Disability Benefit Plan

(For Members Employed in Pennsylvania and States Other Than New Jersey)

This section is the Summary Plan Description (SPD) for the Benefit Fund Disability Benefit Plan for members outside New Jersey and gives you a detailed explanation of the Plan.

For members who work in New Jersey:

Members who work in New Jersey are covered under Private Plan Disability Income Benefits. Please see the section entitled "Disability Benefits – New Jersey."

Disability Benefit Plan (non-NJ)

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Who Is Eligible and When

If you are a member in Wage Class I, II, or III, ***other than members working for New Jersey Employers***, you are eligible for the Disability Benefit Plan described in this section. (Of course, you must be eligible for benefit coverage by the Fund, as described in *Section 1: Eligibility and Enrollment*.

When Coverage Begins

Coverage begins on the 31st day after your Employer begins making contributions to the Benefit Fund. You must be actively at work on the day coverage begins. If you are not, coverage will begin on the first day your Employer is required to make contributions to the Fund.

Your Disability Benefits

Beginning with the first day of absence for an accident or the eighth day for illness, Disability Benefits will replace two-thirds of your Average Weekly Earnings, up to a maximum weekly benefit, as determined by the Plan. Check with the Benefit Fund Office for the current Plan maximum benefit.

For disability purposes, "Average Weekly Earnings" means the average of a member's gross weekly earnings during the last 8 calendar weeks immediately prior to the pay period in which the disability began.

Earnings means wages reported by your Employer as the basis for determining its contributions to the Benefit Fund.

Disability benefits will continue for up to 26 weeks in a 52-week period, as long as you remain disabled.

Disability payments are made until you recover, or for 26 weeks, whichever happens first. You may not receive benefits for more than 26 weeks in a prior 52-week period for any reason. Disability payments are made approximately every two weeks, as long as required documentation is provided.

Substance Abuse Disability Benefits Are Limited

The Fund will not pay disability benefits for substance abuse treatment more than three times in a member's lifetime.

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.

Definition of Disability

You will be considered disabled if you are unable to engage in the regular duties of your occupation due to an illness or injury (including pregnancy). If your Employer offers partial work, the Fund will determine eligibility for partial disability benefits on a case-by-case basis. Work-related illness or injury will be covered only as specifically described under "Coordination with Other Sources of Disability Benefits."

Required Doctor's Oversight and Appropriateness

You must have visited a physician, or be treated by a physician, within 30 days of your last day of regular employment to be eligible for disability benefits. The specialty of the doctor who certifies that you are disabled and who treats you must be appropriate to your condition. For example, if your disability is related to mental illness, only a psychiatrist, psychologist or psychiatric social worker may certify and treat your disability.

Claiming Disability Benefits

If you are disabled due to a non work-related injury or illness, you must call the Benefit Fund to start your disability claim process—and you must follow up with your employer and doctor to make sure that they return the disability claim forms on a timely basis.

If you are disabled, call the Benefit Fund to start the claim process.

- You must call the Benefit Fund (at 1-215-735-5720 or 1-800-531-1199) within 48 hours of the date that your physician informs you that you are disabled, and in no case more than 5 working days after the onset of your disability.
- When you call, a Benefit Fund representative will request information from you to start your disability claim. Make sure you have your doctor's name, address and telephone number handy when you call the Fund.

- If you do not notify the Fund on a timely basis, but can show that it was not possible to do so, your claim will not be reduced. However, if this cannot be shown, the date the Fund actually received your claim will be considered the date you became disabled for purposes of determining when your disability benefits begin.

…Then, the Fund will send forms to you, your doctor and your employer.

To enable the Fund to process your claim, YOU MUST:

- Complete, sign, and return the form that you are sent (this is called Part A), along with any other information requested, ***and***
- Follow up with your doctor and employer to ensure that they complete and return their forms (Parts B and C). If your doctor is not sure when you will return to work, ask the doctor to estimate this date.
- Your claim will not be processed until the Fund receives **Parts A, B, and C** of the claim form (**correctly completed**) as well as any other information requested.
- If all information and parts of the form are not returned within 14 days of the date you notify the Benefit Fund of your disability, your claim will be denied. To pursue receiving disability benefits, you will be required to file an appeal.

If your claim is approved, you should expect to receive your first check about two weeks after the Fund receives all of the information needed to process the claim. Subsequent checks will be paid approximately every two weeks provided proof of disability satisfactory to the Fund is supplied.

Disability Management Process

The Fund has retained a professional disability management firm to review and manage certain types of disability claims. Part of the disability management process may require you to supply further information or to be examined by an independent medical consultant. If you refuse to comply with information requests, provide proof of disability, or be examined, the Fund can deny disability benefits.

When Benefits Begin

The date benefits start depends on whether you are disabled due to an illness or an accident, as explained below:

- **Illness**—Benefits begin as of the 8th day that you are disabled as certified by your physician.
- **Accident**—Benefits begin as of the first day that you are disabled as certified by your physician.

Disability benefits from the Fund will not be paid for any day that you receive full sick pay from your employer. Remember, benefits will be paid for a maximum of 26 weeks in any 52-week period regardless of whether the disability periods are continuous or separate.

Remember, if you do not begin the claim process within the time period required, the Fund will assume that you became disabled on the date the Fund receives your claim.

Special Rule for Maternity Disability

For a normal pregnancy, you may receive disability benefits for up to 4 weeks before the delivery date and up to 6 weeks after the delivery date. (Benefits actually start as of the 8th day of the disability.)

If you become disabled more than 4 weeks before your delivery date, the benefit period may be extended if medical necessity has been established to the satisfaction of the Benefit Fund.

However, if the Fund determines that you were *not* disabled before this 4-week period, then you will *not* receive disability benefits, and your medical coverage will end 30 days after your last day at work. This means you would not receive disability benefits before or after delivery. You would not have any medical coverage for the hospital admission or other medical expenses (unless you had applied and paid for COBRA continuation coverage).

You Return to Work and Disability Recurs

If you recover from the disability, return to work for less than 14 days, and become disabled again from the same or a related disability, benefits for the second period of disability will be considered as a continuation of the first period and will be paid from the first day of the onset of the new disability.

Coordination with Other Sources of Disability Benefits

With Auto Insurance Benefits

Under the no-fault laws of Pennsylvania, auto insurance is your primary coverage in the case of an auto accident. The Fund will coordinate with auto insurance disability benefits and *reduce* its disability benefits by any auto insurance disability benefits payable. If you have no auto insurance or if your auto insurance has no lost wage provision, call the Fund to determine the requirements for submission of a disability claim.

With Workers' Compensation

While a Workers' Compensation Claim Is in Dispute

The Disability Benefits Plan usually does not pay benefits if you have a work-related injury. However, if you file a Workers' Compensation claim and it is rejected, an appeal must be filed with the Bureau of Workers' Compensation.

If you provide proof that your Workers' Compensation claim was rejected and you are appealing the claim denial, the Benefit Fund will pay disability benefits while your claim is in dispute (up to the maximum 26week benefit period), provided you agree, in writing, to repay these benefits if the case is decided in your favor. If you lose the case, you are not required to repay the benefits.

Supplementary Disability Benefits to Workers' Compensation

- If you qualify for and are receiving Workers' Compensation benefits for a Disability, you may also be entitled to supplementary benefits from the Benefits Fund under this Plan.
- Supplementary Disability Benefits will be paid if the weekly disability benefit paid by Workers' Compensation is less than the applicable total benefit determined under the Fund's Disability Benefits Plan. Where the Workers' Compensation benefit has been reduced as a result of a partial Disability, this Plan will continue to pay benefits based on the unreduced amount, minus any wages received, minus Workers' Compensation received.
- You will also continue to be covered for a maximum of 26 weeks with the same level of health benefits to which you were 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. You must also provide proper proof of disability.

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.

How Disability Affects Other Benefits

While you are receiving disability benefit payments, your Benefit Fund coverage continues as if you were actively employed. Coverage will be extended until:

- your eligibility for disability benefits stops or
- you have received 26 weeks of extended benefit coverage.

When Disability Benefits Are Not Paid

Disability benefits will not be paid unless an illness or injury prevents you from working and you are under the care of a licensed physician within 30 days of becoming disabled.

Disability benefits may be stopped if you do not comply with your doctor's treatment plan (with the exception of invasive procedures). There are other situations in which the Disability Plan will not pay benefits. These include:

- failure by the member to provide proper proof of disability or to provide information required by the Benefit Fund to investigate the claim,
- any period of disability greater than 30 days during which the member has not visited a physician or is not being treated under a treatment plan supervised by the member's physician,
- more than three periods of disability benefits related to substance abuse treatment,
- any day that a member receives full sick pay from an employer and
- work-related disabilities for which the member is entitled to Workers' Compensation benefits and not to disability benefits provided by the Fund, except as specifically described under "Coordination with Other Sources of Disability Income."

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.

The Bureau of Health Financing and Program Development is responsible for monitoring the Claims Service Administrator's compliance with these claims appeal procedures. Their address is:

Bureau of Health Financing and Program Development
Pennsylvania Department of Health
Room 1026, Health and Welfare Building
P.O. Box 90, Harrisburg, PA 17108-0090
717-787-5193

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

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.

See the *Plan Information and Rights* section for facts about how benefits are administered and your rights.