Private Plan Disability Income Benefits

(For Members Employed in New Jersey)

Having a steady income if you become disabled and cannot work is important to financial security and peace of mind. The Benefit Fund helps provide financial security for its members working at New Jersey employers through a short-term disability plan that is similar to the New Jersey Temporary Disability Income plan.

This section is the Summary Plan Description (SPD) for Private Plan Disability Income Benefits provided by the Benefit Fund for Members working at New Jersey employers.

Private Plan Disability Benefits (NJ)

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Who Is Eligible And When

A Working Member in Wage Class I, II or III is eligible for the Private Plan Disability Benefit coverage described in this section if he/she:

- is represented for collective bargaining by District 1199C, National Union of Hospital and Health Care Employees, AFSCME, AFL-CIO,
- is employed by a New Jersey Employer in a bargaining unit for which the employer is required to make contributions to the Benefit Fund (a list of New Jersey Employers is available from the Benefit Fund),
- is employed the number of days required under the Collective Bargaining Agreement covering the Member and is working more than 1/5 of the work week and
- has at least one week (in the eight calendar weeks preceding the week in which the disability commenced) in which his or her earnings equal or exceed the "Base Week" earnings requirement.

When Coverage Begins

Private Plan Disability Benefits coverage begins on the day after you complete your Employer 's probationary period, provided you continue to meet the Fund's and the plan's eligibility requirements.

Status as a Private Plan

This disability plan is a part of the Benefit Fund that is intended to qualify as a "Private Plan" pursuant to the New Jersey Temporary Disability Benefits (TDB) Law. Disability benefits under this Private Plan are in lieu of benefits which would otherwise be payable under the State Plan under the New Jersey Temporary Disability Benefits Law (the "State Plan").

Definitions

The following definitions shall apply for purposes of this plan:

- **"Disability"** means a member 's total inability to perform the duties of his/her employment due to any accident or sickness.
- A member who has incurred a Disability shall be a **"Disabled Member."**
- **"Period of Disability"** means, with respect to any member, the entire period of time, during which he/she is continuously and totally unable to perform the duties of his/her employment due to his/her Disability. If two periods of Disability due to the same or related causes or condition are separated by a period of not more than 14 days, they shall be considered as one continuous period of Disability, provided that the member has earned wages during such 14-day period with the Employer who was his/her last Employer immediately preceding the first period of Disability.

- **"Average Weekly Wage"** means the amount derived by dividing the member's total wages earned from his/her most recent New Jersey Employer during the Base Weeks in the eight (8) calendar weeks immediately preceding the calendar week in which Disability commenced, by the number of such Base Weeks.
- **"Base Week"** for this purpose means any calendar week during which the member earned from a New Jersey Employer not less than an amount twenty (20) times the minimum wage in effect on October 1 of the prior calendar year, as determined under the State law. Currently, the earnings required for a Base Week are $123 per week in covered employment.

For Disability purposes, "Average Weekly Wage" means the amount derived by dividing the Member's total wages earned from his/her most recent New Jersey Employer during the Base Weeks in the eight calendar weeks immediately preceding the calendar week in which Disability commenced, by the number of such Base Weeks.

Benefits Provided

- **Weekly and Daily Benefit Amounts:** For each "Period of Disability," a Disabled Member shall receive a weekly Benefit of 2/3 of the Member 's Average Weekly Wage (rounded to the next higher $1.00 if not already a multiple thereof), subject to the maximum as may apply under the State Plan, as determined by the New Jersey Commissioner of Labor.
- **Commencement of Benefits:** Disability Benefits not in excess of a Member's maximum Benefit amount shall be payable on the first (1st) day with respect to a Disability due to accident and on the eighth (8th) consecutive day of Disability due to sickness and each day thereafter that the period of Disability continues. If Disability Benefits are payable for three (3) consecutive weeks with respect to any period of Disability due to sickness, Disability Benefits shall be payable with respect to the first seven (7) days thereof.
- **Duration of Benefits:** The maximum total Benefits payable to any Member for any Period of Disability shall be 26 weeks of Benefits.

Private Plan disability benefits will continue for up to 26 weeks for any one period of disability, as long as you remain disabled.

- **Guaranteed Minimum Benefits:** The Benefits payable under this Private Plan will be at least equal, in both weekly Benefit amount and duration, to those Benefits that would be payable under the State Plan, but for a Member 's participation in this Private Plan.

Supplementary Disability Benefits to Workers' Compensation

- A Disabled Member who qualifies for and who is receiving Workers' Compensation benefits for a Disability may also be entitled to supplementary benefits from the Benefit Fund, which payments are not considered part of this Private Plan.
- Supplementary Disability Benefits will be paid if the weekly disability benefit paid by Workers' Compensation is less than the applicable total Disability rate determined under this Private Plan. Where the Workers'Compensation benefit has been reduced as a result of a partial Disability, this Private Plan will continue to pay benefits based on the unreduced amount, minus any wages received, minus Workers' Compensation received.
- Such Disabled Member will also continue to be covered for a maximum of 26 weeks with the same level of health benefits to which he/she was entitled immediately prior to becoming Disabled and eligible for Workers' Compensation benefits, provided that proof of receipt of Workers' Compensation benefits is supplied to the Benefit Fund within 30 days of the onset of Disability and monthly thereafter. The Disabled Member must also provide proper proof of disability.

Limitation of Benefits

Notwithstanding any provision of this Private Plan to the contrary, Disability Benefits shall not be paid under the following circumstances:

- for the first seven (7) consecutive days of each period of Disability due to sickness; except that if Disability Benefits are payable for three (3) consecutive weeks with respect to any period of Disability, then Disability Benefits shall be payable with respect to the first seven (7) days thereof,
- for more than 26 weeks with respect to any one period of Disability,
- for any period of Disability which did not commence while the Member was covered under this Private Plan,
- for any period during which the Member is not under the care of a legally licensed Physician, Dentist, Podiatrist, Chiropractor, practicing Psychologist or Optometrist, who, when requested by the Benefit Fund, shall certify within the scope of his or her practice, the Disability of the Member, the probable duration thereof, and the medical facts within his or her knowledge,
- for any period of Disability due to injury sustained in the perpetration by the Member of a crime of the First, Second or Third Degree under the laws of the State of New Jersey,
- for any period during which the Member performs any work for remuneration or profit, except as provided under "Supplementary Disability Benefits to Workers' Compensation,"
- if, together with any remuneration the Member continues to receive from the Employer, weekly disability benefits would exceed his/her regular weekly wages immediately prior to Disability or
- for any period during which the Member would be disqualified for unemployment compensation benefits under the New Jersey Unemployment Compensation Law due to a labor dispute, unless the Disability commenced prior to such disqualification.

Non-Duplication of Benefits

This Private Plan does not pay Disability Benefits in situations where benefits are payable from certain other sources. No Benefits shall be paid under this Private Plan for any period with respect to which benefits are paid or are payable under any unemployment compensation or similar law, or under any disability or cash sickness benefit or similar law, of New Jersey or of any other State or of the Federal Government.

Nor shall Benefits be paid for any period with respect to which benefits, other than benefits for permanent partial or permanent total disability previously incurred, are paid or are payable on account of the disability of a covered individual under any Workers'Compensation law, occupational disease law, or similar legislation, of New Jersey or of any other State or the Federal Government, except as specifically provided in this section. However, the Member may be entitled to supplementary benefits from the Benefit Fund if the weekly benefit paid by Workers'Compensation is less than the applicable Disability Benefit under this Private Plan, as described under "Supplementary Disability Benefits to Workers' Compensation" above.

Where a Member 's claim for compensation for temporary disability under the provisions of the New Jersey Workers' Compensation Law is contested, and thereby delayed, and the Member is otherwise eligible for Disability Benefits under this Private Plan, the Member shall be paid the Disability Benefits provided by this Private Plan until and unless he/she receives compensation under the provisions of the New Jersey Workers' Compensation Law. In the event that Workers' Compensation benefits, other than benefits for permanent partial or permanent total Disability previously incurred, are subsequently awarded for weeks with respect to which the Member has received Disability Benefits pursuant to this Private Plan, the Benefit Fund shall be entitled to be subrogated to the Member's rights in such award to the extent of the amount of Disability payments made hereunder that are in excess of the supplementary Disability Benefits that are payable.

Disability Benefits otherwise required hereunder also shall be reduced by the amount paid concurrently under any governmental or private retirement, pension or permanent disability benefit or allowance program to which the Member's most recent Employer contributed on his/her behalf.

Coordination with the State Plan and Other Private Plans

- **Coordination with the State Plan:** In the event that a Member becomes Disabled and Benefits are payable under this Private Plan and the State Plan (as a result of employment with a New Jersey employer that does not contribute to the Benefit Fund), this Private Plan will provide all Disability Benefits to which the Member is entitled under this plan.
- **Coordination with Other Private Plans**: In the event that a Member becomes Disabled and Benefits are payable under this Private Plan and another private plan (as a result of employment with a New Jersey employer that does not contribute to the Benefit Fund), this Private Plan will provide a proportionate share of the Disability Benefits to which the Member is entitled under this plan.

- Such share shall be the weekly Benefit amount calculated under the plan multiplied by a percentage determined by dividing (i) the Member's total wages earned from his/her New Jersey Employer during the Base Weeks in the eight (8) calendar weeks immediately preceding the calendar week in which Disability commenced by (ii) the Member's total wages earned from any applicable New Jersey employer (whether or not contributing to the Fund) during the Base Weeks in the eight (8) calendar weeks immediately preceding the calendar week in which Disability commenced. In no event shall the total weekly Benefit amount from all private plans be less than the weekly Benefit amount provided under the most favorable private plan.

When a Third Party Is Liable

If you or an eligible dependent incurs expenses due to the fault of another party, that party is responsible for any expenses which may result. See "When a Third Party is Liable" in the *Eligibility and Enrollment* section.

Claims Procedures

- If a Member becomes Disabled, he/she must notify the Benefit Fund as soon as practicable. Upon receipt of such notice the Member will be furnished with a proof of claim form which is to be completed by the Member and his/her attending Physician, Dentist, Podiatrist, Chiropractor, practicing Psychologist, Optometrist, or Advanced Practice Nurse. The completed proof of claim form must be returned to the Benefit Fund within 30 days after the commencement of the period of Disability for which claim is made. Failure to furnish notice and proof within the time or in the manner prescribed shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice and proof and that such notice and proof were furnished as soon as reasonably possible.
- If the Member mistakenly applies for benefits under the State Plan, such application shall later be deemed to have been received by the Benefit Fund on the date it was actually received by the New Jersey Division of Employment Security.
- The Benefit Fund shall have the right and opportunity to examine the Member when and so often as it may reasonably require while the claim is pending; however, no claimant shall be required to submit to an examination more often than once a week.
- Participation in this Private Plan will not deprive a covered individual of his/her rights to appeal to the Division of Unemployment and Disability Insurance in case of a disputed claim. In the event the Benefit Fund finds it necessary to deny a claim for Benefits in whole or in part, a copy of the letter of denial will be sent to the Division of Unemployment and Disability Insurance.

Claims Process, Denials, Appeals

No legal action may be commenced against the Claims Service Administrator until the claims appeal process has been exhausted, nor may such action be taken more than two years after the services or supplies were performed or provided.

Initial Claims

General Rules

The applicable Claims Service Administrator will be responsible for processing your claims and/or making benefit determinations. Benefit determinations will be made on a consistent basis,

where circumstances are the same. Determinations will be made in accordance with the terms of the Plan and any applicable internal practices or guidelines that are maintained under the Plan or by the applicable Claims Service Administrator.

The Plan will not charge for or otherwise unduly inhibit or hamper the filing or processing of a claim. Subject to reasonable verification procedures that the Plan may establish, a personal representative may act on a claimant's behalf in filing and pursuing a claim.

Timing of Notifications

By law, your claims must be evaluated and processed within a time frame that depends on the nature of the claim. Different time frames apply depending on whether the claim is urgent, pre-service (but not urgent), or post-service.

A claim will be regarded as urgent if application of the ordinary pre-service time frame could seriously jeopardize your or your Dependent's life, health, or ability to regain maximum function or, in the opinion of a Physician with knowledge of your claim, could subject you or your Dependent to pain that could not be controlled without the care or treatment that requires approval. If your Physician determines that the claim involves urgent care, it will be treated as urgent. Otherwise, urgency will be determined based on what a prudent person with average knowledge of health and science would have concluded.

Claims will be considered pre-service if the amount of the benefits payable to you depends on whether you obtain approval in advance of the care. Urgent claims are typically pre-service. A routine request for precertification is an example of a pre-service claim that is not urgent.

Post-service claims include claims that are filed after care has been received.

The time frames for each type of claim are set forth in the following chart.

Procedure	Nature of Claim		
	Urgent	Pre-Service Non-Urgent	Post-Service
Claims Service Administrator provides notice of incomplete filing	**24 hours**	**5 days**	**N/A**
Claims Service Administrator provides notice of initial determination (or need for an extension)	**72 hours**	**15 days**	**30 days**
Claimant provides additional information (where required)	**48 hours**	**45 days**	**45 days**
Claims Service Administrator provides notice of initial determination after extension begins or additional information received, as applicable	**48 hours**	**15 days***	**15 days***

The Claims Service Administrator will make determinations with respect to urgent claims as soon as possible within the maximum limits. It will make other determinations within a reasonable period that does not exceed the maximum.

If you do not file an urgent or pre-service claim properly, you will receive a notice that directs you how to file it properly. However, this notice will be sent only if the claim is filed with the correct person or office and specifies the claimant's name, condition or symptom, and the treatment, service or procedure for which approval is sought. This notice will be provided within 24 hours of an urgent claim and within 5 days for any other pre-service claim. For urgent claims only, a need for more information will be regarded as an incomplete claim filing (and the need for more information will be communicated within 24 hours).

*** Except where more information is requested, the 15-day period may be increased by unused time from the period for providing notice of the need for extension. Where more information is requested, the determination will be made within 15 days of receipt. If the additional information is not provided on time, the determination will be made within 15 days of the end of the period for the information to be provided.**

Denial Notice

If all or part of your claim is denied, you will receive a written Explanation of Benefits (EOB) Statement or other claim denial notice. In an urgent situation, you may be notified orally of a denial within the appropriate time frame, with written confirmation sent within three days.

All determinations will be final and binding to the extent they are not appealed in accordance with the standard appeals procedure.

The denial notification will be set forth in a manner calculated to be understood by the claimant and must contain: (i) the specific reason or reasons for the adverse determination, (ii) the specific reference to Plan provisions on which the determination is based, (iii) a description of any additional material or information necessary for the person to perfect his claim and an explanation of why such material or information is necessary, (iv) information as to the steps to be taken if the claimant wishes to submit a request for review, including applicable time limits and (v) the claimant's right to bring a civil action under section 502(a) of ERISA. If the benefit determination was adverse, the notification must also contain any internal rule, guideline, protocol or other similar criterion (collectively "Protocols") that were relied upon in making the adverse determination and that a copy of such Protocols will be available to the claimant, free of charge, upon his request. If the benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification must also contain either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan, as applicable, to the claimant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request. For all urgent claims, the notification must also contain a description of the expedited review process applicable to such claims.

Standard Appeals

Submitting the Appeal

If you disagree with a claim decision, you can apply for a claim review. You must send your request for review within 180 days after receiving the claim denial notice. You should state the reason(s) you believe your claim was improperly denied and submit all comments, documents, records, and other information relating to the claim that you believe is appropriate.

In deciding whether to appeal a denial, you may, on request and free of charge, obtain access to and copies of all documents, records or other information relevant to your claim from the applicable Claims Service Administrator.

To file an appeal, you must notify the Director of the Benefit Fund, c/o the Benefit Fund Office, 1319 Locust St., Philadelphia, PA 19107, 215-735-5720.

General Rules

Although certain aspects of the procedures may differ depending on your Claims Service Administrator, many of the basic rules will apply to all appeals.

The Plan will not charge or otherwise unduly inhibit or hamper submission or processing of an appeal. Subject to reasonable verification procedures, a personal representative may act on your behalf in filing or pursuing an appeal.

Claims will be reviewed fully and fairly, taking into account the comments and information you have submitted. The review will be conducted by one or more individuals who are not the same as, or subordinate to the individuals who made the initial determination (or any prior determination on appeal). The determination will be made independently, without deference to the initial claims determination. Determinations will be made on a consistent basis in like circumstances. They will be made in accordance with the terms of the Plan and any applicable internal guidelines maintained by your Claims Service Administrator.

Where a determination requires medical judgment, the claims reviewer will consult a health care professional with appropriate experience and training in the applicable field of medicine. This consultant will not be, or be subordinate to, any consultant previously involved with the internal claim decision or any prior level of review. The Claims Service Administrator will provide for the identification of medical experts whom it consults, whether or not it relied on their judgments.

Timing and Notification

For all claims, there are two levels of appeal to the Claims Service Administrator. If your initial claim is denied, in whole or in part, notice of determination will be provided to you in writing, and you will have 180 days from the date you receive the denial notice to file for a second level of review by the Claims Service Administrator. The specific rules depend on the nature of the claim.

Urgent claims may be appealed orally or in writing, and necessary information, including the determination on appeal, may be transmitted by telephone, fax, or other expeditious methods. Urgent claim appeals will be decided as soon as possible, but in all cases within 72 hours of submission. If your appeal is denied, in whole or in part, and you appeal again, the Claims Service Administrator will conduct the second level of review in accordance with the voluntary appeal procedures described later in this section.

For pre-service claims, your Claims Service Administrator will make available two levels of standard appeals. These appeals will be decided within a reasonable period not to exceed 15 days at each level. If your claim is denied, in whole or in part, notice of the determination will be provided to you in writing.

For post-service claims, your Claims Service Administrator will make available two levels of standard appeals. These appeals will be decided within a reasonable period not to exceed 30 days at each level.

If your claim is denied, in whole or in part, notice of the determination will be provided to you in writing.

Notifications will be set forth in a manner calculated to be understood by the claimant and will contain: (i) the specific reason or reasons for the denial, (ii) specific references to Plan provisions on which the benefit determination is based, (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all material and required information relevant to the claim for benefits, (iv) a statement describing any voluntary appeals offered by the Plan, including information concerning the procedures of the voluntary appeal that would allow the claimant to make an informed decision about whether to appeal and such other information which the Claims Service Administrator determines is appropriate regarding alternative dispute resolution options, (v) a statement of the claimant's right

to bring an action under section 502(a) of ERISA, (vi) a description of the Protocols, if any, used to make the decision and that a copy of the Protocols will be available free of charge upon request, (vii) a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon request by the claimant, and (viii) the statement:

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and State insurance regulatory agency.

All decisions on appeal shall be final and binding to the extent they are not appealed to another level under these standard appeal processes or in accordance with the voluntary appeal provisions described later in this section.

For more information on appealing denied claims, please see the Plan Information and Rights section of this handbook.

After exhausting the Benefit Fund's appeal process, the covered individual may appeal the decision with the State office, provided the appeal is submitted within one year of the date of Disability. The State office address is:

Disability Insurance Service
Bureau of Private Plan Disability Benefits
Labor and Industry Building CN957
Trenton, NJ 08625-0957

Termination of Insurance

- Coverage under this Private Plan will terminate 14 days following the date on which the Member ceases to be in employment with a New Jersey Employer or the date the Member becomes employed by a New Jersey employer that does not contribute to the Benefit Fund, if earlier.
- In the event a New Jersey Employer terminates its participation in this Private Plan, at least 30 days advance written notice will be given by the Employer to the New Jersey Division of Unemployment and Disability Insurance and to all affected participants in this Private Plan. In the event this Private Plan is terminated with respect to any Contributing Employer, at least 60 days advance written notice will be given by the Benefit Fund to the New Jersey Division of Unemployment and Disability Insurance and to all Members covered by this Private Plan.
- In the event a New Jersey Employer fails to make required contributions for two consecutive months, coverage will end 15 days after notice is given by the Benefit Fund to the New Jersey Division of Unemployment and Disability Insurance.

Governing Law

This Private Plan, including its interpretation and administration, shall be administered in accordance with New Jersey Temporary Disability Benefits Law. In the event of ambiguity or conflict, New Jersey law will prevail.

About Taxes

Social Security (FICA) taxes will be deducted from your disability benefit check – but federal income tax will not be deducted. If you want the Fund to deduct federal taxes, you must return the withholding form that the Fund will send to you. At the end of the year, the Fund will send your Employer a record of the payments you received. Your Employer will then make up the necessary withholding statements for you and the IRS.

When Coverage Ends and Plan Information

The *Eligibility and Enrollment* section provides detailed information about when coverage ends and how benefits are affected by certain situations, such as Disability.

The *Plan Information and Rights* section provides facts about how benefits are administered and your rights.