowling	4 MET
Golf	2-4 MET or Light Capacity
Swimming	4 MET
Walking	2-4 MET
Yard Work	3 MET
Dancing	4-6 MET
Racquet Sports	5-10 MET
Running	8.5-16.3 MET
Shoveling	5 MET or Light to Medium Work Capacity
Skating	5 MET
Skiing	6.12 MET

You can easily see how a disability insurer could equate an activity to work capacity, particularly if the activity is performed on a regular basis while on disability. Always be mindful of the type of information you are giving to any insurance company, either in writing or on the phone.



At the beginning of this discussion, I defined the “definition of disability” above as a **2-year own occupation with residual**. The word “residual” means you may work during the elimination period, which is fairly common since most people will try to return to work, but find they just can’t do so on a continuous basis. Your policy will have this same or similar wording:

“You must be continuously disabled through your elimination period. Priced Right will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.”

Gainful occupation means an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment within 12 months of your return to work.

Working During the Elimination Period

The above contract wording is often very difficult to understand and apply to situations. For a 2-year own occupation with residual policy, you may work during the elimination period, but it cannot be **gainful work**. The wages you earn for every day you work during the elimination period must be reviewed to determine if the daily wage is at least equal to your gross disability payment. If the wages are determined to be “gainful”, **then that day cannot count toward satisfying the elimination period**. You can only have 30 such “gainful days” during the elimination period. If there are more than 30 days, then you have to start the elimination period all over again. The 30 days of gainful work, need not be consecutive days. Understand? Well, let me give you this example.

Let’s say Marsha’s date of disability is 4/1/2005. This means her elimination period is from 4/1/2005 to 6/29/2005, 6/30/2005 being the 91st day or the date benefits will begin. Marsha’s LTD monthly benefit is \$1,200 per month or \$300 per week, or \$7.50 per hour. During the elimination period, Marsha tries to work, if she can. Her hourly wage at her job is \$10.00 per hour.

On one of the days Marsha worked, she was able to work 8 hours, for a total of \$80 for that day. The question is whether Marsha’s wages for that day were “gainful” or not. According to the above definition of “gainful”, Marsha’s earnings ARE gainful for that day and therefore, **the day may NOT be counted toward satisfying her elimination period**. In fact, Marsha may only work less than 7.5 hours per day (and earn less than \$1,200 per month) in order for the day to be considered “not gainful” and counted toward her elimination period. If Marsha were to have at least 30 “gainful” days of earnings within her EP, she would have to start all over with a new date of disability and satisfy another new elimination period.

In order to apply the test of the above provision, each day’s wages must be analyzed to determine if the wages earned are gainful or not gainful for that day. This is an area in which both claimants AND insurance companies make numerous errors.

What if the claimant had 25 days of “gainful work” within the elimination period? In this case, the 25 days are added to the end of the elimination period. 6/29/2005 + 25 days = July 24. The EP ends on 7/24 and the first benefit payment date is July 25th. Does this make sense? The claimant MUST satisfy a full 90 days of the Elimination Period. It may look like the EP ran from 4/1/2005 to 7/24/2005 (115 days), but there were 25 days worked with “gainful wages” that did not count toward satisfying the Elimination Period.

I realize the above may be somewhat difficult to understand, but my message is all employees should know the definitions of disability, and gainful, before attempting any return to work during the elimination period. If you are working part-time during the Elimination Period, check your policy and determine what constitutes a “gainful wage”, and find out how many days you are working during the EP and when benefits will begin.

SELF-TEST



Define the following group LTD concepts as you understand them. Use your own group LTD policy and locate the information below for your own coverage.

Certificate Holders _____

The Administrative Record

Evidence of Insurability

Effective Date of Coverage

Transferable Skills Analysis

Material and Substantial Duties

Job versus Occupation

TE&E Form

Waiting Period vs. Elimination Period

The second type of group LTD definition of disability is the

2-year own occupation with partial.

You are disabled when Priced Right determines that:

- *you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness or injury**; and*
- *you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.*
- *during the elimination period, you are unable to perform any of the material and substantial duties of your regular occupation.*

*After 24 months of payment, you are disabled when Priced Right determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful** occupation for which you are reasonably fitted by education, training or experience.*

Please notice the above definition is the same as that given for a **2-year own occupation with residual**, except the employee must NOT work during the elimination period. This is extremely important for you to know before attempting any return to work during your elimination period.

Employers typically encourage workers to return to work as soon as they can, and, if you have been released by your physician to return to work duties, you need to do that. But unfortunately, some employers “talk” their employees into returning to work prematurely. If you attempt a return to work during the elimination period with a **2-year own occupation with partial definition**, you will not be paid disability benefits, until you satisfy a full EP without working. This could mean financial disaster for you and your family if you cannot work, but on the advice of your employer, you try to work anyway during the elimination period, and just can’t sustain it.

This is why I strongly encourage all working Americans with group disability policies to obtain a copy of their policies and understand the consequences of all of the provisions before it is necessary to file a claim. Again, this is also a very good argument to retain a consultant or other trusted resource at the time of filing a disability claim.

The third type of definition of disability found in group LTD policies is LTIP, or, **Long-term Income Protection**. The provision is as follows:

You are disabled when Priced Right determines that:

- *you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness or injury**; and*

- *you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.*

Notice there is no change in definition after 24 months. Group LTIP policies are more expensive for your employer because under this definition, if you cannot perform your own occupation, the disability insurer must pay your claim. In other words, there is no ANY occupation investigation, no TSA, or Labor Market Survey. Simply, the insurance company has a liability to age 65 if you cannot do your own occupation. LTIP definitions allow you to work during the elimination period as long as your earnings are not gainful. Look at the definition of disability in your policy. If you do NOT see the 24 month change in definition mention, chances are you have a LTIP policy, which is much to your advantage.

The final type of disability definition found in group policies is LTOC, or **Long-term Own Occupation**. The definition is as follows:

You are disabled when Priced Right determines that:

- *you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness or injury**; and*
- *you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.*
- *during the elimination period, you are unable to perform any of the material and substantial duties of your regular occupation.*

Again, notice the absence of the 24 month change in definition of disability. But, LTOC policies do not allow the employee to work during the elimination period. You must be totally disabled during the elimination period in order to receive benefits. Like LTIP policies, the disability insurer is committed to pay you benefits if you are unable to perform your OWN occupation. There is no change in definition investigation to locate alternative occupations you can perform which are gainful.

A Word About Indexing...

Many people confuse indexing with a Cost of Living Increase (COLA). These two provisions are very different. Indexing is only considered when you are working part-time and the disability insurer calculates the amount of partial benefit you are entitled to. Indexing is a mathematical calculation using the Consumer Price Index to “take into account” the effects of inflation and the value of the purchasing power of your earnings.

Confusing? In 1934 the cost of loaf of bread was 15 cents and a quart of milk was 9 cents. I think we all agree that something has happened in our economy since 1934 since today a loaf of bread is nearly \$2.00. Due to economic inflation it now takes more dollars to buy the loaf of bread today, than it did in my grandmother’s time. Another way of looking at this is to consider the devaluation of the American dollar. Let’s say the American dollar is worth 1/3 less in its ability to buy goods and services than it used to. This means it would take \$1.33 to buy the same goods we used to buy for just \$1.00.

So, how does all this affect disability? It really doesn’t unless you have been on claim for more than a year and have been working part-time. If your policy was issued, let’s say in 1987, your monthly earnings (on which your benefit is based) could purchase goods and services based on 1987 dollars. If

you have been working for over a year and have been receiving monthly disability benefits, the disability insurer must consider the affects of inflation when calculating your 20% earnings loss.

The Consumer Price Index is a decimal of the increase in economic inflation published by the Department of Labor on a yearly basis. If you are working part-time for more than a year, the claims specialist must look up the CPI index and apply it to the calculation of your monthly benefit. It is always a good idea to ask the specialist to send you a copy of the actual calculation in order to verify “indexing” has been applied when calculating your benefit. Indexing must also be applied when considering whether an identified occupation is “gainful” during a Transferal Skills Analysis.

A typical definition of indexing appearing in Group LTD policies is as follows:

“INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. UNUM reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Indexing is only used to determine your percentage of lost earnings while you are disabled and working.”

In summary, **2-year own occupation with partial** and **LTOC** policies are the same except with the LTOC definition there is no change after the 24th month of paid benefits, and you may not work during the elimination period with either definition.

Similarly, **2-year own occupation with residual** and **LTIP** are the same. You may work during the elimination period, but with LTIP there is no change in definition after the 24th month.

Once again, the definition of disability written into your group LTD policy is the most important provision requiring understanding. The definition of disability in your policy is the provision written into all approval and denial letters from insurance companies and may have lasting legal consequences if you choose to litigate any claim denial. Always check your policy to make sure the disability provision disclosed to you is the one actually written into your policy.

If you do not understand the differences and possible consequences of your “definition of disability”, contact a disability claims consultant, your employer, or other trusted resource for clarification. It’s *that* important.

A GOOD CASE IN POINT – Change in Definition? Not Really.

Mathew began receiving benefits in January 2003. In fact, due to his impairment, he continued to receive monthly disability payments until February 1, 2005 when his benefits were denied.

The written denial communication he received from the insurance company explained “alternative gainful occupations were identified” and “because of the change in definition occurring after 24 months, there were other occupations he could perform, and therefore he was not considered to be totally disabled from performing any occupation.” Mathew and his family were going to be hurt financially by this decision. He decided to check it out. After searching through all of his family papers,

Mathew finally located the “certificate” copy of his policy. He located the “definition of disability” in his policy provided to him by his employer.

It read: “you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness or injury**; and

*you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.*

There was no mention of a “change in definition” after the 24th month, but his denial letter had given him a definition which said, “After 24 months of payment, you are disabled when *Priced Right* determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful** occupation for which you are reasonably fitted by education, training or experience. “

Obviously, the insurance company made a mistake. Mathew called the claims specialist and asked for proof (a photocopy of his policy showing a change in definition). After several days, the specialist returned his call telling him they had in fact made a mistake. Mathew’s benefits were reinstated.

Had it not been for Mathew’s investigation and verification of his policy’s “definition of disability”, his benefits could not have been restored. A good lesson for anyone with a group policy.

SELF-TEST

Name the two types of “definitions of disability” which allow you to work (not gainfully) during the elimination period.

What is the significance of the word “gainful” for residual policies?

Name the four types of “definition of disability” provisions found in group LTD policies.

What is the significance of the TSA (Transferable Skills Analysis) and which two policies will require an “any occupation investigation”?

Under which two “definitions of disability” must you be totally disabled during the elimination period?

What is the difference between a 2-year own occupation with residual policy and LTOC?



A Serious Note about **REGULAR AND APPROPRIATE CARE**.....

All persons making application with an insurance company for benefits are expected and assumed to be in “regular and on-going appropriate care. This means the insurance company may ask you to submit medical evidence of treatment or consultation every 30-45 days.

Most group policies say something like this:

“We may request that you send proof of continuing disability indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 45 days of a request by us.”

“In some cases, you will be required to give (insurance company) authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. (Insurance company) will deny your claim, or stop sending you payments, if the appropriate information is not submitted.”

There is no such thing as entitlement to disability payments from an insurer without regular attendance with a physician who is qualified to render treatment for your specific impairment. “Regular treatment” is defined by most disability insurers as every 30 days, or as often as your physician documents it is necessary to see you in order to adequately treat you to improve your health and well-being, or maintain your medical status at MMI. (Maximum Medical Improvement)

In other words, you may not “fall out of treatment” and expect the insurance company to continue to pay you each month. IT WON’T HAPPEN. Any person who reports to the disability insurer that they are unable to work at all must provide proof of regular and on-going treatment to the insurance company whenever they ask for an update. The insurance company has this right.

In addition, any deviation from 30 day office visits and consultation must be documented in the office treatment notes of the physician. There are some occasions when the physician determines appropriate treatment should be quarterly instead of monthly. If this is true, then the physician should be asked to specifically document in his/her office treatment notes what “appropriate” care is required.

It is also important to choose a physician who is either Board Certified or has a medical specialty within the area of the impairment you are claiming. For example, Family Physicians should not be certifying disability for Depression and Anxiety; Cognitive Deficit is best treated by a Neurologist and so on.

Disability insurers are now state of the art. This means nearly all disability insurers buy physician employees with Board Certified credentials and spend a great deal of time selling their opinions as credible. If you intend to submit a disability claim under a group policy it is best to receive treatment from the best credentialed physicians you can afford.

Claim Information

Your group LTD policy will also contain information relative to filing a claim with the disability insurer. Please find below a typical policy provision describing your responsibility for notification of a claim:

“We encourage you to notify us of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Priced Right, Inc. written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.”

This provision in your group LTD policy basically tells you to notify the disability insurer as soon as you know you will not be able to work, usually within 30 days. With the new integrated plans for STD and LTD, this is generally not a problem since your employer may self-insure a period of short-term disability, and then send you the forms for LTD if it looks as though your disability will go beyond the STD period, generally 13 to 26 weeks.

However, the above provision also states you must notify the company within 90 days after your elimination period or within 1 year. Actually, you have 1 year and 90 days to notify the insurance company of a claim. In the case of severe depression or other legal capacity limitations, there is no limit, but it should be reasonable. A disability insurer must prove you “prejudiced” their investigation in order to deny a claim for “late notice.” Documentation should be placed in your Administrative Record to show how, when, and to what extent you prejudiced the insurance company’s investigation of your claim.

This section of your policy also describes what you must submit to the company as proof of claim:

“WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?:

- *that you are under the regular care of a doctor;*
- *the appropriate documentation of your monthly earnings;*
- *the date your disability began;*
- *the cause of your disability;*
- *the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and*

- *the name and address of any hospital or institution where you received treatment, including all attending doctors.*

We may request that you send proof of continuing disability indicating that you are under the regular care of a doctor. The proof provided at your expense, must be received within 30 days of a request by us.

In some cases, you will be required to give Priced Right, Inc. authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Priced Right, Inc. will deny your claim, or stop sending your payments, if the appropriate information is not submitted.”

This provision in your policy is extremely important since it contains specifically defined terms and conditions which the average lay person probably won't understand. Your group policy may not contain all of the conditions described above, but I've included them for the sake of explanation.

In order to file a disability claim with an insurance company, you must provide certain information. First, you must prove to the insurance company you are under the regular care of a doctor. Regular care is defined as follows for any disability insurer:

- *“you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and*
- *you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.”*

The word Doctor means:

- *a person performing tasks that are within the limits of his or her medical license; and*
- *a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or*
- *a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or*
- *a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.*

Priced Right, Inc. will not recognize you, or your spouse, children, parents or siblings as a doctor for a claim that you send to us.”

Restrictions are defined as those physical or mental activities you may never do because of a physical or mental impairment. Example: Patient is restricted from lifting, or use of repetitive movements involving the use of both left and right hands.

Limitations are those physical or mental activities you may do, but only to a limited extent. Example: Patient is limited to no lifting > 10 lbs., limited standing and walking no > than 10 minutes.

There are three important words in the “Proof of Claim” provision: Regular Care, Doctor, and Appropriate Care.

First, you must prove to the disability insurer you are seeing your primary care physician as often as is normally required for your particular diagnosis. For example, if you have been diagnosed with panic attacks and clinical depression, regular care is determined to be at least twice monthly with a qualified therapist, psychologist, or psychiatrist. If you are filing for disability and are seeing your family physician every two months, you are not under regular care according to the above definition.

Here is another actual example.

Susan, aged 35, has been diagnosed with fibromyalgia and has applied for LTD benefits. Generally accepted medical care is bi-monthly counseling sessions, and monthly or bi-monthly consultations with a Rheumatologist. If Susan is currently treating with a physician licensed in family medicine, on a monthly basis, she is not receiving regular or appropriate care. She is also not being treated by a physician specialized in her particular area of impairment. It is likely her benefits will be denied.

During my employment as a claims specialist, one of my claimant’s in southern Texas was impaired due to a serious cardiac impairment. Although he did not speak English, he communicated to his employer he was treating with a “witch doctor” across the border in a small village in Mexico. We became very concerned for his health and had to communicate to him this type of treatment was not appropriate care. Although he was not happy to seek treatment in the United States with a licensed cardiologist, in order to obtain benefits, he made the appointments and was immediately given all of the necessary cardiac tests. (Thank goodness!)

In the final analysis, the insurance company and their medical staff determine what regular and appropriate care is. Of late, disability insurers hire “board certified” in-house physicians to review claims and render opinions. Therefore, it is always a good idea for employees on disability to seek out the most qualified specialist(s) you can afford in order to compete with the credentials of the insurance company physicians. Disability insurers do not always consider the opinions of your primary care physicians, but their opinions are a lot harder to ignore if your physicians are credentialed and well-known in their field. Homeopaths, physical therapists, acupuncturists and other practitioners may not be considered qualified physicians, and their opinions will do little to change those of the “board certified” physicians of the insurance company.

The next question you may be asking is “What type of proof should I submit?” The above provisions are important, not only in what they DO say, but also in what they DO NOT say. For example, the above provision does not require you to submit only “objective medical evidence” as proof of claim. In fact, the provision does not mention “objective medical evidence” at all. Objective medical evidence consists of lab reports, x-ray results, MRI’s, CAT scans, surgical records, EEG’s, cardio stress test results, PFT’s, or any other medical results which prove you have the disease or impairment your doctor says you do.

This is the type of evidence the insurance company expects to receive from you. The problem is that for some impairments there is no known test or objective data currently available and your physician must make a “clinical diagnosis”. A few examples of such impairments are: Lyme disease, fibromyalgia, CFS, RSD, depression, Multiple Sclerosis, and panic attacks, in addition to many others. Symptoms such as: dizziness, tinnitus, pain, and fatigue are generally considered to be non-verifiable and therefore subjected to the self-reported limitation of 24 months.

As a general rule, you should submit all the medical proof you have concerning your impairment. This includes, office treatment notes from all primary care physicians (OVN's), lab reports, MRI and CAT scan reports, consultations, physical therapy notes, pharmacy records, counseling in-patient or out-patient notes, formalized medical testing such as neuropsychological and psychological evaluations, and social security and/or worker's compensation evaluation reports.

Do not rely on your insurance company to obtain medical records on your behalf since what they obtain is often incomplete and received too late to be considered in the claim decision. Obtain all records you have in support of your claim and submit them to the disability insurer. Except for pre-existing investigations, you are only required to give the insurance company medical information supporting disability for the time period claimed.

A POINT TO PONDER...Objective Evidence Standard?

Why do you think disability insurers require "objective evidence" as proof of claim when there is no such written burden of proof in the policy?

First of all, consider the concept of insurance risk. Disability insurers receive premiums for policies they sell in the anticipation of not having to pay out on all of them. In fact, if disability insurers actually had to pay out on ALL of the policies they sell, there would be no means to make a profit, hence no insurance. This means all disability insurers have a vested interest in paying out only on legitimate claims.

Second, unless the insurance company compels the claimant to submit to an Independent Medical Evaluation, it has no opportunity to actually examine the claimant. The only means of basing their decision to pay or not pay rests with information supplied by physicians outside of their control.

How many private treating physicians act as advocates for their patients? Not all, but some do. Is it fair to say that some physicians may have a tendency to over exaggerate symptoms and disability in order to protect their patients? Disability insurers think so because it is to their advantage to think so.

One way of NOT relying on the recommendations and treatment notes of a claimant's treating physician is to require "objective medical evidence" as proof of claim. "Objective medical evidence" works if you have a broken leg, but not if you have just been diagnosed with fibromyalgia, Lyme disease, lupus, chronic pain, multiple sclerosis, RSD, depression, panic attacks or other diseases and syndromes for which medical science has yet to produce specific tests proving the disease exists.

Another way of NOT relying on the recommendations and treatment notes of the claimant's treating physician is to place all the weight of a liability decision on the insurance company's own physician employees. Disability insurers hire on-staff physicians and pay them to review claims and render an opinion supporting or not supporting restrictions and limitations. In addition, most insurance companies pay their physicians bonuses if they follow the company line.

What may have started out as a way of balancing disability decisions between an "advocate" physician and a profit motive insurance company has now evolved into a predominately prejudiced claims review process decidedly in favor of the disability insurer. And, it all started with requiring "objective evidence" as the burden of proof for all claims.

What is the solution? In my opinion, disability insurers should move toward obtaining more of a "consensus of medical opinion" considering the recommendations of all treating physicians as well as the opinions of on-staff physician employees, IME physicians, etc. For ERISA claims, in the absence of

“consensus of medical opinion”, and acting as a fiduciary, the insurance company is compelled to decide all indeterminable issues in favor of the insured.

It is obviously not profitable to apply the “fiduciary standard” in all claims situations, hence we continue to see the application of the “objective evidence standard.” Interesting, isn’t it?

SELF TEST

Explain these concepts as you now understand them.

What is the significance of regular care and appropriate treatment when determining eligibility for disability benefits from a disability insurer?

What is “objective medical evidence?” Relate this concept to your own disability claim and describe examples of objective medical evidence you need to obtain and send to the insurance company.

In what situations should “indexing” be applied to your claim?

Define “restrictions” and “limitations.” Review your own medical reports from your primary care physician and determine if specific R&L’s have been given on your behalf.

Look at the credentials of your medical treatment providers. Are these physicians qualified to render care for your specific impairment? Which credentials would an insurance company have problems with?

Great job so far! Questions? Talk to a consultant or other trusted resource. If you are still employed, contact your HR Benefits Representative and ask questions. The most important income protection you have is knowledge. Stay with it, until you understand your rights under the group policy you have.

In One Hand, and Out the Other

The Add-Ins

All group LTD policies contain a provision describing how your benefit will be calculated, and how much you will be paid if your claim is approved. A typical policy provision is the following:

“HOW MUCH WILL PRICED RIGHT PAY YOU IF YOU ARE DISABLED?”

We will follow this process to figure your payment:

- 1. Multiply your monthly earnings by 60%.*
- 2. The maximum monthly benefit is \$6,000.*
- 3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your gross disability payment.*
- 4. Subtract from your gross disability payment any deductible sources of income.*

The amount figured in Item 4 is your monthly payment.”

The first step, then, is to multiply the stated percentage against something called monthly earnings. All group policies also contain a paragraph describing how monthly earnings are calculated. For Priced Right, Inc. the provision is as follows:

“WHAT ARE YOUR MONTHLY EARNINGS?”

Monthly Earnings means your gross monthly income from your Employer in effect just prior to your date of disability. It includes your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or include income received from sources other than your Employer.”

Most insurance companies verify your annual salary, hourly wage, or monthly income with your employer. Unfortunately, in my experience, there are many errors resulting in payment of monthly benefits which are not accurate. In an effort to verify monthly earnings, claims specialists normally obtain payroll records just prior to your date of disability. Others simply use the figure reported by your employer on the initial application for disability. The above definition of monthly earnings is the least complex definition, but there are other possible wordings, such as

using the prior year's W-2 information, averaging of commissions, and adding back tax deferred deductions.

The monthly earnings calculation used by disability insurers is not the most obvious. For example, let's say your employer reports your gross weekly salary as \$520.00 per week. Monthly gross benefits are calculated as: $\$520 \times 52/12 = \$2,253.33$. If the calculation simply used $\$520 \times 4 = \$2,080$, you can see your benefits would be much less. The first calculation at least considers the fact there may be several months in which you receive 5 paychecks per month.

Your monthly benefit should be: $\$520 \times 52/12 = \$2,253.33 \times 60\% = \$1,352$. Not, $\$520 \times 4 = \$2,080 \times 60\% = \$1,248$.

How many claimants and attorneys do you think actually verify the calculation of gross monthly earnings to insure the figure is accurate in accordance with policy provisions? These types of calculations are NOT often verified, but incidences of inaccuracies abound. Errors can go in either direction—favorable or unfavorable to you. Claimants are often reluctant to correct errors unfavorable to them, but discovered errors should be corrected either way.

I recommend everyone covered by a group policy figure their own gross monthly benefit on a yearly basis or before filing a claim. If the figure is different from what you have calculated yourself, ask for verification both from the disability insurer, AND your employer. It is your responsibility to ensure you are being paid accurately, fairly and on time.

All group disability policies contain language describing how your monthly benefit will be calculated if you are working part-time. This is one of the most inaccurately calculated amounts associated with group LTD policies. Here again, it is your responsibility to make sure you are being paid accurately each month if you are working.

Policy language associated with the calculation of residual or partial earnings is also the most confusing. Here is what the typical group LTD policy says: (Don't let this scare you!)

“HOW MUCH WILL PRICED RIGHT, INC. PAY YOU IF YOU ARE DISABLED AND WORKING?”

We will send you the monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are 20% or more of your indexed monthly earnings, due to the same sickness or injury, Priced Right, Inc. will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

- 1. Add your monthly disability earnings to your gross disability payment.*
- 2. Compare the answer in Item 1 to your indexed monthly earnings.*

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Priced Right, Inc. will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Priced Right, Inc. will subtract the amount over 100% from your monthly benefit.”

(Good grief, but let’s keep going....)

“After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

- 1. Subtract your disability earnings from your indexed monthly earnings.*
- 2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.*
- 3. Multiply your monthly payment by the answer in Item 2.*

This is the amount Priced Right, Inc. will pay you each month.

During the first 24 months of disability payments, if your monthly disability earnings exceed 80% of your indexed monthly earnings, Priced Right, Inc. will stop sending you payments and your claim will end.

Beyond 24 months of disability payments, if your monthly disability earnings exceed the gross disability payment, Priced Right, Inc. will stop sending you payments and your claim will end.

Priced Right, Inc. may require you to send proof of your monthly disability earnings at least quarterly. We will adjust your payment based on your quarterly disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.”

Have you got all that? Well, let’s make it very simple. For the first 24 months, most insurance companies have an incentive program to encourage you to return to part-time work. Some call it “Work Incentive Benefit Program” (WIB) others simply call it a “Return to Work Advantage.” (RTWA) Basically, the benefit is calculated as follows for the first 24 months when you are working:

Monthly benefit from the insurance company

+ Earnings from your employer

Total Monthly Income

Indexed (remember, adjusted for inflation) pre-disability earnings

- Total Monthly Income above

Amount of Offset or reduction from monthly benefit.

Here’s an example: Linda’s monthly benefit from Priced Right, Inc. is \$2,500 per month. She earned \$1,750 in wages for the month of April. Linda’s pre-disability indexed earnings from her employer were \$5,500 per month.

$\$2,500 + \$1,750 = \$4,250$ Total Monthly Income

Since \$4,250 is less than 100% of \$5,500, there is no reduction in the amount of her monthly benefit and she will be paid the full amount of \$2,500. Also, \$2,500 is less than 80% of your pre-disability earnings.

NOTE: Remember, anytime you earn more than 80% of your pre-disability earnings, your claim is closed. $\$5,500 \times 80\% = \$4,400$. You would have to earn in excess of \$4,400 in any given month in order to lose your benefits.

This is a pretty good deal, isn't it? For the month of April, you get to keep your full benefit of \$2,500 plus the \$1,750 you earned by working part-time. That's \$4,250, which is 77.27% of what you were making before you became impaired. If you did not work part-time, you would only be paid 60% of pre-disability earnings as allowed in your policy. There is no doubt but that working part-time can increase your disability income without penalty.

What if Linda had earned \$3,300 for the month of April?

$\$2,500 + \$3,300 = \$5,800$ is more than \$5,500 so....

$\$5,800 - \$5,500 = \$300$

Linda receives $\$2,500 - \$300 = \$2,200$ for her April monthly benefit.

What if Linda earned \$4,475 for the month of April? \$4,475 is more than 80% of her pre-disability earnings and therefore her claim will be closed for April and no further benefits paid. \$4,475 is 81.36% of pre-disability earnings and therefore there is no earnings loss and benefits are denied.

In simple terms, Linda can work part-time for 12 months (does not need to be consecutive) and as long as she does not make more than she was making before she became disabled, she can receive her full benefit. (Subject to the 80% limitation, of course.) If she does make more, her monthly benefit will be reduced by the excess earnings.

Remember, if you are working part-time, it is up to you to ensure you are being paid accurately. I recommend you request verification of the calculation of your monthly benefit every month when working part-time. This is an area in which many payment errors exist. (The above calculations are given for illustration purposes only, but I think you get the idea.)

What happens if you continue working part-time after 12 months? According to the above definition, your monthly benefit will now be calculated using a "proportionate loss" formula. This method pays you for the percentage of income you have actually lost. Here's the formula:

$$\frac{\text{Indexed pre-disability earnings} - \text{Part-time Earnings}}{\text{Indexed pre-disability earnings}} = \text{Loss \%}$$

Monthly benefit x Loss % = monthly benefit

Let's use the same example as above for Linda for the month of April.

$$\frac{\$5,500 - \$1,750}{\$5,500} = 68.18\% \quad \$2,500 \times 68\% = \$1,700.$$

Linda will be paid \$1,700 for the month of April. Another way of looking at this is that Linda lost \$800 of her monthly benefit which represents a 32% earnings loss. In this case Linda receives \$1,700 from the insurance company AND \$1,750 from her employer in part-time earnings, a total of \$3,450 for the month of April. This is 62.7% of her pre-disability earnings instead of 60%. Again, not a bad deal.

Under the above provision, after 24 months, if you work and earn more than the amount of your monthly benefit, your claim will be closed. There are provisions in some policies which require a 3 month averaging to determine earnings exceeding 80%. Check your policy.

I hope you can easily see calculations of your monthly benefit while working part-time is an area destined for miscalculation. Most insurance companies will not release your monthly benefit until you have submitted payroll records as proof of monthly earnings. Some companies require this proof only quarterly, and then ask you to provide a copy of your tax return at the end of the year to “true it up”, which allows for even more errors in your payment. I strongly recommend you submit proof of part-time earnings on a monthly basis, verify the amount you are being paid each month, and notify the disability insurer of errors immediately.

Whenever an individual returns to work part-time, it is crucial to maintain earnings records and ask your disability insurer to provide you with their own internal calculations in order to verify your earnings loss ratio. You can easily see for this individual, without the 3 consecutive month averaging, he would have received a check for January, April, July, October and December. With the 3 month averaging, he receives checks in January and December only. This makes one wonder whether the averaging is such a good deal after all in some cases.

Looking at the issue of “earnings loss” from the opposite direction, this employee may not earn in excess of 80% of his indexed BME, or \$8,831.94 per month. Earning this amount or over, the employee will not receive a check for that month. If a 3 month consecutive average shows income of over 80%, the claim will be denied.

You may notice the indexed BME changes in September. This is because the claimant’s benefits begin date was 9/1, and therefore the indexing year is from 9/1 of the current year to 8/31 of the next year. Given the increasing rates of inflation, the “indexed BME” should increase each year allowing the employee to earn slightly more than the year before without going over the 80%.

I strongly recommend employees who are able to return to work part-time maintain accurate records of earnings and keep track of how close you are to earning 80% of your indexed BME. In order to do this, you should ask for earnings calculations from your claims handler on an on-going basis.

Cost of Living Increases

Some employers pay an extra premium to Priced Right, Inc. for a special cost of living benefit increase. Here is how it reads in the policy:

“WILL YOUR PAYMENT BE ADJUSTED BY A COST OF LIVING INCREASE?”

Priced Right, Inc. will make a cost of living adjustment (COLA) after you have received 1 full year of payments.

Your payment will increase by 3% beginning on the first anniversary of payments and each following anniversary to exceed 5 anniversary adjustment periods while you continue to receive payments for your disability.

Each month Priced Right, Inc. will add the cost of living adjustment to your monthly payment. When Priced Right, Inc. add the adjustment to your payment, the increase may cause your payment to exceed the maximum monthly benefit. “

Using Linda’s same monthly benefit of \$2,500, and after benefits have been paid for 1 year, Linda’s monthly benefit increases to \$2,575 for the second year. ($\$2,500 \times 1.03 = \$2,575$) A schedule of benefits for the five payments required by Linda’s policy are as follows:

1 st Increase	$(\$2,500 \times 1.03 = \$2,575)$
2 nd Increase	$(\$2,500 \times (1.03) \times (1.03) = \$2,652.25)$
3 rd Increase	$(\$2,500 \times (1.03) \times (1.03) \times (1.03) = \$2,731.81)$
4 th Increase	$(\$2,500 \times (1.03) \times (1.03) \times (1.03) \times (1.03) = \$2,813.77)$
5 th Increase	$(\$2,500 \times (1.03) \times (1.03) \times (1.03) \times (1.03) \times (1.03) = \$2,898.19)$

COLA’s are most often calculated using “net benefits” when there are offsets or allowable reductions in benefits. For example, if Linda had been awarded social security disability income benefits of \$1,200, then the calculations would be:

$(\$2,500 - \$1,200) \times 1.03 = \$1,339$. This is a \$39 increase in payable monthly benefit.

Disability insurers often “forget” to pay COLA’s; therefore, once again it is your responsibility to ensure you are receiving all of the income you are entitled to under the provisions of your policy. Ask for specific verification of the calculated COLA amount on a yearly basis. Some group LTD policies allow the payment of a COLA for the duration of your policy rather than 5 years. Percentages can fluctuate from 3%-5% as well.

Another point to keep in mind is that COLA is always calculated on your NET BENEFIT. Using the same information above, if Linda had been awarded a \$1,000 benefit from Social Security then the COLA calculation is as follows:

$(\$2,500 - \$1,000) \times 1.03 = \$1,545$ benefit amount

All offsets to the monthly benefit are taken first before COLA’s are calculated. This includes worker’s compensation, primary and family SSDI, pensions and any other offset listed in the policy.

A word of caution. A COLA is very different from INDEXING. Your policy requires the insurance company to “index” only under certain conditions when determining your benefit i.e. working part-time, or determining pre-disability income. In order to receive a COLA increase, your policy must have a separate provision allowing the additional benefit.

Also, do not confuse your policy COLA with cost of living increases awarded annually from Social Security. The social security COLA’s are yours to keep and do not reduce your monthly benefit.

Survivor Benefits

Nearly all group LTD policies provide for a payment to your survivors or estate in the event of death while receiving disability payments. Here is the wording from Priced Right, Inc.:

“WHAT BENEFITS WILL BE PROVIDED TO YOUR FAMILY IF YOU DIE?”

*When Priced Right, Inc. receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 3 months of your gross disability payment, if, on the date of your death:*

- *your disability had continued for 180 or more consecutive days; and*
- *you were receiving or were entitled to receive payments under the plan.*

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.”

Let’s continue to use the example of Linda who is currently receiving \$2,500 from Priced Right, Inc. as a disability benefit. Linda’s benefit is payable from the 10th of one month through the 9th of the next following month. She also owes a balance of \$1,500 overpayment from an award of SSDI. Linda dies on April 26th of the current year.

What is the amount of her survivor benefit? Since Linda passed away on the 26th of the month, her survivors are entitled to 16 days of benefit: $\$2,500/30 = \83.33 per day x 16 days = \$1,333.28. (16 days includes the 10th, but not the 26th or date of death)

Second, her policy pays 3 times her gross benefit:

$\$2,500 \times 3 = \$7,500 + \$1,333.28 = \$8,833.28 - \$1,500$ overpayment = \$7,333.28 total survivor’s benefit.

Obviously, it is important for anyone receiving group LTD benefits to inform their survivors of their entitlement to a survivor’s benefit in case of death. Very often, if not contacted and challenged, the disability insurer will not make this payment to your spouse, children, or estate. Here again, information as to what you are entitled to under your group plan is important and could cost your family added benefits in the case of death.

I strongly recommend claimants photocopy the Survivor’s Benefit page from their policy, explain it to those who need to know, and place it with their family important papers. Estate planners should also be made aware of this valuable information.

Disability Plus Coverage

Various group LTD policies contain added riders providing additional benefits if certain conditions are met. Recently, a very popular add-on benefit is the payment of an additional benefit if you are unable to perform “Activities of Daily Living”, referred to as ADL’s. Here is the wording from the Priced Right, Inc. group LTD policy:

“WHEN WILL YOU BE ELIGIBLE TO RECEIVE DISABILITY PLUS BENEFITS?”

Priced Right, Inc. will pay a monthly Disability Plus benefit to you when we receive proof that you are disabled under this rider and are receiving monthly payments under the LTD plan. Disability Plus benefits will begin at the end of the elimination period shown in the LTD plan.

You are disabled under this rider when Priced Right, Inc. determines due to sickness or injury:

- *you lose the ability to safely and completely perform 2 activities of daily living without another person’s assistance or verbal cueing; or*
- *you have a deterioration or loss in intellectual capacity and need another person’s assistance or verbal cueing for your protection or for the protection of others.*

ACTIVITIES OF DAILY LIVING mean:

- *Bathing-the ability to wash yourself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.*
- *Dressing-the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.*
- *Toileting-the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.*
- *Transferring-the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches, or grab bars or other support devices including mechanical or motorized devices.*
- *Continence-the ability to either voluntarily control bowel and bladder function; or if incontinent, be able to maintain a reasonable level of personal hygiene.*
- *Eating-the ability to get nourishment into the body.*

HOW MUCH WILL PRICED RIGHT, INC. PAY IF YOU ARE DISABLED?

The Disability Plus benefit is 20% of monthly earnings to a maximum monthly benefit of the lesser of the LTD plan maximum benefit or \$5,000.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.”

If you are unable to perform as least two of the above, you must ask your physician to certify in writing you are unable to perform specific ADL’s, and send it to your claims specialist. Once the disability insurer has been informed of your inability to perform certain ADL’s, you will be paid an additional benefit of 20% of your pre-disability earnings. For Linda, her benefit would increase from \$2,500 per month to \$3,600. ($\$5,500 \times 20\% = \$1,100$ increase in benefit.) **Notice the increase percentage is applied to your pre-disability earnings, not your monthly benefit.**

Claims specialists are often very poorly trained in identifying and paying added-on benefits in group LTD policies. Again, it is your responsibility to know in advance what you are entitled to under your policy. The premium for this rider is fairly expensive, and those employers who *do* add it to their plans, intend for their employees to receive the extra benefit under certain conditions. Read your policy carefully in advance of any claim, and ask questions if you do not understand what you are entitled to. Omission of the payment of \$1,100 per month is the loss of \$13,200 per year!

Worksite Modification Benefit

Many disability insurers now provide additional benefits to your employer for modifications to your workstation which can make it possible for you to return to work in some capacity. Here is a sample contract provision:

“HOW CAN PRICED RIGHT, INC. HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?”

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Priced Right, Inc..

When this occurs, Priced Right, Inc. will reimburse your Employer for the cost of the modification, up to the greater of:

- *\$1,000; or*
- *The equivalent of 2 months of your monthly benefit.*

This benefit is available to you on a one time basis only.”

Linda’s worksite modification benefit can be a minimum of \$1,000 or a maximum of \$5,000, which is her monthly benefit of \$2,500 x 2. This type of benefit, payable to Employers, can provide incentive for employers to bring back employees to their regular jobs.

Remember, certain conditions must be met before the worksite modification is payable: 1) the modification to your worksite must enable you to do the material and substantial duties of your regular occupation; 2) a vocational or ergonomic specialist from the insurance company must work with your employer to implement the change; 3) the disability insurer must agree with the modification; 4) a written agreement must exist between the employer and the insurance company as to the nature of the change; and 5) the agreement must be in writing.

While the above policy provision may in fact assist you to return to work, it is extremely important to make sure your physician has, in fact, released you to return to work. On occasion, disability insurers have been known to enter into deals with employers to bring you back to work prematurely. These situations almost never result in a permanent solution.

The above benefit is not used very often by employers who go the extra mile to bring their employees back on the job. This benefit can help cover the extra cost of making modifications on the job that meet ergonomic or OSHA standards.

Dependent Day Care Expenses

Another added-on benefit in group LTD policies is the Dependent Day Care Expense Reimbursement Program. Here is the policy wording from the Priced Right group LTD plan:

“WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN PRICED RIGHT’S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?”

While you are participating in Priced Right’s Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

- 1. are incurring expenses to provide care for a child under the age of 15; and/or*
- 2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.*

The payment of the Dependent Care Expense Benefit will begin immediately after you start Priced Right’s Rehabilitation and Return to Work Assistance Program.

Our payment of the Dependent Care Expense Benefit will:

- 1. be \$350 per month, per **dependent**; and*
- 2. not exceed \$1,000 per month for all dependent care expenses combined.*

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

- 1. the date you are no longer incurring expenses for your dependent;*
- 2. the date you no longer participate in Priced Right’s Rehabilitation and Return to Work Assistance program; or*
- 3. any other date payments would stop in accordance with this plan.”*

This is a pretty good deal isn’t it? The disability insurer will pay expenses you incur to care for your children, and/or other dependents if you agree to participate in a Return to Work Assistance Program. If you have two children in Day Care, plus you must pay someone to take care of your dependent mother while you are at work, you can receive \$1,000 per month. Notice this provision does not say Priced Right will pay actual expenses incurred. It says “...\$350 per dependent per month up to a maximum of \$1,000.” This can be a great added-on benefit, if you have been released by your primary care physician to participate in a Return to Work Assistance Program, and have young children in Day Care programs. Unfortunately, this provision is often omitted from the majority of group LTD plans due to the increase in premiums charged to employers.

Be sure to check your policy carefully to determine if it contains one or both of the above add-on provisions, and use the benefits to assist you to return to work if you are able.

Minimum Monthly Benefit

Most, but not all, group disability policies contain a provision requiring disability insurers to pay you a minimum monthly benefit. Here's how the provision is generally worded:

“WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT?”

The minimum monthly payment is the greater of:

- \$100; or
- 10% of your gross disability payment.

Priced Right, Inc. may apply this amount toward an outstanding overpayment.”

Even if the insurance company subtracts other income from your monthly benefit, you are still entitled to a minimum benefit payment. Linda's minimum monthly payment is \$250 representing 10% of her monthly benefit of \$2,500. If the monthly benefit is less than \$1,000, the insurance company still pays a minimum of \$100.

The insurance company can, of course, take the minimum benefit and reduce your benefit to \$0 in order to recover an overpayment due to them. Some policies do not have a minimum benefit provision, therefore, it is always a good idea to check your policy and know in advance what the minimum benefit is. A \$50 minimum is also quite common.

A Word About Social Security Advocacy Programs

Most disability insurers employ subsidiary or outsourced vendors to assist you in making application for Social Security Disability Income (SSDI) benefits. On occasion, it is misunderstood by claimant's this service is free. It is not always free.

Since SSDI awards are reductions in the monthly benefit, disability insurers want you to apply for benefits as soon as possible so that their cost of providing you with a benefit is reduced. A typical policy provision offering SSDI assistance might be as follows:

“HOW CAN PRICED RIGHT'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?”

In order to eligible for assistance from Priced Right's Social Security claimant advocacy program, you must be receiving monthly payments from us. Priced Right can provide expert advice regarding your claim and assist you with your application for appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- *helping you find appropriate legal representation;*
- *obtaining medical and vocational evidence; and*
- *reimbursing pre-approved case management expenses.”*

The four levels of SSDI application are:

- initial application for benefits;
- appeal reconsideration; and
- administrative law judge hearing.

Most disability insurers provide referrals to resources who can assist you with making your initial application for SSDI, and processing the reconsideration appeal. Is this service free to you? Yes, it is.

However, if the disability insurer refers you to an attorney who assists you with your case, mostly at the ALJ level, the service is NOT free, since it will cost you 25% of your social security retroactive award. If the attorney is successful in obtaining a favorable decision, social security will reduce your retroactive award by 25% and send it to the attorney as payment of his fee. Although, the Social Advocacy Program description above might infer the services are entirely free, they are not, beyond a certain level.

Revenue Income Sharing Provisions/Pension Contributions

Universities and other state or public employers, or unions may purchase a special provision that requires the disability insurer to contribute a certain percentage of your benefit to an investment account, mostly the TIAA CREF management fund. For as long as you receive a disability benefit, the insurance company has an additional liability to contribute toward your retirement. This feature of group LTD policies requires an expensive premium, but if you have this provision in your policy, it is a good idea to ask the insurance company to provide you with proof of the contribution on a quarterly basis.

A typical wording for a Pension Contribution provision might be the following:

“PENSION PLAN CONTRIBUTION

While an insured is receiving disability benefits, an extra benefit will be paid to the insured to cover his contributions to the employer’s pension plan. To figure the amount of this benefit, take 15 % of basic monthly earnings.

This benefit will not exceed \$3,500 per month.

The other benefits section of this policy will not apply to this extra benefit.”

This provision is frequently overlooked and not paid by the disability insurer. Unfortunately, these payment omissions are the result of inadequately trained claims examiners, but oftentimes management is reluctant to “fix” these errors since the recognition of the additional liability increases their financial reserves and thus adversely affects their profits.

When one considers such omissions not only deprives the claimant of the principal amount of the investment, it is true the claimant is also deprived of any interest or dividend income which could have been generated over time as a result of investments in the plan portfolio. When such errors are corrected, it is reasonable to assume the insurance company should contribute all amounts of the principal investment, plus reasonable compounded interest, but disability insurers are reluctant to pay interest since the “market is too volatile to figure overall interest and dividend income.”

Again, I feel I must continue to reinforce the notion it is the responsibility of the certificate holder (you, the employee) to know and understand what benefits you are entitled to should you become disabled. With regard to Income Revenue Protection and Pension Contribution provisions, hold the insurance company accountable for their contributions to your retirement fund as soon as you begin receiving long-term disability benefits. Calculate the contribution yourself and verify the amount being contributed is accurate.

This discussion concludes the “benefit” features - add-ins, of most group LTD policies. These are the benefits you are entitled to because there are specific policy provisions which direct the payment of these benefits. You are entitled only to those features for which there are specific provisions written in your policy. If your policy does not contain language describing a certain feature, your employer has NOT included that benefit in the group plan, and you are not entitled to be paid for that benefit.

All employees covered under a group LTD plan provided by their employers should obtain a certificate copy of the policy and specifically locate all of the plan provisions requiring the payment of benefits. I strongly recommend each employee calculate what their yearly income would be in case of disability.

One of the major themes of this book is to encourage all group LTD enrollees to arm themselves with knowledge about their group LTD plans in advance of sickness or injury. Nothing should come as a surprise when you suddenly find yourself in a position of depending on disability income.

The Recurrent Provision

This provision is also very helpful to you when attempting a return to work full-time. Simply, the recurrent provision allows you to go back on claim if you attempt a full-time return to work, but are not able to continue within 6 months. You will not need to meet another elimination period; the insurance company is required to re-open your claim and continue to pay you for the same cause of disability.

The “recurrent provision” is one of those contractual writings the disability insurer often omits from disclosure. For example, many disability insurers have a procedure called an “Advance Pay and Close”. In this situation, the claims representative is allowed to pay you x months of benefits in anticipation of your being able to return to work full-time. Many claimants are tempted by the lump sum payment and agree to attempt to return to work full time, but are unsuccessful doing so due to ill-health. If you try to go back to work full-time and just cannot do it within a period of 6 months, you have the contractual right to be placed back on claim and receive benefits.

The wording for such a provision will look something like this:

“WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?”

If you have a recurrent disability, Priced Right, Inc. will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- *you were continuously insured under the plan for the period between your prior claim and your recurrent disability; and*
- *your recurrent disability occurs within 6 months of the end of your prior claim.*

Your recurrent disability will be subject to the same terms of this plan as your prior claim.

Any disability which occurs after 6 months from the date of your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions.

If you are covered under another group long term disability plan on the date of your recurrent disability and are entitled to payments under that plan, you will not be eligible for further payments from Priced Right, Inc.

RECURRENT DISABILITY means a disability which is:

- *caused by a worsening in your condition; and*
- *due to the same cause(s) as your prior disability for which Priced Right, Inc. made a Long Term Disability payment.”*

Although the Recurrent Provision allows you to come back on claim after a failed return to work, remember, the disability insurer will require proof of a worsening medical disability before doing so. Also, this provision only applies to FULL-TIME attempts, not part-time. As a consultant, my best advice is to make sure you have actually been released to return to work by your primary care physician(s) before attempting any return to work activity.

A GOOD CASE IN POINT – Sharon’s Pension Contribution

One day, Sharon, a Senior Claims Specialist with a major disability insurer was completing her monthly review of LTD claims in her block. In pulling a claim for a teacher working for the university system in Texas, she happened to notice the policy had a “Revenue Income Protection” provision requiring her company to make monthly deposits in the TIA/CREFF fund for retirement. The provision required the employee to be participating and contributing to the company defined benefit program. The disability insurer’s monthly contribution was 4% of the teacher’s benefit of \$4,100 per month.

In reading the file, Sharon discovered the previous claims specialist had not made the required pension contributions, and in fact, no contributions had been made during the 2 years benefits had been paid. A quick calculation estimated approximately \$30,000 had not been paid to the TIA/CREFF fund on behalf of the claimant.

Sharon took the underpayment matter to her consultant, who was not pleased with the discovery of the amount owed the fund. In addition, Sharon was told not mention “interest” to the insured since the payment of interest would incur additional liability for the company.

Reluctantly, the consultant agreed a check should be mailed to the TIA fund for \$35,340, not including interest.

Pension funds accrue interest because monies contributed to them are invested in various portfolios consisting of mutual funds and corporate bonds. Since pension contributions had not been made to the claimant's fund for such a long time, interest compounded over time could have been significant. Also, by recording the new deduction, the disability insurer would suddenly show an increase in the financial reserve for this claimant – a liability showing up on the financial statements of the disability insurer.

These types of errors are quite common for claims handlers to make. It is always a good idea to know what you are entitled to under your policy and be able to speak with the claims handler if the pension contribution is not made. It is also important for the employer, who is the Plan Administrator, to also keep track of pension contributions being made by any disability insurer on their employee's behalf. If you find the disability insurer to be in error, contact your Human Resource Benefit Representative right away.

SELF TEST

Obtain a copy of your LTD policies, and locating the provisions in your policy, complete the worksheet below.

Using your policy's definition of monthly earnings, calculate your BME (Basic Monthly Benefit, or pre-disability earnings).

Using the BME figure from above, calculate your gross monthly benefit.

Describe how the insurance company will calculate your residual earnings if you are able to return to work.

Does your policy contain a COLA provision? If so, calculate all of the yearly increases or at least the first 5 if your policy allows the benefit for the duration of your claim.

Are you entitled to a Worksite Modification Benefit, or reimbursement of Child Care Expenses? Based on the number of your dependents, calculate the Child Care Expense benefit you are entitled to, if applicable.

Does your policy contain a provision allowing you an additional benefit if you are unable to perform certain Activities of Daily Living? If so, calculate the extra benefit, remembering to use your pre-disability earnings in the calculation.

What is an Income Revenue Protection or Pension Contribution provision? Check your policy to determine if you are entitled to this extra benefit. If yes, calculate the amount of contribution the disability insurer is required to make on a monthly basis.

What is the difference between “indexing” and a “COLA” benefit?

How will your disability insurer calculate your residual earnings if you are able to work part-time beyond 24 months?

Find the minimum benefit provision in your policy and calculate it here.

If you still have questions, contact your HR Benefit representative or other trusted resource. It's that important. Great job! Now, let's move on.....

The Take Backs

The next set of policy provisions are those which reduce your monthly benefit or limit/exclude the payment of specific benefits. The first step, of course, is to locate all policy provisions adding on benefits to arrive at your gross disability benefit. Then, reduce your gross monthly benefit by the “take backs” or “offsets” allowed by your policy.

Those policies without provisions for offsetting (reducing) other income are referred to as “non-integrated”. These types of policies are not often issued to employers because the premiums are much higher.

In most instances your policy contains a long provision generally entitled, “**WHAT ARE DEDUCTIBLE SOURCES OF INCOME**”, or “**OTHER SOURCES OF NET INCOME.**” These provisions are frequently missed since the wording of the provision title does not specifically say “These are sources of income we will subtract from your benefit.” So often people tell me “ I can’t live on this amount of money. I didn’t know my benefit would be reduced by my children’s social security award.” This is indeed unfortunate since SSDI money is needed to buy medicine and pay bills. Know your group LTD policy in advance and understand which types of income will be deducted from your monthly benefit.

Here is the policy wording from Priced Right’s group LTD plan:

“WHAT ARE DEDUCTIBLE SOURCES OF INCOME?”

Priced Right will subtract from your gross disability payment the following deductible sources of income.

1. The amount that you receive or are entitled to receive under:

- a worker’s compensation law.*
- an occupational disease law.*
- any other act or law with similar intent.*

This first paragraph means Priced Right will subtract from your gross monthly benefit any amount you receive for worker’s compensation. In fact, for most STD group plans you may not receive worker’s compensation AND a disability benefit. For LTD, the amount you receive is an offset (a reduction). Also, disability amounts received for any state recognized occupational disability such as Black Lung Disease will be deducted. If you are receiving any other disability-disease related money from your state or employer, it is also a reduction from your gross disability benefit.

This provision also allows Priced Right, Inc. to deduct any worker's compensation settlement amount you receive for the same disability. Contract language varies as to how the insurance company will prorate and offset your lump sum payment. If the settlement document from worker's compensation stipulates specific amounts for attorney's fees and/or medical expenses, these amounts are not included in the offset amount. Generally, for LTD, worker's compensation settlement offsets are prorated over the claim's maximum benefit period, i.e. to age 65.

2. *The amount that you receive or are entitled to receive as disability income payments under any:*

- *state compulsory benefit act or law.*
- *automobile liability insurance policy.*
- *Other group insurance plan.*
- *Governmental retirement system as a result of your job with your employer.*

Generally, group disability contracts contain offset language for any amount you receive, or are entitled to receive as disability income payments under any state compulsory benefit act or law. This provision allows Priced Right to reduce your monthly benefit by any state disability insurance you receive. New York, New Jersey and California have state mandated disability laws. Check with your state to see if you will receive an additional disability payment from your state in case of sickness or injury. If so, the amount you receive will be deducted from your gross monthly benefit. State disability payments are only for limited periods of time i.e. California pays for 12 months.

Some states also have laws requiring automobile insurers to include disability payments when you are injured in an automobile accident and you cannot work. If you receive reimbursement from your automobile insurance for disability, this amount is deducted from your benefit.

If you are receiving disability payments from another group plan (from a previous employer), these payments are also deductible from your gross monthly benefit. In addition, any other governmental retirement system amounts paid to you by your employer are offsets.

Social Security Reductions and Payback

3. *The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:*

- *the United States Social Security Act.*
- *The Canada Pension Plan.*
- *The Quebec Pension Plan.*
- *Any similar plan or act.*

This provision allows your disability insurance carrier to deduct both Primary and Family social security payments from your monthly gross benefit. Generally speaking, social security will pay you one-half of amounts awarded to you for your dependent children under the age of 18, or a student under the age of 25. Not all policy provisions say "your spouse and your children." If this wording is omitted, then only your SSDI benefit is an offset. If there is no provision at all allowing an offset for social security, then your policy is "non-integrated". This

“take back” provision is the most important in your policy if you are supporting dependent children and become disabled.

So many times I am contacted by individuals who, after being awarded primary and family social security, say “I didn’t know my insurance company could subtract my SSDI award for both me and my children. I can’t live on this amount of money!”

The goal of this manual is to give all group LTD insureds an opportunity to examine, review and understand the significance of disability insurance, and how it may affect the ability to pay bills in case of disability.

I strongly encourage you contact the social security administration and request a benefit review to determine (if you were awarded SSDI today) how much you would be entitled to each month. It may take 6 weeks or more to get this information, but once you do, reduce this amount from your disability benefit calculation to arrive at your net benefit. It is likely this will be the amount the insurance company will pay you. Long-term disability is nearly always unforeseen, and it is best to be prepared ahead of time, and **BE IN THE KNOW**, rather than taken by surprise in times of financial crisis.

A WORD OF CAUTION about SSI (Supplementary Social Security Income). Group LTD policies generally do not offset SSI. As you may know, SSI is an emergency disability benefit intended to provide support money to individuals earning under a certain level of income. It is intended for those who have income at or below the established poverty level. Qualifying individuals are usually awarded SSI, and receive money right away, but eventually the SSI is converted to SSDI. Disability insurers may not offset SSI, but once it is converted to SSDI, the insurance company will then go back and retroactively offset any SSI and SSDI amounts you have received. This could result in an overpayment of benefits to the insurance company.

If your group LTD policy is “integrated”, meaning the disability insurer has a right to reduce your gross monthly benefit by certain other income, it is important for you to understand why the company requires you to apply for social security disability, and how your future benefit will be reduced if you are awarded SSDI or SSI benefits. If the policy provision states “you, your spouse or children”, any amounts you receive for your spouse and dependent children will also be considered an offset and will produce a sizable overpayment.

Please Note: SSDI COLA’s (increases) awarded on a yearly basis do NOT increase the amount of the monthly benefit offset. You actually get to keep the increases you receive from Social Security without penalty. Locate this provision in your policy:

“WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?”

One Priced Right, Inc. has subtracted any deductible source of income from your gross disability payment, Priced Right, Inc. will not further reduce your payment due to a cost of living increase from that source.”

Social Security cost of living increases DO NOT increase the amount of offset from your benefit!

4. *The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:*

- *the United States Social Security Act.*
- *the Canada Pension Plan.*
- *the Quebec Pension Plan*
- *any similar plan or act.*

5. *The amount that you:*

- *receive as disability payments under your Employer's retirement plan.*
- *Voluntarily elect to receive as retirement payments under your Employer's retirement plan.*
- *are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.*

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Priced Right will consider you and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Priced Right will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

This provision allows the disability insurer to reduce your gross monthly benefit by any amounts you receive from Social Security as retirement income, as well as any amounts you receive from your employer in a defined contribution retirement plan. Notice monies received from a 401(k) or 403(b) pension plan are not offsets to your benefit. Although most claimants seem to focus on social security there are quite a few other sources of income, which if received, will be deducted from your monthly benefit. Worker's Compensation, for example, is nearly always an offset from disability payments.

Reductions allowed from disability monthly benefits can create an "overpayment" situation with any disability insurer. For example, if your LTD policy allows an "offset" for both primary and family social security and you receive *unreduced LTD benefits* for a period of time, when you receive the retroactive lump sum from Social Security, the chances are this amount (or most of it) is due back to the disability insurer.

For example let's say your date of disability is 1/1/2004 and you are eligible to receive SSDI 6/1/2004. (5 months later) Your LTD has a 90 Elimination period. So your first UNUM benefit is payable on 4/1/2004. Your disability insurer pays you your full monthly benefit of \$1,000, even though your policy says the insurance company is entitled to reduce your benefit if you were paid SSDI. Social Security makes a decision on your SSDI claim on 10/1/2004 and awards you monthly benefits of \$789 retroactive to 6/1/2004, and they send you a check for \$3,156.

Since your disability insurer has been paying you a full benefit of \$1,000 per month, the insurance company is entitled to recover \$789 per month since 6/1/2004 because **YOU CANNOT RECEIVE A FULL BENEFIT AND SOCIAL SECURITY FOR THE SAME TIME PERIOD.** The insurance company is not entitled to recover the retro active amount from 4/1/2004-5/31/2004 since no money was received from SSDI for that period of time.

If SSDI is awarded to dependent children then the insurance company is entitled to recover this overpayment as well.

Here's another example. Martha has three dependent children under the age of 18. She was recently awarded primary (for herself) SSDI in the amount of \$2,400 per month for the period 1/1/2005 to the present say 10/1/2005. She received \$21,600 as a retroactive lump sum from social security, a period of 9 months of benefits. Martha's children are entitled to ½ of her primary award (\$1,200) divided among her three dependent children. Therefore, each one of her children also received a monthly benefit of \$400 effective on the same date of 1/1/2005. This means Martha's children each received a retroactive lump sum award of \$3,600. (\$400 x 9 = \$3,600)

Let's add up the retroactive lump sum awards for Martha and her children:

Martha's award for herself	\$21,600
Each child \$3,600 x 3 =	<u>\$10,800</u>
Total Received	\$32,400

Now, Martha also started getting disability benefits from her insurance company beginning 2/1/2005 in the amount of \$1,800 per month. Her minimum monthly benefit is \$100. *Martha's LTD policy allows offsets for both her social security award AND amounts awarded to her children.* How much does she owe the insurance company? Here is how to do the calculation. (This is also how the insurance company figures the amount owed.)

How much was Martha actually paid by the insurance company?

For the period 2/1/2005 – 10/1/2005 \$1,800 x 8 = \$14,400

How much SHOULD Martha have been paid?

For the period 2/1/2005 – 10/1/2005	\$1,800 x 8 =	\$14,400
SSDI for herself for the same period	\$2,400 x 8 =	(\$19,200)
SSDI for her children	\$1,200 x 8 =	<u>(\$9,600)</u>
Amount of overpayment		(\$14,400)
Minimum monthly payment	\$100 x 8 =	<u>\$800</u>
Net overpayment		<u>\$13,600</u>

Martha owes the insurance company \$13,600 because the insurance company paid full benefits to her of \$1,800 for 8 months. Social security eventually awarded her \$2,400 a month in benefits for the same period of time. Since the insurance company did not reduce the \$1,800 to the minimum monthly benefit of \$800, Martha was overpaid by the insurance company and must repay the insurance company. Her disability insurer is not entitled to recover any money for the month of January since Martha's disability benefits began 2/1/2005.

Going forward Martha will only receive the \$100 minimum monthly benefit since the offsets to her monthly benefit exceed the amount of payment she is entitled to for LTD.

What is interesting is that IF Martha had hired an attorney to assist her in obtaining SSDI benefits, social security would have paid her attorney 25% of the lump sum award of \$32,400 or \$8,100! In this case, the disability insurer is only entitled to recover \$5,500 (\$13,600 - \$8,100) as the overpayment since the amount owed is reduced by the amount paid to the attorney. In this case, Martha would only have received a lump sum payment of \$24,300.

The next question is whether the overpayment should be repaid to the disability insurer, and the answer is “yes it should”. However, nearly all disability insurers will negotiate the terms of repayment even though initially they want the amounts owed to be repaid in a lump sum. Most repayment plans expect to fully recover the amount owed within a twelve month period. In the above example, Martha could only give up the \$100 minimum monthly benefit for 136 months to prepay the amount owed. In addition, there is always the possibility the insurance company will reduce her monthly benefit to \$0 anyway, deny her claim, and chase her for the overpayment.

Traditionally, disability insurers “pass off” the liability for disability payments to the federal government through social security. Because of this, a pattern has developed within the claims process whereby the insurance company requires the insured to apply for social security; collects the lump sum award; and then denies the claim after the change in definition at the 24th month. Therefore, the unfortunate scenario of an insured receiving SSDI, paying back large amounts of money only to find their claim (and future income) denied. Left without any financial support, the insured is devastated.

Therefore, the insured must consider that repaying a large lump sum back to the insurance company could mean the “giving up” of future income. Most people who are eligible for social security and receive a lump sum need the money for health care, prescriptions, and other overdue bills. It is always a good idea NOT to turn over a lump sum award to a disability insurer without a letter from the insurance company stating the claim has been approved for benefits beyond the 24th month. Remember from earlier discussions, there is usually an “any occupation” investigation before a decision to pay the claim on the 25th month can be made.

Insurance companies are now being asked to take into consideration the decisions of Social Security, but whether this is done across the board is anyone’s guess. However, the best bet for repayment of a social security retroactive lump sum is simply to make the best deal you can for reduction of your monthly benefit over time. Then, save the overpayment and collect interest on the lump sum to help you pay for future expenses.

Most group disability policies will also tell you specifically what is not a deductible source of income. Here is an example of what such a provision may look like:

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Priced Right will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans;
- Profit sharing plans;
- thrift plans;
- tax sheltered annuities;

- *stock ownership plans;*
- *non-qualified plans of deferred compensation;*
- *pension plans for partners;*
- *military pension and disability income plans;*
- *credit disability insurance;*
- *franchise disability income plans;*
- *a retirement plan from another Employer;*
- *individual retirements accounts (IRA's);*
- *individual disability income plans;*
- *salary continuation or accumulated sick leave plans*

In my opinion, the most important to take note of is the 401(k) plan, and salary continuation. If you leave your job and your employer pays you a certain number of weeks of salary as “salary continuation”, these amounts should not be deducted as an offset to your benefit. Also notice veteran or GI benefits are not offsets to disability income.

Please keep in mind your employer chooses what benefits to add and amounts to be deducted from your benefit each renewal period, generally on a yearly basis. Non-integrated plans with COLA and other riders are the most expensive. Your Human Resource Department may only spend budgeted dollars on employee benefits. Unfortunately, many STD/LTD plans are “skeleton plans” with the least amount of premium. Nevertheless, you are entitled to benefits described in the provisions of your policy, and the insurance company is entitled to reduce your benefit only by amounts indicated in your policy.

If you are unhappy with the provisions in your LTD policy, you have the right to make recommendations to your Human Resource Department for future amendments and changes. Participation in an employer sponsored group STD/LTD plan is considered an employee benefit in most employee handbooks.

The Exclusion Provision

This is another interesting provision in your policy often referred to as the Exclusion Provision. Here is the wording:

“WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?”

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- *intentionally self-inflicted injuries;*
- *active participation in a riot;*
- *loss of a professional license, occupational license or certification;*
- *commission of a crime for which you have been convicted under state or federal law;*
- *pre-existing condition.*

Priced Right, Inc. will not cover a disability due to war, declared or undeclared, or any act of war. Priced Right, Inc. will not pay a benefit for any period of disability during which you are incarcerated.”

The wording of this provision is somewhat self-explanatory, and the only application I observed in my experience as a claims examiner was that of several claimants who after being

awarded benefits, committed a crime and went to jail. Disability insurers will not pay benefits to those jailed for crimes, even though they may be impaired while in jail.

As a matter of interest, this provision came into question by disability insurers after the 9/11 attack. Generally, the exclusion provision says a disability from an act of war is not covered. Was the 9/11 attack an act of war? Although technically, victims of the 9/11 attack weren't covered due to the implication of an "act of war", all companies reviewed the claims anyway as a matter of national emergency. This does not mean the 9/11 claims were paid indiscriminately, but at least the claims were not denied outright due to the exclusion provision.

Pre-existing Conditions

Nearly all group LTD policies contain some type of pre-existing condition provision. These provisions protect the disability insurer from paying on a claim for conditions which existed before the insured became effective on the current policy. There are many types of pre-existing condition provisions, 6/12, 3/12, 6/12/24, 6/12/12 etc. The pre-existing condition provision is the second most important provision in your group LTD policy, and it requires your total understanding before submitting a claim for LTD benefits.

Priced Right, Inc. has the following pre-existing condition provision in its policy with Disability Claims Solutions:

“WHAT IS A PRE-EXISTING CONDITION?”

You have a pre-existing condition if:

- *you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage, or you had symptoms for which an ordinarily **prudent person** would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and*
- *the disability begins in the first 12 months after your effective date of coverage.”*

This provision as written for Disability Claims Solutions contains a “prudent person” definition. A prudent person is someone who is reasonably expected to seek consultation or treatment when symptoms or disease is known to exist. For example, it would not be reasonable for someone with cancer not to seek treatment for three months in order to avoid being denied benefits due to a pre-existing condition. It is considered “prudent” and “reasonable” for any person to seek treatment when they know or suspect they are sick.

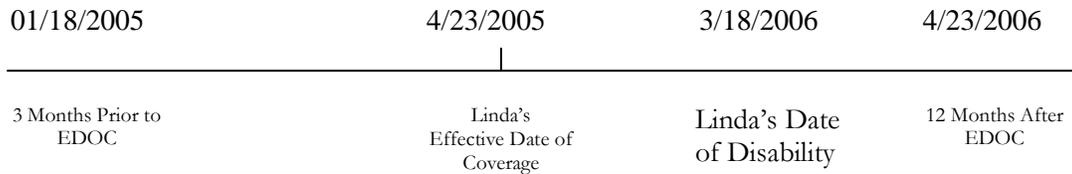
The intent of pre-existing condition provisions is to prevent individuals from seeking disability coverage only after being diagnosed with disease. Nevertheless, there are several pieces of information required in order to determine if a claim has been made for a pre-existing condition. Most disability insurers have specific internal guidelines for reviewing and processing a claim with a potential pre-existing condition.

1. **The Effective Date of Coverage**- the first date you are covered for disability group insurance. You may want to go back and review the information previously given concerning “Waiting Period” and annual enrollment.

2. **The Date of Disability**- the date after your last date worked, or the first date of treatment by a qualified physician.
3. **The Pre-Existing Period**- the period for which you may have sought consultation or treatment prior to your effective date of coverage.

Here is a good example. Linda West was hired by Disability Claims Solutions as an Administrative Assistant on April 23, 2005. On March 18, 2006, Linda’s physician recommended she stop working due to severe COPD for which she needed immediate and on-going treatment. Does Linda have a payable claim? Or, does she have a pre-existing condition? Let’s take a look.

Using the time-line approach, and the above definition of pre-existing conditions in the Priced Right group LTD policy, we can pictorially capture Linda’s situation.



These are important dates in determining your pre-existing period and whether your claim will be subjected to a pre-existing condition investigation.

Since the “Waiting Period” provision in the Priced Right, Inc. policy indicates “None”, Linda’s first date of coverage for group LTD through her employer’s plan *is* also her date of hire of 4/23/2005.

The pre-existing condition provision (above) directs if Linda goes out on disability within 12 months of her effective date of coverage, AND she received treatment in the 3 months prior to her effective date of coverage, she is NOT eligible for benefits.

Twelve months after Linda’s effective date of coverage (4/23/2005) is 4/23/2006. Linda’s date of disability is 3/18/2006. Did she go out on disability within one year of her effective date of coverage? (4/23/2006) Yes, she did.

What is her pre-existing period then? It is three months prior to her effective date of coverage: 1/23/2005-4/23/2005. The insurance company will now conduct what is called a “pre-existing condition investigation” to determine if Linda received “*treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines*” from 1/23/2005-

4/23/2005. If she did, Priced Right, Inc. will deny her claim for benefits claiming she has a pre-existing condition.

Linda was actually treated by a respiratory specialist and had a Pulmonary Function Test on 3/10/2005. Her pharmaceutical records also indicated she was prescribed medications, including medications for a nebulizer during this same period of time. Clearly, according to the definition of a pre-existing condition, Linda's claim for benefits on 3/18/2006 is due to a pre-existing condition.

Let's change the example slightly assuming Linda had symptoms of respiratory illness during the above three months, but did not seek treatment. If the disability insurer can prove Linda's symptoms were severe enough so as to cause a "prudent person" to seek treatment, her claim would also be denied since she did not act as a "prudent person" by delaying treatment.

Again, let's change the example. Assume Linda did not go out on disability until 4/25/2006. What then? Since Linda's date of disability is NOT within 12 months of her effective date of coverage, her claim is NOT subject to a pre-existing condition investigation and her claim will be reviewed according to medical merit rather than eligibility under the pre-existing condition provision. In other words, if Linda had been able to postpone or wait until after 12 months of her effective date of coverage, it is likely her claim may not have been denied, or at least for pre-existing condition reasons.

The above pre-existing condition provision is called a 3/12 provision – 12 months after EDOC, and 3 months prior to EDOC. A 3/12 provision is, by far, the most common, but here is another example:

- *“you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 12 months just prior to your effective date of coverage; and*
- *the disability begins in the first 12 months after your effective date of coverage.”*

This provision is called a 12/12 provision. It means if you received treatment within 12 months of your EDOC, your claim is considered pre-existing – a much tougher condition to meet. Notice this provision, as I've given it, also includes the "prudent person" wording. Another version of this provision is 12/24 which is also difficult to meet since your date of disability needs to fall greater than 24 months after your effective date of coverage.

Another variation, 6/12/24, for example, allows a treatment free period. If your disability falls within 24 months of your EDOC, AND you were treatment free for 12 months after your EDOC, you are not subject to the pre-existing condition. Here is just one example of a "treatment free" pre-existing provision.

“You have a pre-existing condition if:

- *you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to your effective date of coverage; and*

- *the disability begins in the first 12 months after your effective date of coverage unless you have been **treatment free for 3 consecutive months after your effective date of coverage.***

“TREATMENT FREE MEANS you have not received medical treatment, consultation, care or services including diagnostic measures, or taken prescribed drugs or medicines for the pre-existing condition.”

The above provision is a 12/3/12 provision which means you are not subject to a pre-existing condition investigation if you are “treatment free” for the 3 months following your EDOC. There are other variations of pre-existing condition provisions, but it is extremely important to locate the wording in your own policy and determine your pre-existing period before attempting any application for benefits.

Anytime you have choose to have elective surgery the pre-existing provision in your policy is very important and should be examined and determined before leaving work.

Continuity of Coverage

Your policy may contain a provision which protects you from pre-existing conditions if you were previously covered for LTD under another plan. These situations include coverage if your current employer changes to another insurer, or, you were covered under a prior plan with another employer and there was no lapse in coverage. A typical provision will read as follows:

“WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO PRICED RIGHT, INC.?”

Priced Right, Inc. may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Priced Right, Inc. plan; or
2. the prior carrier’s plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy item 1 or 2 above, Priced Right, Inc. will not make any payments.

If you do satisfy item 1, we will determine your payments according to the Priced Right, Inc. plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Priced Right, Inc. plan provisions, however, your payment will be the lesser of::

- a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or

- b. the monthly payment under the Priced Right, Inc. plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.”

What does all this mean to you? This provision is referred to as the “continuity of coverage” provision, and it is extremely important if you were covered by a prior group LTD policy when you are determined to be pre-existing under the current one. This provision can prevent the current disability insurer from denying your claim due to a claimed pre-existing condition under the current policy when you were covered previously by another plan.

These situations can result from previous employment with a different employer, or most often, when your current employer changes plans to a new insurer. Please notice the tests are as follows:

1. Is the insured pre-existing under the current Priced Right, Inc. plan?
2. If yes, then is the insured pre-existing under the old policy?
3. If no, pay under the plan with the lesser benefit.

Buy Ups

Employees should also be very careful about “buy ups” in coverage. Sometimes, workers are offered the opportunity to increase coverage during an annual enrollment period, say, from 60% to 70%. If you were covered by the group plan for 60% previously, but then opted for 70% benefit in the new enrollment period, you will be subject to a pre-existing investigation for the 70% payout should you become disabled within the time period for pre-existing conditions.

Here’s an example,

Let’s say Linda is covered under the Priced Right, Inc. policy for the years 2000, 2001, 2002, 2003, 2004 at the rate of 60% of her basic monthly earnings. In January 2005, Linda’s employer offered her the option of a 70% benefit if she wished to contribute a small premium each month. Linda opted for the 70% benefit in January 2005, but then became disabled in June. Since the Priced Right, Inc. policy contains a 3/12 pre-existing exclusion provision, she is subject to a pre-existing condition exclusion for the 70% payout. If Linda otherwise met the conditions of her policy for the definition of disability, she would be paid at the 60% rate.

Many employees who “buy up” in coverage believe they are immediately entitled to the 70% coverage. Not so. If you become disabled before December 31, 2005, your current condition is pre-existing and you are only entitled to payment of the 60%. There is a lesson here. If you are facing elective surgery and can put off the medical time off from work for 12 months, your disability will not be pre-existing and you can be paid at the 70% or the newly elected rate.

Mental and Nervous and Self-Reported Disability

Most STD/LTD group policies contain a provision limiting the payment of benefits when the impairment is due to mental and nervous disease or resulting from self-reported causes. Mental illness and self-reported symptoms are defined as follows:

*“**MENTAL ILLNESS** means a psychiatric or psychological condition regardless of cause such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.”*

*“**SELF-REPORTED SYMPTOMS** are manifestations of your condition which you tell your doctor, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.”*

“WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?”

Disabilities due to sickness or injury, which are primarily based on self-reported symptoms, and disabilities due to mental illness have a limited pay period up to 24 months: (12 months in some policies.)

Priced Right, Inc. will continue to send you payments beyond the 24 month period if you meet one or both of these conditions:

- 1. If you are confined to a hospital or institution at the end of the 24 month period, Priced Right, Inc. will continue to send you payments during your confinement.*

If you are still disabled when you are discharged, Priced Right, Inc. will send you payments for a recovery period of up to 90 days.

If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Priced Right, Inc. will send payments during that additional confinement and for one additional recovery period up to 90 more days.

- 2. In addition to Item 1, if, after the 24 month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Priced Right, Inc. will send payments during the length of the reconfinement.*

Priced Right, Inc. will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Priced Right, Inc. will not apply the mental illness limitation to dementia if it is a result of:

- Stroke;*
- trauma;*
- viral infection;*

- *Alzheimer's disease; or*
- *Other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment."*

If you have been diagnosed with a mental, nervous or self-reported disability, your benefits are limited to 12 or 24 months depending on the language in your policy provision. For those claimants who expect to be totally disabled from mental illness, it is a good idea to apply for Social Security Disability benefits right away in order to ensure continued financial support after the 12 or 24 months allowed by your disability policy.

Unfortunately, this group LTD provision has been misused by the insurance company, in some cases, to claim impairments are psychiatric in nature when they are not. Fibromyalgia is a good example. Many disability insurers claim fibromyalgia is a mental disease and does not have physical symptoms preventing someone from returning to work. Other diseases which may fall prey to "abuse of discretion" by the insurance company include MS, RSD, CFS, Lyme Disease, headaches, cognitive or memory problems, depression, and neurological diseases.

Mental and nervous provisions can vary from policy to policy. Some contractual wording actually includes naming specific impairments the insurance company will consider to be limited to 24 months. Examples of such impairments include headaches, tinnitus, fatigue, and chronic pain. A new contractual wording actually names "fibromyalgia" as a condition limited to 24 months. As always, it is a good idea to check your policy and understand how your benefits will be limited before you become ill or injured.

It is also important to note the 24 months indicated above need not be consecutive. Assume you received benefits for 12 months for Depression, and then another 5 months for a broken pelvis. Then, another 16 months for Depression. Under the above provision, you may only receive benefits for a total of 24 months for mental and nervous impairment, and it need not be consecutive.

The above provision wording was taken from a UNUM Life Insurance policy, however, some disability insurers are writing group policies that are much more restrictive and specific. For example, here is the policy wording from a Reliance Standard group LTD policy.

MENTAL OR NERVOUS DISORDERS: *Monthly Benefit for total disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless you are in a Hospital or Institution at the end of the twenty-four month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.*

If you are confined in a Hospital or Institution and:

- (1) Total Disability continues beyond discharge;*
- (2) The confinement was during a period of Total Disability; and*
- (3) The period of confinement was for at least fourteen consecutive days;*

then, upon discharge, Monthly Benefits will be payable for the greater of:

- (1) the unused portion of the twenty-four month period; or*
- (2) ninety (90) days;*

but, in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:

- (1) Bipolar disorder (manic depressive syndrome);*
- (2) schizophrenia;*
- (3) delusional (paranoid) disorders;*
- (4) psychotic disorders*
- (5) depressive disorders;*
- (6) anxiety disorders;*
- (7) somatoform disorders (psychosomatic illness);*
- (8) eating disorders; or*
- (9) mental illness*

In addition, this same policy states:

- 1. Monthly Benefits will be limited to a total of 24 months in your lifetime for all total Disabilities caused or contributed to by:*

- ↳ Chronic fatigue syndrome; or*
- ↳ Environmental Allergic or Reactive illness; or*
- ↳ Self-reported Conditions.*

No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

- 2. Monthly Benefits will be limited to a total of 24 months in your lifetime for all total Disabilities caused or contributed to by musculoskeletal and connective tissue disorders of the neck and back, including any disease, disorder, sprain and strain of the joints and adjacent muscles of the cervical, thoracic and lumbosacral regions and their surrounding soft tissue.*

No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

Provisions such as the one above makes one wonder exactly what does *not* qualify under this mental and nervous provision. The insurance company could conclude any illness is either self-reported, or somatic in origin. (“Somatic” or “somatization” generally means “in your head, “imagined, or even psychotic.”)

These types of provisions open the door for the disability insurer to claim benefits should be limited to 24 months for almost any reason. Policies should always be checked carefully to determine whether the disability insurer has the right to limit benefits and under what condition.

A GOOD CASE IN POINT—Natalie and Her Depressive Disorder

Natalie is a 50-year-old Obstetrician employed by Women’s Health Center in Columbus, Ohio until March 2003 when she was forced to take time off from her occupational duties due to severe Depression, Anxiety and Panic Attacks. Natalie was also diagnosed with atrial fibrillation often brought about by stress.

Due to her diagnosis of depression, Dr. Natalie was paid 24 months of benefits under the mental and nervous provision of her policy. But, her benefits were denied on the 25th month because it was determined the atrial fibrillation was not serious enough to preclude her from working.

Was Natalie still unable to perform the material and substantial duties of her own occupation as an Obstetrician due to depression and anxiety? Yes she was. But, her group policy limited her benefits to 24 months. Unfortunately, Natalie’s physical cardiac diagnosis was not serious enough to pay total disability.

This is an interesting situation occurring often. Natalie cannot receive payments for a mental and nervous condition even though she is still unable to work, and benefits are denied for physical reasons. Oftentimes, individuals take much longer than 24 months to recover, yet are ineligible for benefits due to the 24 month limitations.

SELF-TEST

Once again, using your group LTD policy, locate and explain all of the deductions (offsets) the disability insurer will subtract from your monthly benefit. Also, be watchful for other exclusions pre-existing information.

Refer to the section in your policy entitled “Other Sources of Income.” What deductions from your benefit would the insurance company be likely to subtract?

On a scrap piece of paper, draw a pre-existing condition timeline and write in the following key dates described below. Depending on the pre-existing condition provision in your policy all of the below may not apply.

**Effective date of coverage 12 months from your Effective Date of Coverage
Your date of disability 3 months before your Effective Date of Coverage
6 or 12 months of treatment free period**

What is your pre-existing period?

What is the first date you may be eligible for disability benefits without having a pre-existing condition?

If you are disabled due to a mental or nervous condition, what is the date your benefits will end? _____

Is the 12 or 24 month limitation consecutive?

- Yes
- No

What is the estimated amount of your primary and family social security award?

Given all of the above, calculate your estimated or expected net monthly benefit.

How Does Social Security Define Disability?

SSA and federal law defines disability as follows, "The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." (citing 42 U.S.C. §§ 423(d)(1)(A) and 1382c(a)(3)(A)).

Therefore, applicants for Social Security Disability should consider the following before making application for Social Security Disability or SSI benefits:

1. A claimant may fit the definition of disability and be considered eligible for Social Security Disability on the basis of one impairment, or on the basis of several impairments. But the condition must be severe enough to significantly affect the ability to work. This means the impairment must last at least twelve months, or be expected to last that long. It also means that while "back conditions" usually fall into the severe category, "wrist and ankle sprains" seldom qualify as severe disabling conditions.
2. A disabled individual may be working when they apply for Social Security Disability, and may continue to work even after they have been approved---as long as they do not earn more than the SGA amount. The SGA amount changes periodically, but currently it is \$860.00 per month. (for 2006) It is important to remember this is a gross income amount, i.e. before taxes have been deducted.
3. A person earning more than the SGA amount who applies for Social Security Disability or SSI benefits will, essentially be denied the same day without having their impairments or medical records even considered. This is referred to as a "technical denial".

How Much Does a Social Security Lawyer Cost?

On most, but not all, Social Security cases, lawyers charge what is called a "contingent fee." This means that the lawyer's fee is a percentage (usually 25%) of any back pay the government owes you by the time you finally win the case, and if you do not get benefits the lawyer does not charge you anything. Some firms do not require a retainer fee for most types of cases. Don't be afraid to ask exactly how any lawyer charges - it's your case and your money.

There are some kinds of Social Security problems for which you may need a lawyer, but you will not be due any back pay if you win. A lawyer cannot take this kind of case on a percentage - there is nothing to figure a percentage on. The lawyer may want to charge by the hour (whether you win or lose), or you may make some other arrangement.

Fees should be clearly set out before you decide to hire a particular lawyer. All lawyer fees are regulated by Social Security. In some cases, your attorney must file a written application with Social Security at the end of the case, and the final amount of the fee is then set by the government. For most types of benefits (but not SSI), Social Security will hold out the 25% of your back pay, and send your lawyer a check for the fee they approve. In other cases, you will have to pay the lawyer yourself. SSI claims are the most common kind of case in which you must pay your lawyer directly, but this can also happen in certain other cases which do not involve back pay if you win. Be sure to ask your lawyer how his or her fee will be paid in your particular case.

Since 1991, a fee of 25% of any back pay due, up to a limit of \$4,000, will be automatically approved in many cases. However, you, your lawyer, or the administrative law judge may still ask for the fee to be individually reviewed in a given case, if one of you object to a fee of 25%.

As I indicated earlier, referrals by insurance companies to SSDI resources are not free.

GROUP LTD 101 GLOSSARY

ACTIVE EMPLOYMENT means you are working for any employer and you are receiving earnings for your work. You must be performing the important or material and substantial duties of your regular occupation (not your job). In addition, you must be working the minimum number of hours indicated in the plan summary. You must be considered a legal employee by:

- working at your employer's place of business; or
- at an alternative work site at the request of your employer; or
- working at a location to which your occupations requires you travel.

ACTIVITIES OF DAILY LIVING mean:

- Bathing-the ability to wash yourself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing-the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting-the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring-the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches, or grab bars or other support devices including mechanical or motorized devices.
- Continence-the ability to either voluntarily control bowel and bladder function; or if incontinent, be able to maintain a reasonable level of personal hygiene.
- Eating-the ability to get nourishment into the body.

ADL's usually apply when the group LTD policy has a Disability Plus Rider, or pays an additional benefit when a claimant is ADL's restricted.

ADMINISTRATIVE RECORD is the compilation of all documents, both paper and electronic, generated by both the claimant and the insurance company in the decision-making and management of a group disability claim. The Administrative Record should contain a copy of the employee's group policy, a Summary Plan Description (SPD), and all communications, medical records, in-house reports, etc. which have been created and used in the decision-making, and liability determination process.

ADVERSE SELECTION occurs when a group policy design encourages employees with a predisposition for disability to participate in the plan at a higher rate than the general population. This may affect an employer with an older or unhealthy employee base.

BASIC MONTHLY BENEFIT (BMB) often referred to as “Monthly Benefit” is your gross monthly income for which you are insured under the policy. The BMB is always subject to the maximum allowable benefit in your policy.

BASIC MONTHLY EARNINGS (BME) means your pre-disability income from your employer as defined in the “What Are Monthly Earnings?” provision of your policy. Usually, this is your salary or hourly wage just prior to your date of disability.

CERTIFICATE BOOKLET is the copy of your policy (Plan) provided to you by your employer. Your copy is often in the format of a booklet rather than the official copy of the policy signed by your employer. The certificate copy contains the same information as the official policy.

CLAIMANT is any employee who has filed a claim for group STD/LTD benefits while covered by an employer sponsored group LTD plan.

CONTINUITY OF COVERAGE is the provision which allows payment for a pre-existing condition when the claimant was insured under a prior plan. The insured is paid under either the current plan or the prior plan whichever has the lesser monthly benefit.

DEDUCTIBLE SOURCES OF INCOME are other sources of income which will be subtracted from your monthly disability benefit. These sources are listed in your policy.

DISABILITY INSURANCE is defined as insurance protection against the risk of loss of income due to disability resulting from injury or illness.

DISABILITY EARNINGS are monies received while you are disabled and working, plus earnings you COULD receive if you were working to your maximum capacity.

DOCTOR is a:

- person performing tasks that are within the limits of his/her medical license issued within the respective states; and
- person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- person with a doctoral degree in Psychology (Ph.D., or Psy.D) whose primary practice is treating patients; or
- person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

ELIGIBLE GROUP means the class of employees covered by the group plan. All employees must be included in the eligible group in order to be covered by the employer’s group plan.

ELIMINATION PERIOD: is a continuous period of time for which benefits are not paid. It begins on the day after your last day worked and ends on the number of days indicated in your policy, generally 30,60,90,180. If you have a 90 day elimination period, your benefit begin date is the 91st day.

EMPLOYEE means a citizen of the United States who is engaged in performing work activity for an employer. The employee must be employed the minimum number of hours designated in the policy in order to be eligible for benefits.

EMPLOYER is the Policyholder, and includes any division, subsidiary, or affiliated company named in the policy.

ERISA is the Employment Retirement Income Security Act of 1974 and is the body of federal law which governs most group disability and health benefit (called cafeteria) plans. Governing jurisdiction is the US Department of Labor which is a federal jurisdiction.

EVIDENCE OF INSURABILITY is a statement about an employees health required if the employee waits until after the 31st day to enroll for LTD benefits, or refuses coverage before reinstatement. The insurance company will use this information to underwrite the employee's medical condition separately from the designated employee group.

GAINFUL OCCUPATION means an "occupation that is or can be expected to provide the claimant with an income at least equal to 60% of his/her indexed monthly earnings." There are many variations to this definition. Another example might be: " an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment within 12 months of your return to work. The concept of "gainful occupation" is used most often during "any occupation investigations."

GRACE PERIOD is the period of time following the premium due date during which premium payment may be made, generally 31 days.

GROSS DISABILITY PAYMENT is the monthly benefit payment amount before the insurance company subtracts deductible sources of income and part-time earnings. (Disability earnings)

HOSPITAL OR INSTITUTION means a accredited facility licensed to provide care and treatment for the condition you are now claiming disability.

IMPAIRMENT means a medical diagnosis given to an individual by a medical doctor which includes specific restrictions and limitations preventing productive work. This is different from a diagnosis of disease which may not cause a worker to cease job duties.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% (any percentage), or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. Usually, the insurance company reserves the right to use some other similar measurement.

Indexing is only used to determine the percentage of lost earnings while you are disabled and working. Indexing is very different from a COLA, and is not used for regular benefit increases.

INJURY means an injury resulting from an accident and not related to any other cause. In order to be eligible, you must have sustained the injury while covered under the plan.

INSURED is a term used to describe any person covered under a plan, most often, an individual disability policy.

LABOR MARKET SURVEY is conducted along with a Transferable Skills Analysis to determine if the occupations located in the TSA can be found within a 40 mile radius of your geographical location.

LEAVE OF ABSENCE means the employee is temporarily absent from active employment for a period of time which has been approved in writing by the employer. A normal vacation time or any time you are on disability is generally not considered a temporary layoff or leave of absence.

MATERIAL DUTIES are those which are characteristic to specific occupational tasks without which the occupation could not be distinguishable into any specific category or job specification. These duties are qualitative in nature and are those duties, which if eliminated, indicate the occupation, as defined, would not exist.

MENTAL OR NERVOUS ILLNESS means any psychiatric or psychological condition regardless of cause such as schizophrenia, depression, manic depressive or bipolar illness, anxiety personality or adjustments disorders and other conditions. A Mental and/or Nervous impairment is normally treated by a mental health physician using psychotherapy, psychotropic drugs, or other similar methods of treatment.

MONTHLY PAYMENT means the amount you are actually paid by the insurance company. This amount is after any “offsets” or deductible amounts have been subtracted from your basic monthly benefit.

PARTIAL BENEFITS OR PARTIALLY DISABLED means you are working part-time, *and* you have met a period (the EP) of total disability. In other words, you did not work during the Elimination Period prior to returning to work.

POLICYHOLDER means your employer for group LTD plans.

PRE-EXISTING CONDITION means any impairment for which you received medical treatment, consultation, care or services including diagnostic measures, or taken prescribed drugs or medicines during any given period as described in your policy.

PRUDENT PERSON means a person who reasonably seeks treatment when there are physical or mental symptoms indicating the presence of disease. A prudent person is one who seeks treatment, consultation, or other medical advice when it is reasonably evident they are sick.

REGULAR AND APPROPRIATE CARE means:

- you visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat your disabling condition(s); and
- you are currently receiving appropriate care by a doctor whose specialty or experience is appropriate to the impairment you have.

RESIDUAL BENEFITS OR RESIDUALLY IMPAIRED means you are working part-time, *and* you also worked part-time during the Elimination Period. This is compared to Partial Benefits where the insured does NOT work during the EP.

RETIREMENT PLAN means a plan generally called a “defined contribution plan” or “defined benefit plan”. These are plans which are not 100% funded by the employee. Retirement plans, as defined, are offsets to gross monthly benefit in most policies.

RISK MANAGEMENT is the totality of internal disability claims review processes wherein the insurer collects, gathers and creates documentation (from medical, vocational and administrative sources) to support claims decisions which promote corporate profitability by denying the least numbers of claims submitted for payment.

SELF INSURED relates most often to short-term disability benefits, and refers to a situation where the employer funds (or pays for) the disability benefits rather than the disability insurance company. For example, if you receive 26 weeks of STD and your checks are written by your employer, then the plan is self-insured. Employers typically pay the insurance company to review your claim and make an ATP, or “advice to pay” to the employer. Employers have a great deal of influence over whether or not to pay a benefit that is self-insured.

SELF-REPORTED IMPAIRMENTS are manifestations of your condition which you tell your doctor, but are not verifiable using tests, procedures or clinical examination, and other methods usually accepted in the practice of medicine. Examples of self-reported symptoms might include headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

SUBSTANTIAL ASSISTANCE means the physical assistance of another person without which one would not be able to perform an activity of daily living; or the constant presence of another person within arm’s reach which is necessary to prevent, by physical intervention, injury to oneself while one is performing an activity of daily living.

SUBSTANTIAL DUTIES are job tasks which represent the largest proportion of total tasks performed in an 8-hour work day. Substantial duties are also recognizable as those which if eliminated, prevent the occupation from existing. These duties are quantitative, and suggest the performance of specific occupational duties for the majority of an 8-hour workday.

SUBSTANTIAL SUPERVISION means continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect one from threats to one’s health or safety.

SUMMARY PLAN DESCRIPTION (“SPD”) is the summary of the important provisions of a group sponsored LTD plan. This summary is required under the ERISA statutes and should appear at the beginning of all ERISA LTD plans. The omission of the “SPD” by the Plan Administrator is against the law.

TRANSFERABLE SKILLS ANALYSIS is the “any occupation investigation” conducted by the disability insurer to document and locate, given your current restrictions and limitations, other occupations you are able to do because of your education, training and experience. A TSA is generally conducted between 9-18 months of paid benefits.

WORKING PART-TIME generally means the ability to work and earn between 20% and 80% of your indexed monthly earnings. (BME)

ADDITIONAL INFORMATION OF INTEREST TO GROUP LTD CLAIMANTS

The Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 (FMLA) is a federal law permitting employees to take a maximum of 12 weeks of unpaid, job-protected leave in a 12 month period to care for themselves or an eligible family member in the case of a serious health condition, or upon the birth, adoption, or foster care placement of child. To protect the rights of employees, the FMLA prohibits an employer from interfering with the employee's attempt to exercise his/her leave rights or retaliating against an employee for opposing practices in an unlawful manner under the FMLA. If an employer engages in these prohibited acts, the FMLA allows the employee to bring suit for damages.

Although the 12 weeks are generally taken consecutively, they can also be taken in shorter increments for ongoing care reasons, such as to attend to your own or an eligible family member's monthly medical treatments.

To be eligible for an FMLA-designated leave, you must have been an employee for at least 12 months and have worked at least 1,250 hours during the 12 months prior to the start of your leave. Some states have enacted family leave or related laws that may provide additional leave time for one or more categories of leave based on eligibility requirements established under applicable state law. If you are eligible for FMLA leave, and the medical reason for the leave qualifies, your entitlement will begin on the first day that the leave commences. Any FMLA leave time used in the preceding 12 months is generally subtracted from your total entitlement.

The Family and Medical Leave Act entitles employees to retain any employer-paid health benefits while FMLA leave is in effect. Upon return from FMLA leave, an employee must be restored to the employee's job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. In addition, an employee's use of FMLA leave cannot result in the loss of any employment benefit which the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under the employer's attendance policy.

All employees should check with their HR Benefits representatives to determine if you need to make an application for FMLA. For most employers FMLA runs consecutively with STD. Remember, FMLA is an unpaid job-protected leave, but does not pay benefits. It merely prevents your employer from terminating your employment, or discriminating against you in cases where you need to care for yourself or your family.

Please note that the scope of the federal Family and Medical Leave Act does not currently provide for the care of a domestic partner. However, it is permissible for employers to extend benefits eligibility beyond what the federal law provides. Please check with your employer for FMLA employer policies.

Disability Claimant's Bill of Rights

As a direct or indirect party to a legal contract involving insurance coverage for disability or income replacement, you are entitled to legal and contractual rights of expectation that the provisions agreed to are adjudicated in a fair, unbiased and equitable manner by the disability insurer.

1. **You have the right of full disclosure.** As the insured party to a disability contract you have the right to receive and examine all collected data, both paper and electronic, collected by the disability insurer in the process of reviewing your claim for benefits. This includes all administrative and chronological records, conversations, meetings, data base checks, field surveillance, and any other data affecting your privacy as an individual. This information must have been used by the insurance company to deny your claim for benefits. Under ERISA regulations you have the right to receive a copy of your policy and claim file within 30 days of requesting it. If it has not been provided to you within the designated time frame, the insurance company may be fined \$110 per day.
2. **You have the right to privacy and respect.** You have the right to expect medical records and any other private information which reflects upon your credibility, integrity or reputation, to be kept private and treated with respect. You have the right to know what type of information is requested over and above that which is needed in making a fair decision on your claim. You have the right to know when your claim is being reviewed in a public forum and by whom. (Such a roundtables.) You also have the right to know the name and title of the person who will actually be making the decisions on your claim. Quite often, it is not the claims specialists who do this.
3. **You have the right to a timely claim decision.** You have the right to expect your disability insurer will make every effort to render a claims decision within 30 days (ERISA claims) or that period of time indicated in the policy provisions. You have the right to be notified in writing every 30 days as to the reason why your claim decision is delayed. ERISA regulations require the insurance company to keep you informed by sending “tolling letters” if the claim decision is not made within the 30 day period.
4. **You have the right to a fair and objective claim review.** You have the fiduciary right to expect your disability insurer will make every effort to consider ALL recommendations and opinions given to the insurer by your primary care physicians, consultants, counselors, and any other specialist who is qualified to render an opinion concerning your ability to work. (ERISA claims or industry standards if an Individual Disability policy) You have the right to expect the disability insurer will consider the experience and qualifications of your doctor as equal to those of its own in-house physicians, and to make fair and honest attempts to reconcile professional differences of opinion.
5. **You have the right to fair representation of facts.** As the insured you have the right to a clear understanding as to the party or parties responsible for making the liability decision for your claim. You have the right to know who is authoring communications to you from your insurer, and the names of all employees, consultants, directors, and others who are offering medical or administrative opinions concerning the facts of your claim.
6. **You have the right to withhold authorization of release of information which is overly broad.** Any individual has the right to retain privacy rights to information without fear of loss of benefits. It is your right not to sign Authorizations of Release which are overly broad, or, which allows the disability insurer to obtain information outside of what is required for a fair and objective review of your claim within the provisions of your policy. Many of the newer ERISA disability policies contain provisions which require you to sign an Authorization and cooperate with the insurance company or risk loss of benefits.

7. **You have the right to ask questions.** As an individual outside of the specialty of the insurance industry, or understanding of that industry, you have the right to knowledge, explanation, definition, instruction and full understanding of the provisions of your policy without fear of loss of benefits. You have the right to ask questions concerning your claim as often as is necessary for your understanding of the facts without fear of retaliation, suspicion, or unfair investigation tactics.
8. **You have the right to ethical conduct.** As an insured you have the right to expect your disability insurer, and its representative employees act in “good faith.” You have the right as an employee or policyholder to expect your insurance company creates and maintains a clearly defined disability claims review process which lends toward the fair, objective and timely, review of all claims submitted as part of its product business. You have the right to expect your insurance company have in place a process which routinely and consistently corrects flaws within the review process; recruits, trains and retains individuals qualified to review disability claims; and provides a forum for independent appeal processes.
9. **You have the right of non-discrimination.** All insured have the right to expect their insurance company not discriminate on the basis of indemnity amount, self-reported or physical impairment, education, training or experience, occupation, age, sex, mental and nervous disorder. Policyholder, geographical region, claim location, event, physician, claim duration, months of paid benefits, or any other target objective identified by management. You have the right of expectation that your claim will not block of business” due to any of the above. be targeted by management for denial as a “
10. **You have the right of appeal.** As an insured covered under the Employment Retirement Security Act of 1974 (ERISA) you have the legal right to a timely independent appeal review of your claim. For non-ERISA individual disability claims, you have the right to report discrepancies to your state authorities and to retain legal counsel, and request “reconsideration” of the denial decision.

This “Bill of Rights” was written by Linda Nee, a Disability Claims Consultant. Although there is no law or regulation upholding these rights as an official document, the rights described herein are reasonable and should be expected from any disability insurer with a duty to uphold generally accepted industry standards to review claims objectively, and without bias or financial prejudice.

What Rights Are You Entitled To Under ERISA?

(Employment Retirement Income Security Act of 1974)

As an employee covered under your employer’s group STD/LTD plan, you have certain rights and protections under ERISA. All plan participants have these rights among others:

- the right to examine, without charge, at the Plan Administrators’ location, and other locations, all claim file documents including a copy of your insurance policy, and all documents filed by the insurance company with the U.S. Department of Labor, such as detailed annual reports and policy (plan) descriptions;

- you have the right to obtain copies of all documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies; and
- you have the right to receive a summary of the insurance company's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of their summary annual report.

In addition to overseeing your rights as a plan participant, ERISA imposes duties upon those who operate your "plan", creating a "fiduciary" responsibility to act prudently, and in the interest of you and other plan participants and employees.

In addition, a fiduciary has the responsibility to discharge duties with respect to the Plan solely in the interest of the insured with care, skill, prudence, and reasonable diligence such that a prudent person would use under the same circumstances. (29 U.S.C. 1104 & 1106) It is the responsibility of all Plan Administrators to act as a "fiduciary" and not an "adversary."

No one, including your employer, may terminate your employment, or discriminate against you in any way to prevent you from obtaining a benefit or exercising any right under the ERISA statutes.

If your benefits are denied, the insurance company is required to provide you a written explanation of the reason for the denial. You have the right of appeal, and to have your claim reconsidered.

ERISA provides steps you can take to enforce your rights under the law. If you request materials from the insurance company and do not receive them within 30 days, you may file suit in a federal court. In such cases, the court may award you \$110.00 per day until you receive the materials.

You have the right to file a lawsuit in federal court if your claim has been denied. However, if you do not prevail in the decision, the judge may order you to pay court costs and fees.

You must be told in writing why the insurance company denied your claim, and your denial letter must contain the following information:

- the specific reason or reasons for denial with reference to those policy provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and of why that material or information is necessary; and
- the steps to be taken if you wish to have the decision reviewed.

Another Discussion on ERISA

One of the most important aspects of ERISA is the guidelines it establishes to help employees understand their benefit plans better (Health, Disability, and Retirement) when they are eligible to participate in the plans, and how the plans work. In addition, you have the right under ERISA to obtain additional information about the plans offered by your employer, specifically those that make up your benefit program.

For examine, you may examine, without charge, copies of the formal benefit plans offered by your employer, such as the official plan texts, master group insurance contracts and trust agreements that legally govern the operation of these plans. These documents, as well as various reports filed with the U.S. government, should be available for your review in the Human Resources Office of your employer. Some employers offer copies of the original documents for a small fee. Finally, as required by law, once a year you should receive a summary of the annual financial report filed with the IRS for each plan. This is especially true for pension, retirement or TIAA-CREF plans.

Under ERISA you also have the right to request a statement, once a year, free of charge, telling you whether you have a right to a benefit under any TIAA-CREF Plan at your normal retirement age if you stop participating in the plan now, and if so, how much your plan benefits would.

ERISA also sets legal guidelines for the people responsible for the operation of your group employer plans. These people, called “fiduciaries”, must act solely in the interest of the plan participants and beneficiaries and must exercise prudence in performing their duties. As explained earlier in this discussion, if your claim for a benefit is denied, in whole or in part, you will be automatically receive a written explanation of the reason for the denial.

You also have the right to have your employer (the Plan Administrator), or the appropriate insurance company review and reconsider your claim. If, after following this appeal procedure, you still feel you are being denied all or part of a benefit, you have the right to file suite in federal or state court. If you believe that a fiduciary has misused plan funds, or if you are discriminated against for asserting your right, or if documents you request in writing are not furnished within 30 days, you may seek assistance from the Department of Labor or file suite in a federal court.

If you take legal action, the court will decide who should pay court costs and legal fees. If you win your case, the court may order the person you have sued to pay these costs and fees. On the other hand, if you lose, the court may order you to pay these costs and fees, for example, if the court find your case to be frivolous. In the case of requested documents, the court may in certain cases require your employer to pay up to \$110 per day until the material is received.

For ERISA cases it is extremely important to communicate with your treating physicians as they are your strongest ally. Many courts place great emphasis in the treating physician’s definition of medical necessity or give great deference to the treating physician’s opinion. When reviewing ERISA disability claims, the court limits the review to the Administrative Record, giving deference to the decision maker in the Administrative proceeding. Normally, the insurance company has contradicted the findings of the treating physicians.

Some courts are guided by the well-established “treating physician rule” whereby the opinions of treating physicians must be given great weight. (i.e. Social Security cases) Normally in cases where the insurance company’s in-house physicians have a financial interest in the outcome, his opinions may not be entitled to as much weight. In most other cases, the courts should give substantial weight to the opinions of the treating physician.

But, hold on...

The application of the “treating physician’s rule”, although applied in social security cases, was not applied consistently in the circuit courts. This inconsistency, as it applied to the federal statute, was, unfortunately, clarified on appeal to the US Supreme Court by Justice Ginsburg on May 27, 2003. In *Black & Decker Disability Plan v. Nord*, the Supreme Court of the United States held that "ERISA does not require plan administrators to accord special deference to the opinions of treating physicians," therefore, effectively ending the use of the treating physician rule in ERISA-governed claims.

The Importance of Documentation in the Administrative Record

As discussed earlier, under ERISA you have the right to obtain a copy of your Administrative Record (your claim file), and all information the insurance company and/or your employer (the Plan Administrator) used to deny your disability claim.

Nearly all disability claim files will contain several types of information as indicated below:

1. All of the application information sent by your employer to the disability insurer. This includes, the “Employer’s Statement”, “the Claimant’s Statement”, and “the Attending Physician’s Statement”. Information from your employer may also include payroll, salary, disability enrollment documentation, a Job Analysis or Job Description form, and other employment data.
2. All of the information YOU have submitted to the insurance company in support of your claim. This should include all medical information YOU provided to the insurance company.
3. Medical documentation and requests for medical documentation initiated by the insurance company.
4. Medical reviews conducted by in-house medical, physicians, vocational, and claims representatives employed by the insurance company.
5. Calculation data. Calculations of BME and monthly benefit amounts; indexed figures, COLA validations; etc.
6. Internal diary notes.

The unwritten rule with regard to claim documentation is this: “If the activity is not documented in the claim file, it didn’t happen!” For ERISA claims, in particular, the Administrative Record is expected to contain a complete record of every action, referral, calculation, conversation, phone call, review, roundtable, walk-in, consultation, and decision. If it does not, then the insurance company and Plan Administrator can be held responsible for not implementing a claims process which provides a complete record of your claim.

Many insurance company’s are adopting diary software to assist in maintaining a complete record of all disability claims. One of the most popular is SOAP NOTES, which is technically a type of Medical Progress Notes used to create patient records in medical offices. The definition of SOAP NOTES is as follows:

S – SUBJECTIVE DATA

This section of the note includes information from the claimant, such as the claimant’s description of pain or the record of a recent telephone interview. (TPC or just PC) All claim files will contain detailed documentation of conversations you have had with the disability insurer.

O – OBJECTIVE DATA

Objective data is generally data that can be measured. Physical examination, laboratory data, RN or physician reviews, vocational reviews, observations, surveillance requests etc. are considered to be objective data.

A – ASSESSMENT

The assessment section of the SOAP notes includes the insurance company's interpretation of the claimant's condition or level of progress. The conclusions drawn from the information in the claim file are generally more than a restatement of the impairment or cause of disability.

P – PLAN

The plan includes the insurance company's plan to manage the claimant's disability, collection of additional data about the impairment, individual or family education, and primary plan direction. Generally, this section describes how the disability insurer plans to "resolve" the claim. The overall plan can be revised, modified, or continue previously proposed interventions.

I – INTERVENTION

This section of the SOAP note is optional and includes the claimant's reactions to any intervention by the disability insurer.

E – EVALUATION

This section may be used to conclude the SOAP note. It includes a brief summary of the disability insurer's plan. Generally, if the plan needs to be revised, it will be stated in the evaluation section and a new SOAP note will then be written.

Other disability insurers simply use NAVALINK or Imaged systems to keep track of all internal actions taken on your claim. The point is—copies of all of these notes, regardless of method, should be included in your Administrative Record. If they are not, chances are you have received an incomplete copy of your Administrative Record.

Remember, if your claim has been denied, you are entitled to a complete copy of your Administrative Record. If you feel the information you received is incomplete contact your employer or the US Department of Labor.

MALINGERING

The definition of malingering as defined by any disability insurance company as: "the deliberate exaggeration of psychological and/or physical complaints for purposes of tangible secondary gain." (i.e. monetary rewards, etc.) According to the organizations who review medical claims including disability, the use of the health care system and its resources are severely impacted by patients who malingering. Access to clinicians by patients with valid concerns can be obstructed as well as costs escalated by needless tests for falsified symptoms."

There are four major types of "malingering as described below:

Pure Malingering—This situation exists when an individual claimant falsifies all symptoms.

Partial Malingering—The individual has legitimate symptoms, but exaggerates the impact they have upon daily functioning.

Symptom Emulation—This person acts out the symptoms of disability but denies the existence of problems which would account for the symptoms (i.e. drug or substance abuse, divorce or family stress etc.)

False Imputation—Situations in which the individual has valid symptoms, but is dishonest as to the source of problems, attributing them , for example, to an automobile accident when the cause was, in fact, an injury occurring in the home.

Again, according to insurance companies, “the malingering individual is seeking tangible gains such as time-off from work and/or financial gain. Underlying motivations may differ among such patients. Indeed, there may be individuals who falsify their symptoms because they believe that it is inevitable that such symptoms will arise later.”

A WORD ABOUT MALINGERING

This consultant is of the opinion that if any individual is physically or mentally able to work, they should work. Furthermore, to deliberately misrepresent symptoms or exaggerate a disability in order to gain financially is fraud, and you may be prosecuted under any number of laws existing in the individual states. Your disability policy may have several provisions describing the actions an insurance company will take against you if it is discovered you have given false or misleading information to them.

Having said that, however, it is also my opinion individuals who have a legitimate disability preventing them from working should not be falsely accused of “malingering” when they are not. I recommend to all of my clients that they respond and act in a truthful and honest manner in all of their dealings with a disability insurer.

The following tests are commonly used in Neuropsychological Exams to determine whether an insured is exhibiting signs of malingering:

The three main tests used to determine malingering are:

- Computerized Assessment of Response Bias (CARB)
- Minnesota Multiphase Personality Inventory (MMPI)
- Test of Memory Malingering (TOMM)

The following tests, also used by other subspecialties of psychology, have found recent application in the identification of malingerers in the clinical setting:

- California Verbal Learning Test (CVLT)
- Functional Capacity Evaluations
- Million Clinical Multi-axial Inventory (MCMI)
- Portland Digit Recognition Test (PDRT)
- Rey-15 Item Memory Test
- Stroop test
- Wechsler Memory Scale (WMS)
- Wisconsin Card Sorting Test (WCST)

- Word Memory Test (WMT)
 - Wechsler Adult Intelligence Scale (WAIS)
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So, What's the Bottom Line?

Consider these worst case scenarios.

Due to severe joint and muscle pain, Christine's employer agrees to cut her hours from full-time to only 20 per week. After several weeks, she found it more and more difficult to work due to fatigue and memory problems. Her physician recommended she stop working which Christine did the very next day. After speaking with her HR benefits representative two weeks later, she was surprised to find out since she was working only 20 hours per week, she was not in an "Eligible Class" which requires her to work full-time (40 hours) in order to obtain STD/LTD benefits. Christine is now out of work for medical reasons, with no benefits, and, her employer (who originally approved the reduction in hours) won't take her back. What is Christine going to do now?

Mary Delgado is a 51-year-old mother of three. After a recent heart attack and CABG (Coronary Artery Bypass Graft), she applied for STD/LTD benefits and was approved. Due to the provisions in her LTD policy which require her to apply for Social Security Disability Income benefits (SSDI) she immediately applied and after eighteen months of receiving disability benefits, Mary is approved for SSDI.

Mary's monthly disability benefit is only \$1,700 per month, and it has been difficult raising a family of four on such a meager amount. When her disability specialist asked her to sign a Payment Option form, Mary selected to be paid the full amount, or unreduced amount of her benefit. She just couldn't live on any less than \$1,700 per month.

As a result of her SSDI award, Mary received primary benefits of \$1,000 and a combined \$500 benefit for her dependent children. This award resulted in a retroactive lump sum of \$25,000 from Social Security. Mary notifies the disability insurer of the SSDI award amounts and is advised by her claims specialist she must sign over the \$25,000 payment from Social Security to the disability insurer. Mary is devastated since she'd hoped to buy the kids new school clothes and catch up on her bills.

At the time of her cardiac surgery Mary was completely unaware of the "offset" or possible reduction in her monthly disability benefit. Reluctantly, Mary signs over the \$25,000 to the disability insurer and begins to receive \$200 from the insurance company each month. (\$1,700-\$1,500) Again, Mary is completely surprised by the fact her monthly benefit is also reduced by the amount of social security award for her children. Shortly after signing over the retroactive check to her insurance company, her claim is denied for future benefits since the disability insurer now claims she can work.

Mary wonders what is going to happen to her and her children while she is still unable to work. She knew she had long-term disability insurance as a benefit from her employer, and planned on a combined income of \$1,700 + the award for SSDI if she were ever injured or became sick while on the job. Unfortunately, Mary was taken by surprise, and was forced to move in with her parents in order to adequately support her children.

These are only two of many, many situations in which employees covered by group STD/LTD plans are caught by surprise after relying on disability payments in case of sickness or injury. Christine's dilemma is very common. What could she have done?

As soon as she began to experience difficulty performing the material and substantial duties of her own occupation, Christine should have gone directly to her HR benefits representative and obtained a copy of her certificate policy describing benefits she was entitled to. Under "Eligible Class" and "Minimum Hours Requirement" Christine might have noticed the "40 hour, full-time" eligibility requirement for STD and LTD benefits.

Instead of reducing her hours to 20, Christine could have continued to work full-time until her physician recommended she stop working altogether. Christine should not now have any eligibility problems for benefits since she met the "Minimum Hours Requirement" in her policy just prior to cessation of working in her occupation.

Unfortunately, Mary is a middle class victim of laws which allow all disability insurers to transfer their risk and liability onto the federal government through the social security system. The best defense for these types of issues is KNOWLEDGE. Recognizing her responsibilities as a single parent, Mary could have obtained a copy of her certificate STD/LTD policy from her employer and examined it carefully to determine what her income level would be in case of sickness or injury. Of particular significance is the "Other Income Deductions" section of her policy which describe those sources of income the disability insurer may deduct. This knowledge and understanding of the insurer's "offset" rights under the policy could have changed Mary's decision to repay the SSDI retroactive lump sum, or opt out of estimate reductions from her current benefits.

The objective of a book such as this is to inform. Current ERISA laws and case decisions are not currently in favor of the claimant or the insured. The disability insurers and employers, while it is assumed they have some responsibility for explaining the policies they offer to employees, generally fall short of supplying any useful or meaningful information preventing abuses in the claims review process.

In the absence of information from any other reliable source, it is extremely important for ALL working Americans covered by an ERISA group STD/LTD policy to obtain certificate copies of their Plan Document, and do the following.

You may use this list as a check off list for your own particular policy and circumstance. I recommend you place a copy of this book, along with your policy reviews in a special folder and review it once a year as your salary and other relevant information changes. Waiting until you are actually sick, injured and out of work, can be a disaster for you and your family.

POLICY REVIEW WORKSHEET

- Based on your date of your enrollment in the LTD group plan, and date of hire, determine your effective date of coverage.
- If your employer has multiple locations for a single parent company, check your policy for the location you are currently working in to make sure it is listed and qualifies your for coverage.
- If you missed the annual enrollment for LTD and have been asked to fill out “Evidence of Insurability”, make a special note to sign up on time the following year. Contact the HR rep to make sure you know when and where the next annual enrollment will take place.
- Assuming a yearly date of disability and a timeline, draw out any potential pre-existing condition period using the “Pre-Existing Condition” definition in your policy. You should calculate your pre-existing period before going out on disability for any reason.
- Determine what “Class of Eligible Employee” you are in, and the number of hours you must be working just prior to your date of disability in order to be eligible for benefits.
- Keep copies of all your payroll stubs and prior year’s W-2. You may need this information to determine your pre-disability earnings. Find the definition of “Earning” in your policy and figure your BME (Basis Monthly Earnings) defined as what you were making before you became disabled. Use the policy as the basis for your calculations.
- Once you have the BME figure calculate 80% of this figure. If you return to work part-time, and are eligible for “Residual Earnings” you may not earn in excess of this figure, adjusted for inflation. (Indexing) Receiving earnings in excess of the 80% will result in a claim denial.
- Locate the definition of “Elimination Period” in your policy and determine whether you are allowed to work or not work during the EP. If you policy says you may NOT work during the EP, and you return prematurely, you may not receive any benefits at all.
- Read the “Definition of Disability” provision in your policy. In fact, read it several times and make sure you understand completely under what circumstances you may be considered disabled.
- Go online to <http://online.onetcenter.org/> and the DOT and download a copy of the “Occupational Description” of your material and substantial duties. You may not get an exact description, but choose the occupation the closest to your own. These occupational descriptions will tell you what your “material and substantial duties” are.
- Locate other “Add In” provisions in your policy and estimate the monetary value of these benefits. Examples include COLA’s, Rehabilitation, Child Care, Disability Plus Riders etc. Using your calculator, figure your estimated gross monthly disability

benefit. If your policy contains a COLA provision, calculate at least a 5 year schedule of benefits.

- Contact Social Security and ask for a determination of your eligibility and amount of both Primary and Family Social Security. (SSDI) You can fill out a form and ask social security to provide you with this information at any time. If you have not worked the required number of “quarters” for SS or SSDI, you should know about it before you are sick or injured.
- Determine whether your policy is non-integrated (does not allow offsets) or integrated. Check the provisions specifically dealing with social security and determine whether the offset will be only for amounts awarded to you (Primary SSDI), or Primary and Family (Both you and your dependents under the age of 18 or 24 and a full time student.)
- Obtain an application for FMLA and have it on hand in case you need it. This application can be obtained from your employer.
- Examine your policy provision for all of the “Take Backs” listed in your policy and calculate your “net benefit.” This is your bottom line. Gross Benefit + Add Ins – Take Backs = Net Benefit. This is an important figure, and it should be calculated each year as your salary and work circumstance change.
- Check the Glossary in your policy to determine if it gives a specific definition of “Gainful”. If it does, and reading your policy provisions, calculate the likely figure the insurance company will use to determine if any occupations identified during a TSA will be gainful.
- Make a contact list of all of your state resources, i.e. Human Resource Department, Food Stamp Division, Medicaid, Utility Assistance, WIC programs etc. Obtaining this information when you are not feeling your best is quite a chore. Be prepared, and make a contact list long before you need the information on it. Include the contact information for both the Insurance Commissioner and the DOL on this list.
- Ask questions. If you have questions after completing the above worksheet, contact your HR benefits representative or other trusted resource for the answer, and don’t wait. Check the Glossary in this book for definitions you may have missed.
- If you are able to return to work part-time, begin an earnings record or journal to keep track of your monthly earnings and the computations of your earnings loss ratio. Contact your claims handler and request a copy of the insurance computation spreadsheet so you can verify the accuracy of the checks received, and the 20% earnings ration (or 3-year averaging as the case may be.)

This book suggests you should be informed and ask questions before you need to apply for benefits. YOU BET! Your disability insurer can only take you by surprise if you put off knowing the provisions of your policy and what benefits you are entitled to.

The worst thing you can be is “uninformed” if you are covered by an employer sponsored group LTD plan.,j/

Daily Activities Worksheet For Social Security Applications

This Daily Activities Worksheet asks for information about your impairment that your doctor may need in order to provide an accurate report to the insurance company or social security. You may print and use this form in making application for social security disability. (SSDI or SSI)

Name of Applicant: _____
Social Security #: _____ Date: _____

Part I. ARE YOU WORKING?

1. Are you working? Yes No
2. If not, can you work all day, five days a week, year round? Yes No
3. Did your health stop you from working? Yes No
4. If so, when did you stop being able to work (month, day, year)? _____

Part II. ACTIVITIES OF DAILY LIVING

TYPICAL MONTH. Please state how many good, fair, and bad days you have each month.
(Consider a month to be 30 continuous days.)

a. **GOOD DAYS** -- days when you do well and complete all living and home care activities.
Total good days a month: _____

b. **FAIR DAYS** -- days when you function with serious difficulty and fail to complete some living and home care activities. Total fair days a month: _____

c. **BAD DAYS** -- days when you function very poorly and fail to complete most living and home care activities. Total bad days a month: _____

d. Please describe your **TYPICAL MONTH** in terms of GOOD, FAIR, and BAD days, and give examples of how bad days or fair days are worse.

Are there days when you don't go out because of your health? If yes, how many days a month does your health keep you in? _____

Please explain:

Compared with a year ago, are you functioning: Better? Worse? About the same? Please explain.

Caring For Yourself

- a. **PERSONAL NEEDS.** Do you have serious difficulty taking care of any personal needs, including the following, due to your medical condition? (Check and describe any that apply, and give additional examples if these don't cover your situation.) These are called "Activities of Daily Living." (in bold)

___ **Bathing**

___ Using stairs

___ Holding onto objects

___ **Using the toilet**

___ Getting to the toilet

___ Making decisions

- ___ Doing things on time
- ___ Taking medicines
- ___ Hair care
- ___ **Eating**
- ___ Keeping well-informed
- ___ Using the telephone
- ___ Caring for others
- ___ Shopping
- ___ Recreation
- ___ **Transferring**

- ___ Finishing things
- ___ Shaving
- ___ **Dressing**
- ___ Sleeping on time/in right dose
- ___ Understanding/following instructions
- ___ Personal business/finance
- ___ Visiting people
- ___ Getting places
- ___ Hobbies
- ___ Group activities, like church or clubs

Other Activities? Describe:

b. **MEALS.** Do you prepare or serve meals? Yes No If so, what meals do you do?

BREAKFAST. Describe what you do. How many days a month? ____

LUNCH. Describe what you do. How many days a month? ____

DINNER. Describe what you do. How many days a month? ____

Caring For The Place You Live.

- a. **THINGS YOU DO.** Describe the home care activities you do regularly.
- b. **THINGS OTHER PEOPLE DO.** Describe the home care activities which other people do for you including your spouse, children and neighbors etc.
- c. **THINGS THAT DON'T GET DONE.** Describe any home care activities which need to be done, but do not get done because of your health.
- d. **THINGS YOU DID BEFORE THAT YOU DON'T DO ANYMORE.** In the past, did you do things you don't do now due to your health? If so, describe them and why you don't do them now.

WORK RELATED ACTIVITIES. Do you have serious difficulty doing any of the following on a sustained basis? (Describe any that apply.)

- | | |
|--------------------------------|-------------------------------|
| ___ Sitting | ___ Standing |
| ___ Walking | ___ Crawling |
| ___ Crouching/squatting | ___ Speaking |
| ___ Hearing | ___ Seeing |
| ___ Remembering | ___ Understanding |
| ___ Carrying out instructions | ___ Concentrating |
| ___ Lifting | ___ Carrying |
| ___ Pushing/pulling with hands | ___ Pushing/pulling with legs |

- Reaching up, out, down
- Grasping, handling, fingering
- Keeping your balance
- Adjusting to changes
- Working productively all day, every day, year round
- Traveling (driving or using public transportation)
- Functioning in bad environments, like those involving risks, heat or cold or humidity, pollutants, fumes, drafts, irritants like noise or vibration
- Finishing what you start
- Bending over
- Getting along with people who supervise you
- Getting along with people who annoy you

OTHER ACTIVITIES YOU CANNOT DO. Please Describe:

DO YOU REMEMBER ANYTHING ELSE THAT MIGHT HELP YOUR DOCTOR OR SOCIAL SECURITY UNDERSTAND YOUR IMPAIRMENTS?

If yes, please explain.

APPLICANT STATEMENT

The information listed above is complete and correct to the best of my knowledge.

Signature of Applicant _____ Physician Name _____

Date: _____ Physician Contact Information:

Phone/Fax _____

Understanding your group LTD policy is a lot of work, but it's well worth the effort. We can never know when an unforeseen illness will prevent gainful productive work and cause a financial hardship for you and your family.

I sincerely hope this book has given you the inspiration to contact your HR department and obtain a copy of your policy. Sit down. Roll up your sleeves, and arm yourself with the knowledge you need to ensure a fair, and objective review of your claim, should you ever need to make one. You and your family's future may very well depend on it.

COMMON REASONS FOR GROUP LTD CLAIM DENIALS

The following are the most common reasons why a group long-term disability claim may be denied by any disability insurer..

1. **You aren't eligible.** There are many "eligibility" criteria which must be met in order to meet the provisions of your Plan--you must be in an Eligible Class; you must be working a certain number of hours (20 or 30, generally); your condition may not be pre-existing; your impairment must not be self-inflicted; etc. Generally, if you do not meet the eligibility requirements, your claim will not be paid at all, and it will be denied within a very short period of time. Numerous claims are denied each day by the insurers because the claimants do not meet eligibility provisions in their policies. And, rightfully so. **Any employee who does not meet the eligibility requirements in group policy is not entitled to benefits.** If, after examining your employer's LTD group policy, you have questions about your eligibility for benefits, contact your HR benefits representative right away. It is extremely important to read the policy and understand all eligibility requirements before going out on disability. Most disability insurers will investigate eligibility for benefits as a first priority. Any individual who fails to meet eligibility requirements is not entitled to benefits and generally the claim is denied within a relatively short period of time.
2. **You do not meet the definition of disability.** Almost all disability claim denials fall into this category. All group LTD contain a provision describing under what conditions an employee may qualify for benefits. Generally, these include: "are unable to perform the material and substantial duties of your own or any occupation, and you must have at least a 20% earnings loss." Whether or not the employee can perform the substantial duties of his/her own or any occupation is largely a matter of documented opinion made by the insurance company using the credentials and expertise of Certified Vocational/Rehabilitation Specialists. In general, all denials except for eligibility are attributed to whether you meet the definition or not, as interpreted by the disability insurer.
3. **There is no objective evidence to support your claim for total disability.** Most group LTD policies do not contain any provision requiring "objective medical evidence" as a burden of proof of disability. Still, almost all disability insurers give "no objective evidence" as a cause for termination of benefits. The "objective evidence rule" is simply an internal strategy allowing the claims specialist to deny claims submitted for impairments for which medical science has yet to find a mode of "objective evidence." Impairments such as mental disorders, fibromyalgia, chronic fatigue, lupus, SLE, Lyme disease, RSD and many others are often denied for no other reason than the absence of "objective medical evidence." Also, you should ensure your doctor's letter describes any

objective evidence that does exist, and ask him/her to address the issue of objective evidence in the appeal letter to the insurance company. Your primary care providers should always address whether your symptoms are consistent with your diagnosis. Be cautious of IME source providers who advertise themselves as “applying the objective evidence standard” in their evaluations. Using such a service for IME’s is making the claim from the outset the disability insurer is applying the “objective evidence standard.”

4. **We have spoken to your doctor and he/she agrees with us** If you suspect your doctor is not telling you about conversations with the insurance company, request a copy of your medical file, in writing. Any paper exchanged between your doctor and the insurance company should be in your file. You should always try to maintain an open, honest relationship with your doctor, and discuss all aspects of your medical condition as well as your claim with him/her. Ask your doctor to keep you informed should the disability insurer contact his office for records or a doc-to-doc call.
5. **Your impairment is self-reported.** This is “lack of objective medical evidence” in sheep’s clothing. Albeit, some new policy series of LTD now contain provisions which allow the disability insurer to deny or limit the benefits for self-reported impairments by naming them specifically. Some policies even list specific impairments such as headaches, chronic pain, blurry vision, ringing in ears, fatigue etc. It isn’t surprising. Self-reported impairments are those symptoms for which there are no medical tests known to “objectify” the diagnosis. The only “proof”, if you will, is that you *tell* your doctor the symptoms, and as a result, your physician makes a “clinical” diagnosis. Check your policy and locate any provisions which address self-reported impairments.
6. **Our in-house “Board Certified” Physician has concluded...** Don’t be intimidated by these credentials, but it is important your physicians hold equivalent or better credentials than those of the in-house insurance physicians. For example, most disability insurers will not regard medical documentation from: 1) chiropractors 2) occupational therapists 3) homeopathic physicians 4) acupuncturists or 5) physician assistants or unlicensed physical therapists as credible. Read your policy carefully, paying particular attention to the definition of “Doctor” and mentions of regular and appropriate care.
7. **You have been paid 24 months under the mental and nervous or self-reported provisions of your policy.** Not all, but most group LTD policies, and some IDI policies, limit benefits for mental and nervous disorders and self-reported impairments to 12 or 24 months. The problem with this is often classifying co-morbid complaints, inaccurately, into primary and secondary diagnoses. For example, fibromyalgia has two elements, one physical, and one mental, requiring counseling. Disability insurers like to classify fibromyalgia as a mental disorder first, and then as a “secondary” physical impairment. Doing so, limits benefits to 24 months, when in fact fibromyalgia is a physical syndrome not exclusively a mental one.
8. **You are not disabled from performing ANY OCCUPATION.** Not all, but most group LTD policies are 2, 3, or 5 year own occupation policies. This means that for the first 2, 3, 5 years, you must show you cannot perform your own occupation. After that, the definition of disability more closely resembles that of social security in that you must show you are unable to perform ANY occupation for which you have training, education or experience. The ANY OCCUPATION INVESTIGATION is too detailed to describe in this writing, but if your claim is denied after 24, 36, or 60 months, you should consult

a professional attorney or consultant to assist you with your appeal. Please refer to the previous discussion of “any occupation” investigations.

9. **You are not receiving “appropriate care”.** I think it’s fair to say that any individual who is claiming total disability should consult a qualified physician on a regular basis. All group LTD policies require the attendance, care and treatment of a qualified physician with a specialty for the impairment claimed. In addition, “regular and appropriate” care is required at a frequency deemed appropriate by the medical community. For example, if a claimant is diagnosed with a serious mental disorder requiring ECT treatments, but is seeing a family physician every two months, the disability insurer may conclude there is no regular treatment. In other words, the claimant must be receiving care sufficient to cause him/her to improve over time. If the disability insurer concludes the individual is not receiving “appropriate or regular care”, normally the claim can be denied.

10. **Surveillance- Inconsistent reports of physical activity.** Technically, group LTD claims cannot be denied on the basis of surveillance alone. There is no policy provision allowing surveillance as the cause for a claim denial. The purpose of surveillance is to document and prove inconsistent reports of physical activity. For example, if a claimant informs the claims specialist they are unable to walk, but are seen jogging several miles, there is reason to challenge the credibility of the insured. Since the disability insurer cannot deny your claim based on surveillance alone, the company will usually send the surveillance CD to your physician and ask him/her comment. Once your physician sides with the insurance company, you are no longer considered disabled, and the disability insurer can then deny the claim, claiming you no longer meet the definition of disability given in the provisions of your policy. There are times when surveillance places the insured in a Catch-22 position. Many impairments actually require exercise and the continuance of regular activity in order to get better. Often, your treating physician includes a certain amount of exercise and activity in the treatment plan. The key is to be consistent in your reporting to the disability insurer.

Each claim circumstance is unique, and should be discussed with a qualified ERISA attorney in matters of law. However, it IS a good idea to keep all of the above in mind when reviewing your policy on an annual basis as recommended by the author.

New Developments for Group Claims

Diagnosis Does Not Equal Impairment

Of late, some disability insurers are including the following wording in their written communications:

“ I am sure you are aware that a condition in and of itself does not necessarily equal disability, and conditions may improve, stabilize or worsen over the course of time. Therefore, our on-going consideration of your claim includes updated medical information, reviews and when appropriate, Independent Medical Examinations.”

Let’s just take the first sentence and take a look at it. *“I am sure you are aware that a condition in and of itself does not necessarily equal disability, and conditions may improve,*

stabilize or worsen over the course of time.” This statement is actually true. There are many, many Americans with disabilities who continue working every day. While your doctor may diagnose you with a disease, it does not necessarily follow that this disease will constitute “an impairment.”

The word “impairment” implies you have restrictions and limitations precluding (preventing) you from working, or performing your normal job or occupational duties. Some employees diagnosed with Multiple Sclerosis continue to work for many years, while others cannot depending on the progression of the disease. This is why most disability insurers could ask you the question, “You’ve been working with this disease for many years. What changed *now* to cause you to apply for disability?”

What is it exactly the disability insurer is telling you by including the above language in a letter to you? First, the insurance company wishes to make absolutely sure you understand that just because you have been diagnosed with a disease, AND have been paid disability benefits for it in the past, it does not necessarily follow that you will be unable to perform the material and substantial duties of your occupation forever. In fact, most disability insurers take the view that for most diseases, proper medication and treatment will improve your condition enough to allow you to return to normal productivity over time. Of course, there are exceptions, but for the most part this is the common belief held by most disability insurers.

Second, the insurance company is also informing you they fully intend to follow-up with your progress by requesting medical information, conducting reviews and asking for Independent Medical Evaluations. In effect, this means your monthly disability payments are not guaranteed at any time.

Definition of Disability?

Due to various recent litigations in the various states, the definition of disability has been redefined by law in some states. A good example is California, who in 2005 conducted an in-depth investigation into the claims practices of UNUMProvident.

California state law defines “occupation” as follows:

“Total Disability” Definitions.

“Total disability” shall be defined in California Contracts during the usual or own- occupation period as:

a disability that renders one unable to perform with reasonable continuity the **substantial and material acts necessary to pursue his or her usual occupation in the usual and customary way** and during the another or any-occupation period shall be defined as:

“a disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his or her usual occupation in the usual and customary way and to engage with reasonable continuity in another occupation in which he or she could reasonably be expected to perform satisfactorily in light of his or her **age**, education, training, experience, **station in life**, physical and mental capacity.”

This is very good step for the state of California to take because it forces the disability insurer to examine the claimant's capacity for work by looking at the person's job and not using an outdated occupational description from the DOT. If the issue of "occupational description and application" becomes an issue for your claim, it would be a good idea to check with your state insurance office to find out if there are laws on the books which require disability insurers to define occupation in a certain way.

One of the good aspects of the California requirement is that it also includes age, station in life, and physical and mental capacity in the definition beyond 24 months. Normally, the definition used by the insurers is limited to: "training, education, and experience." Considering one's age and station in life when deciding whether they can work full-time is fair.

Going on Leave AND Disability?

One of the Voluntary Group Long Term Disability Insurance policies issued by Provident Life and Accident Insurance Company has the following wording:

“WHEN COVERAGE ENDS

Termination of Status as Covered Persons

Covered Persons; coverage will automatically cease under this Policy on the earliest of the following:

2. the date they cease to make premium contributions;
3. the date this Policy terminates;
4. the date their employment with the Employer terminates;
5. the date on which they cease to meet the Covered Person requirements shown in Section II – Schedule of insurance;
6. **the date on which their lay-off or leave of absence exceeds the period shown in the Schedule of Insurance under Lay-off or Leave of Absence Period (2 weeks); or**
7. the date they cease to be a member of an Eligible Class;
8. if they are legal residents, the date on which they have been residing outside the United States, its territories, or Canada for a period of 6 months or more consecutive months.”

A Voluntary Group Long Term Disability policy is one which is 100% contributory through one's employer. Employees may choose to sign up for the policy and pay the premiums by payroll deduction through the employer. Most of these policies are not subject to ERISA. Please take a careful look at number five above.

This provision statement in a disability policy says that your LTD coverage terminates after you have been laid-off or on a Leave of Absence period for more than 2 weeks. Let this really sink in for a moment. **YOU LOSE YOUR LTD COVERAGE AFTER BEING OUT ON LEAVE FOR MORE THAN TWO WEEKS!**

Suppose your employer insists you apply for FMLA leave after an absence from work for three consecutive days. Suppose the LTD plan from your employer also has a 90 day Elimination Period. So, upon the recommendation of your employer, you apply for FMLA leave on 1/3/2006 and you also stop working at your job on that date, and begin scheduling doctor's appointments

and previous records from your treating physicians. It takes at least three weeks to get your appointments. When you do, your doctors give you restrictions and limitations effective January 22, 2006. According to the above provision, your LTD coverage ended on January 18, 2006, so you were no longer covered after that date.

An employee must be treated by their physician AND obtain restrictions and limitations preventing work PRIOR to going out on leave, OR within two weeks of going out on leave. Without the good intentions of their Human Resource Department, most employees would not even think to consider this seriously and will lose their LTD coverage after being on leave more than two weeks.

This type of wording not only causes employees to lose their LTD coverage, but denies the opportunity of meeting the 90 day elimination period allowed in the policy to qualify for benefits. Since the employees pay 100% of the premium, this “set up”, if you will, requires particular attention by the employee.

Social Security Work Incentives

If you are receiving Social Security Disability benefits you may have a “trial period” which allows you to test your ability to work for at least nine month. During your trial work period, you will receive your full Social Security benefits regardless of how much you are earning as long as you report your work activity and you continue to have a disabling impairment. In 2007, a trial work month is any month in which your total earnings are \$640 or more, or, if you are self-employed, you earn more than \$640 (after expenses) or spend more than 80 hours in your own business. The trial work period continues until you have worked nine months within a 60-month period.

After your trial work period, you have 36 months during which you can work and still receive benefits for any month your earnings are not “substantial.” In 2007, earnings of \$900 or more (\$1,500 if you are blind) are considered substantial. No new application or disability decision is needed for you to receive a Social Security disability benefit during this period.

After your benefits stop because your earnings are substantial, you have five years during which you may ask us to start your benefits immediately if you find yourself unable to continue working because of your condition. You will not have to wait for your benefits to start while your medical condition is being reviewed to make sure you are still disabled.

If your Social Security disability benefits stop because of your earnings, but you are still disabled, your free Medicare Part A coverage will continue for at least 93 months after the nine-month trial work period. After that, you can buy Medicare part A coverage by paying a monthly premium. If you want to end your Part B coverage, you must request it in writing. If you work, you may have to pay for certain items and services that people without disabilities do not pay for. For example, because of your medical condition, you may need to take a taxi to work instead of public transportation. Social Security may be able to deduct the cost of the taxi from your monthly earnings before it determines if you are still eligible for benefits.

In summary then, during the trial work period, there are no limits on your earnings. During the 36-month extended period of eligibility, you usually can make no more than \$900 a month or your benefits will stop. But, the work expenses you have as a result of your disability are deducted when Social Security counts your earnings to see if they can help you keep more of your benefits. If you have extra work expenses, your earnings could be substantially higher than

\$900 before they affect your benefits. This substantial earnings amount usually increases each ye

Anytime you feel your claim has not received a full, fair and objective review as required by ERISA, or, in keeping with your policy provisions, consider writing to your state's insurance commissioner to request assistance. In addition, the U.S. Department of Labor has jurisdiction for enforcing ERISA statutes under the Employment Retirement Income Security Act of 1974, and therefore, you should also inform the DOL in your state of the circumstances of your claim and situation.

In addition, it is important to ask your Human Resource benefits representative any questions you may have concerning your application for short-term disability, particularly if the STD portion of your benefit is self-insured by your employer.

Remember, your knowledge about your group policy is essential. You have rights. And, the most important duty you have as a beneficiary of any group LTD plan is to obtain a copy "certificate" and obtain full explanations as to what you are entitled to, AND what the insurance company is entitled to. There are definitely "Add-Ins" and "Take Backs" to these policies. Being armed with the same level of knowledge and understanding as that of the disability insurer, it is then YOUR responsibility to ensure any claim for benefits receives a full, fair and objective review under the law. Don't let an insurance company get the best of you. Stay informed.

RESOURCES

U.S. Department of Labor

<http://www.dol.gov/>

Consumer Price Indexes for CPI Indexing

<http://www.bls.gov/cpi/>

Social Security Administration

<http://www.ssa.gov/>

Merck Manual:

<http://www.merck.com/pubs/mmanual>

Social Security Office Locator

<http://s00dace.ssa.gov/pro/fo/fo-home.html>

O*NET Online—Occupational Descriptions

<http://online.onetcenter.org/>

ERISA Rights

http://combinedwelfarefund.com/erisa_rights.htm

http://www.local4funds.org/SPDHW/Your_ERISA_Rights.htm

Americans With Disabilities Act (ADA)

<http://www.usdoj.gov/crt/ada/adahom1.htm>

Family Medical Leave Act of 1993 (FMLA)

<http://www.nalc.org/depart/cau/fmla.html>

Fibromyalgia

<http://www.mayoclinic.com/invoke.cfm?id=DS00079>

Important Information about COBRA

http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html

HIPPA

<http://www.cms.hhs.gov/hipaa/hipaa2/default.asp>

Malingering

<http://www.emedicine.com/med/topic3355.htm>

Nothing written in this book should be construed to be legal advice. I am not an attorney and therefore I am unable to give you legal advice concerning any aspect of your claim from a legal perspective. I strongly urge you to seek competent legal guidance in all matters relating to federal and state laws.

However, an experienced consultant involved early in the disability application process can mean the difference between benefits approved or benefits denied. Many attorneys are reluctant to act as “case managers” simply because they are not qualified to do so in areas of medical or claims process expertise.

**UNITED STATES DEPARTMENT OF LABOR
DICTIONARY OF OCCUPATIONAL TITLES**

EXERTIONAL STANDARDS

SEDENTARY

Exerting up to 10 pounds of force occasionally and/or negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

LIGHT

Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly to move objects. Even though the weight lifted may be only a negligible amount, a job should be treated as Light Work if:

1. It requires walking or standing to a significant degree;
2. It requires sitting most of the time, but entails pushing and/or pulling of arm or leg controls; and/or

3. When the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

MEDIUM

Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. (Exerting force means lifting.

HEAVY

Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects.

VERY HEAVY

Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects.

“Occasionally” means activity or condition exists up to 1/3 of the time in an 8 hour day (2.57 hours in an 8 hour day)

“Frequently” means activity or condition exists from 1/3 to 2/3 of the time in an 8 hour day. (5.33 hours in an 8 hour day)

“Constantly” means activity or condition exists more than 2/3 of time in an 8 hour day. (More than 5.33 hours in an 8 hour day)

Knowing and understanding “Exertional Standards” is essential to the understanding of your group disability claim and how the disability insurer will determine if you are able to work or not.

The U.S. Department of Labor has established specific standards to identify the work energy expended in the performance of occupations in the United States. Examine your occupation carefully to determine at which level you are currently working. If your claim is denied there may be a “difference of opinion” as to which category your occupation fits into. Always remember to obtain the DOT for your occupation from the U.S. Department of Transportation.

Social Security Disability Financial Advantages

INCREASED MONTHLY INCOME: Social security Disability has yearly built-in cost-of-living increases indexed to inflation indicators. You will receive this increase every year, however, the increase is not an offset to your monthly disability benefit. In other words, you are allowed to keep the yearly increase from Social Security, and the disability insurers do not increase their monthly offset as a result of it.

INCREASE IN RETIREMENT AND SURVIVORS’ BENEFITS: Social Security Disability entitlement “freezes” your Social Security earnings record. Social Security regulations stipulate that any years “wholly or partially within a period of disability” will be excluded from the

computation of future benefits. Thus, the amount of your eventual Social Security retirement benefit may be substantially higher because these lost years of earnings will not be considered in future computations.

POTENTIAL TAX ADVANTAGES: Since January 1, 1984 a portion of an individual's Social Security benefits may be taxable if certain criteria are met. However, some individuals retain their Social Security benefits tax free. This may vary depending on your premium contributions for your LTD coverage. You should consult a qualified tax advisor to determine the extent to which SSDI is taxable to you.

MEDICARE COVERAGE: After you have received Social Security Disability benefits for 24 months, regardless of your age, you also become eligible for Medicare benefits. This includes Part A, Hospital Benefits, and Part B, Medical Benefits.

TRIAL WORK PERIOD: Trial work allows you to test your ability to return to work without losing Social Security benefits. If you return to work after being awarded Social Security Disability benefits, Social Security will continue to pay for a period of nine non-consecutive months in addition to the income you receive from your employment. If you continue to work beyond the nine months, Social Security will suspend your benefits but will automatically begin to pay you again if you cease work within three years.

COBRA: Special COBRA rules apply for individuals and certain family members that are found disabled by Social Security. You and your family may be eligible for an extension of COBRA coverage for an additional 11 months beyond the original 18 month entitlement period.