Disability Claim Policies & Procedures

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Please be aware that the guidelines in this publication are intended to be considered by New York Life Group Benefit Solutions claim professionals as a reference and guideline for evaluating and managing claims. Each claim is unique, and should be evaluated and managed considering these guidelines, combined with the expertise and judgment of the reviewer, taking into account the specific details of that claim and the specific language of the policy/plan. If there is any inconsistency between the policy/plan, and the information in this publication, the policy/plan will govern.

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DISABILITY CLAIM POLICIES AND PROCEDURES

BACK TO TABLE OF CONTENTS TABLE OF CONTENTS

DISABILITY CLAIM POLICIES AND PROCEDURES 2

BACK TO TABLE OF CONTENTS TABLE OF CONTENTS 2

NEW YORK LIFE GROUP BENEFIT SOLUTIONS DISABILITY CLAIM PRACTICES 4

ACTIVE SERVICE AND ELIGIBILITY FOR SHORT TERM DISABILITY AND LONG TERM DISABILITY 6

ACTIVE SERVICE FOR WAIVER OF PREMIUM 12

ADVERSE CLAIM DETERMINATION GUIDELINES FOR POLICIES PROVIDING DISABILITY BENEFITS 14

ADVERSE DETERMINATION LETTER CONTENT FOR POLICIES PROVIDING DISABILITY BENEFITS 16

ANY OCCUPATION INVESTIGATION GUIDELINES 22

APPEAL AFFIRMATION LETTER CONTENT FOR POLICIES PROVIDING DISABILITY BENEFITS 28

APPROPRIATE CARE 32

CLAIM MANAGER APPEAL WORKFLOW 35

CLAIMANT COOPERATION IN POLICIES PROVIDING LONG TERM DISABILITY BENEFITS 38

ELIGIBILITY REVIEW FOR WAIVER OF PREMIUM CLAIMS 42

ELIMINATION PERIOD AND BENEFIT START DATE 44

ERISA GUIDELINES FOR POLICIES PROVIDING DISABILITY BENEFITS 48

EVALUATING DISABILITY AS OF LAST DAY WORKED 53

EVALUATING JOB OR OCCUPATION REQUIREMENTS 56

EVALUATING OWN OCCUPATION IN CALIFORNIA ISSUED LONG TERM DISABILITY POLICIES 58

EXCLUSIONS IN DISABILITY POLICIES 61

EXTENDED DEATH BENEFIT WITH WAIVER OF PREMIUM 65

FUNCTIONAL CAPACITY EVALUATION REFERRALS 68

GATHERING MEDICAL INFORMATION AND DOCUMENTING CONCLUSIONS 70

GUIDELINES FOR USE OF EXTERNAL MEDICAL RESOURCES 77

INDEPENDENT MEDICAL EVALUATION AND PEER REVIEW REFERRALS 80

LATE SUBMITTALS 83

LIFE WAIVER OF PREMIUM ANY OCCUPATION EVALUATIONS 89

LIMITED BENEFIT PERIODS IN DISABILITY POLICIES 92

LONG TERM DISABILITY ADVANCE PAY AND CLOSE 98

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LONG TERM DISABILITY CLAIMS WITH NO DEFINED RESTRICTIONS AND LIMITATIONS 102

LONG TERM DISABILITY EXPERT RESOURCE MEDICAL REVIEW 104

MISREPRESENTATION INVESTIGATION DURING THE CONTESTABLE PERIOD FOR DISABILITY CLAIMS 107

MISREPRESENTATION INVESTIGATION DURING THE CONTESTABLE PERIOD FOR WAIVER OF PREMIUM AND ACCELERATED DEATH BENEFITS 112

MODIFIED OCCUPATION 118

ONGOING CLAIM REQUEST FOR INFORMATION 121

POLICY EXCLUSIONS BASED ON MEDICAL NECESSITY 125

PRE-EXISTING CONDITION LIMITATION AND INVESTIGATION 127

PREGNANCY LEAVE GUIDELINES 138

PROOF OF LOSS FOR CALIFORNIA-ISSUED LONG TERM DISABILITY POLICIES 143

PROOF OF LOSS PROVISION IN DISABILITY POLICIES 145

RECEIPT OF CLAIM FOR LINKED LIFE WAIVER OF PREMIUM 149

RECEIPT OF CLAIM OR APPEAL 151

RECEIPT OF NEW INFORMATION ON ADVERSELY DETERMINED CLAIMS WHEN NO APPEAL HAS BEEN FILED 153

RECEIPT OF NEW INFORMATION ON CLOSED CLAIMS 155

RELEASE OF INFORMATION FROM GROUP OPERATIONS POLICIES AND PROCEDURES 157

REQUIREMENTS FOR HANDLING DISABILITY APPEALS 162

SECOND EYE REVIEWS LONG TERM DISABILITY 169

SECOND EYE REVIEWS SHORT TERM DISABILITY 171

SHORT TERM DISABILITY AND SOCIAL SECURITY AWARDS 172

SHORT TERM DISABILITY EXPERT RESOURCE MEDICAL REVIEW 174

SOCIAL SECURITY AWARDS AND DISABILITY DETERMINATIONS 175

SOCIAL SECURITY AWARDS AND THE WAIVER OF PREMIUM EVALUATION 178

STATE COMPLIANCE GUIDELINES FOR POLICIES PROVIDING DISABILITY BENEFITS 181

TRANSFERRABLE SKILLS ANALYSIS AND LABOR MARKET SURVEY REFERRAL PROCESS 185

WORKERS COMPENSATION AND THE LONG TERM DISABILITY EVALUATION 188

WORKERS COMPENSATION AND WORK-RELATED EXCLUSIONS AND THE SHORT TERM DISABILITY EVALUATION 194

CONFIDENTIALITY AND DISCLAIMER 199

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New York Life Group Benefit Solutions Disability Claim Practices

1.0 Purpose/Overview

2.0 Disability Claims and Claim Professionals

3.0 Purpose of Policies and Procedures

4.0 Commitment in Administering Claims

5.0 Integrity, Impartiality and Independence

6.0 Disclosure of P&Ps and Reliance on P&Ps

1.0 Purpose/Overview

The purpose of these guidelines is to discuss New York Life Group Benefit Solutions' (NYL GBS) commitment to providing prompt, fair, consistent and unbiased administration of disability claims.

2.0 Disability Claims and Claim Professionals

This guideline applies to NYL GBS employees who have substantive involvement in the disability claim process.

A claim is a "disability claim" if the benefit is conditioned on a showing of disability, or requires the claim manager to make a determination of disability to decide the claim. This includes a claim for Short-term disability, Long-term disability, and Waiver of premium under a life insurance policy.

3.0 Purpose of Policies and Procedures

The Policies and Procedures (P&Ps) provide guidelines for the manner in which NYL GBS administers disability claims. They contain administrative processes and safeguards designed to promote the goal of consistent claim administration across similarly situated claims in accordance with applicable federal and state regulations and the governing policy/plan provisions.

The P&Ps are not intended to be a set of absolute rules. Claim professionals are expected to use their experience and judgment in applying the P&Ps to the administration of a particular claim. Exceptions may be necessary due to a claim's particular circumstances, or applicable plan provisions. If there is any inconsistency between the policy/plan, and the information in these procedures, the policy/plan will govern.

4.0 Commitment in Administering Claims

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Claims professionals are expected to evaluate all claims completely and thoroughly, by using their best efforts to obtain necessary information, and to make an accurate determination by applying the available information and analysis to the terms of the policy/plan. If the evidence demonstrates that the claim should be paid under the terms of the policy/plan, then the claim should promptly be approved. If the evidence demonstrates that the claim should not be paid under the terms of the policy/plan, then the claim should promptly be denied.

5.0 Integrity, Impartiality and Independence

NYL GBS expects its claims professionals to maintain the highest standards of integrity, impartiality and independence. No employee, policyholder or any other person can influence the evaluation or determination of a claim or appeal based on considerations other than the evidence and the terms of the policy/plan.

NYL GBS will never make an employment-related decision related to its employees based on whether an employee has denied or approved, or is likely to deny or approve, one or more claims for disability benefits. This includes decisions regarding hiring, compensation, promotion, termination or other similar matters. NYL GBS employees should report any concerns to their manager or the NYL Ethics Hotline.

6.0 Disclosure of P&Ps and Reliance on P&Ps

For claims filed on or after April 1, 2018, NYL GBS will make available to customers those disability claim P&Ps that provide guidelines for the manner in which we administer disability claims. On occasion, a customer may ask a Claim Manager to identify specific sections in the P&Ps that were “relied on” in making a claim determination. The information below provides guidance to respond appropriately to the customer:

The Policies and Procedures are not relied upon to determine claim outcome. The Disability Claim Policies and Procedures provide guidelines for the manner in which we administer disability claims. Our claim staff is trained on our Disability Claim Policies and Procedures, which describe claim processes, unless the circumstances of the particular claim or the policy/plan provisions make an exception necessary. The Policies and Procedures disclosed to customers include the guidelines generally applicable to processing their claim. Depending upon the experience of the Claim Manager and/or the issues presented in any given claim, the Claim Manager may or may not have needed to actually review any part of these Policies and Procedures during claim management. Generally, our claim decisions are based upon the Claim Manager’s judgment and review of the claim file as a whole, including any information and medical documentation obtained, provided or gathered. Such information is then evaluated and considered in light of applicable policy or plan provisions.

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Back to Table of Contents

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Active Service and Eligibility for Short Term Disability and Long Term Disability

1. Purpose/Overview
2. Active Service
3. Termination of Insurance and Continuation of Insurance
4. Takeover Provision / Continuity of Coverage
5. Class of Eligible Employees
6. Eligibility Waiting Period
7. Effective Date of Coverage
8. Waiver of Premiums

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1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the policy provisions to consider when determining a customer's eligibility for Short Term or Long Term Disability coverage, including Active Service, Termination of Insurance and Continuation of Insurance, the Takeover Provision / Continuity of Coverage, Classes of Eligible Employees, Eligibility Waiting Period, and Effective Date of Coverage (or Insurance).

For every claim, it is important to consult the eligibility provisions within the policy to determine whether the customer was covered on the date of Disability. Some claims will involve specific eligibility questions (e.g., customer was out of work on the date of their Disability).

2.0 Active Service

The policy will typically require that an Employee be in Active Service to be eligible for coverage. The definition of Active Service may vary. For example, policies may or may not:

- Specifically define what an approved paid leave of absence includes.
- Require that the Employee be performing the Employee's Regular Occupation working at one of the Employer's usual places of business or at some location to which the Employer's business requires an Employee to travel. "Usual place of business" may include work at home and telecommuting as supported by the Employer.
- Include scheduled holidays, vacation days or a day which is not one of the Employer's scheduled workdays provided the Employee was performing their Regular Occupation immediately prior to the holiday, vacation day, or day which is not a scheduled workday.

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When the policy is non-contributory, the Employee's coverage becomes effective on the first date they become eligible. If an Employee was not in Active Service on the date their coverage would otherwise become effective, coverage will become effective on the date they return to active service.

If there is a gap in time between the Employee's last day worked and their incur date, confirm with the Employer if the Employee was in Active Service as defined by their policy. If the Employee was not in Active Service, please see the provisions noted below.

Policy language varies, consult the individual policy provisions for each claim.

3.0 Termination of Insurance and Continuation of Insurance

The policy will include a Termination of Insurance provision, which lists the situations in which an Employee will no longer be eligible for coverage. Policy language varies, consult the individual policy provisions for each claim.

Example of a Termination of Insurance provision:

> "An Employee's coverage will end on the earliest of the following dates:
>
> 1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
> 2. the date the Policy is terminated;
> 3. the date the Employee is no longer in an eligible class;
> 4. the day after the end of the period for which premiums are paid;
> 5. the date the Employee is no longer in Active Service;
> 6. the date benefits end for failure to comply with the terms and conditions of the policy
>
> Disability Benefits will be payable to an Employee who is entitled to receive Disability Benefits when the Policy terminates if he or she remains Disabled and meets the requirements of the Policy. Any period of Disability, regardless of cause, that begins when the Employee is eligible under another group disability coverage provided by any employer, will not be covered."

Some policies contain a Continuation of Insurance provision, which modifies the Termination of Insurance provision. In certain circumstances, coverage may be continued if the insured Employee is no longer in Active Service.

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Other policies provide for Continuation of Coverage. If insurance premiums are paid, coverage may continue for an Employee whose Active Service ended due to an Employer-approved unpaid leave of absence.

Some policies stipulate the length of time insurance or coverage will continue, if a person is not in Active Service and becomes disabled while away from work for a reason described in the Continuation of Insurance provision (for example, Family Medical Leave, sick leave, or other approved leave of absence). Disability Benefits will begin on the later of the end of the Benefit Waiting Period or the date they are scheduled to return to Active Service.

For Massachusetts residents, look for a State Modifying Provisions Amendment Rider attached to the policy that modifies Continuation requirements when an employee leaves their employer or there is a Plant Closing/Partial Plant Closing. If you have a Massachusetts resident claim and do not see the Rider in the policy, contact the Account Manager to ensure the policy is not missing a required Rider.

For more information on State Modifying Provisions Amendment Riders, see “State Modifying Provisions Amendment Rider”.

4.0 Takeover Provision / Continuity of Coverage

The Takeover Provision / Continuity of Coverage provision describes how our policy interacts with a prior carrier's policy. Coverage may or may not be extended for Employees who were not in Active Service on the effective date of the policy. Information on file from the customer and the employer, compared against these provisions, determines whether the claim is covered under our policy or the Prior Plan.

These provisions also address the Elimination Period, Pre-Existing Condition Limitation, and how benefit amounts would be determined if an Employee was covered under a prior Disability policy on the day before the effective date of this policy.

Consider the Takeover and Continuity of Coverage policy provisions along with the Continuation of Insurance section of the policy any time the customer is not in Active Service on the date the disability occurs.

5.0 Class of Eligible Employees

If an Employee does not fall within one of the Classes of Eligible Employees, that Employee is not covered.

Examples of classes:

- Salaried/hourly
- Full time/Part Time Employees
- Executives/managers/professionals/support staff

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- Employees earning greater than $50,000 or less than $50,000
- Union/Non-Union Employees

Compare the policy with the information provided by the Employer to determine if the Employee is a member of a Class of Eligible Employees.

Class of Eligible Employees may include US citizenship or permanent US residency. We will rely on the employer to validate if an employee meets this requirement. We do not need to validate further with the employer or employee unless there are other inconsistencies that need to be verified.

6.0 Eligibility Waiting Period

A policy may define the waiting period which an Employee is required to satisfy based on date of hire (i.e., before or after the Policy Effective Date).

Examples of Eligibility Waiting Periods:

- Employees that were hired on or before the effective date of the policy
  - No Waiting Period
  - The first of the month following 30 days from the date of hire
- Employees that were hired after the effective date of the policy
  - The first of the month following 30 days from the date of hire
  - After 60 days of Active Service

Policy language may vary, so consult the individual provisions for each claim.

7.0 Effective Date of Coverage

The Effective Date of Coverage is the first day the Employee is covered under the policy after satisfying all the eligibility requirements for coverage.

Factors that may impact the Effective Date of Coverage:

- **Employee Contribution -** Contributory-The Employee contributes (all, or in part) to the cost of the premium. An Employee must enroll to receive the coverage and the effective date of coverage depends on the date that action is completed. It is important to ensure that premiums for the Employee have been paid.
- **Non-Contributory Plan** – The Employee does not contribute to the cost of premium. The premium is paid in full by the Employer.

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- **Annual/Open Enrollment** – A period of time, during which an Employee may elect to enroll in the group policy or increase their amount of insurance if already enrolled. Review the "Effective Date of Coverage" in the policy to determine if a Statement of Physical Condition or Evidence of Insurability (EOI) is required.

- **Late Entrant** – An Employee may be considered a late entrant when:

    - Coverage is requested after the expiration of their initial eligibility period

    - Coverage is outside of an Annual/Open Enrollment period (see the policy as enrollment during Annual/Open Enrollment may require the employee meet the Insurability Requirement and submit EOI).

  If an Employee's effective date of coverage is later than the policy effective date and the applicable eligibility waiting period, the Employee must submit EOI before receiving coverage. The coverage must be approved through the Medical Underwriting Department. Contact the Medical Underwriting Department (internal or Employer if Employer administered), to confirm and document the date the EOI was submitted and obtain the approved effective date of coverage.

If an Employee transfers classes, validate if they are included in an Eligible Class.

8.0 Waiver of Premiums

The language in the STD and LTD policies differs regarding waiver of premiums. In order for coverage to remain in force during and after a Disability claim, premiums must be waived (LTD), or paid (LTD, STD). If premiums are not paid and there is no waiver (or the waiver terminates), an Employee's coverage will lapse after their Disability ends.

If there is no gap between the Last Day Worked and the Incur Date, then the Premium Paid Through Date does not need to be verified. If there is a gap in the date, verify the policy language for Active Service and Continuation of Insurance.

Standard STD policy language provides:

> "Disability Insurance continues if an Employee's Active Service ends due to a disability for which benefits under the Policy are or may become payable. If an Employee does not return to Active Service, this insurance ends when the Disability ends, or when benefits are no longer payable, whichever comes first."

The STD policy does not include a waiver of premium once STD benefits are payable. These premiums would be due in order to guarantee coverage for future STD claims.

Standard LTD policy language indicates:

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> "Disability Insurance continues if an Employee's Active Service ends due to a disability for which benefits under the Policy are or may become payable. Premiums for the Employee will be waived while Disability Benefits are payable. If an Employee does not return to Active Service, this insurance ends when the Disability ends, or when benefits are no longer payable, whichever comes first."

Consistent with this LTD policy language, once the individual qualifies for LTD benefits, premium payments for LTD insurance are waived.

Back to Table of Contents

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Active Service for Waiver of Premium

1.0 Purpose/Overview

2.0 Active Service Definition

3.0 Claim Management

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the Active Service for Waiver of Premium. For more information on Active Service for Life policies, please see "Active Service and Takeover Provisions for Life Policies".

2.0 Active Service Definition

The definition of Active Service may vary from policy to policy. Two examples include:

Active Service definition example 1:

An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. *He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.*
2. *The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence.*

Active Service definition example 2:

An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. *He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.*
2. *The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence other than disability or sick leave after {7} days.*

An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

3.0 Claim Management

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Other provisions of the policy are dependent upon the employee's Active Service status. These other provisions range from eligibility for coverage, coverage amount changes, effective date of insurance, continuation of insurance, enrollment time frames as well as policy changes and policy re-writes. Review of the other provisions of the policy will identify where Active Service is applicable.

The wording "disability or sick leave after {7} days" may vary from policy to policy. An employee absent due to Short Term Disability (STD) or Long Term Disability (LTD) would not be considered in Active Service after they are absent for 7 days.

If the policy does not include "disability or sick leave after {7} days" and the employee is on "an employer approved paid leave of absence" (including sick leave) then the employee may be considered in Active Service for the length of the paid leave. State Paid Leave programs, STD and LTD are not typically considered "an employer approved paid leave of absence".

Paid leaves of absence may include Jury Duty and Bereavement. Military Leave or Reserve Duty and Family Medical Leave of Absence (FMLA) are normally unpaid leaves and may not result in the employee being in Active Service. If the employee is paid for military duty (differential pay which is the difference between the salary paid by his employer and the salary paid by the military), they may be considered in Active Service.

Please see your Team Leader or Technical Specialist if you have any questions.

Back to Table of Contents

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Adverse Claim Determination Guidelines for Policies Providing Disability Benefits

1.0 Purpose/Overview

2.0 Adverse Determination Defined

3.0 Claim Review

1.0 Purpose/Overview

The purpose of these guidelines is to provide information on adverse claim determination review for disability benefits (i.e. Short Term Disability (STD), Long Term Disability (LTD), Waiver of Premium). For letter content, refer to “Adverse Determination Letter Content for Policies Providing Disability Benefits.”

2.0 Adverse Determination Defined

Under Department of Labor regulations issued under the Employee Retirement Income Security Act of 1974 (ERISA), an "adverse benefit determination" refers to any negative decision on an individual's claim for benefits, including but not limited to a denial, reduction, termination of, or failure to make payment (in whole or in part) for, a benefit. It also includes any adverse determination based on a customer’s (claimant) eligibility for coverage under the applicable policy, and any rescission, cancellation or discontinuation of disability coverage that retroactively affects any customer, even if there is no adverse effect on any particular benefit at that time.

These guidelines should be used for adverse determinations made on claims under ERISA-governed policies. Most plans we insure are governed by ERISA with a few exceptions. Refer to “ERISA Guidelines for Policies Providing Disability Benefits” for a description of plans that may not be subject to ERISA. If you are unsure of whether ERISA applies to your policy/claim, consult your Senior Claim Manager (SCM), Technical Coach (TC) or Team Leader (TL) for advice. Do not assume that ERISA applies to a claim if you are unsure.

All claims should be reviewed in the same manner, regardless of whether they are governed by ERISA. Adverse determination letters for ERISA-governed claims, however, must contain certain language required by ERISA.

3.0 Claim Review

Every claim should be investigated and reviewed without any presumption as to whether it will be approved or denied. If, after a thorough review, you determine that a claim meets the terms and provisions of the policy, you should approve the claim. If you determine that a claim does not meet the terms and provisions of the policy, your decision that the claim cannot be approved is an adverse determination.

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The suggestions below are provided to assist you in conducting a comprehensive investigation.

- Follow all ERISA and state compliance timeframe requirements for handling the claim.
- Review the policy to understand the relevant provisions pertaining to the claim, including any pertinent definitions, limitations or exclusions.
- Resolve relevant questions; make a reasonable effort to close out all investigative issues pertaining to the facts of the claim that are important to your ability to make a reasoned decision.
- Attempt to resolve any material discrepancies that exist regarding claim facts. For example, if it appears that a health care professional has given conflicting restrictions and limitations for the same relevant time period, consider appropriate steps to resolve the discrepancy.
- Document evidence from appropriate sources that supports the determination you reach, including steps taken in the claim evaluation process and an explanation of your reasons for those steps. For example, if information was previously requested but you are prepared to make a claim decision before it is received (or are required to do so by timeframe requirements), document the reason that the requested information is not necessary to make the claim determination, or why it is necessary or appropriate make the determination without the previously requested the information.
    - Remember that per ERISA regulations, a customer must be allowed at least 45 days from notification to provide information that is necessary to make a claim determination. It is the customer's responsibility to provide information necessary to establish the disability claim, but we should offer reasonable support to the customer in gathering the necessary information during that 45 day period.
- Obtain appropriate medical evaluations, as needed.
- Obtain appropriate occupational and/or vocational evaluations, as needed.
- If the customer has been approved for Social Security Disability Income (SSDI) benefits, refer to "Social Security Awards and Disability Determinations." For STD claims received on or after April 1, 2018, refer to "Short Term Disability and Social Security Awards".
- Obtain management review, as needed.

Back to Table of Contents

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Adverse Determination Letter Content for Policies Providing Disability Benefits

1.0 Purpose/Overview

2.0 Adverse Determination Letter Content

3.0 Quote Policy Provisions that Apply to the Decision

4.0 Provide Explanation of the Decision

5.0 Description of Appeal or Claim Review Procedures and the Applicable Time Limits

6.0 Description of Additional Information Needed to Perfect the Claim

7.0 Internal Guidelines

8.0 State Required Language

9.0 Waiver of Premium

10.0 Culturally and Linguistically Appropriate Notices

1.0 Purpose/Overview

The purpose of this guideline is to provide information on adverse claim determination letter content. For guidance on claim review, refer to "Adverse Claim Determination Guidelines for Policies Providing Disability Benefits."

2.0 Adverse Determination Letter Content

It is our policy to give the same level of review to all claims, whether the claims are governed by ERISA or not. However, there is certain specific content that must be included in determination letters for ERISA claims, and that should not be included in non-ERISA adverse determination letters.

All correspondence tool templates are compliant with these requirements.

3.0 Quote Policy Provisions that Apply to the Decision

This is required for both ERISA and Non-ERISA adverse determinations.

You should include quotes from the policy provisions that you have determined are pertinent to the determination (e.g. Definition of Disability, Exclusions, Other Benefits, Pre-Existing Condition Limitation, etc.). Policy language that you include in this section of the adverse determination letter should be quoted word-for-word. Paraphrasing could cause confusion about whether you are applying the terms of the contract as written, or applying the paraphrased language.

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It is recommended to include only the parts of the provision that apply to the claim determination. You may use ellipses to remove irrelevant information such as other exclusions, etc.

4.0 Provide Explanation of the Decision

This is required for both ERISA and Non-ERISA adverse determinations.

The explanation should include, where applicable:

- A discussion of the facts that you have determined to be relevant to the claim determination, and an explanation of the application of the policy provisions to those facts. Your explanation should briefly summarize the information submitted and state how the information resulted in the claim determination you reached.

  For example, the facts may have led you to conclude that the customer does not satisfy the contractual definition of Disability, or that a policy exclusion, limitation, or eligibility issue (such as an elective surgery, Limited Benefit Periods, or Pre-existing Condition) governs the claim decision. In any case, the rationale supporting your determination should be based on the information as a whole obtained in the claim investigation and you should include an explanation of your reasons for the decision.

- A discussion of the reasons why you disagree with, or do not find sufficient the information or views presented by, the customer, health care professionals treating the customer, and/or vocational professionals who evaluated the customer.

  "Views" that you should address may include factual information such as medical history, examination findings, test results, and diagnoses, as well as opinions provided on behalf of the customer relating to functional capacity, restrictions and limitations, or disability.

- If applicable, a discussion of the reasons why you disagree with, or do not find sufficient the information or views presented by, any internal or independent expert resources (medical or vocational) who reviewed the claim, regardless of whether or not you relied on that information or views in making the benefit determination.

- A discussion of the reasons why you disagree with, or do not find sufficient, a disability determination made by the Social Security Administration, as presented by the customer to the plan. Refer to "Social Security Awards and Disability Determinations" for further information and guidelines. For Short Term Disability claims received on or after April 1, 2018, refer to "Short Term Disability and Social Security Awards".

You are not required to agree with, or defer to, the views, opinions or conclusions of any medical professional, vocational professional, consulting expert or the Social Security Administration. You should consider those views, opinions and conclusions, and if you disagree with them or do not follow them, provide an explanation.

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In the rare situation that a disability determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the letter should include either an explanation of the scientific or clinical judgment supporting the determination, applying the terms of the policy to the customer's medical circumstances, or a statement that such explanation will be provided free of charge upon request. If you believe these exclusions may be applicable, you should consult with your Senior Claim Manager or Technical Coach for guidance.

5.0 Description of Appeal or Claim Review Procedures and the Applicable Time Limits

This is required for both ERISA and Non-ERISA adverse determinations.

The adverse determination letter should advise the customer of the procedures for requesting a review of the claim determination. Included in this section are the timeframes that apply to the customer's appeal. The last paragraph in this section, known as the Waiver paragraph, advises the customer that our decision was made in good faith, and that nothing in the letter should be interpreted as a waiver of any of our rights.

Much of the information in this section applies to both ERISA and Non-ERISA claims, however; some of the adverse determination language differs or is not required for Non-ERISA claims, as noted below. The correspondence tool template includes language that is compliant with the regulation.

Select the applicable example to view the language required.

ERISA Required Description of Appeal or Claim Review Procedures and the Applicable Time Limits

If you disagree with our determination and wish to have it reviewed, please follow the steps described below.

Based on the information provided by your Employer, your claim is governed by the Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA). ERISA requires that you go through the Company's administrative appeal review process prior to pursuing any legal action challenging our claim determination.

If you appeal, the appeal process will provide for a review that does not afford deference to the claim determination and will be conducted by a person who is neither the individual who made the claim determination, nor the subordinate of such individual.

Here's how to submit your administrative appeal review request:

- Submit your appeal letter to us within 180 days of your receipt of this letter.
- Your appeal letter should be sent to *{insert underwriting company's name here and address}*.

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- Your appeal letter may include written comments as well as any new information you may have.
- You may also submit additional information. Additional information may include, but is not limited to: medical records from your doctor and/or hospital, test result reports, therapy notes, etc. These medical records should cover the period of *{insert medical record start date}* through *{insert 'present' or medical record end date}.*
- You may also wish to have your doctor(s) provide some or all of the following: *[Insert Specific Information the Claimant May Consider to Perfect Their Claim]*

You have the right to bring a legal action for benefits under the Employee Retirement Income Security Act of 1974 (ERISA) section 502(a) following an adverse benefit determination on appeal.

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.

Please be aware that you are entitled to receive, upon request and free of charge, information relevant to your claim for benefits.

Non- ERISA Required Description of Appeal or Claim Review Procedures and the Applicable Time Limits

If you disagree with our determination and wish to have it reviewed, please follow the steps described below.

- Submit your appeal letter to us within 180 days of your receipt of this letter.
- Your appeal letter should be sent to *{insert underwriting company's name here and address}*.
- Your appeal letter may include written comments as well as any new information you may have.
- You may also submit additional information. Additional information may include, but is not limited to: medical records from your doctor and/or hospital, test result reports, therapy notes, etc. These medical records should cover the period of *{insert medical record start date}* through *{insert 'present' or medical record end date}.*
- You may also wish to have your doctor(s) provide some or all of the following: *[Insert Specific Information the Claimant May Consider to Perfect Their Claim]*

If you appeal, the appeal process will provide for a review that does not afford deference to the claim determination and will be conducted by a person who is neither the individual who made the claim determination, nor the subordinate of such individual.

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Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.

Please be aware that you may receive, upon request and free of charge, information relevant to your claim for benefits.

6.0 Description of Additional Information Needed to Perfect the Claim

This is required for both ERISA and Non-ERISA adverse determinations.

You should provide a description of any additional information you believe is necessary for the customer to provide for further consideration of the adverse determination, clearly expressing an offer to consider additional information. This paragraph should focus on additional information that would be specific to the claim at hand, and should explain exactly what information is needed and why it is important to the claim determination. You should not provide merely a statement saying that we will review any additional information that the customer believes may be important, nor should it imply that the adverse determination will be reversed if such information is provided.

7.0 Internal Guidelines

This is required for ERISA adverse determinations.

Beginning with claims received on or after April 1, 2018, the Department of Labor regulations require an adverse benefit determination letter to include "the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied on in making the adverse determination, or, alternately, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist." When an adverse benefit determination is made, the customer will be afforded access to or otherwise will receive our standard policies and procedures for administering disability claims in order to comply with this regulation. The adverse determination letter template in the Correspondence Tool includes language advising the customer how to access those procedures. If you relied on any policies, procedures, or guidelines that are not in the standard policies and procedures for disability claims, you should consult with your Senior Claim Manager, Technical Coach and/or Policies & Procedures Department for guidance on providing further information that may be necessary to comply with the regulations.

8.0 State Required Language

This language is required for Fully Insured ERISA and Non-ERISA adverse determinations.

Refer to “State-Required Language for Letters” for a complete list of required states and language.

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This language is not required for Administrative Services Only (ASO) plans. It is also not required where we are notifying the customer that benefits will end due to return to work, death, or maximum policy duration due to age.

9.0 Waiver of Premium

For ERISA and Non-ERISA claims, insert any required Conversion language, if applicable, as outlined in "Life Waiver of Premium Conversion and Portability."

10.0 Culturally and Linguistically Appropriate Notices

This is required for ERISA adverse determinations.

Beginning with claims received on or after April 1, 2018, for customers located in a county where 10% or more of the population is literate only in a non-English language (as determined by the U.S. DOL and U.S. Census Bureau), the Department of Labor regulations require the adverse benefit determination letter to include a brief notice in the non-English language about the availability of translation services. This notice is included in the adverse determination letter template in the Correspondence Tool.

Back to Table of Contents

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Any Occupation Investigation Guidelines

1.0 Purpose/Overview

2.0 Beginning the A/O Investigation

3.0 Medical and Vocational Reviews

4.0 Delayed A/O Determinations

5.0 Completing the A/O Determination

6.0 Common Definitions of Disability

7.0 Other Definitions of Disability

8.0 Policies Issued in California

9.0 Louisiana Residents

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1.0 Purpose/Overview

The purpose of this procedure is to provide guidance on timing and process to complete the Any Occupation (A/O) review on Long Term Disability (LTD) claims.

Important Note Regarding Plan Design: LTD plans (and the corresponding level of benefits) are established by the client/employer, and benefit levels may vary significantly across plans and/or by class within plan. For example, some plans provide Regular Occupation (or specialty occupation) benefits for the life of the claim such that there is no A/O date and no A/O review is required. It is important to review the applicable policy language prior to any A/O review.

2.0 Beginning the A/O Investigation

Once the claim transitions to an A/O investigation, the Claim Manager (CM) sends the LTD Any Occ Notice letter to notify the customer of the upcoming review. The CM should also make a phone call to discuss the investigation, confirm the status of the customer's condition, and obtain contact information for any relevant treatment providers.

If additional medical information is needed, the CM should request relevant medical information that provides insight into the customer's current functional capacity. Where applicable, requests may include (but are not limited to):

- Copies of medical or other treatment records (hospital records, office notes, history/physical report, diagnostic studies/laboratory studies, treatment plan, medical referrals)
- Social Security related medical information

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- Motor Vehicle Accident records
- Workers Compensation records

For additional guidance on gathering information during this phase, refer to "Ongoing Claim Request for Information."

Following receipt of any updated medical information, the CM should outreach to the customer to ensure that the file includes all relevant information to consider in the A/O review.

If the customer advises that there is additional information that is available now or at a future date, the CM should discuss with the customer whether the information is likely to impact or clarify the customer's functional ability. For example, if surgery is scheduled prior to the A/O date, the determination should be paused until that information is available. If additional records are requested, it should be clear that the records would likely help to understand the customer's medical history and whether/how their condition might impact functionality.

The customer should be advised that if they agree that all relevant information is on file, the CM will proceed with a review of the claim.

If the customer is reached, thoroughly document the call in the system. Clear documentation should support the rationale for not requesting certain records or information (where applicable).

If the customer cannot be reached by phone, send a letter summarizing the relevant information in the file and asking the customer to contact us if there is additional information to obtain and consider before completing the claim evaluation. The letter should include a reasonable response deadline, such as two weeks.

A claim is ready for an A/O determination when the below criteria are met:

- The customer is medically stable, with no further change anticipated in the customer's established functionality before the A/O date.
- There are no known upcoming office visits prior to the A/O date, or such visits are unlikely to impact the customer's established functionality.

3.0 Medical and Vocational Reviews

Once it is confirmed that all relevant information is on file, utilize expert medical resources where necessary and appropriate to confirm functionality. For additional guidance on utilizing medical resources to document medical findings and/or functional capacity, refer to:

- "Gathering Medical Information & Documenting Conclusions"
- "Independent Medical Evaluation and Peer Review Referrals"

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- "Functional Capacity Evaluation Referrals"
- "Guidelines for Use of External Medical Resources"

Once functionality is established and any necessary clarification of restrictions and limitations is complete, the CM will confirm whether a referral to a Rehabilitation Specialist (RS) is appropriate. This may vary from claim to claim depending on functional ability and other facts and unique characteristics of the claim. The CM should attempt to obtain complete vocational information, including the customer's education, training and experience if the file does not already contain this information.

When determining alternate occupations during the A/O evaluation (if any), the RS may utilize resources such as Transferrable Skills Analysis (TSA) and/or Labor Market Survey (LMS) along with their expertise to determine whether alternate occupations are appropriate based on any restrictions and limitations. The RS should identify occupations based on the requirements of the policy. For unique state requirements, see section 8.0 (California) and 9.0 (Louisiana) below.

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4.0 Delayed A/O Determinations

Provide status updates to the customer throughout the A/O investigation. If it appears that a claim decision will not be made by the A/O date, send the Any Occ Review Pending letter. Use this letter to notify the customer that the evaluation may extend beyond the A/O date and benefits may be put on hold until a decision is made. Benefits will be placed on hold as of the A/O date, where applicable and appropriate, until the investigation is complete.

If a claim decision of "not disabled Any Occ" is made after the A/O date, send the Any Occ Adverse Determination letter. The termination date coded in the system should remain as the actual A/O date.

5.0 Completing the A/O Determination

If an Any Occ Approval is determined, send the Any Occ Approval Letter.

If an Any Occ Adverse Determination is being made, payment through the A/O date may be considered on Fully Insured LTD claims if all of the following criteria are met and clearly documented to the claim file:

- A/O evaluation is complete, and alternate occupations in line with contract requirements have been identified.
- The customer is medically stable, with no further change anticipated in their functionality or identified restrictions and limitations (R/L's) before the A/O date.

Once it has been determined that a payment can be made through the A/O date, contact the customer to explain that absent any objection, the remaining benefits due are scheduled to be

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paid in advance. If the payment represents a future calendar year, advise the customer that we make no assertions regarding tax implications.

At the time of the decision, CM should send the Any Occ Denial Letter. The letter template in the Correspondence tool provides guiding language to assist the Claim Manager in including all required components in the adverse letter.

If including overpayment details in the letter, the following sample language can be used:

- Your benefits will be applied to recover your outstanding overpayment in full.
- We will apply $ xxxx toward your outstanding overpayment, resulting in a remaining balance of $ xxxx; you will be responsible for coordinating a repayment plan with the Financial Accuracy Calculation Team.

6.0 Common Definitions of Disability

A typical policy states in relevant part:

"Definition of Disability/Disabled
…

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. *unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience;*

   [AND/OR]*

2. *unable to earn 60% or more of his or her Indexed Earnings."*

* The conjunction used between paragraph one and paragraph two is important.

Under the standard definition of Disability, "and" appears between paragraph one and paragraph two. As a result, a customer *must* satisfy **BOTH** the paragraph one requirements **AND** the paragraph two requirements to be considered *Disabled*.

Under the enhanced definition of Disability, "or" appears between paragraph one and paragraph two. As a result, a customer need only satisfy **EITHER** the paragraph one requirements **OR** the paragraph two requirements to be considered *Disabled*.

For customers covered under policies issued in California, see section 8.0.

For residents of Louisiana, see section 9.0.

7.0 Other Definitions of Disability

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Some policies may not refer to indexation or provide a specific earnings percentage at all in the Definition of Disability. See below for an example of this language:

An Employee is Disabled if, because of Injury or Sickness,

1. he or she is unable to perform the material duties of his or her own occupation; and
2. after Disability Benefits have been payable for 24 months, he or she is unable to perform the material duties of any occupation for which he or she may reasonably become qualified based on education, training or experience.

In these instances, claims should be adjudicated under the policy as written.

For customers covered under policies issued in California, see section 8.0.

For residents of Louisiana, see section 9.0.

8.0 Policies Issued in California

California Issued LTD Policies

The state of California has specific guidelines relating to the Definition of Disability for LTD claims governed by California issued policies. The procedures outlined in this section apply only to group LTD policies that were issued in California.

The issue state can be found on the face page of the policy, and is usually identified by the following language:

“This Policy describes the terms and conditions of coverage. It is issued in California and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.”

Definition of Disability

During the Any Occupation period, the following is the definition of Total Disability governing group LTD policies issued in California:

“A disability that renders one unable to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.”

Station in Life

As part of the A/O evaluation for an LTD claim governed by a California issued policy, consideration should be given to the customer’s station in life. In evaluating a level of earnings that is commensurate with the customer’s station in life, determine the appropriate level of earnings as defined in the policy.

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For policies issued in California, where the policy does not state a specific percentage as the wage replacement threshold in the Definition of Disability, the guideline to use is 80% of the customer's indexed covered earnings as an earnings threshold for the any occupation review.

Document the claim file with appropriate consideration of all of the factors considered, including station in life where applicable, during the A/O evaluation.

9.0 Louisiana Residents

The state of Louisiana has guidelines relating to the Definition of Disability for claims of residents of Louisiana. As a part of the evaluation of Disability for a customer who resides in Louisiana, the percentage of Indexed Earnings, if any, that qualifies the customer to meet the definition of Disability/Disabled may not be less than 80%.

Please note that wage requirement of 80% should be used for all Louisiana residents regardless of the specific policy language.

Back to Table of Contents

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Appeal Affirmation Letter Content for Policies Providing Disability Benefits

1.0 Purpose/Overview

2.0 Appeal Affirmation Letter

3.0 Content of ERISA Appeal Affirmation Letters

4.0 Content of Non-ERISA Appeal Affirmation Letters

1.0 Purpose/Overview

The purpose of these guidelines is to provide information on appeal affirmation letter content. For guidance on appeal claim review, refer to “Requirements for Handling Disability Appeals.”

2.0 Appeal Affirmation Letter

An appeal affirmation letter is written independently from the initial adverse determination. However, it should include the same level of detail as described in “Adverse Determination Letter Content for Policies Providing Disability Benefits.”

Use the Appeal Affirmation Letter template in the correspondence tool to ensure that the applicable requirements are met.

3.0 Content of ERISA Appeal Affirmation Letters

If an appeal under an ERISA plan is affirmed, the letter should include:

- The specific policy provisions upon which the decision is based
- An explanation of any medically related exclusion or limitation applicable to the decision
- The specific reasons for the decision. For claims received on or after April 1, 2018, this must include the rationale for disagreeing with or not following the views of any internal or external medical or vocational experts who reviewed the claim
- An explanation of the reasons why you disagree with the information or views presented by the customer, health care professionals treating the customer, and/or vocational professionals who evaluated the customer
- For claims received on or after April 1, 2018, a summary of the information submitted by the customer in the Review and Respond process and an explanation of the consideration of that information in our determination, or a statement confirming that no information was received

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- An explanation of the reasons why you disagree with, or do not find sufficient, a disability determination made by the Social Security Administration, as presented by the customer

- If the appeal decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the customer's medical circumstances, or a statement that such explanation will be provided free of charge upon request

- A statement that the customer will be provided with reasonable access to all documents, records, and other information relevant to the claim, upon request and free of charge

- For claims received on or after April 1, 2018, the specific internal rules, guidelines, protocols, standards or other similar criteria, if any, that were relied upon in making the claim decision

- A statement informing the customer that all administrative levels of appeal with us have been exhausted and no further appeals will be considered

- A statement that the customer has a right to bring a legal action for benefits under ERISA section 502(a)

- A statement indicating the customer or customer's plan may have other voluntary alternative dispute resolution options

- The standard non-Waiver paragraph advising that nothing in the letter should be construed as a waiver of any rights

- For claims received on or after April 1, 2018, a brief notice in the non-English language about the availability of translation services for customers located in a county where 10% or more of the county's population is literate only in a non-English language

- For claims received on or after April 1, 2018, the policy provisions applicable to filing lawsuits

- For claims received on or after April 1, 2018, any applicable contract limitations on legal actions

- For claims received on or after April 1, 2018, the final date to file a lawsuit calculated using the State Limits for Legal Action calculation tool. If the policy does not include the provisions that address the limitations on legal actions or timing for filing a lawsuit (which should be rare), the following statement should be included in the letter: *"Your Policy does not contain any language providing a specific time limit for bringing legal action to recover benefits due under the Policy. You should consult your own legal counsel regarding your rights, and when they might expire."*

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4.0 Content of Non-ERISA Appeal Affirmation Letters

If the first appeal under a Non-ERISA plan is affirmed, the letter should include:

- The specific policy provisions upon which the decision is based
- An explanation of any medically related exclusion or limitation applicable to the decision
- The specific reasons for the decision, including rationale for disagreeing with or not following the views of any internal or external medical or vocational experts who reviewed the claim
- An explanation of the reasons why you disagree with the information or views presented by the customer, health care professionals treating the customer, and/or vocational professionals who evaluated the customer
- For claims received on or after April 1, 2018, a summary of the information submitted by the customer per the Review and Respond process and an explanation of the consideration of that information in our determination, or a statement acknowledging that no information was received, as applicable
- An explanation of the reasons why you disagree with, or do not find sufficient, a disability determination made by the Social Security Administration, as presented by the customer
- A statement that the customer will be provided with reasonable access to all documents, records, and other information relevant to the claim, upon request and free of charge
- The specific internal rules, guidelines, protocols, standards or other similar criteria, if any, that were relied upon in making the claim decision
- A statement that the customer has the opportunity to submit written comments or documents for consideration
- A statement describing the second/additional voluntary level of appeal that is offered (the additional voluntary level of review will mirror the timeframes of the first appeal)
- The standard non-Waiver paragraph advising that nothing in the letter should be construed as a waiver of any rights
- A brief notice in the non-English language about the availability of translation services for customers located in a county where 10% or more of the county's population is literate only in a non-English language

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- For claims received on or after April 1, 2018, the policy provisions applicable to filing lawsuits
- For claims received on or after April 1, 2018, any applicable contract limitations on legal actions

If the second appeal under a Non-ERISA plan is affirmed, the letter should include the contents listed above. The letter should also include a statement informing the customer that for consideration of further appeals, the information submitted must be new information that was not previously considered as part of the review process.

Back to Table of Contents

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Appropriate Care

1.0 Purpose/Overview

2.0 Appropriate Care Defined

3.0 Claim Management

4.0 Appropriate Care and the Claim Decision

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of Appropriate Care, which is a defined term in disability policies.

2.0 Appropriate Care Defined

If Appropriate Care is included in the policy, it will be defined and may be found in the Definitions section of the policy. It may also be referenced in other policy provisions, such as Termination of Benefits, and Disability Benefits.

Appropriate Care:

> "Appropriate Care means the Employee:
>
> 1. Has received treatment, care and advice from a Physician who is qualified and experienced in the diagnosis and treatment of the conditions causing Disability. If the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the Physician is a practitioner in that specialty.
>
> 2. Continues to receive such treatment, care or advice as often as is required for treatment of the conditions causing Disability.
>
> 3. Adheres to any treatment plan prescribed by the Physician, including the taking of medications."

Disability Benefits:

"The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. …"

Termination of Benefits Provision:

> "Benefits will end on the earliest of the following dates:…
>
> 6. the date the Employee is no longer receiving Appropriate Care."

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Policy language may vary; consult policy provisions for each claim.

Appropriate Care is in disability policies to ensure the customer seeks treatment to improve their medical condition. It helps to ensure the customer receives medical care that is provided by a qualified physician with the appropriate expertise and is designed to treat their medical condition(s).

3.0 Claim Management

Treatment is needed to establish initial and ongoing disability. During the evaluation of a claim, review the treatment plan to determine if the customer is participating in treatment that is in line with generally accepted medical standards for the disabling condition, as well as for any secondary diagnoses.

When determining if a customer is receiving Appropriate Care, consider the following:

- Is the treatment reasonable and in line with generally accepted medical standards for the disabling condition?
- Would additional treatment impact the recovery process?
- Are there documented risk factors and side effects of treatment plan?
- Is the treating provider recommending invasive or non-invasive treatment?
- Has the customer mentioned difficulty accessing healthcare due to location, limited transportation, financial/insurance, etc. difficulties?

If it is determined that a customer does not satisfy Appropriate Care, the customer may be required to engage in Appropriate Care in order to be or remain entitled to disability benefits.

If there are indications that a customer is not receiving Appropriate Care, review the claim with appropriate resource such as Senior Claim Manager (SCM), Technical Coach (TC), Team Leader (TL), Nurse Case Manager (NCM), or Medical Director (MD).

Work with the customer, the treating provider and others, as appropriate, to establish what constitutes Appropriate Care for that individual. Also consider the customer's ability to obtain and maintain the agreed upon Appropriate Care.

If it is determined that the customer may not be receiving Appropriate Care as defined in the policy, the language of the policy should be provided to the customer in writing. This letter will inform the customer of the language, and will provide the customer with an opportunity to seek Appropriate Care within a reasonable period of time. The specifics of each customer's scenario should be considered when determining a reasonable time period.

The Claim Manager (CM) is responsible for explaining Appropriate Care to the customer. However, managing Appropriate Care is a collaborative effort among the CM, the NCM or Behavioral Health Specialist (BHS), and other appropriate resources. The CM and NCM/BHS work closely together to communicate the same message to the customer and treating providers.

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4.0 Appropriate Care and the Claim Decision

If the Appropriate Care definition impacts the claim, the claim should be documented with the established plan and course of action to help the customer comply with obtaining Appropriate Care.

The evaluation of Appropriate Care, and the steps taken to assist the customer in complying with this provision, are not always factors to be used in determining whether the customer is Disabled. This is to be determined by the CM on a claim-by-claim basis, depending on the facts specific to the claim.

If an adverse determination results from a customer refusing to engage in Appropriate Care, the file should be thoroughly documented, and an adverse determination letter sent. See “Adverse Claim Determination Guidelines for Policies Providing Disability Benefits” and “Adverse Determination Letter Content for Policies Providing Disability Benefits.”

Back to Table of Contents

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Claim Manager Appeal Workflow

1.0 Purpose/Overview

2.0 Identification of an Appeal

3.0 Distinguish an Appeal from a Request for Explanation (10 Day Response Letter)

4.0 Appeal Request Received Greater than 180 Days

5.0 Core Team Actions Upon Overturn

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the appeal workflow for a Claim Manager, including identification of an appeal upon receipt.

“Requirements for Handling Disability Appeals” contains additional information for Appeal Specialists on administering appeals.

2.0 Identification of an Appeal

Adverse claim determination letters provide customers with specific instructions to request an appeal of a claim decision they disagree with. These instructions advise customers who want an appeal review to "submit a written request within 180 days" of the receipt of the adverse determination letter.

Only written requests for a review of a claim decision or action (from either a customer or a customer representative) are considered as an appeal. If a verbal request for an appeal is received, the Claim Manager (CM) should refer the customer to the instructions outlined in the adverse determination letter.

In the absence of a written request for an appeal review, the receipt of new information on a closed claim does not constitute an appeal. Refer to the release “Receipt of Information on Closed Claims,” for guidance.

A customer may have more than one claim (e.g. Long Term Disability, Short Term Disability, Waiver Of Premium) for which there is an adverse determination. Do not assume that an appeal is for all denied claims or for just one denied claim. Call the customer to clarify the claim or claims being appealed and document the claim file accordingly.

3.0 Distinguish an Appeal from a Request for Explanation (10 Day Response Letter)

For disability claims received on or after April 1, 2018, Department of Labor (DOL) regulations permit a customer, or a customer’s representative, to request that we provide a written

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explanation when the customer believes we have failed to strictly comply with DOL regulations. The Company has 10 calendar days to respond to that request. While the customer can assert our failure to comply with DOL regulations at any time, it may occur following an adverse determination and that request is not an appeal.

Below are guidelines to help distinguish between a standard appeal request, and a request for a 10 day response letter. Requests for a 10 day response letter may include one or more of the following:

- Reference to a failure to "strictly adhere" or "strictly comply"
- Quoting of the specific DOL regulation
- Reference to violation of a regulation
- Requesting a response in 10 days

If you receive such a request, complete the Allegation Referral Form and forward it immediately to the point person identified for handling. If you are unsure whether the customer is requesting an appeal or a 10 day response letter, contact the customer to clarify intent. Where needed, discuss the request with your Senior Claim Manager (SCM), Technical Coach (TC), Team Leader (TL), or Policies & Procedures Team.

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4.0 Appeal Requests Received Greater than 180 Days

Customers covered under an ERISA plan have up to 180 days (calendar days) to file an appeal following the date of receipt of the Adverse Determination letter. We allow the customer up to 185 days from the date of the determination letter to account for mail delivery.

For appeal requests received more than 185 days from the date of the adverse determination or uphold letter the Core Team should complete the following actions within 10 calendar days of receipt of the request for appeal.

- Review the appeal request
- Send the Late Appeal Submission Letter to the customer
- Establish a Task in the system due 30 days from the date of the letter (90 days for LTD policies issued in California) to follow up with the customer for the written explanation for the late appeal submission.
- Refer the claim to the appropriate Senior Appeal Specialist (SAS) via the Appeal Department Queue

If there is a paper claim file, ensure that it contains a complete copy of the policy, including amendments.

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If the Core Team CM receives written explanation for the late appeal submission, it should be forwarded to the appropriate SAS.

Refer to “Requirements for Handling Disability Appeals” for additional information.

5.0 Core Team Actions Upon Overturn

Upon receipt of an appeal, the Appeal Specialist completes the appeal evaluation to determine whether the initial adverse decision should be upheld or overturned. If the decision is made to overturn the denial, the Core Team should complete the following actions within ten (10) calendar days of the date of the Appeal Team’s overturn notification letter:

- Send written notification of the determination, including an explanation of benefits payable, to the customer, client, and/or third party
- Change status in system to reflect the status of the claim
- Release benefits due, factoring in any interest, if applicable
- Update the plan for ongoing claim management (unless the overturn determination results in a one-time payment)

At times, an Own Occupation overturn may occur during the timeframe when the Any Occupation definition applies. When this happens, release benefits due through the Own Occupation period, factoring in any interest, if applicable. Then refer to “Any Occupation Investigation Guidelines” to complete the Any Occupation investigation.

Back to Table of Contents

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Claimant Cooperation in Policies Providing Long Term Disability Benefits

1.0 Purpose/Overview

2.0 Claimant Cooperation Defined

3.0 Definition of Disability Defined

4.0 Customer's Responsibility to Cooperate in the Claim Investigation

5.0 Considerations in Assessing Customer's Cooperation in the Claim Investigation

6.0 Impact to the Claim Investigation

7.0 Claimant Cooperation Adverse Determination Letter

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the Claimant Cooperation provision and the impact of the provision on the administration of the Long-Term Disability claims.

2.0 Claimant Cooperation Defined

Most standard policies define Claimant Cooperation as:

> "**Claimant Cooperation**
>
> Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due. "

Policy language can vary so it is important to consult policy provisions for each claim.

3.0 Definition of Disability Defined

During the investigation (initial or ongoing) of a claim, our policies require that the customer meet the Definition of Disability/Disabled. See the sample policy provision below:

> **"Definition of Disability/Disabled**
>
> The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:
> 1. unable to perform the material duties of his or her Regular Occupation; and

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2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training, or experience; and

2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability."

4.0 Customer's Responsibility to Cooperate in the Claim Investigation

Our ability to establish a customer's functional capacity and ongoing disability are key to upholding the terms of the policy language referenced above. However, there may be times when we are unable to gather necessary information ourselves and require assistance from the customer. This provision would apply when the customer possesses information without which we cannot properly adjudicate the claim or refuses to submit to examination.

It is the responsibility of the Claim Manager (CM) to make reasonable efforts to seek information on behalf of the customer. However, if the customer needs to provide information or needs to participate in the administration of the claim, clear communication from us is essential. During the investigation, CMs should explain to the customer, both verbally and in writing:

- What medical and/or financial information is needed.
- Why this information is necessary to the claim investigation.
- Why an in-person examination may be necessary and the customer's obligation to submit to that exam under the terms of our policy.
- Specific language of the cooperation provision and why/how it applies.

Communication with the customer and setting clear expectations regarding their role in supplying information, authorization or participation during initial and ongoing claim investigations is important to the fair management of the claim.

We should provide the customer with a detailed explanation of what information is needed from them and why this information is needed at this specific time in the claim investigation.

Timely follow up with the customer is very important. These communications should provide the customer ample time for information to be provided. It is important that we are being proactive and consistent when communicating what outstanding information is needed for the ongoing evaluation of the claim. For Initial Investigations, refer to "ERISA Guidelines for Policies Providing Disability Benefits" and "State Compliance Guidelines for Policies Providing Disability Benefit".

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If partial information is received during the evaluation, the CM should review the information received to determine if it provides what is needed to evaluate customer's functional capacity and meets the terms of the policy.

5.0 Considerations in Assessing Customer's Cooperation in the Claim Investigation

The Claimant Cooperation provision does not necessarily impact a CM's investigation if the claim can be evaluated with the information we already have. However, if information is needed, consider the following when assessing whether customer's cooperation is needed to proceed with the claim investigation:

- Is the customer refusing to provide authorization or return specific forms?
  - The failure to provide authorization or requested forms may not constitute lack of cooperation, especially where their policy has an examination provision.
- Is the customer refusing to submit to an examination or repeatedly cancelling and re-scheduling?
  - Failure to show or repeated cancellations may constitute lack of cooperation.
- Is the customer not responding to mail or phone outreach?
  - Determine whether there may be a legitimate reason for delayed or unreturned phone calls. There may be extenuating circumstances that would prevent them from responding like in-patient treatment, severe medical event or natural disaster impacting phone and mail service.

6.0 Impact to the Claim Investigation

If a customer is not cooperating, there may be additional paths or other options for resolving the outstanding issues on the claim. It is important to establish that there is no alternate path to obtaining or developing information necessary to the proper administration of the claim. In other words, the customer's lack of cooperation is preventing our ability to determine whether benefits are payable.

Before proceeding with a claim determination relying on the Claimant Cooperation provision, the CM has to find the customer's lack of cooperation is impacting the CM's ability to sufficiently investigate or evaluate the claim. Questions to consider include:

- Are you able to determine the customer's current function?
- Are you able to determine if the customer meets the Definition of Disability?
- Are you able to determine if customer meets other provisions of the policy (e.g., Pre-Existing Condition Limitation, Eligibility for Insurance, etc.)?

If the answer to any of the questions is "yes," then the customer's lack of cooperation is not impacting your claim investigation and you should proceed with the rest of your evaluation as normal.

- For example, if the customer has not returned an updated Disclosure Authorization but the CM received current medical information from the treating provider that confirms the customer is in a coma, then we are able to determine the customer still meets the Definition of Disability despite the lack of cooperation.

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If the answer to any of the questions is “no,” lack of cooperation exists on the claim. This could lead to an adverse claim determination if unable to answer these questions.

- For example, the CM has exhausted efforts to get a Disclosure Authorization and we are unable to gather any updated information to confirm the customers current function and the customer is not willing to attend an IME.

Consult with your Senior Case Manager, Technical Coach (TC),Team Leader and/or clinical resources (Nurse Case Manager, Behavioral Health Specialist, Medical Director) if you have any questions in assessing factors to consider, actions we can take, and the appropriate application of the Claimant Cooperation provision in the claim investigation.

7.0 Claimant Cooperation Adverse Determination Letter

If the requested information is not received by the deadline given in the “LTD Claimant Cooperation Final Request” letter and the information in the claim file does not support continued Disability, CM should proceed with the adverse claim determination.

CMs should use the “LTD Claimant Cooperation Adverse Determination” letter in the Correspondence tool to communicate the decision. The letter should provide the customer with an explanation of “How Was the Claim Decision Reached” in the adverse determination letter. This is an essential element to answer in the letter. If you are unable to answer this question, you should consult with your TL or TC and not proceed with the decision.

Back to Table of Contents

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Eligibility Review for Waiver of Premium Claims

1.0 Purpose/Overview

2.0 Eligibility Investigation

3.0 Policy Provisions

4.0 Proof of Enrollment

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of eligibility for the Waiver of Premium benefit under a life insurance policy.

2.0 Eligibility Investigation

Eligibility is determined by reviewing the information provided by the employer in conjunction with the customer's enrollment application, claim file documentation and policy. Upon receipt of the Waiver of Premium claim, review this information to confirm:

- Last day of work
- Date of hire
- Claim Form/Eligibility Feed (if applicable)
- Enrollment
- Policy (effective date, class, waiting periods, age at incur date)

Most policies contain a filing requirement that outlines the proof of loss standard. Generally, the required time period for submission is one year and 90 days from the date of loss or last day worked. Refer to "Late Submittals" for additional information.

If the policy was cancelled prior to the date of disability or the date of disability was prior to the effective date of the policy, the customer is not eligible for the benefit. The claim documentation should be returned to the employer with an explanation and recommendation to file a claim with the other insurance carrier, if applicable.

3.0 Policy Provisions

Review the claim file and policy documentation to determine whether the employee is in a covered class of employees as defined by the life insurance policy. Class descriptions vary from policy to policy, so you must review the policy at hand.

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Most policies require the employee to satisfy an Eligibility Waiting Period before coverage becomes effective. A policy may define the waiting period based on date of hire (i.e., before or after the Policy Effective Date). A policy may also define when coverage will become effective based on an employee's Active Service as defined by the policy. Refer to "Active Service for Waiver of Premium" for additional information.

Most policies have a "limiting age" after which a Waiver of Premium cannot begin. An employee who has reached the limiting age on the last day worked cannot qualify for the Waiver of Premium benefit. The standard limiting age in most policies is 60, but the limiting age may vary from policy to policy, so you must review the policy at hand.

The employee must satisfy the policy's Benefit Waiting Period, typically a consecutive period of 6, 9 or 12, months during which the employee must be continuously disabled before becoming entitled to the Waiver of Premium benefit.

4.0 Proof of Enrollment

Most policies require the employee to enroll for contributory/voluntary life coverage within 31 days of first becoming eligible. If the employee does not enroll within that time, coverage will not be effective until satisfactory proof of good health is received, and coverage is approved by Medical Underwriting.

Enrollment forms should be requested and compared with the policy effective date and the date of hire. If the enrollment form is signed more than 31 days after the original effective date or date specified in the policy, additional information should be requested to clarify under what circumstances coverage was issued. If the employee did not satisfy the late enrollment requirements, the claim may be denied.

If the employee did satisfy the late enrollment requirements and coverage was approved by Medical Underwriting, the claim should be reviewed to determine if the date of loss occurred during the two-year contestable period.

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Elimination Period and Benefit Start Date

1.0 Purpose/Overview

2.0 Policy Language

3.0 Evaluating the Elimination Period and Benefit Start Date

4.0 Leap Year Factor

5.0 Trial Work Days and the Elimination Period

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview on how to determine the Elimination Period (EP) and the Benefit Start Date (BSD) for Short Term Disability (STD), Long Term Disability (LTD), and Waiver of Premium (WOP) claims.

2.0 Policy Language

The EP is defined as the period of time a person must be continuously Disabled before being eligible to receive disability payments. Older policies refer to this waiting period as the Benefit Waiting Period (BWP). Throughout this release, regardless of whether the policy refers to BWP or EP, we will refer to EP for both.

Below is sample policy language defining the Elimination Period and Disability/Disabled. Policy language may vary so review the policy for the specific wording regarding these provisions.

"Elimination Period 6 months

The Elimination Period is the period of time an Employee must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes."

“Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and

2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

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1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and

2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability."

3.0 Evaluating the Elimination Period and Benefit Start Date

Utilize the definition of the EP when calculating the BSD. Although the sample language above defines the EP in months, it may be defined in days, weeks or months.

- If the policy states 180 days of continuous disability, the BSD would be day 181.
- If the policy states 2 weeks of continuous disability, the BSD would begin the first day after 2 weeks have passed.
- If the policy states 6 months of continuous disability, the BSD would be the first day after 6 months have passed.

The BSD is the first day following the end of the EP. Below are some examples of the BSD based off the same incurred date, but various EPs:

Incurred Date	Elimination Period	Benefit Start Date
1/8	90 days	4/8
1/8	13 weeks	4/9
1/8	6 months	7/8

The Disability Calculator will assist in determining the BSD.

4.0 Leap Year Factor

Every four years the calendar adds one day (February 29). This addition affects those BSDs with EPs defined in days and weeks. EPs defined in months are rarely affected, because we count a month from the first calendar day of that month to, and including, the last calendar day of that month, regardless of whether it is 31 days, 30 days, 28 days or 29 days. In cases of rolling months, the leap year will change the BSD when the incurred date and the EP combine to end the EP on 2/28. In a leap year, the BSD would be 2/29. In a non-leap year, the BSD would be 3/1.

The year 2020 is a leap year, and the adjustment must be made for EPs stated in days or weeks, because February 2020 includes 29 days.

Some examples to compare to non-leap years are:

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Incurred Date	Elimination Period	Benefit Start Date
1/8/20	90 days	4/7/20
1/8/20	13 weeks	4/8/20
1/8/20	6 months	7/8/20

5.0 Trial Work Days During the Elimination Period

Some older policies may define the EP (or BWP) specifying the number of days the customer may return to work and how it will impact the EP. Example:

"A period of Disability is continuous even if the Employee can return to Active Service for up to 30 days during the Benefit Waiting Period. The Benefit Waiting Period will be extended by the number of days the Employee can return to Active Service."

In those situations, apply the language as it is written. However, more current policy language, as stated in 2.0, does not provide any limitation on the number of days a customer may return to work during the EP. Therefore, if the customer returns to work during the EP, the customer's earnings will be examined in the same increments benefits are paid (i.e. monthly for most LTD policies) and the steps outlined below should be applied.

Whether the customer returns to work to their Regular Occupation or another occupation may impact the EP based on the definition of Disability/Disabled. If the definition of Disability defines the earnings test when working in their Regular Occupation, and the customer returns to work during the EP to a modified occupation or a different occupation, then their earnings while they are working will not have an effect on the EP.

Request pay stubs or other proof of earnings for the time worked during the EP. Evaluate the average earnings over the entire EP to determine whether or not the definition of disability has been met, based on the definition of Disability earnings test. Determine if the earnings exceed the required percentage, and if so, at what date they do so.

In some cases, the customer may exceed the earnings test percentage at a certain point during the EP and a new incurred date will need to be established. With this sample language, our focus is on the total amount earned during the entire EP.

Determining a New Incurred Date

1. Determine the incurred date.

2. Calculate the BSD based on the EP given in the policy.

3. Determine the indexed earnings allowed for the entire EP.

4. Determine the total amount that the customer could earn during the EP without beginning a new EP (this is typically 80% of their Indexed Earnings, but check the Definition of Disability/Disabled in the policy). For example, if the customer's Indexed

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Earnings were $3,000/month, their EP was 6 months, and the percentage in the definition of Disability was 80%, the customer could earn no more than a total of $14,400 during the entire EP ($3,000 x 6 months x 80% = $14,400).

5. Obtain the customer's pay stubs and add up the earnings received during each month on a rolling month basis (beginning with the BSD) over the entire EP. Earnings calculated for each month should consist of pay stubs on which the check issue date is within the rolling month (not the pay period of the check).

6. Compare the total amount paid to the customer during the EP (in #4, above) with the total percentage the customer was contractually permitted to earn (in #3, above). If the customer did not earn more than the percentage permitted, incur the claim on the original BSD (in #2, above).

7. If the customer's earnings exceeded the amount contractually allowed, count backwards through the EP to determine the first pay date that the customer exceeded the percentage permitted in the definition of Disability.

8. Incur the claim on the day after that first pay date in which the customer exceeds the percentage allowed.

The effect a return to work will have on the EP will vary depending on the type of work the customer is performing (their own occupation, or a modified/other occupation), and the amount of money they are earning.

Back to Table of Contents

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ERISA Guidelines for Policies Providing Disability Benefits

1.0 Purpose/Overview

2.0 Plans Subject to ERISA

3.0 Plans Not Subject to ERISA

4.0 ERISA Regulations

5.0 ERISA Impacts On Claim Handling

6.0 Time Permitted to Make an Initial Decision

7.0 Responsibility for Employer Violations

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1.0 Purpose/Overview

The purpose of these guidelines is to provide a general overview of the Employee Retirement Income Security Act of 1974 (ERISA), how to determine whether a plan is subject to ERISA regulations, and how those regulations impact claim handling for policies providing disability benefits (i.e. Short Term Disability (STD), Long Term Disability (LTD), Waiver of Premium).

2.0 Plans Subject to ERISA

ERISA governs any insurance plan established or maintained by an employer that covers one or more employees. The plan can cover non-employees (such as family members) as long as one or more employees are covered.

Regulations governing ERISA claims impose requirements on the content and timing of certain communications and other aspects of claim handling.

Nearly all of our policies providing disability benefits are subject to ERISA.

3.0 Plans Not Subject to ERISA

Although there are some policies that are not subject to ERISA, the same level of evaluation and review should be given to all claims, regardless of the applicability of ERISA. Nevertheless, you should seek to establish the ERISA/non-ERISA status at the outset of each claim. Whether or not ERISA applies may cause certain laws (e.g. federal vs. state; and court made rules) to apply to a claim affecting its processing and/or outcome. Furthermore, our letters may indicate inclusion or exclusion of certain notices that flow from a claim's ERISA/non-ERISA status.

Non-ERISA policies may include (but are not limited to) certain:

- Governmental Plans that include employees of federal, state and municipal governments, including county and government agencies (e.g. public schools/school districts, public colleges and universities and Native American tribal governments).

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However, Native American casinos typically are ERISA plans.

- Church Plans that include employees of a church, convention, or an association of churches or other religious entities (e.g. temple, synagogue, or mosque, and entities associated with churches, such as schools or hospitals). Churches may opt-in to ERISA coverage, and some entities, such as church affiliated hospitals may also be subject to ERISA.

- Association Plans that include groups that are not based on an employee/employer relationship (e.g. members of a professional association, amateur sports associations, camps and some school programs)

- Consumer Marketing Plans related to direct mail solicitation or credit card holders (e.g. Travel Clubs, etc.)

Because the applicability of ERISA is determined by the law, we will typically follow our client's determination. ERISA applicability should be verified if it is not readily apparent. Do not assume a policy is subject to ERISA if you are unsure. For LINA (Life Insurance Company of North America) and NYLGICNY (New York Life Group Insurance Company of NY) business, you may look to the coverage file for the "ERISA Coverage Worksheet" where the Plan Sponsor indicates the ERISA status of their plan. We may reasonably rely upon the representations in that form. For older Connecticut General (CG) business, the coverage or data card may provide information regarding an account's ERISA status as communicated by the client.

If ERISA status is not clearly evident, you may contact the Account Manager to confirm ERISA status. An additional resource is the website http://www.freeerisa.com. It provides certain information and from filings which indicate whether that the Plan Administrator or Plan Sponsor believe the plan at issue is subject to ERISA. If you have any questions or doubts, refer the matter to your Senior Claim Manager, Technical Coach or Team Leader for clarification.

4.0 ERISA Regulations

ERISA imposes certain requirements on policy documents, annual reports, plan descriptions, and claim procedures. The Department of Labor revised the regulations in January 2017 relating to disability claims filed beginning April 1, 2018. These regulations are intended to ensure timely benefit determinations, improve customers' access to information on which a benefit determination is made, and ensure customers will be afforded a full and fair review of adversely determined claims.

Regulations governing ERISA claims impose requirements on the content and timing of communications, and other aspects of claim handling. ERISA requires that we strictly comply with the DOL regulations governing disability claim procedures. Failure to follow ERISA procedures on claims where ERISA regulations apply may result in a customer being considered to have exhausted his/her administrative remedies. This means that customers may be entitled to bring immediate legal action before we have completed the claim determination process. This may result in our losing the opportunity to complete the internal claim review and

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determination process. Instead, we may be required to defend an initial adverse determination based only on the information already in the file. Other penalties may apply.

5.0 ERISA Impacts On Claim Handling

In general ERISA requires that we maintain six types of claim-related procedures for compliance:

- Strict Adherence – DOL regulations impose requirements on how long we have to make an initial claim determination and to decide an appeal. The regulations permit some extension of these time limits, but only in certain circumstances.

- Initial Claim Processing – Reasonable rules must be established and maintained regarding the process for initial claim handling and decisions.

- Appeal Processing (Claims received on or after April 1, 2018) – Before an adverse determination is made on appeal, we must disclose new information considered on appeal, and any new rationale for our decision, so that the customer has a fair opportunity to respond.

- Request for Explanation (10 Day Response Letter) (Claims received on or after April 1, 2018) - DOL regulations permit a customer to request that we provide a written explanation when the customer believes we have failed to strictly comply with the regulations, and allows 10 calendar days to respond to that request. If you receive such a request, you should complete the referral checklist and forward it immediately to the designated point person.

- Additional Communication Requirements - Customers must be updated on the status of claim investigations at certain points in the life of a claim.

- Disclosure of Policies & Procedures (Claims received on or after April 1, 2018) – When an adverse decision is made (initially or on appeal), customers must be provided with access to the internal policies and procedures relied upon.

These procedures and time limits are described in more detail in procedures “State Compliance Guidelines for Policies Providing Disability Benefits”, “Adverse Claim Determination Guidelines for Policies Providing Disability Benefits”, “Receipt of Claim or Appeal” and “Requirements for Handling Disability Appeals.”

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6.0 Time Permitted to Make an Initial Decision

Disability claim coverage determinations must be made within a reasonable period of time, but not later than 45 days from the receipt of the claim. "Receipt of claim" means a statement of loss made by either the submission of a claim form or reporting the claim by phone, even if the

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statement does not include all of the information necessary to decide the claim. See “Receipt of Claim or Appeal” for further information on determining the Date of Receipt.

If, because of reasons beyond our control, more time is needed to make the claim determination, we can extend the timeframe up to 30 days provided the customer is advised in writing prior to the end of the 45-day period that additional time is needed. Internal delays caused by our staff or process do not meet the standard of being beyond our control.

Our written advisory must explain the:

- Circumstances requiring an extension
- Date a decision can be expected
- Standards on which the benefit determination is based (i.e. policy language)
- Unresolved issues that prevent a benefit determination
- Specific information, if any, which is needed to complete the benefit determination process and the sources that maintain the necessary information

We may extend the time period for up to another 30 days if we are still unable to make a benefit determination due to circumstances beyond our control as long as we notify the customer before the first 30 day extension expires. All written advisory requirements listed above must be included in the communication to the customer.

If during either extension period, we decide to request additional information from the customer, the customer must be provided at least 45 days to supply it. Under California issued LTD policies, the customer must be provided at least 90 days to supply the information. See “Proof of Loss for California Issued LTD Policies” for additional information.

If the reason for taking the extension is due to a customer's failure to provide necessary information that has been requested from the customer, the ERISA regulations provide that the time period for making an initial decision may be tolled (stopped). Specifically, the days from the date on which the request for necessary information was sent to the customer until the date the customer responds to the request, do not count toward the maximum 105 days allowed and is considered a "tolling period". The tolling period ends on the date in which the customer's response to the request is received, without regard to whether the customer's response supplies all of the information necessary to make a claim determination.

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7.0 Responsibility for Employer Violations

In some circumstances we may be held responsible for actions taken by the employer/policyholder that do not afford plan participants the full benefit of their insurance program. Examples could include refusing to allow a covered employee to submit a claim or

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understating the employee's available benefits. In situations where we believe this may be occurring, please consult your Legal Referral Specialist.

Back to Table of Contents

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Evaluating Disability as of Last Day Worked

1.0 Purpose/Overview

2.0 Policy Provisions

3.0 Factors to Consider

4.0 Gathering Information

1.0 Purpose/Overview

The purpose of these guidelines is to provide factors to consider when evaluating Disability when the customer did not have treatment on or around the last day worked.

2.0 Policy Provisions

Our standard disability polices contain provisions which require the customer to be under the Appropriate Care and treatment of a medical provider during a time of Disability. Continuous certification of Disability from the last date worked/last date of Active Service through the Benefit Waiting Period/Elimination Period is required under our standard policies.

During the initial evaluation of a claim, it may be necessary for the Claim Manager (CM) to gather medical information which documents the customer's inability to perform the material duties of the applicable job or occupation due to a disabling condition as of the customer's last date worked.

It is important to confirm that the customer remained in Active Service, as defined by the policy, prior to becoming Disabled. Where the customer receives first treatment for the disabling condition after the last date worked, additional evaluation may be needed to determine if this is the case.

3.0 Factors to Consider

Generally, the date of Disability (i.e. incur date) is the date following the last date worked/last date of Active Service. When claims resulting from a specific disabling event are presented, the date of first treatment generally is close in time with the disabling event and certification of Disability as of the last day worked can be readily apparent.

However, there may be instances when certification of Disability may not be so easily determined. For example, when a customer:

- Stops working but does not seek treatment until after their last day worked
- Has an ongoing medical condition and may or may not have sought medical treatment immediately before, on or after their last day of work

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- Contacted the treating provider but, was unable to obtain an immediate appointment

In these situations, and in the absence of actual treatment on/around the last date worked, the CM needs to determine what restrictions and limitations reasonably existed as of the last day worked, to determine if the claimed date of Disability is reasonably supported. Consider the customer's total situation and medical information, including restrictions and limitations, leading up to and following the last date worked.

When determining the date of Disability, consider:

- The last date worked and the number of hours worked
- Applicable earnings loss
- Whether the customer is currently under the care of a provider
- The first and/or most concurrent date of medical treatment
- The course of medical treatment leading up to and following the last date worked
- Restrictions and limitations that support Disability
- Reasons given by the customer and/or the client for stopping work on a particular date
- Consideration of the claim as a whole with input from appropriate medical resources

4.0 Gather Information

If the existence of restrictions and limitations, or the reason why the customer left work on a particular date is not clear, the CM should utilize the following guidance when gathering additional information.

Discuss with the customer the reasons they stopped work on that particular day.

- Was there an exacerbation of a long standing medical condition?
- Did the medical condition deteriorate?
- Did the medical condition remain static, yet the customer was unable to continue working due to the condition?
- Was there a change at work that impacted the customer's ability to continue working (a change in duties or the workplace itself)?

Discuss with the customer and/or the Employer any non-disability related workplace or other factors occurring prior to the last date worked. For example:

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- Was the customer's position subject to job elimination or company downsizing?
- Had the customer expressed they didn't want to do the job any longer?
- Was there a documented performance issue unrelated to the medical condition?

Gather available medical information beginning before the last date worked through the current date.

- Consult with an internal medical resource or the treating provider to determine the period of time to obtain information which would be helpful in understanding the customer's condition.
- Consult a medical resource as appropriate for guidance on whether medical information supports a conclusion that the customer reasonably had the claimed restrictions and limitations and was unable to perform their occupation on the stated date of disability.

After the CM has gathered all appropriate information and obtained the review with a medical resource as necessary, consult with the Senior Claim Manager, Technical Coach or Team Leader prior to making an adverse decision. Consultation is not necessary if the claim is approved.

Back to Table of Contents

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Evaluating Job or Occupation Requirements

1.0 Purpose/Overview

2.0 Occupation and Job

3.0 Claim Management

1.0 Purpose/Overview

The purpose of this procedure is to provide guidance on interpreting the term "occupation", and to provide guidance on how to differentiate between "job" and "occupation" for LTD claims with policies in which the definition of Disability is evaluated based on "occupation".

There may be exceptions to these procedures in the state of California. For policies issued in California, see “Evaluating Own Occupation in California Issued Long Term Disability Policies”.

2.0 Occupation and Job

If the term “occupation” or “regular occupation” is used within the Definition of Disability, evaluate the claim based on analysis of the type of work generally performed for employers in the national economy, and not the work performed for the specific Employer. This is true for policies that define Regular Occupation and those that do not, unless the policy specifically states otherwise.

If the term "job" or any variation of "job" (such as "regular job") is used within the Definition of Disability, evaluate the claim based on analysis of the work performed for the specific Employer.

Some occupational classifications have subspecialties. For example, neurosurgeon is a surgeon subspecialty. If the material duties noted on the Job Description (JD) are consistent with the material duties of the occupation neurosurgeon, then the Rehabilitation Specialist (RS) may consider neurosurgeon as the occupation rather than surgeon.

3.0 Claim Management

Each claim is unique and should be evaluated on a case by case basis while considering the claim file as a whole. While claim approval should not require an Occupation Identification (Occ ID or OI) in situations where the customer has no functional ability (e.g., coma), an Occ ID should be obtained for ongoing claim management.

An Occ ID may not be needed if the customer is ineligible for benefits due to a non-medical reason (e.g., due to an exclusion, limitation or eligibility provision) and an adverse determination will be issued.

Consider the following when obtaining an Occ ID:

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- Consult the policy. The Definition of Disability may vary from policy to policy. The Definition of Disability may refer to "occupation", "regular occupation", "job" or "regular job".
- Request a copy of the JD and/or a Job Requirements Form if one has not already been provided. If the Employer cannot provide a JD, send a Job Requirements Form to the Employer for completion. For claims submitted on paper, the section outlining the percentage of duties may not be sufficient. In this situation, obtain a full JD or Job Requirements Form as well.
- Once the JD and/or Job Requirements Form has been received, refer the claim to the RS for an Occ ID when the Definition of Disability is defined as "Occupation" or "Regular Occupation".
- The RS will utilize a standard occupational classification system to identify the Occ ID which is the occupational title and code that has material duties that best match the material duties of the job.
- Once the best occupational match is identified, the RS evaluates data to establish the demands of the occupation as it is performed in the general labor market in the national economy. The RS may use multiple vocational resources for this analysis.
- The RS returns the claim to the Claim Manager (CM) for claim management. If it is unclear whether the restrictions and limitations (R&L) are in line with the demands of the occupation, obtain clarification from the RS and document the file.

The RS's maintain Occ ID listings by account in a shared drive in each office. Use of these Occ ID listings without a formal referral to an RS during a claim investigation should be documented in the file. If further clarification of an occupation accessed from the Occ ID listing is needed, contact the RS to discuss.

If it is determined that the customer is not disabled from his/her Occupation after obtaining information in the Occ ID library, a RS should review the file to ensure that the correct Occ ID was used prior to an adverse determination. Document the RS review in the file.

Back to Table of Contents

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Evaluating Own Occupation in California Issued Long Term Disability Policies

1.0 Purpose/Overview

2.0 California Issued Policies

3.0 Own Occupation

4.0 Gathering Information

5.0 Evaluating Information

1.0 Purpose/Overview

The purpose of this procedure is to provide guidance in applying the Definition of Disability, during the Own Occupation period, to Long Term Disability (LTD) claims governed by policies issued in California.

2.0 California Issued Policies

The state of California has issued specific guidelines around the Definition of Disability for LTD claims governed by California issued policies. The procedures in this release apply only to group LTD policies issued in California.

The issue state can be found on the face page of the policy, and is usually identified by the following language:

"This Policy describes the terms and conditions of coverage. It is issued in California and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address."

3.0 Own Occupation

During the Own Occupation period, the following is the definition of Total Disability to be applied for group LTD policies issued in California:

"A disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way."

The customer's usual occupation is the occupation the employee routinely performs at the time the disability begins. When evaluating the occupation the customer routinely performs at the time the disability begins, we must consider the duties of the occupation to be the substantial and material acts necessary to pursue the customer's usual occupation in the usual or customary way.

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Similar to the vocational analysis under standard contract wording, the Own Occupation analysis under a policy issued in California will require a determination of the appropriate occupational title and code as typically found in a standard occupational classification system. However, for policies issued in California, further research may be necessary to ensure that the occupational demands aligned with that occupational title and code accurately reflect the occupation as performed for the customer's Employer.

4.0 Gathering Information

As part of your evaluation, gather the following information, where applicable:

Obtain a Job Description from the Employer. If we have for a particular account a collection of standard job descriptions for common roles, make sure that the relevant job description is in the claim file so that the file contains the necessary documentation.

If the Employer cannot provide a Job Description, request the employer to provide a completed Job Requirements form. It is recommended that this form be completed by the customer's supervisor or reporting manager.

Where needed, review the job requirements with the customer and/or Employer, and clearly document to the claim file a summary of those communications. In the event there is a discrepancy between the customer's reported duties and the duties as reported by the Employer, attempt to resolve the discrepancy.

Should there be other discrepancies or should additional questions arise, the Claim Manager should attempt to resolve and if unable, should refer the claim to the Rehabilitation Specialist (RS). These may include questions regarding the duties indicated, whether or not certain duties are truly material to the occupation, etc.

5.0 Evaluating Information

Once the information in section 4.0 has been gathered, refer the claim to the RS to obtain a Occ ID. Clearly indicate in your referral that the policy is issued in California. The RS should then find the occupational code/title that best fits the substantial and material activities of the actual position, or job, as performed for the Employer and set forth in the Job Description or Job Requirements form.

When assessing "substantial and material" duties, the RS should consider the following:

- How did the customer spend his/her time? What duties were performed on a regular basis?
- From what regularly performed activity was income generated?
- Consider each duty of the job, and whether or not the customer's inability to perform it alters the existence or purpose of the job.

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- How long had the customer been performing the reported duties?
- Do the reported activities represent modified or temporary work? Consider whether the customer is performing duties that differ from how that occupation is performed for the Employer as a whole.

Once the substantial and material duties have been determined, the RS will consider the occupational title/code that most closely aligns with these duties. From there, the RS will consider the usual and customary manner in which the substantial and material duties are performed. The substantial and material duties of the job performed for the Employer should be the benchmark for determining the occupational classification. In certain circumstances, this may be a combination of more than one occupational code/title. The RS should use their expertise to determine the appropriateness of the occupational code(s)/title(s) that are most applicable, and should document their professional opinion to the claim file.

Back to Table of Contents

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Exclusions in Disability Policies

1.0 Purpose/Overview

2.0 Consult Policy Language

3.0 Suicide, Attempted Suicide or Self-Inflicted Injury Exclusion

4.0 War or Any Act of War Exclusion

5.0 Active Participation in a Riot or Terrorism

6.0 Commission of a Felony

7.0 License Revocation, Restriction or Non-Renewal

8.0 Incarceration

9.0 Additional Short Term Disability Exclusions

10.0 Exclusions and Co-Morbid and Co-Existing Conditions

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview for applying defined policy exclusions found in Disability policies.

2.0 Consult Policy Language

Most disability policies contain an exclusions provision. Sample policy language:

"Exclusions

“The Insurance Company will not pay Disability Benefits for a Disability that results, directly or indirectly, from

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless solely due to Injury or Sickness otherwise covered by the policy.

In addition, the Insurance Company will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution."

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Policy language may vary, consult the individual policy provision for each claim.

3.0 Suicide, Attempted Suicide or Self-Inflicted Injury Exclusion

Disability policies may allow for the exclusion of suicide, attempted suicide or self-inflicted injuries.

Any Disability resulting from a suicide attempt or self-inflicted injury would not be covered under the policy.

However, if a customer is in treatment for a mental illness otherwise covered by the policy, the customer may be entitled to benefits due to Disability resulting from the mental illness.

For example, if a customer was injured from a self-inflicted injury that resulted from a suicide attempt such as an injury from falling, the Disability resulting from that injury (e.g. broken leg) would not be covered. However, the customer may be entitled to benefits due the Disability resulting from Major Depression Disorder.

If a customer who is receiving Disability Benefits dies from suicide, eligible family member(s) would remain entitled to Survivor Benefits, if the benefits are otherwise payable. The suicide exclusion for Disability Benefits does not apply to Survivor Benefits. Refer to "Survivor Benefits and Family Monthly Income" for additional information regarding Survivor Benefits.

4.0 War or Any Act of War Exclusion

Determining whether the War Exclusion applies is a factual analysis. Develop the following facts to evaluate each element of the provision:

1. Was there a declared or undeclared war?
   - Was there a declared war?
   - If not, was there an armed conflict (e.g., potential undeclared war)?
   - Was the war or armed conflict between nations or governments?
   - Who were the nations or governments involved? What happened?
   - When was the war or armed conflict?
   - What is the particular event, act or series of events or acts relating to the war or armed conflict that is at issue?
2. If there was a war, declared or undeclared, then does the illness or injury result directly or indirectly from that declared or undeclared war or act of war?
   - When was the customer exposed to the particular act /event noted above?
   - How is the customer's illness or injury connected to the declared or undeclared war or act of war?
   - Are there other contributing factors connected to the illness or injury?

Injuries or illnesses stemming from miliary service alone (not war connected) would not be excluded.

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If the Claim Manager determines that the War Exclusion may apply, the claim and supporting documentation should be referred to the Legal Referral Specialist (LRS) for legal review.

5.0 Active Participation in a Riot or Terrorism

Disability policies may have an exclusion for Disabilities that result, directly or indirectly from, "active participation in a riot."

This exclusion applies to Disabilities resulting from a riot or an act of terrorism when the customer was a participant in the riot, and not a bystander.

Bystanders who are injured in a riot or terrorism attack would not be excluded by this provision.

6.0 Commission of a Felony

Disability policies may exclude a Disability that results from the commission of a felony.

If a customer or the medical records indicate a felony may have been committed, it is important to complete a factual analysis of how the Disability is related to the felony.

It may be helpful to obtain police reports and engage the GBS Fraud Prevention and Detection Team or Claims Research Assistance for assistance.

Be aware that commission of a felony does not require a conviction, unless otherwise stated in the policy.

Once the information is gathered, if there are questions as to whether to exclusion would apply, a legal referral can be made through the LRS.

7.0 License Revocation, Restriction or Non-Renewal

Disability policies may exclude a Disability that results from a license revocation, restriction, or non-renewal.

If a customer's license, permit, or certification, necessary to perform the duties of their occupation, has been revoked, it is important to complete a factual analysis of how the Disability is related to the loss of credentials.

If the Disability results from an Injury or Sickness otherwise covered by the policy, and the loss of license, permit or certification is due to the Injury or Sickness, the exclusion does not apply.

If the sole reason the customer is unable to perform their occupation is due to loss of license, permit or certification and not an Injury or Sickness, the exclusion would apply.

Policy language may vary, consult the individual policy provision for each claim.

7.0 Incarceration

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Disability policies may note that benefits are not payable for any period of Disability while a customer is incarcerated in a penal or corrections institution.

Refer to the policy language to determine the specific type of incarceration that is excluded. House arrest or other types of modified incarceration are not penal or correction institutions.

During incarceration, benefits would be suspended. If the customer is released from incarceration, they may become entitled to benefits again, contingent upon all other policy provisions.

8.0 Additional Short Term Disability Exclusions

Additional information is available in the following releases regarding Workers' Compensation and Work Related Exclusions and Exclusions regarding Cosmetic Surgery or surgical procedures that are not Medically Necessary:

Policy Exclusions Based on Medical Necessity

Workers Compensation and Work Related Exclusion and the Short Term Disability Evaluation

10.0 Exclusions and Co-Morbid and Co-Existing Conditions

A customer may have more than one disabling condition. It may be determined that one or some of the customer's conditions are excluded and others are not. If the claim is approved, the approval letter should identify the condition(s) excluded and therefore not included in the approval determination. Include appeal language for those conditions determined to be excluded.

Back to Table of Contents

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Extended Death Benefit with Waiver of Premium

1.0 Purpose/Overview

2.0 Extended Death Benefit Introduction

3.0 Extended Death Benefit Policy Language

4.0 Extended Death Benefit Communication Process

5.0 Waiver of Premium with Rehabilitation

6.0 Non-Standard Extended Death Benefit

7.0 Conversion/Portability Upon Termination of the EDB on Non-Standard Extended Death Benefit Language

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1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the Extended Death Benefit (EDB) provision in Life policies for Linked Waiver of Premium and the corresponding claim process.

2.0 Extended Death Benefit Introduction

EDB is a provision within the life insurance policy that allows coverage to continue without premium payment once a customer has satisfied the definition of Disability.

The EDB provision defines disability as being Disabled from the customer's Regular Occupation or receiving Disability benefits under the Employer's plan. It allows the customer to return to work during the Benefit Waiting Period (BWP) without losing coverage. Each claim is unique and should be evaluated on its own merits. Review the policy for the specific wording regarding the EDB provision.

3.0 Extended Death Benefit Policy Language

An EDB provision in a policy may provide:

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If an Employee becomes Disabled and is less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date the Employee is no longer Disabled; or

2. 12 months after the end of Active Service.

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Amount of Insurance

If an Employee dies while he or she is Disabled and coverage is extended under this provision, the Insurance Company will pay a Death Benefit equal to the amount in effect on the date the Employee became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. The Insurance Company will pay benefits only if due proof of the Employee's continuous Disability is received within one year of the date of the loss.

"Disability"/"Disabled" means because of Injury or Sickness the Employee is unable to perform all the material duties of his or her Regular Occupation; or is receiving disability benefits under the Employer's plan.

"Regular Occupation" means the occupation the Employee routinely performs at the time the Disability begins. The Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Policy language may vary. Refer to the policy for specific Waiver of Premium policy language.

4.0 Extended Death Benefit Communication Process

When a customer is receiving LTD benefits, provided the criteria stated in the policy has been satisfied, we will assume receipt of an EDB claim with Waiver of Premium claim.

The Date of Receipt will be the date the LTD Claim Manager refers the referral task in the system. The Date of Receipt must be documented.

An EDB decision letter should be sent within 10 days of the date of the referral.

If the customer is Disabled from their Regular Occupation, but is not disabled from any occupation, conversion should be offered within 31/62 days of the end of the EDB period.

5.0 Waiver of Premium with Rehabilitation

Waiver of Premium with Rehabilitation provision allows a customer to return to work on a part-time basis for up to 18 months after the end of the EDB period. If the customer has the standard 9 month Life Waiver of Premium (Waiver) BWP, and the rehabilitation provision with the EDB provision, the customer receives up to a total of 30 months of coverage (12 months or Regular Occupation definition of disability under the EDB and 18 months of Any Occupation coverage under our standard policy).

Typical policy language provides as follows:

Rehabilitation During a Period of Disability

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"If the Insurance Company determines that a Disabled Employee is a suitable candidate for rehabilitation, the Insurance Company may require the Employee to participate in an assessment and Rehabilitation Plan, not to exceed 18 months, at our expense. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, insurance under the Policy will end."

"Good Cause" means a medical reason preventing participation, in whole or in part, in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

"Rehabilitation Plan" means a written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. Rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;

2. Work, which may include modified work and work on a Part-time basis.

"Part-time" means regularly working less than the number of full time hours set by the Employer as a regular work day for Employees in an Eligible Class of Employees in the Policy."

"Conversion/Portability will be offered for individuals who do not:

- meet the Waiver of Premium definition of disability
- participate in a rehabilitation program
- show good cause for not participating in a rehabilitation program."

Back to Table of Contents

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Functional Capacity Evaluation Referrals

1.0 Purpose/Overview

2.0 Schedule a FCE

3.0 FCE Results

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the referral process for Functional Capacity Evaluations (FCE). A FCE is an examination of a variety of functions intended to measure a customer's ability or inability to perform and sustain various activities over a given period of time. These examinations can be used to supplement the customer's medical record, or provide greater detail as to the extent of the claimed impairment. "Guidelines for Use of External Medical Resources" provides additional guidance on referral indicators for Long Term Disability (LTD) claims.

2.0 Schedule a FCE

The Claim Manager (CM) may discuss the rationale and reason for an FCE with the Medical Director (MD), Nurse Case Manager (NCM), Vocational Staff and/or Team Leader (TL).

If the claim issues cannot be addressed through internal resources and a referral is warranted, the CM will document the rationale for the FCE, as well as next steps.

The CM will complete the FCE Referral Form, and send it via Internal Resource Referral (IRR) task to the Vocational Staff.

The CM will contact the customer by phone to advise that an FCE will be scheduled and that the vendor will contact them directly to schedule the FCE. The CM should also explain the purpose of the FCE. The CM should also notify the customer in writing using the IME/FCE Notification letter. Document the claim file with the rationale for the FCE referral.

The Vocational Staff will contact the vendor to initiate the referral. The Vocational Staff will verify with the vendor if a prescription or approval from the customer's treating provider is needed prior to scheduling the FCE. If approval is required and not already obtained, the Vocational Staff may contact the CM for assistance in obtaining the necessary approval.

The vendor will schedule the FCE and notify the customer of the FCE appointment date/time/location in writing and/or a telephone call. The CM should document the claim file with the specific details outlining the efforts made by the vendor to notify the customer of the FCE appointment. Sample Claim Strategy documentation: "*Vendor notified cx of the FCE appointment by letter on {insert date}".*

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Once the exam has been scheduled, the CM should also contact the customer by phone to remind them of the exam.

Prior to the appointment, the Vocational Staff will forward the medical records and other pertinent claim records to the FCE vendor and document the file accordingly.

If the customer requests reimbursement for mileage incurred while driving to the FCE, the standard mileage rate for business will apply. Mileage should be calculated using the "Internal Revenue Service (IRS) Standard Mileage Rate" which is located on the IRS Website.

If the customer contacts the vendor and asks to reschedule or cancel the exam, the FCE should be rescheduled within 7-10 calendar days of the original appointment. If the customer is unable to comply with this time period and does not have a reasonable explanation (e.g. funeral, natural disaster, hospitalization, etc.) the exam will be cancelled. This information will be communicated to the claim team.

If the customer fails to attend an FCE as scheduled, make a reasonable effort to contact the customer to determine why they did not attend. If the customer has a reasonable explanation, the customer is given another opportunity to attend an exam. Follow the guidelines above to re-schedule the FCE. If the customer does not have a reasonable explanation, no further rescheduling will take place and the information will be communicated to the claim team. Document what the offered reason was, and why it was not reasonable. If a customer fails to attend a scheduled examination without reasonable explanation, we may consider them non-cooperative under the policy's Claimant Cooperation Provision and benefits may cease.

3.0 FCE Results

The vendor will submit the completed FCE according to the time frames established in the agreement or contract. The Vocational Staff will review the report for clarity and comprehensiveness upon receipt. If clarification is needed, the report will be returned to the vendor for clarification and the file documented accordingly. The Vocational Staff will follow up with the vendor to obtain clarification via a signed report.

The Vocational Staff will return the report to the CM for further evaluation of Disability. Claim documentation and future actions should be in line with the direction provided in "Gathering Medical Information and Documenting Conclusions."

Back to Table of Contents

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Gathering Medical Information and Documenting Conclusions

1.0 Purpose/Overview

2.0 Introduction

3.0 Gathering Medical Documentation

4.0 Triggers for Gathering Additional Information

5.0 Reviewing Medical Information

6.0 Evaluating Medical Support of Disability

7.0 Evaluating Claims with Co-Morbid or Co-Existing Conditions

8.0 Summary

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1.0 Purpose/Overview

The purpose of this procedure is to review the process for documenting and confirming a customer's medical status.

2.0 Introduction

Standard definition of disability wording requires that disability arise from illness, sickness, or injury. Given this, documenting and confirming a customer's medical status is an important component of disability determinations.

Documenting and confirming medical status involves forming an understanding of functional capacity, expected resolution of the disabling condition, and feasibility of return to work. To facilitate this process, this release provides guidelines for the following:

- Gathering relevant credible medical information
- Utilizing available resources to clarify restrictions and limitations
- Attempting to resolve discrepancies in medical statements or conclusions
- Outlining and documenting the medical conclusions on which a disability determination may be based
- Evaluating functional capacity with the presence of co-morbid or co-existing conditions

As stated above, this release focuses on the medical component of a disability evaluation. It does not contemplate issues of eligibility or exclusion, which may otherwise impact a claim evaluation.

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3.0 Gathering Medical Documentation

Medical documentation can assist with claim management by providing a better understanding of functional capacity, expected resolution of a condition, and feasibility of return to work. Relevant medical documentation can be drawn from many sources including, but not limited to, the following:

- Medical records supplied by those providing treatment in person or remotely (e.g. telemedicine), including, but not limited, to office notes, treatment records and plans, clinical findings, medical tests including raw scores, pharmacy records
- Medical texts, articles, and other publications that are considered to be generally acceptable sources of medical information

Along with these most commonly utilized sources, additional information that may assist includes but is not limited to:

- The customer's own statements, including information gathered during phone calls or personal interviews
- Observations of the customer's activities (personal interviews, surveillance, IME or FCE observations)
- Financial records
- Data from administrative/regulatory agencies for the purpose of determining the status of licensing and/or certification

4.0 Triggers for Gathering Additional Information

Vague Statements

Vague statements of impairment made by the treating or certifying physician generally do not provide enough detail to make determinations about the nature or degree of functional impairment resulting from a customer's condition(s). Examples include:

- "Customer is totally disabled"
- "Customer is temporarily totally disabled"
- "Customer unable to do any activity"
- "Customer cannot work"
- "Customer off work until MM/DD/YYYY"

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These types of general preclusion statements do not explain how or why the claimed impairment limits the customer from performing their occupation. Statements made without clarification or specific comment to restrictions and limitations may trigger additional questions and it is appropriate to seek further clarification from the treatment provider making the vague statements.

Co-Morbid or Co-Existing Conditions

Co-morbid or co-existing conditions can impact the overall functional capacity of an individual and should be evaluated for their combined effect on the customer.

Claim Managers should seek further clarification from treatment providers when they identify additional conditions or symptoms for which the claimant is or has been treated - or has reported - whether or not the customer or provider is asserting Disability based on these conditions.

Appropriate Care

Standard language in our group disability contracts require a customer "be under the Appropriate Care of a Physician," with Appropriate Care and Physician both further defined. As medical information is gathered and reviewed, consideration of this provision may include noting the following:

- Specialty of the treating physician
- Length of time treating with and/or frequency of treatment
- Nature of the treatment being rendered or the treatment plan prescribed by the treating physician
- Correlation of nature and level of treatment to nature and level of impairment assigned/claimed
- Potential familial relationship between the customer and treating physician
- Third party statements (employment records, etc.)

5.0 Reviewing Medical Information

Once all requested information has been gathered, review by appropriate resources occurs. Above and beyond members of the Core Teams, this review can be accomplished either by internal or external medical resources. Reviews of medical information may result in claims discussions, written documentation of conclusions, and possibly even further recommendations or suggested next steps. When our opinion of a customer's functionality differs with the treatment provider's conclusion of the customer's functionality, limitations and abilities, contact with the treatment providers and/or utilization of external medical resources may be appropriate in an attempt to clarify functional discrepancies.

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Internal Medical Resources

Each Field Claim Office is staffed with medical resources who are available to review and provide analysis of medical information contained in a claim file. These medical resources may:

- Offer advice on the completeness of medical records on file and recommend what, if any, additional information is needed to clarify a claimant's medical status
- Assess medical information and assure it is pertinent to the claim
- Contact treatment providers in an attempt to clarify information supplied
- Assist in drafting narratives or questions for an Independent Medical Evaluation (IME), Functional Capacity Evaluation (FCE), Peer Review, or communications with treating physicians
- Apply medical expertise relative to diagnosis, level of impairment, and expected recovery
- Evaluate restrictions and limitations in relation to the reported disabling condition

Releases “Short Term Disability Expert Resource Medical Review” and “Long Term Disability Expert Resource Medical Review” provide additional detailed information on the workflow and referral processes for utilizing internal medical resources. The need for and use of internal medical resources may vary from claim to claim and will occur where the Claim Manager deems necessary, based on the facts of the file.

External Medical Resources

Various external medical resources are also available to review and provide analysis of medical information contained in a claim file. The need for and use of external medical resources may vary from claim to claim and will occur where the Claim Manager deems necessary, based on the facts of the file. Generally, these resources can be helpful in clarifying discrepancies in medical information or opinions and in identifying current functional status and level of impairment. This type of clarification may be particularly useful where, e.g., treatment records do not provide sufficient detail to determine the level of impairment, a treatment provider assigns restrictions and limitations that do not correlate with the clinical findings and observations documented in their treatment notes, there is an inconsistency of information provided by different treatment providers, etc.

Where deemed necessary, an IME, FCE, Peer Review, or other form of external review/exam can be utilized to either obtain additional information or clarify existing information. The release “Guidelines for Use of External Medical Resources” provides additional information on when the use of external resources should be considered. Releases “Independent Medical Evaluation and Peer Review Referrals” and “Functional Capacity Evaluation Referrals” provide additional

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detailed information on the workflow and referral processes for utilizing external medical resources.

6.0 Evaluating Medical Support of Disability

Non-Disputed Medical Conclusions:

Upon review of medical documentation, our internal medical resources may concur with the conclusions and functional capacity stated by the treating physician. What was reviewed, the agreed upon restrictions and limitations, expected duration, and any suggested ongoing follow-up for information will typically be documented in the claim file by the medical resource. Utilizing these conclusions, the Claim Manager will continue with the claim management process and evaluation of disability.

In the event we obtained a Peer Review, IME, and/or FCE, and the treating physician agrees with conclusions stated in these reports, the Claim Manager will also continue with the claim management process and evaluation of disability.

Disputed Medical Conclusions:

Upon review of medical documentation, our internal medical resources may disagree with the conclusions and functional capacity stated by the treating physician. What was reviewed, restrictions and limitations the reviewer feels are supported, expected duration, and any suggested next steps will typically be documented in the claim file by the medical resource.

When our opinion of customer's functionality differs with the treatment provider's conclusion of the customer's functionality, limitations and abilities, contact with the treatment providers may be appropriate in an attempt to clarify functional discrepancies. When these efforts do not resolve the questions of functional status and level and impairment, use of external resources may be appropriate in attempt to gain understanding of the customer's functional capacity, or to provide additional documentation and rationale for the medical conclusions on which the evaluation of disability will be based.

Following a review of medical documentation and discussion with the treatment provider, there may be instances when agreement on functional capacity cannot be reached. When this occurs, the internal and/or external medical resource provides a summary of available documentation and detailed rationale to support the medical conclusions on which the Claim Manager's evaluation of disability will be based. If a disagreement regarding the extent of the customer's functional capacity exists, the medical resource may consider the following in this summary:

- Cite findings from medical documentation in the customer's own medical records or external examinations. (see "medical documentation" above for additional information on what this may consist of).

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- Utilizing the cited findings and substantial evidence contained in the file, provide rationale for functional capacity.

- Provide detailed explanation why the treating physician's conclusions exceed the findings or why these findings are inconsistent with the substantial evidence contained in the claim file.

7.0 Evaluating Claims with Co-Morbid or Co-Existing Conditions

Whole Person Analysis

When evaluating a claim with co-morbid or co-existing conditions, Claim Managers should consider the impact of those conditions on the whole person and determine if the combined effect impacts the individual's ability to function in an occupational setting. Specifically, Claim Managers should review all data available including customers' reports of symptoms as well as physical findings.

All conditions that are relevant to the customer's ability to function, including their combined effect on the whole person, should be considered.

Claim Managers and Expert Resources should consider and afford appropriate weight to all conditions whether or not the customer or the customer's physician is asserting disability on the basis of the specific condition.

When co-morbid or co-existing conditions exist, Claim Managers and Expert Resources share responsibility to ensure that all conditions are considered and afforded appropriate weight. In addition, when multiple resources are used, opinions should be coordinated to present a coherent view of the customer's medical condition(s), capacity, and restrictions and limitations.

Co-Existing vs. Co-Morbid Conditions

- A customer has **co-existing** conditions when they have multiple conditions, but all of the conditions may not impact their functionality.

- A customer has **co-morbid** conditions when they have multiple conditions that independently impact their functionality.

In assessing and addressing each of these conditions within the context of their overall impact on the customer's functionality, consideration should be given to the currency of each condition, e.g. conditions or symptoms the customer experienced in the past may not impact current functionality.

The following information should be evaluated and documented in the claim file as it pertains to the customer's functional capacity:

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- Each condition should be identified along with any stated or identified restrictions and limitations
- The combined effect of the diagnoses and impairments should be assessed for their impact on the whole person
- Any additional information that explains the rationale of any conclusions reached.

8.0 Summary

Reviewing a customer's medical status and confirming functional capacity are main components of determining disability. Medical information can be gathered from a variety of sources and our medical staff should be utilized, as needed, when reviewing the information on file, drawing medical conclusions, and proposing next steps.

Medical conclusions assist a Claim Manager by providing a basis for functional capacity, expected resolution of the disabling condition, and feasibility of return to work.

The claim evaluation and determination of disability are the responsibility of the Claim Manager. Claim determinations are based on conclusions drawn from multiple factors including medical, occupational, and financial documentation applied to the policy provisions at hand.

Back to Table of Contents

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Guidelines for Use of External Medical Resources

1.0 Purpose/Overview

2.0 Guidelines for the Use of External Medical Resources

1.0 Purpose/Overview

The purpose of this procedure is to provide guidelines for determining whether an external medical is appropriate.

2.0 Guidelines for the Use of External Medical Resources

A. *Treating Provider Related.* When medical information in the claim file lacks clarity or sufficiency to assess the customer's medical condition, functional status and level of impairment or where the claims handler has reason to question the opinions or information provided by the customer's treating provider, the appropriate internal medical resource should contact the treating provider either by phone or by letter for clarification or additional information. If telephone contact cannot be arranged, a letter outlining the question(s) and issues should be sent to the treating provider(s), which invites a reply either by phone or by letter.

Following outreach to treating providers, if the customer's condition, functional status and level of impairment are still unclear, or if the claims handler disagrees with the opinions or information provided by the treating provider, the use of external medical resources, such as a Peer Review, an Independent Medical Evaluation (IME), Functional Capacity Evaluation (FCE), should be considered under the following guidelines, unless it is determined that the customer's medical condition, functional status or level of impairment meets the policy's requirements.

1. A Peer Review consists of an independent review and analysis of the customer's medical records. A Peer Review should be sought whenever the question primarily concerns an issue of data interpretation, and therefore an examination of the customer would not be useful to understand the reported condition causing impairment.

2. An IME or FCE is an examination of the customer by a healthcare professional and is typically conducted at the request of the company. These examinations can be used to supplement the customer's medical record or provide greater detail as to the extent of the claimed impairment. An IME or FCE should be considered when there are disputed or unclear medical conditions, functional status or levels of impairment. These guidelines are the controlling document but releases "Independent Medical Evaluation and Peer Review Referrals" and "Functional Capacity Evaluation Referrals" may be consulted to provide additional detailed information on the workflow and referral processes for utilizing external medical resources.

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An IME or FCE of the customer should be sought whenever there is lack of agreement and the opinion of the company's internal medical resource is the primary basis for denial or termination of benefits unless the following conditions are satisfied and well documented in the file:

a) The Medical Director (a medical professional with the highest level credentials in the appropriate specialty relating to the reported condition regarding which there is disagreement or a lack of clarity) has reviewed the specific claim, focusing particularly on the area or areas of disagreement between the treating provider(s) and the reviewing internal medical resource;

b) The Medical Director reviewing the file performs their own separate analysis of the issue or issues upon which there is disagreement, including any other information in the file deemed by the Medical Director to be relevant to the claim decision, and

c) The Medical Director reviewing the file concludes that the position of the internal medical resources involved in the claim file and in disagreement with the treating provider is correct, after having determined that the treating provider's opinion is not well supported by medically acceptable clinical or laboratory diagnostic techniques and is inconsistent with the other substantial evidence in the claim file.

If the Medical Director reviewing the specific claim file is unable to reach the conclusion outlined in subparagraphs a) through c) above, then an IME or FCE should be performed. If there is a lack of clarity or a disagreement regarding more than one reported condition, then an IME/FCE should be performed unless Medical Directors with the appropriate specialty relating to each of these conditions are able to reach and document these conclusions.

If the Medical Director agrees with the treating provider's opinion, there is agreement as to the current existence of a disabling condition and no IME or FCE is needed at the present time.

B. *Other Circumstances.* An IME or FCE (or in circumstances relating to an issue of data interpretation, in which case a Peer Review) should be sought whenever any of the following occurs unless the decision is made to pay, or continue to pay, the claim:

1. A prior IME or FCE found disabling limitations and the current impairment is based on the same limitations.

2. An internal medical resource or other company resource, e.g., legal, compliance, or benefit specialist responsible for the claim, states that an IME/FCE is needed;

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3. There is a difference of opinion between two or more of the internal medical resources with respect to the existence of a disabling condition; or

4. The customer or the treating provider requests an IME or FCE, either directly or through the customer's representative.

C. *Professional Criteria.* A Peer Review, IME or FCE must be obtained and conducted on the basis of objective, professional criteria:

1. The company shall select individuals to conduct Peer Reviews, IMEs, and FCEs solely on the basis of objective, professional criteria, and without regard to results of previous reviews or examinations conducted by such individuals; and,

2. Neither the company nor any of its officers or employees shall attempt to influence the impairment determinations of professionals conducting Peer Reviews, IMEs, and FCEs.

Back to Table of Contents

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Independent Medical Evaluation and Peer Review Referrals

1.0 Purpose/Overview

2.0 Identify Claim Issues

3.0 Schedule an IME/Peer Review

4.0 Follow Up for Results of an IME/Peer Review

5.0 Ongoing Claim Management

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the workflow after it has been determined that a referral for an Independent Medical Evaluation (IME) or Peer Review is appropriate in a disability claim. “Long Term Disability Expert Resource Medical Review” and “Guidelines for Use of External Medical Resources” contain additional guidance for Long Term Disability (LTD) claims.

2.0 Identify Claim Issues

The Claim Manager (CM) may discuss the rationale and reason for an IME/Peer Review with internal resources, such as a Medical Director (MD), Nurse Case Manager (NCM), Behavioral Health Specialist (BHS), and/or Team Leader (TL).

If the claim issues cannot be addressed through internal resources and a referral is warranted, the CM and NCM/BHS may discuss the appropriate referral specialty and formulate questions for the IME/Peer Review prior to making the referral.

Sample questions can be selected from standard templates for completion during an IME or Peer Review. Questions may be modified or added to fit the unique circumstances of the claim at hand. The Physical Abilities Assessment (PAA) form may also be requested for completion during an IME.

3.0 Schedule an IME/Peer Review

After discussing with internal resources, the referral form should be completed and emailed to the appropriate IME Peer Review mailbox. The CM also creates a general follow-up task which should be titled “IME Referral” or “Peer Review” and routes it to the department, “External IME-PR-MDR Referrals”. The IME task should include the diagnosis, first and second choice of specialty being requested, and advise that the IME questions are uploaded. The CM does not need to include any information in the Peer Review task.

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The NCM/BHS/designee completes the task and refers to the designee to engage outside vendors and manage the IME/Peer Review process.

IME Referrals:

The CM contacts the customer by phone to advise that an IME will be scheduled and that the vendor will contact them directly to schedule the IME. The CM should explain the purpose of the IME. The CM should also notify the customer of the IME in writing using the IME/FCE Notification letter. Document the claim file with the rational for the IME referral.

The vendor will schedule the IME and notify the customer of the IME appointment date/time/location in writing and/or a telephone call. The CM should document the claim file with the specific details outlining the efforts made by the vendor to notify the customer of the IME appointment. Sample Claim Strategy documentation: “Vendor notified cx of the IME appointment by letter on {insert date}”

Once the exam has been scheduled, the CM should also contact the customer by phone to remind them of the exam.

If the customer requests reimbursement for mileage incurred while driving to the IME, the standard mileage rate for business will apply. Mileage should be calculated using the “Internal Revenue Service (IRS) Standard Mileage Rate” which is located on the IRS Website.

If the customer contacts the vendor and asks to reschedule or cancel, the IME should be rescheduled within 7-10 calendar days of the original appointment. If the customer is unable to comply with this time period and does not have a reasonable explanation (e.g. funeral, natural disaster, hospitalization, etc.), the evaluation will be cancelled. This information will be communicated to the claim team.

If the customer fails to attend an IME as scheduled, make a reasonable effort to contact the customer to determine why they did not attend. If the customer has a reasonable explanation, the customer is given another opportunity to attend an exam. Follow the guidelines above to re-schedule the exam. If the customer does not have a reasonable explanation, no further rescheduling will take place, and the information will be communicated to the claim team. Document what the offered reason was, and why it was not reasonable. If a customer fails to attend a scheduled examination without reasonable explanation, we may consider them non-cooperative under the policy’s Claimant Cooperation Provision and benefits may cease.

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4.0 Follow up for Results of an IME/Peer Review

The vendor should submit the completed report (i.e. IME, Physical Ability Assessment, and/or Peer Review) according to the time frames established in the agreement or contract.

The NCM/BHS/designee should follow up with the vendor for a timely report.

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The NCM/BHS will review reports for clarity and comprehensiveness upon receipt. If clarification is needed, the NCM will return the report to the vendor for clarification and document the file accordingly. The NCM will follow up with the vendor to obtain clarification via a signed medical report.

5.0 Ongoing Claim Management

The NCM/designee will return the file to the CM for further evaluation of Disability. Claim documentation and future actions should be guided by the procedure in “Gathering Medical Information and Documenting Conclusions.”

Back to Table of Contents

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Late Submittals

1.0 Purpose/Overview

2.0 Policy Language

3.0 Investigative Categories

4.0 Receipt of Claim

5.0 Customer Responds

6.0 No Response from Customer

7.0 Adverse Claim Decision

8.0 Policies Issued in California

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1.0 Purpose/Overview

The purpose of these guidelines is to provide information to assist in managing a disability claim that has been submitted late. A late submittal is generally defined as a disability claim submitted after the time period specified in the Proof of Loss provision of the policy or plan.

2.0 Policy Language

The Proof of Loss provision in our standard disability policies states:

“Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.”

Policy language may vary, so consult the individual policy provision for each claim.

3.0 Investigative Categories

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When considering whether to accept a claim that is submitted late, we should first consider the contract language, which typically will require us to determine whether the customer's reason for delay is reasonable.

In addition to the policy language, courts in different states have adopted different criteria about how to evaluate whether to accept a claim that has been submitted late. These criteria are based on each state's case law, and thus should be considered when evaluating late claims. Please note that we should be managing these claims based on the laws of the state in which the customer lived at the time the disability began, regardless of the relocation of the customer at a later date.

The first two categories, Reasonable States and Strict Time Limit States, are broken out separately for purposes of investigative categories, but we will investigate late claims from these states in the same manner when our policy provides for reasonable excuse. The third category, Prejudice States, require us to evaluate more than the reasonableness of the excuse.

1. Reasonable Excuse States

- Alabama
- Illinois
- New York

These are states in which we will only accept the claim for consideration of disability if we determine that the customer's reason for the late claim filing is reasonable. Determining whether a delay is reasonable may be difficult, because the term "reasonable" can be vague. However, we must generally view reasonableness as subjective, and from the point of view of the customer.

Some guidelines to follow when considering reasonableness are listed below:

- Has the customer provided a reason for the delay? The Late Submittal Acknowledgment letter asks the customer to explain the reason for the late submittal; a failure to provide an explanation should be taken into account in determining whether the customer had a reasonable excuse.
- Mental incompetence is always considered a reasonable basis for an excuse. If a customer claims mental incapacity as the reason for the delay in submission of the claim, investigate the claim fully to determine if mental incapacity was, in fact, the reason for delay. You should accept the mental incompetence excuse as reasonable unless you determine that there is not a reasonable basis to conclude that the customer was mentally incompetent.
- Not knowing the proof of loss provision exists or what it requires generally is not considered a reasonable excuse.

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- Consider the extent of the customer's sophistication in terms of level of education as well as work experience and training.

- The customer's awareness that a loss has occurred. Did the customer realize that their condition would prevent them from working? Or did they have a basis to reasonably think, for a reasonable time, that they would recover and return to work?

- After the loss, how diligent was the customer in pursuing whether coverage was available? For instance, did they contact their benefit department to inquire about coverage? If a customer stated that they didn't know that they had disability coverage, once they were told they could file a claim, what steps did they take to do so?

2. Strict Time Limit States

- Arkansas
- Colorado
- District of Columbia
- Georgia
- Idaho
- Massachusetts
- Mississippi
- South Carolina

These states permit us to make an adverse claim determination based solely on the customer's failure to file their claim within the timeframes outlined in the policy. However, where our policy language states that we will excuse the delay if notice was not reasonably possible, ask the customer to explain their reason for the late filing, and manage these claims in the same manner as the "Reasonable Excuse States", above. If there is no reasonable excuse, then an adverse claim determination may be made.

3. Prejudice States

All remaining states not listed in 1 or 2 above.

For all other states that don't fall into one of the two categories listed above, we must determine if we have been prejudiced in our ability to make a determination on the claim. Prejudice means that it is not reasonably possible for us to determine whether the customer is disabled as a result of the time that has elapsed between the onset of the condition claimed to be disabling

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and the submission of the claim (i.e. we can't obtain the information necessary to adequately determine if the claim for disability is supported, etc.). If we have been prejudiced by the delay, we may deny the claim.

In addition, based on our policy language, we should also determine if the reason for the delayed filing was reasonable, as outlined in 1 above.

4.0 Receipt of Claim

When a late submittal is received, the same steps for acknowledging should be taken initially regardless of the state in which the customer resides. The Late Submittal Acknowledgment letter should be sent to the customer within the current compliance timeframes for acknowledging claims. The letter should not be altered in any way, except for filling in the appropriate blanks. Alterations may change the letter's entire meaning and may result in our having to accept liability when we otherwise did not have liability. Refer to the Legal Referral Specialist (LRS) or Compliance Specialist if you find the need to alter the Late Submittal Acknowledgment letter. This letter may be used for both Fully Insured and Administrative Services Only (ASO) accounts.

In Prejudice States, in order to determine if we are prejudiced in our review, we must investigate the claim. Begin the medical and administrative investigation of the claim after sending the Late Submittal Acknowledgment Letter. Requesting medical information and other necessary information at this time will prevent further delay in making a claim determination and will not forfeit our right to make an adverse claim determination at a later date, if deemed appropriate. Our acknowledgment letter informs the customer that we are reserving our right to use the late submittal defense even though we are beginning our investigation of the claim.

The customer should provide their written explanation for the reason for delayed claim submission to us within 30 days (90 days for Long Term Disability (LTD) policies issued in California) of the date of our acknowledgment letter.

At the same time the claim investigation is started, request eligibility information (i.e., proof of enrollment) from the employer, where applicable.

5.0 Customer Responds

If the customer resides in a state where we do not need to prove prejudice, once the explanation for late submittal is received, refer the file to the Team Leader (TL). The TL will make a determination regarding the reasonableness of the explanation for the late submission. If the excuse for the delay is accepted as reasonable, continue to investigate the claim as we would normally do for a disability determination.

If a decision on a late submittal cannot be made within 10 days of the receipt of the customer's reason for delay, a second letter should be sent to the customer explaining the delay. This letter advises the customer that we have received and are reviewing their response. It also informs them that if we proceed with our investigation, we are reserving our rights to assert any

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contractual provision of the policy. This is necessary because the customer might misinterpret our continuing investigation (after receipt of the customer's reason for delay) as acceptance of their excuse for late submittal, and of the claim. This second letter attempts to prevent any such misinterpretation.

If you are in need of additional guidance, please refer to the LRS.

6.0 No Response from Customer

If the customer resides in a state where we do not need to consider prejudice, and the customer has not responded within the 30 day time frame (90 days for LTD policies issued in California), consult your Team Leader (TL), Technical Coach (TC) or Senior Case Manager (SCM) to determine next steps. If an adverse claim determination is appropriate, the decision letter must be an adverse determination letter. It must include the policy provision regarding "Notice of Claim", our attempt(s) to determine the reason for the delay, and the customer's lack of cooperation in providing the reason for the delay.

If the customer resides in a state requiring prejudice and the customer has not responded within the 30 day time frame (90 days for LTD policies issued in California), continue the investigation and send the customer a second request. The second request should explain that we are continuing our investigation to evaluate whether we have been prejudiced by the delay. We must include the disclaimer that by continuing to investigate the late submittal, we are not waiving any right to assert any contractual, statutory, or common law defenses to the claim.

7.0 Adverse Claim Decision

If our determination is that the delay was not reasonable, our adverse claim determination letter, should explain the reasons why the delay was unreasonable. It is not sufficient to state only that the delay was unreasonable, or that the customer's excuse was unacceptable. For example, if the customer was paying premiums, that might be a reason to conclude that an excuse that the customer was unaware they had coverage is unreasonable.

If we establish that we are prejudiced and an adverse determination is appropriate, our adverse determination letter should explain how we were prejudiced. Additionally, even if we were prejudiced, we should also explain the reason(s) that the delay was unreasonable.

The adverse determination letter should describe in detail the attempts to obtain information, and explain the basis for the "unreasonableness" of the delay. This letter should also include appeal rights. The state-specific information in this release should not be referenced in an adverse determination letter.

8.0 Policies Issued in California

The state of California has issued specific guidelines around Proof of Loss for claims governed by California issued policies.

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The issue state can be found on the face page of the policy, and is usually identified by the following language:

"This Policy describes the terms and conditions of coverage. It is issued in California and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address."

The Proof of Loss provision governing claims under California issued policies states:

"*Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."*

Late Submittal Claim Review

Customers covered under California issued policies are allowed up to one year to provide Proof of Loss if it is reasonable that they were unable to provide it within 90 days of the date proof was otherwise due. When evaluating a late submittal under a California issued policy, you should determine whether the reason for the delay is reasonable. See Reasonable Excuse States in section 3.0 above, for guidelines to follow when considering reasonableness.

Back to Table of Contents

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Life Waiver of Premium Any Occupation Evaluations

1.0 Purpose/Overview

2.0 Standard Policy Language

3.0 Evaluating Disability

4.0 Linked Waiver of Premium and Stand-Alone Waiver of Premium

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of Any Occupation (A/O) evaluations for Life Waiver of Premium (Waiver).

2.0 Standard Policy Language

Life Waiver of Premium is a provision in standard life insurance policies that allows a customer to maintain life insurance coverage while disabled without further premium payments (in other words, premiums are waived) provided the criteria stated in the policy have been satisfied.

Many of our policies use standard Waiver language, but it is important to review the policy at hand. Some common examples of the Definition of Disability found in life policies are as follows and depends on whether the policy does or does not have the Extended Death Benefit (EDB) language:

Example 1: (Non-EDB & EDB policy):

"An Employee is Disabled if, because of Injury or Sickness, he or she is unable to perform all the material duties of any occupation for which he or she may reasonably become qualified based on education, training, or experience."

Example 2: (EDB Policy):

"'Disability'/'Disabled' means because of Injury or Sickness an Employee is unable to perform the material duties of his or her Regular Occupation, or is receiving disability benefits under the Employer's plan, during the initial (6,9 or 12) months of Disability. Thereafter, the Employee must be unable to perform all of the material duties of any occupation which he or she may reasonably become qualified based on education, training or experience, or is subject to the terms of a Rehabilitation Plan approved by the Insurance Company."

Refer to Receipt of Claim for Linked Life Waiver of Premium for guidance with claims applicable to the EDB provision.

3.0 Evaluating Disability

The following are general guidelines for A/O evaluations for Waiver claims. Each claim is unique and should be evaluated based on a case-by-case basis while considering the claim file as a whole.

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The evaluation includes an assessment of the customer's current medical status including restrictions and limitations (R&Ls), transferable skills and reasonableness of the customer's qualifications for performing A/O. Information to gather and factors to consider in determining Disability under these definitions of Disability include:

- Copies of medical or other treatment records (e.g., hospital records, office notes, history/physical report, diagnostic studies/laboratory studies, treatment plan, medical referrals)
- Social Security related medical information, see "Social Security Awards and the Waiver of Premium Evaluation".
- R&Ls
- Skills, given their training, education, and experience
- Ability to perform the requirements of at least one identified occupation based on the R&Ls and skills.

For Waiver, the Disability definitions do not contain language regarding wage replacement and therefore, this is not a factor to consider. In the event a Waiver definition does specify wage replacement criteria, this should be factored into the evaluation along with all other points of consideration outlined above.

Rehabilitation Specialist:

The Waiver Specialist (WS) should attempt to obtain complete vocational information, including the customer's education, training and experience.

Once we have established functionality by clarifying R&Ls, the WS will confirm if a referral to a Rehabilitation Specialist is appropriate. This may vary from claim to claim depending on functional ability and other facts regarding the unique characteristics of the claim.

When determining alternate occupations during an A/O evaluation, the Rehabilitation Specialist may utilize resources such as Transferrable Skills Analysis (TSA) and/or Labor Market Survey (LMS) along with their expertise to determine whether alternate occupations are within the customer's R&Ls. The Rehabilitation Specialist should identify occupations which are in line with the customer's training, education, and employment history; and which could reasonably be performed on a sustained basis.

Refer to Any Occupation Investigation Guidelines for guidance on use of resources in conducting A/O evaluations.

4.0 Linked Waiver of Premium and Stand-Alone Waiver of Premium

When a customer has both a Long Term Disability (LTD) claim and a Life Waiver of Premium claim with us, the claim is referred to as a Linked Waiver of Premium claim. The LTD claim will be managed by the LTD Claim Manager (CM) and the Waiver claim will be managed by the WS on the Waiver Team.

When a customer has only Group Term Life Insurance coverage with a Life Waiver of Premium provision with us, the claim is referred to as a Stand-Alone Waiver of Premium claim. The claim will be managed by a WS on the Waiver Team.

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Back to Table of Contents

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Limited Benefit Periods in Disability Policies

1.0 Purpose/Overview

2.0 Policy Language Samples

3.0 Application of the Limited Benefit Periods

4.0 When the Limitation May Not Apply

5.0 Timing and Process

6.0 Delayed Notice

7.0 System Task and Coding

1.0 Purpose/Overview

The purpose of these guidelines is to provide guidance on the process, notification, and timing when applying Limited Benefit Periods.

This release was previously known as “Mental Illness Limitation Requirements and Investigation Procedures.”

2.0 Policy Language Samples

It is important to review the applicable policy language prior to setting the claim under any applicable limitation.

Limited Benefit Periods may include ‘Limited Benefit Periods for Mental or Nervous Disorders’ and ‘Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse.’ Some older policies may combine mental/nervous disorders and alcoholism/drug addiction or abuse into one limitation.

See samples below:

Example 1:

“Limited Benefit Periods for Mental or Nervous Disorders

The Insurance Company will pay Disability Benefits on a limited basis for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, during an Employee’s lifetime, no further benefits will be payable for any of the following conditions.

1) Anxiety disorders

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2) Delusional (paranoid) disorders
3) Depressive disorders
4) Eating disorders
5) Mental illness
6) Somatoform disorders (psychosomatic illness)
**7) Psychotic disorders*
**8) Bipolar affective disorder (manic depressive syndrome)*
**9) Schizophrenia*

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse

The Insurance Company will pay Disability Benefits on a limited basis for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, during an Employee's lifetime, no further benefits will be payable for any of the following conditions.

1) Alcoholism
2) Drug addiction or abuse

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above."

*These additional conditions may be included in policies issued after April 1, 2022

Example 2:

*"**Mental Illness, Alcoholism and Drug Abuse Limitation***

We will pay Disability Benefits on a limited basis for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid during your lifetime, no further benefits will be payable for any of the following conditions:

- *Alcoholism*
- *Anxiety disorders*
- *Delusional (paranoid) disorders*
- *Depressive disorders*
- *Drug addiction or abuse*
- *Eating disorders*
- *Mental Illness (MI)*
- *Somatoform disorders (psychosomatic illness)*

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If, before reaching the lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against the lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above."

If the policy includes additional conditions in the Limited Benefit Periods and they may apply to the claim you are reviewing, consult with your Technical Coach (TC) or Team Leader (TL) prior to applying the limitation.

3.0 Application of the Limited Benefit Periods

When applying the Limited Benefit Periods consider:

- The Limited Benefit Period is a lifetime maximum. The limitation or timeframe is cumulative over the duration of the customer's lifetime while the policy is in force. Should the policy intend the limitation to apply on a "per disability" basis, the policy will state "per disability." Confirm if any prior claims for the customer have been paid under the Limited Benefit Period.

- If the policy has separate limitation periods for Mental and Nervous Disorders and Alcohol and Drug Addiction or Abuse, the limitations could potentially run concurrently or separately. The onset date of each disabling condition would determine when the Limited Benefit Period for that condition begins. If a customer has both a mental health and alcohol/drug related condition at the same time, the limitations would run concurrently.

- If a customer continues to be disabled beyond the maximum Limited Period for a condition that does not fall under the Limited Benefit Period (i.e., a non-limited condition), the customer may continue to be eligible for benefits. However, any subsequent period of disability solely due to a limited condition would not be covered.

- A customer may have multiple conditions where one (or more) falls under the Limited Benefit Periods and one (or more) does not. If the limited condition would render them disabled on its own, these months will count toward the Limit Benefit Period.

- If a customer is intermittently disabled due to a limited condition and continuously disabled due to another condition(s), the Limited Benefit Period would apply only to those time periods during which the limited condition was disabling.

- If the customer's primary disabling diagnosis changes to a limited condition, the customer should be notified in writing of the policy's Limited Benefit Period, with the explanation that benefits are payable as defined in the limitation.

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4.0 When the Limitation May Not Apply

If the policy does not outline a list of specific diagnoses subject to the Limited Benefit Periods for Mental or Nervous Disorders, or where the list does not include Dementia, Schizophrenia, Bipolar Affective Disorder or Psychotic Disorders do not apply the Limited Benefit Period to those conditions.

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Otherwise, apply the policy language as it is written.

The Limited Benefit Period for Alcoholism and Drug Addiction or Abuse does not apply to injuries incurred while the individual is under the influence of alcohol or drugs. Alcoholism and Addiction are disorders that occur with extended use/abuse over time and should be considered when evaluating the Limited Benefit Period.

Conditions that result from prolonged use of drugs and alcohol would fall under the limitation. If there are questions about the extent that Alcoholism or Drug Abuse caused the disabling condition, consult with Expert Resources such as the Nurse Case Manager (NCM) and Medical Director (MD). If additional questions, refer to your TC or TL.

When reviewing a claim where a Developmental Disorder (such as Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD)) is identified, consider that Developmental Disorders are underlying conditions and pre-date a claimed disability. Developmental Disorders would not fall under a Limited Benefit Period.

5.0 Timing and Process

Communication of the Limited Benefit Period

Use the LTD Mental Illness Approval letter in the correspondence tool and include the Limited Benefit Period policy language. Explain that benefits are payable only for the maximum time defined in the policy provided the customer remains totally disabled due to a condition that falls under a Limited Benefit Period. Clearly state that benefits are payable solely based on the limited condition if that is the case. This is particularly true if there are other existing medical conditions, but we have found that they are not disabling conditions.

There may be claims that are approved primarily for a non-limited condition and a co-morbid limited condition has been identified. When the limited condition is not disabling on its own, the customer should be notified that their policy has a Limited Benefit Period provision which may apply at a future date. Then, if at any point during the life of the claim, the limited condition becomes disabling, the Limited Benefit Period will apply from that point forward and the customer should be notified accordingly.

No mention of the limited condition, or any other medical information, should be included in the approval letter to the employer.

At least three months prior to the established benefit exhaustion date, call the customer and explain the Limited Benefit Period, the investigation, and the possibility that benefits will be exhausted at the end of the Limited Benefit period. If beginning the Any Occupation investigation, the change in the definition of disability should also be discussed.

Send the LTD Any Occ Notice for Mental Illness letter in the correspondence tool to advise the customer that according to the Limited Benefit Period policy provision, benefits are due to end at the Limited Benefit Period. The letter also advises the customer of the investigation of the

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current medical conditions. If the Any Occupation date coincides with the Limited Benefit Period benefit exhaustion date, quote the definition of Disability in the letter and explain how it affects the claim.

Obtain all current medical documentation from the customer and the customer's medical providers.

If the Any Occupation period starts after the Limited Benefit Period is exhausted, only a non-limited condition should be considered for the Any Occupation review. During the Any Occupation investigation, the requests to treating providers should be focused on the non-limited condition(s).

Following receipt of updated medical information, verify the primary disabling diagnosis. Determine whether there are conditions which would cause limitations in the absence of the limited condition.

6.0 Delayed Notice

Where the primary disabling diagnosis is a limited condition, but we did not advise the customer of the Limited Benefit Periods in the approval letter, call and write to the customer as soon as you identify the limitation applies. Send the letter called MI Limit Delayed Notification.

The letter provides the customer with the date the limitation became effective, and the date benefits will end (or should have ended). In circumstances where the Limited Benefit Period is near or has been reached, benefits will continue while we review the claim and any additional documentation from the customer/provider to validate whether the claim is still subject to the limitation.

7.0 System Tasks and Coding

If a claim is initially under the Limited Benefit Period, the Benefit Period should equal the contractually defined duration based on the Maximum Benefit Period policy language. Conversely, the Benefit Term Date should equal the Limited Benefit Period language duration.

For example, if a claim falls under the Limited Benefit Period of 24 months, and the contractual Benefit Term Date is Age 65, then the system coding would be:

Period Code	07 – (Age 65)
Benefit Term Date	Contractual Limited Benefit Period date (usually 24 months from BSD for standard policies)
Termination Type	3 – (Benefit Period Limit)

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During the course of a claim, if the customer's primary diagnosis changes from a non-limited condition to limited condition, we should change the Diagnosis Code, Period Code and the Benefit Term Date. Update the new Period Code to reflect the new total expected duration: this equals both the Limited Benefit Period and any past benefit period that has already been paid.

For example, the policy has a 24-month Limited Benefit Period provision with a benefit start date of 1/1/23. We determine that a limited condition is the primary disabling diagnosis on 6/1/24. The 24-month Limited Benefit Period will apply beginning on that date.

Period Code	14 – (3 ½ years)
Benefit Term Date	5/31/26 – (24 months from 6/1/24)

At approval or update of the primary diagnosis to a limited condition, set a General Follow-up Task at least three months prior to the benefit exhaustion date to notify the customer of the upcoming benefit maximum/exhaustion date. If the Any Occupation date is the same as the Limited Benefit Period exhaustion date, the Any Occupation investigation should be done concurrently.

Back to Table of Contents

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Long Term Disability Advance Pay and Close

1.0 Overview

2.0 AP&C Criteria

3.0 Excluded from AP&C to an Estimated RTW Date

4.0 AP&C at the Maximum Duration

5.0 Maximum AP&C Time Periods

6.0 Communication

7.0 AP&C Decision Letter

8.0 Disability Beyond the AP&C Date

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1.0 Overview

These guidelines provide an overview on use of the Advance Pay and Close (AP&C) payment option for Long Term Disability (LTD) Claims. An AP&C is a voluntary payment option which allows a customer to receive the remaining LTD benefits due in advance of when they are entitled to them.

For information on advance payments for Any Occupation decisions, see “Any Occupation Investigation Guidelines.”

2.0 AP&C Criteria

Fully Insured (FI) LTD claims that meet the following requirements may be considered for AP&C:

- We have accepted liability through the maximum duration payable under the provisions of the policy, or
- There is an agreed upon recovery/return to work (RTW) date.

If an overpayment exists on a claim reach out to the Financial Accuracy Calculation Team (FACT) prior to making a decision to AP&C.

3.0 Excluded from AP&C to an Estimated RTW Date

The following claim scenarios are excluded from AP&C to an Estimated RTW date:

- Claims beyond the maximum AP&C time period, as outlined in Section 7.0 below,

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- Administrative Services Only (ASO) and Advice to Pay (ATP) plans,
- Claims with a dispute about functional capacity,
- Claims that may be impacted by future treatment or surgery within the relevant time period,
- Claims with a primary or secondary disabling condition that is psychiatric, cognitive, or under a Limited Benefit Period,
- Claims with a Power of Attorney or where concerns about the customer's ability to make financial decisions exist,
- When the customer does not agree to the AP&C.

If the customer does not agree to the AP&C option, ongoing claim management should continue, as appropriate. The customer should be informed that declining the AP&C will have no impact on the payment of the remaining monthly benefits due.

4.0 AP&C at the Maximum Duration

AP&C may be considered at the maximum duration of the policy with benefits paid through the Benefit Termination Date. The maximum duration is defined as the Maximum Benefit Period in the schedule of benefits, not through a Limited Benefit Period. If an overpayment exists on a claim reach out to the Financial Accuracy Calculation Team prior to making a decision to AP&C.

At 12 months prior to the Benefit Termination Date, contact the customer to explain that absent any objection, the remaining benefits due are scheduled to be paid in advance:

- Document the outcome of the phone call and proceed with releasing the remaining benefits and closing the claim. If the customer does not respond to calls, a letter may be sent advising that benefits will be issued through the Benefit Termination Date unless the customer objects. Allow 30 days for the customer to respond to the letter. If no response indicating objection is received, proceed with issuing benefits through the Benefit Termination Date. A closure letter should be sent once benefits are issued.
- If the customer does not want their remaining benefits to be paid in advance, the claim should remain open, and benefits should continue to be paid monthly until the Benefit Termination Date is reached. When the final benefit payment is ready to be released, send a closure letter to the customer.

5.0 Maximum AP&C Time Periods

The maximum AP&C time period varies depending on the nature of the decision. We can consider payment up to:

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- 90 days in advance of the agreed upon recovery or return to work date when all applicable criteria previously stated are present and well documented.

- 12 months in advance of the maximum duration under the policy. Refer to Section 4.0 for additional information.

- 12 months in advance of the maximum duration under the policy when the full benefit is being withheld for an overpayment and full recovery will not occur by the maximum duration. Attempts should be made to obtain the customer's agreement as other benefits may be tied to the customer receiving disability benefits. However, if reasonable attempts go unanswered, proceed with the AP&C. Refer to Section 4.0 for additional information. Consult with the Financial Accuracy Calculation Team prior to completing an AP&C to address repayment of the overpayment.

- 60 days in advance of the maximum duration under the policy. The customer's agreement is not required.

6.0 Communication

You are required to provide the customer with notice of the agreed upon Recovery/RTW, or Maximum Duration provision and explain AP&C.

Advise the customer of the following:

- AP&C is a voluntary payment option, and that declining the AP&C will have no impact on the payment of the remaining monthly benefits due.

- Absent any objection, the remaining benefits due will be paid in advance and verbal confirmation is acceptable.

- If applicable, to confirm with their employer that accepting the AP&C will not affect other employer sponsored benefits.

- If benefits are taxable, that we make no assertions regarding the tax implications of the AP&C for the customer.

Document in the system the items discussed in the phone call.

7.0 AP&C Decision Letter

Send a letter to the customer confirming the advance pay and close. The letter should contain:

- Any applicable provisions such as the Maximum Duration provision,

- The check amount, date, and time period the check represents,

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- The basis of the time frame for the AP&C.

The letter should advise the customer that:

- It is the customer's responsibility to contact us, should return to work or recovery NOT occur on the agreed upon date,
- If the customer returns to work or recovers prior to the agreed upon date, the claim may be overpaid, and a repayment will be due,
- If the customer returns to work or recovers after the anticipated date, additional benefits may be due, where applicable. Case management steps will need to be accomplished to determine this. (Not applicable for maximum duration claims).

When AP&C benefits paid represent a future calendar year, the letter should advise that we make no assertions regarding tax implications.

If including overpayment details in the letter, the following sample language can be used:

- Your benefits will be applied to recover your outstanding overpayment in full.
- We will apply $ xxxx toward your outstanding overpayment, resulting in a remaining balance of $ xxxx; you will be responsible for coordinating a repayment plan with the Financial Accuracy Calculation Team.

8.0 Disability Beyond the AP&C Date

We may consider extending benefits past the paid-through date upon the customer's request, if the customer was not paid through the maximum duration. If the request is verbal, direct the customer to the AP&C letter for written requests for extension. Additional information received should be reviewed for consideration. If our decision remains unchanged, issue a complete adverse determination letter with required appeal language. If the payment was previously made through the Maximum Duration, remind the customer of the relevant policy provisions.

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Long Term Disability Claims With No Defined Restrictions and Limitations

1.0 Purpose/Overview

2.0 Claim Management

1.0 Purpose/Overview

The purpose of these guidelines is to outline considerations when a Long Term Disability (LTD) customer's treating providers do not provide functionality or restrictions and limitations (R & Ls).

2.0 Claim Management

Once we have gathered available medical information (see "Gathering Medical Information and Documenting Conclusions"), review the medical to assess the customer's functional capacity. If their functional capacity is unclear and no providers have provided R&Ls, the Claim Manager (CM) should:

1. Make at least two (2) attempts to complete a customer call. As part of that call, the CM should ask which providers are keeping the customer off work. If the customer states there are no specific treating providers keeping them off work, but they are not capable of returning to work, then inquire which condition(s) is primarily keeping the customer out of work.

    a. If the customer states they are not restricted from returning to work to either their own occupation or another occupation, review the claim with your Technical Coach (TC) or Team Leader (TL) to consider a claim determination or next steps.

    b. If the customer states there is no restricting provider, but believes they still cannot return to work, ask why (which condition, what they cannot do). Proceed to step 3.

    c. If the customer confirms there is a provider keeping them off work, identify that provider, and proceed to step 2 if the information on file suggests the customer can perform their regular (or suitable alternative) occupation. Otherwise, proceed to step 3.

    d. If the customer cannot be reached, proceed to either step 2 or 3 as appropriate.

2. Send a Functional Capacity Letter to the restricting treating provider(s).

    a. Once the letter is faxed, the CM should call the provider to confirm receipt and to ask for the turnaround time of the response. If no response within 10 days (or the agreed upon turnaround time) complete one, follow up.

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b. If the treating provider(s) agrees regarding the customer's functional capacity, consider next steps depending on whether the customer is in the own occupation or any occupation period of Disability.

c. If the treating provider(s) disagrees regarding the customer's functional capacity or does not respond, proceed to step 3.

3. Escalate the claim to a Nurse Case Manager (NCM) or Behavioral Health Specialist (BHS).

   a. The NCM/BHS will contact the treating provider(s) the customer noted as restricting, or those that align with the primary condition(s) that is preventing the customer from working. If we have already received the Functional Capacity Letter described in section 2, only contact the provided if clarification on their response is needed. If no clarification is needed, proceed to 3c.

   b. If the provider(s) confirms that the customer can return to work, the file is returned to the CM to consider next steps depending on whether the customer is in the own occupation or any occupation period of Disability.

   c. In cases where the provider(s) does not respond or indicates the customer cannot RTW and why:

      1. if the file contains current medical information, the NCM/BHS will complete the specialty selection template and escalate to a Medical Director (MD). Go to d) below.

      2. if the file does not contain current medical information, the NCM/BHS will return the file to the CM to determine next steps which may include consideration of an IME or FCE.

   d. The MD will review the file (which includes current medical information) and provide an analysis which includes an assessment of all functionally impairing conditions, associated limitations and any reasonable activity R & Ls.

   e. The MD will send the analysis to the treating provider(s) asking whether they agree or disagree with the R & Ls as we have defined them.

   f. If the treating provider(s) disagrees, review the claim in line with "Guidelines for Use of External Medical Resources."

   g. If the treating provider agrees (or indicates agreement by not responding pursuant to the terms clearly stated in the letter) the file is documented and returned to the CM for next steps.

Questions should be directed to your TC or TL.

Back to Table of Contents

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Long Term Disability Expert Resource Medical Review

1.0 Purpose/Overview

2.0 When Review with an Expert Resource is Not Necessary

3.0 Claim Management Actions

4.0 NCM/BHS Actions

5.0 Return to Work Opportunities

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the Claim Manager (CM), Nurse Case Manager (NCM) and Behavioral Health Specialist (BHS) roles in the medical review of Long Term Disability (LTD) claims.

2.0 When Review with an Expert Resource is Not Necessary

There are instances when an Expert Resource (NCM/BHS) medical review is not necessary. For example, when:

- A definite return to work or return to work release is confirmed within four weeks
    - If the established return to work is extended, discuss with NCM/BHS to determine next steps
- The customer has completed a vocational rehabilitation plan and functionality issues have been resolved
- The customer is currently hospitalized, having surgery, or receiving functionally limiting treatment (e.g., chemotherapy, daily dialysis)
- The customer is recovering from major surgery and the return to work plan/date is within expected durations
    - If the established return to work exceeds expected durations, discuss with NCM/BHS to determine next steps
- A routine pregnancy overlaps with the LTD period
- An adverse determination is made for non-medical reasons (e.g., not eligible)
- Agreement with the imposed Restrictions and Limitations (R/L's) and there is no conflict with the treating provider's opinion. Ensure all relevant conditions have been considered for the overall impact on the customer's function as outlined in section 7.0 in Gathering Medical Information and Documenting Conclusion.

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If there is no conflict with the providers, proceed with next steps, including an adverse decision if appropriate. For example:

- Own Occ: The CM agrees with the treating provider's R/L's. If the CM is able to determine that the agreed upon R/L's do not preclude working in the customer's occupation, the CM can proceed with claim decision without additional medical review.
- Any Occ: The CM agrees with the treating provider's R/L's. The CM can proceed with a referral for a TSA, and then make an Any Occ decision, without additional medical review.

3.0 Claim Management Actions

Prior to review with NCM/BHS, recent medical information should be on file and a successful outreach to the customer within the last three months should be completed. The CM should outline the specific questions or issues that need to be resolved in order to reach a claim determination prior to the discussion. Claims without specific questions and/or instructions for the NCM/BHS may be returned to the CM for clarification and completion.

CMs are required to review claims with the NCM/BHS prior to an adverse claim determination based on medical reasons unless there is agreement with imposed r/ls as outlined in section 2.0. Otherwise, the NCM/BHS should review the medical information, document the resulting medical rationale, and provide sufficient reasons and explanation why the medical information on file does not support the proposed restrictions and limitations.

When all appropriate medical reviews are completed, the CM may proceed with the claim decision, unless the CM determines that additional investigation or evaluation is necessary.

A claim may be reviewed with the NCM/BHS at any point during the life of a claim.

If the purpose of the review is for assistance in obtaining current medical information while a claim is being paid, refer to Ongoing Claim Request for Information.

4.0 NCM/BHS Actions

If the provider supplies medical records but declines to provide functionality or defined R/L's, refer to Long Term Disability Claims With No Defined Restrictions and Limitations.

If the medical information supports the restrictions and limitations provided by the treating providers, the NCM/BHS documents the rationale and provides recommendations for continued medical management, as needed. Documentation should include follow-up time frames for specific treating providers and relevant information concerning the medical condition as it may affect return to work (RTW) capabilities.

When medical information in the claim file is insufficient or lacks sufficient clarity to assess the customer's medical condition, functional status and level of impairment, or where the NCM/BHS

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has reason to question the opinions or information provided by the customer's treating provider, the NCM/BHS should contact treating providers either by phone or by letter for clarification or to request additional information. If phone contact cannot be arranged, a letter outlining the question(s) and issues should be sent to the treating providers, requesting a reply either by phone or by letter.

If the customer's condition, functional status, and level of impairment remains unclear after treating provider contact, or if the NCM/BHS disagrees with the opinions or information provided by treating providers, additional medical resources (internal or external) should be used as outlined in “Guidelines for Use of External Medical Resources”, unless it is determined that the customer's medical condition, functional status, or level of impairment meets the policy's requirements.

5.0 Return to Work Opportunities

When Return to Work (RTW) opportunities are identified, the CM and NCM/BHS should discuss the claim to identify issues that may impact vocational involvement prior to consulting with a Vocational Coach (VC).

VCs may partner with NCM/BHS to assist in determining occupational capabilities, as appropriate. VCs may also obtain guidance on medical issues that impact RTW, for example:

- Limitations specific to the physical demands of occupations being considered as the RTW goal.
- Duration of current limitations and restrictions.
- Timelines for improvement in functionality.
- Timelines for an increase in activities (e.g., part-time to full-time work).
- Any medical information that impacts a successful RTW outcome.

The VC and NCM/BHS can determine appropriate next steps in RTW planning. Possible appropriate next steps may include:

- NCM/BHS/VC contact with the customer for more information about self-reported functionality, current treatment plan, treating providers, etc.
- NCM/BHS contact with treating providers to clarify any medical information discussed with the VC that may impact a successful RTW.

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Back to Table of Contents

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Misrepresentation Investigation During the Contestable Period for Disability Claims

1.0 Overview

2.0 Incontestability Provision

3.0 Evaluating for Misrepresentation

4.0 Claim Management

5.0 Causal Relationship

6.0 Intent to Deceive

7.0 Timing of the Investigation

8.0 Appeal

1.0 Overview

These guidelines provide an overview for misrepresentation investigations during the Contestable period for Disability claims.

2.0 Incontestability Provision

If one party provides materially inaccurate information that influences the other party's decision to enter into a contract, the affected party may have the right to void the contract. In the insurance context, coverage can sometimes be challenged when a policy was issued based on material misrepresentations made by the customer. This process is known as rescission of coverage.

Generally, many of our policies include an incontestability provision. Medically underwritten coverage may be rescinded, within a defined period of time (commonly 2 years), if it is determined that the customer misrepresented medical history within the time frame specified on the application for coverage; and the misrepresentation materially affected the risk undertaken by the underwriting company.

Below is a sample policy definition of the term "Incontestability":

"Incontestability

All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

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After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage."

Policy language can vary, consult the individual policy language for each claim, including the State Modifying Provisions at the back of most policies.

State law may provide further guidance on rescission and may require a causal relationship between the item misrepresented and the ultimate cause of loss or may require that the customer intended to deceive the insuring company to gain insurance coverage. See Sections 5.0 and 6.0 for further information.

3.0 Evaluating for Misrepresentation

For a Disability claim to be contestable, all the following conditions typically must exist:

- The policy must contain an Incontestability provision,
- We are still within the policy contestable period (usually within the first two years after the effective date of coverage, increase in coverage or reinstatement),
- All or part of the customer's disability insurance coverage is contributory,
- The coverage was medically underwritten, and evidence of insurability (EOI) was provided by the customer. To determine if coverage was medically underwritten, review policy provisions carefully, such as (but not limited to):
    - Eligibility for Insurance
    - Effective Date of Insurance
    - Insurability Requirement.

Some examples of coverage that may be medically underwritten include:

- an elected, employee-paid benefit (or a portion of the benefit), or basic coverage,
- a late entrant or recently re-enrolled insured,
- an elected increase in a previous benefit.

If these conditions are present, the customer's medical history should be investigated to ensure that it was accurately represented on the application.

There may be more than one contestable clock running. A new contestable period begins if a benefit increase is elected at some point later than election of basic coverage. The misrepresentation investigation may apply to the entire amount of coverage or just the benefit increase amount.

The Medical Underwriting Risk Management Team, also known as LVSC Risk Management Team (RMT), is responsible for advising whether, based upon the information gathered, coverage would have been issued had the company been made aware of the customer's actual medical history.

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4.0 Claim Management

Once a claim is identified as being possibly subject to a misrepresentation investigation, complete the following steps. If a Pre-Existing Condition (PCL) investigation is needed, gather records to support that investigation at the same time. However, the misrepresentation investigation should be completed to establish coverage exists prior to communicating an adverse determination due to a policy provision, including but not limited to PCL.

1. Obtain a copy of the Application, or EOI, (or Statement of Physical Condition) from RMT if it's not already on file.
2. A letter should be sent to the customer to advise of the misrepresentation investigation. Request a signed authorization to release information if an authorization is not already on file.
3. Request a pharmacy canvass (IntelliScript Pharmacy Records Request).
4. Ensure a referral to RMT has been completed in the Material Misrepresentation SharePoint.
5. RMT will review EOI forms and any existing medical records in the claim system. If additional information is needed, RMT will notify the Claim Manager (CM) of what they should request.
6. If RMT does not find evidence of misrepresentation, the CM will be notified so disability claim management may continue.
7. If RMT finds evidence of misrepresentation, coverage may be rescinded after further consideration. See section 5.0 for Causal Relationship and section 6.0 for Intent to Deceive.
8. RMT will notify the customer of rescission of coverage (after consideration of sections 5.0 and 6.0). A copy of the letter and RMT's recommendation will be given to the CM to put in the claim file.
9. RMT may rescind all the coverage or only a portion of the coverage. If only partial coverage is rescinded, the claim may be considered for the portion that is not rescinded.
10. Because disability benefits cannot be paid based on coverage that was not in force when the disability began, the disability claim may be denied (either in full or in part). As this is an adverse decision, the CM will notify the customer via a letter that complies with the requirements outlined in Adverse Determination Letter Content for Policies providing Disability Benefits.
11. Consider whether a referral to the GBS Fraud Prevention and Detection Team or Claims Research Assistance for further review and investigation is appropriate.

If disability coverage will be rescinded, RMT will also review other coverages the employee may be enrolled in to determine if any are impacted by this rescission.

5.0 Causal Relationship

In certain states, the cause of loss, or disability, must be related to the misrepresentation on the application/EOI for a rescission of coverage to take place. This is referred to as Causal Relationship.

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If RMT recommends rescission of coverage and the customer resides in the following states, RMT and the CM (and/or the Technical Coach/Team Leader) will review and assess to determine if the disabling condition(s) is related to the misrepresentation. If the disability is unrelated to the misrepresentation, the coverage may not be rescinded, and the claim can typically be evaluated. If the disability is related to the misrepresentation, the coverage may be rescinded. The rescission letter should explain the rationale and basis for the rescission of coverage.

Listed below are the states that currently require a causal relationship:

- **Kansas**
- **Missouri**

6.0 Intent to Deceive

In certain states, for a rescission of coverage to take place, we must show that the disability customer's misrepresentation on the application and EOI was intentional and meant to deceive the insuring company in order to obtain coverage.

If RMT recommends rescission of coverage and the customer resides in the following states, RMT and the CM (and/or the Technical Coach/Team Leader) will review RMT's recommendation, reasoning, and relevant medical documents to determine the customer's intention.

- **South Carolina** (see Lanham v. Blue Cross, 349 S.C. 356 (2002))
- **Texas** (see AMERICAN Nat'l v. Arce, 672 S. W. 3d 347 (TX 2023))

Some points to consider may include, but are not limited to:

- When was the diagnosis of the misrepresented condition made?
- Is the misrepresented condition clearly communicated to the customer by the treating provider(s)?
- Is the misrepresented condition mentioned by multiple providers? On multiple dates?
- What treatment or procedures has the customer undergone and when?
- How are the questions answered on the EOI form? Are some conditions listed and others not or is it noted there are no conditions/treatment?

There may be other questions or considerations when assessing the customer's intention. Prior to deciding that the customer intended to deceive us, review with your Team Leader (TL), Technical Coach (TC) or Senior Claim Manager (SCM). Legal consultation may also be considered. The rescission letter should explain the rationale and basis for the rescission of coverage.

7.0 Timing of the Investigation

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Under the typical incontestability provision, the investigation must be completed and the coverage rescinded by adverse benefit determination letter during the Contestability Period.

8.0 Appeal

RMT will handle appeals received on rescissions of disability coverage (also known as 'living rescissions'). They will manage the communication and the review. RMT will coordinate with the Appeal Team on appeals in states identified in sections 5.0 and 6.0.

If the outcome of RMT's appeal review is to uphold the rescission, RMT will notify the customer, sending the appropriate correspondence. They will also provide their decision to the Disability claims team and/or the Appeal Team for file documentation and any communication on the disability claim, as needed.

If RMT determines a rescission will be overturned, they will notify the Disability claims team and/or the Appeal Team who in turn will notify the customer. The claims team will begin reviewing the disability claim.

Appeals received on the disability claim determination should be referred to the Appeal Team who will partner with RMT as appropriate.

Back to Table of Contents

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Misrepresentation Investigation During the Contestable Period for Waiver of Premium and Accelerated Death Benefits

1.0 Purpose/Overview

2.0 Incontestability Provision

3.0 Evaluating for Misrepresentation

4.0 Claim Management

5.0 Causal Relationship

6.0 Intent to Deceive

7.0 Timing of the Investigation

8.0 Appeal

9.0 New York Requirements

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1.0 Purpose/Overview

These guidelines provide an overview for misrepresentation investigations for Waiver of Premium (Waiver) and Accelerated Death Benefits claims under the life insurance policy.

For policies issued in New York, see section 9.0.

2.0 Incontestability Provision

If one party provides materially inaccurate information that influences the other party's decision to enter into a contract, the affected party may have the right to void the contract. In the insurance context, coverage can sometimes be challenged when a policy was issued based on material misrepresentations made by the customer. This process is known as rescission of coverage.

Generally, many of our policies include an incontestability provision. Medically underwritten coverage may be rescinded, within a defined period of time (commonly, 2 years), if it is determined that the customer misrepresented medical history within the time frame specified on the application for coverage; and the misrepresentation materially affected the risk undertaken by the underwriting company.

Below is a sample policy definition of the term "Incontestability":

"Incontestability

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All statements made by the Employer or by an Insured are representations do not warranty. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage."

Policy language can vary, consult the individual policy language for each claim, including the State Modifying Provisions at the back of most policies.

State law may provide further guidance on rescission and may require a causal relationship between the item misrepresented and the ultimate cause of disability or may require that the customer intended to deceive the insuring company to gain insurance coverage. See Sections 5.0 and 6.0 for further information.

3.0 Evaluating for Misrepresentation

For a Waiver or Accelerated Death Benefit claim to be contestable, all the following conditions typically must exist:

- The policy must contain an Incontestability provision,
- We are still within the policy contestable period (usually within the first two years after the effective date of coverage, increase in coverage or reinstatement.)
- All or part of the customer's life insurance coverage is contributory,
- If non-contributory coverage, the amount of insurance is over the Guaranteed Issue limit,
- The coverage was medically underwritten, and evidence of insurability (EOI) was provided by the customer. To determine if coverage was medically underwritten, review policy provisions carefully, such as (but not limited to):
    - Eligibility for Insurance
    - Effective Date of Insurance
    - Insurability Requirement

Some examples of coverage that may be medically underwritten include:

- an elected, employee-paid benefit (or a portion of the benefit), or basic coverage,
- a late entrant or recently re-enrolled customer,
- an elected increase in a previous benefit.

If these conditions are present, the customer's medical history should be investigated to ensure that it was accurately represented on the application.

There may be more than one contestable clock running. A new contestable period begins if a benefit increase is elected at some point later than election of basic coverage. The

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misrepresentation investigation may apply to the entire amount of coverage or just the benefit increase amount.

The Medical Underwriting Risk Management Team, also known as LVSC Risk Management Team (RMT), is responsible for advising whether, based upon the information gathered, coverage would have been issued had the company been made aware of the customer's actual medical history.

If the policy is issued in New York, contact the Legal Referral Specialist (LRS) to obtain legal guidance prior to beginning the investigation. See section 9.0.

4.0 Claim Management

Once a claim is identified as being possibly subject to a misrepresentation investigation, complete the following steps. The misrepresentation investigation should be completed to establish coverage exists prior to communicating an adverse determination due to other policy provisions.

1. Obtain a copy of the Application, or EOI, (or Statement of Physical Condition) from RMT if it's not already on file.
2. A letter should be sent to the customer to advise of the misrepresentation investigation. Request a signed authorization to release information if an authorization is not already on file. If the claim is in SRO, request names and addresses of all providers where the insured was treated (the period of time will vary depending on the application - usually 5 or 10 years) prior to the application date (if known).
3. Request a pharmacy canvass (IntelliScript Pharmacy Records Request).
4. A Referral to RMT should be completed in the Material Misrepresentation SharePoint, if not already completed.
5. For claims in AdminSuite, RMT will review EOI forms and any existing medical records in the claim system. If additional information is needed, the RMT will notify the Waiver Specialist (WS) of what they should request.
6. For claims in SRO:
    a. Request relevant information from all providers identified in #2 prior to the application date. Meaningful attempts must be made, and all efforts should be exhausted to obtain the information needed.
    b. Review medical information as it is received to identify other sources of medical treatment to request.
    c. As medical information is received, refer the records to RMT for their review.
7. If RMT does not find evidence of misrepresentation, the WS will be notified so waiver claim management may continue.
8. If RMT finds evidence of misrepresentation, coverage may be rescinded after further consideration. See sections 5.0 for Causal Relationship and 6.0 for Intent to Deceive.
9. RMT will provide the WS with their recommendation, and it is the WS's responsibility to write a letter advising of the rescission of coverage and the denial or partial denial of the waiver claim. Because coverage was not in force when the disability began, the WS will

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notify the customer that their waiver claim (either in full or in part) is denied. As this is an adverse decision, the CM will notify the customer via a letter that complies with the requirements outlined in Adverse Determination Letter Content for Policies providing Disability Benefit

10. RMT may rescind all the coverage or only a portion of the coverage. If only partial coverage is rescinded, the claim may be considered for the portion that is not rescinded.
11. Consider whether a referral to the GBS Fraud Prevention and Detection Team or Claims Research Assistance for further review and investigation is appropriate.

If waiver coverage will be rescinded, RMT will also review other coverages the employee may be enrolled in to determine if any are impacted by this rescission.

5.0 Causal Relationship

In certain states, the cause of loss, or disability, must be related to the misrepresentation on the application/EOI for a rescission of coverage to take place. This is referred to as Causal Relationship.

If RMT recommends rescission of coverage and the customer resides in the following states, RMT and the WS (and/or the Technical Specialist/Team Leader) will review and assess to determine if the disabling condition(s) is related to the misrepresentation. If the disability is unrelated to the misrepresentation, the coverage may not be rescinded, and the claim can typically be evaluated. If the disability is related to the misrepresentation, the coverage may be rescinded. The rescission letter should explain the rationale and basis for rescission of coverage.

Listed below are the states that currently require a causal relationship:

- Kansas
- Missouri
- Nebraska
- Rhode Island

6.0 Intent to Deceive

In certain states, for a rescission of coverage to take place, we must show that the customer's misrepresentation on the application and EOI was intentional and meant to deceive the insuring company in order to obtain coverage.

If RMT recommends rescission of coverage and the customer resides in the following states, RMT and the WS (and/or the Technical Specialist/Team Leader) will review RMT's recommendation, reasoning, and relevant medical documents to determine the customer's intention.

The states are:

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Connecticut	Nebraska
Colorado	Ohio
Iowa	Oklahoma
Louisiana	Pennsylvania
Massachusetts	South Carolina
Minnesota	Texas
Missouri	Virginia

Some points to consider may include, but are not limited to:

- When was the diagnosis of the misrepresented condition made?
- Is the misrepresented condition clearly communicated to the customer by the treating provider(s)?
- Is the misrepresented condition mentioned by multiple providers? On multiple dates?
- What treatment or procedures has the customer undergone and when?
- How are the questions answered on the EOI form? Are some conditions listed and others not or is it noted there are no conditions/treatment?

There may be other questions or considerations when assessing the customer's intention. Prior to deciding that the customer intended to deceive us, review with your Team Leader (TL) or Technical Specialist (TS). The rescission letter should explain how we reached the conclusion that the customer intended to deceive us to obtain coverage.

7.0 Timing of the Investigation

Under the typical incontestability provision, the investigation must be completed and the coverage rescinded by adverse benefit determination letter during the Contestability Period.

8.0 Appeal

RMT will handle appeals received on rescissions of coverage (also known as 'living rescissions'). They will manage the communication and the review. RMT will coordinate with the Appeal Team on appeals in states identified in sections 5.0 and 6.0.

If the outcome of RMT's appeal review is to uphold the rescission, RMT will notify the customer, sending the appropriate correspondence. They will also provide their decision to the Waiver claims team and/or the Appeal Team for file documentation and any communication on the waiver claim, as needed.

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If RMT determines a rescission will be overturned, they will notify the Waiver claims team and/or the Appeal Team who in turn will notify the customer. The claims team will begin reviewing the waiver claim.

Appeals received on the waiver claim determination should be referred to the Appeal Team who will partner with RMT as appropriate.

9.0 New York Requirements

There are specific requirements relating to rescissions of policies delivered (i.e., issued) in the state of New York.

Any policy issued in New York will be underwritten by New York Life Group Insurance Company of New York. The issue state can be found on the face page of the policy, and is usually identified by the following language:

> *This Policy describes the terms and conditions of coverage. It is issued in New York and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.*

Before considering rescinding a policy that is issued in New York, contact the LRS for legal guidance. They will assist with any claim-specific questions.

New York state requirements are included in Circular Letter No. 1 (2017).

Back to Table of Contents

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Modified Occupation

1.0 Purpose/Overview

2.0 Modified Occupation Assessment

3.0 Questions and Factors to Consider

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the factors to consider when evaluating a modified occupation.

2.0 Modified Occupation Assessment

Standard disability policies define Regular Occupation as:

> **Regular Occupation**
> The occupation the Employee routinely performs at the time the Disability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

During the initial evaluation of a new claim, if the employer or customer indicates the occupation being performed as of the incur date was a modified occupation (not the occupation the customer typically performed) the Claim Manager (CM) should gather additional information about the customer's job duties both before and after the modification. As part of the claim evaluation, the CM should consider whether the modified occupation constitutes the customer's Regular Occupation as defined in the policy. Determining the customer's Regular Occupation ensures that our Disability determination compares requirements of the appropriate occupation to the reported restrictions and limitations.

If the claim has been approved and the customer returns to work during the Regular Occupation period in what he/she considers to be a modified occupation, the CM should proactively gather as much information as is available regarding the duties the customer is performing in order to determine whether or not the customer is performing his/her Regular Occupation.

3.0 Questions and Factors to Consider

The following questions/factors will help assess whether the modified occupation should be considered the customer's Regular Occupation.

- Did the customer and/or the employer intend the modified occupation to be a new occupation on a temporary or permanent basis?

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- Clarify the employer's expectations regarding the duration of the modified occupation at the time the customer began working in that role.
- Was this a newly created job? Did the employer create work for the customer? Or, did the employer consider this a transfer to another available, budgeted position?
- Is there a Job Description on file at the employer for the modified occupation?
- Do other employees perform this modified occupation, or is the customer the only one?
- Is the modified occupation considered an occupation in the general labor market?

In order to help someone stay at work or return to work, employers may create positions, fill an employee's work time with temporary projects, or assemble a collection of tasks that do not translate very readily to what would be considered an occupation in the general labor market. A Vocational Coach (VC) can help in identifying whether the new occupation is one that is normally found in the national economy.

- What is the nature of the modified occupation?
  - Is it consistent with the customer's restrictions and limitations, education, training, and experience?
  - Is the income earned from the modified occupation out of proportion to the expected wages for the same occupation in the national economy?

Employers may place an employee in an occupation different from their Regular Occupation, hoping that he/she will be capable of performing the requirements of the new modified position in an attempt to keep the employee at work. The employee may or may not have the functional abilities/skill set to perform the modified occupation on a sustained basis. The questions and factors outlined above allow appropriate consideration of the customer's attempts to try an occupation that may be unsuitable given his/her overall ability; including positions for which the customer typically would not have been considered for in the general labor market. Utilizing the expertise of the VC to identify the expected wages for the modified occupation can assist in answering questions about whether the customer's income is proportionate for the same occupation in the national economy.

- Is the customer no longer working in a modified occupation?
  - Was it due to job elimination? Was everyone's job eliminated?
  - Was it that the customer didn't want to do the job any longer?
  - Was the company downsizing? Does the employer plan on replacing the customer?

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- Was it related to the claimed disabling condition? Specifically, did the medical condition deteriorate, remain static, or was the customer no longer able to continue working at either his regular or modified occupation due to the condition?

Along with the other factors outlined above, the time spent in the modified occupation should also be a consideration. The longer the customer is in the modified occupation, the more likely it is that the modified occupation is the customer's Regular Occupation. As outlined above, the CM should utilize VC expertise to assess whether the modified occupation exists in the general labor market (or national economy if the policy defines such) and not make a claim decision solely on how long the customer has been in the modified occupation.

Back to Table of Contents

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Ongoing Claim Request for Information

1.0 Purpose/Overview

2.0 Requesting Medical Information

3.0 Policies Issued in California

4.0 Follow-up Request

5.0 Scheduling an Examination

6.0 Claim Determination

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the process for managing ongoing disability claims.

If a claim determination has not yet been made whether to approve or deny a claim, follow the timeframes for initial claim processing outlined in the releases “ERISA Guidelines for Policies Providing Disability Benefits” and “State Compliance Guidelines for Policies Providing Disability Benefits”. If the claim is on appeal following a denial or termination, you should use the procedure “Requirements for Handling Disability Appeals”.

2.0 Requesting Medical Information

During the ongoing management of disability claims, updated information is necessary to evaluate eligibility for continued benefits. It is important to work closely with customers and their providers to obtain the necessary information.

We strive to give customers and their providers reasonable opportunities to respond to our requests for information. Call the customer to advise that additional information is needed and will be requested. Clarify current providers, ask for information about any changes in the customer’s condition, and where applicable, identify and gather Social Security Disability Insurance (SSDI) related information. If you are unable to reach the customer by telephone, and there is a valid authorization on file, request updated information from the providers on file.

In addition to the telephone call, send a letter advising the customer what type of information he/she is required to provide to determine ongoing eligibility for benefits. Enclose forms, as appropriate. Advise the customer that we will follow up on the request within 30 days. (For policies issued in California, refer to section 3.0.) Document all of your attempts to obtain information from the customer and provider(s).

Request necessary medical records and completion of supplemental forms from the provider(s), Worker’s Compensation carrier, and the Social Security Administration, as applicable.

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3.0 Policies Issued in California

The state of California has issued specific guidelines around Proof of Loss for claims governed by California-issued policies. The requirements noted here apply only to group LTD policies issued in California.

The policy issue state can be found on the face page of the policy, and is usually identified by the following language:

"This Policy describes the terms and conditions of coverage. It is issued in California and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address."

Proof of Loss

In relevant part, the Proof of Loss provision governing claims under California issued policies states, "*Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss.*"

Ongoing Claim Management for California Issued Policies

During the ongoing management of a claim under a California issued policy, if updated information is needed to support periods of continuing Disability, we must allow customers a minimum of 90 days to provide this information. In correspondence with the customer, he/she should be notified of this 90-day timeframe. When updated information is needed, you should work closely with the customer and the provider(s), throughout this 90-day period, to obtain compliance with our request for necessary information.

4.0 Follow-up Request

If the necessary information is not received within 30 days of the first request, a second requests should be sent to any party that has not yet responded, utilizing all applicable means (phone, fax and/or mail).

Advise the customer via telephone and letter that the requested information has not been received. Explain the following policy provisions, as applicable to the claim: Claimant Cooperation, and Physical Examination.

If the customer has responded to our requests and appears to have made efforts to assist in obtaining the information, but the necessary information has not been received within 30 days of the first request, notify the customer that we will schedule an examination (IME or FCE, as appropriate) if the information is not received within the established timeframe of the follow-up request.

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If the customer has not responded to our requests, and we have been unable to gather the necessary medical records, it is unclear whether the customer is continuing to make a claim for benefits. Since the customer's cooperation and/or assertion of ongoing disability are essential factors in scheduling an examination, send a letter asking the customer to contact us so that we can move forward with scheduling an examination if the necessary information is not received within the established timeframe. Reference the following policy provisions, as applicable to the claim: Claimant Cooperation, and Physical Examination.

Customers covered under a California issued policy must be allowed a minimum of 90 days to provide information. See 3.0 for additional information about policies issued in California.

5.0 Scheduling an Examination

For Long Term Disability claims, if you are unable to obtain the necessary medical information by the established timeframe and the customer has been responsive, proceed with requesting an examination (either an IME or FCE, as appropriate) if it is determined to be necessary in the absence of the requested information.

If we asked the customer to contact us to cooperate with scheduling an examination, and he/she confirms a continuing claim for benefits, proceed with scheduling an exam if it is determined to be necessary in the absence of the requested information. If the customer fails to cooperate with us in scheduling the examination, you may proceed with the claim determination relying on the Claimant Cooperation provision.

See "Independent Medical Evaluation and Peer Review Referrals" and "Functional Capacity Evaluation Referrals" for additional referral indicators for an examination. When notifying the customer of an examination, provide the policy provision which states that the Company has the right to examine a customer as often as it may reasonably require.

6.0 Claim Determination

If the customer attends the examination, review the report and further evaluate continued eligibility for benefits, referring to Expert Resources as needed.

If the customer fails to attend the examination as scheduled, refer to release "Independent Medical Evaluation and Peer Review Referrals" or "Functional Capacity Evaluation Referrals" for guidance on when rescheduling the exam may be appropriate.

If you have been unable to obtain information necessary for continued evaluation of the claim, and the customer has failed to cooperate with your efforts to obtain or schedule an examination, you may proceed with the claim determination relying on the Claimant Cooperation provision in the following scenarios.

- The customer fails to respond to our requests to contact us to schedule an examination, or

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- The customer refuses to attend an examination, or
- The customer misses an examination for a reason determined not to be reasonable, or
- The customer does not reschedule the examination within the established timeframe and does not have a valid reason. You should document what the offered reason was, and why it was not reasonable.

Follow the timing guidelines previously established and the state requirements, as applicable (i.e. California requirements).

If an adverse determination is made relying on the Claimant Cooperation Provision because the customer failed to cooperate with our efforts to obtain or schedule an examination, the determination letter needs to:

- Be consistent with current guidelines for ERISA adverse determinations, if applicable (see "Adverse Claim Determination Guidelines for Policies Providing Disability Benefits")
- Quote the Claimant Cooperation and Physical Examination provisions, if applicable
- Explain in reasonable detail the attempts made to gather medical records from all applicable parties, the outcome of those efforts, the reason an IME/FCE was needed, the efforts to schedule the examination, and the outcome of those efforts

Use the IME FCE Non Cooperation Adverse Determination letter to ensure that all of the above items are addressed. If the adverse determination is made relying on the Claimant Cooperation provision as outlined above, the Termination Type should be coded as "Denied, Other Contract Limit", because the customer failed to satisfy that contractual provision. If the policy does not have a Claimant Cooperation Provision, determination of continued eligibility for benefits should be made based on the available information on file.

Back to Table of Contents

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Policy Exclusions Based on Medical Necessity

1.0 Purpose/Overview

2.0 Consult Policy Language

3.0 Determining if a Surgery is Medically Necessary

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview for handling claims involving surgeries that may not be Medically Necessary.

2.0 Consult Policy Language

Many Short Term Disability policies contain an exclusion for surgical procedures that are not Medically Necessary. An example of this policy language is below:

> "The Plan will not pay any Disability Benefits for a Disability that results, directly or indirectly, from…
>
> 6. any cosmetic surgery or surgical procedure that is not Medically Necessary. "Medically Necessary means the surgical procedure is (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. The Plan will pay benefits if the Disability is caused by the Employee donating an organ in a non-experimental organ transplant procedure."

Policy language may vary, so consult the individual policy provisions for each claim.

3.0 Determining if a Surgery is Medically Necessary

When it is unclear if a customer's surgical procedure was Medically Necessary, refer the claim to Expert Resources for review. Factors to consider include:

- Has a diagnosis been established?
- Is the surgery part of a treatment plan to treat a diagnosis related to the Injury or Sickness?
- Is the surgery in line with generally accepted medical standards to treat the diagnosis?
- Are there any comorbidities (including mental health) that impact the need for the surgical intervention?

If additional questions remain after the medical review is completed, refer the claim to your Legal Referral Specialist for additional guidance.

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Unless policy language specifically excludes coverage for Disability resulting from surgical procedures that are not Medically Necessary, claims resulting from surgery that may not be Medically Necessary must be administered as any other claim under the policy. Unless otherwise excluded, if the surgical procedure results in a customer being unable to perform the duties of his/her occupation, evaluate the claim under the other applicable policy requirements.

Back to Table of Contents

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Pre-Existing Condition Limitation and Investigation

1.0 Purpose/Overview

2.0 Policy Language

3.0 Applying the PCL

4.0 Treatment Free Period

5.0 Added or Increased Benefits

6.0 State Restrictions

7.0 Accident and Acute Injuries

8.0 PCL Investigation

9.0 PCL and Co-Morbid and Co-Existing Conditions

10.0 Proving Pre-Existing Condition

11.0 Time Limits

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1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview on applying and interpreting policy language for the Pre-Existing Condition Limitation (PCL).

2.0 Policy Language

Policies may limit benefits for conditions that are pre-existing. The PCL will be defined in the policy. The Takeover Provision, which is also defined in the policy, may be applicable when considering the PCL Provision. Below is sample policy language for these provisions. It is important to review the policy for the specific wording regarding these provisions.

Pre-Existing Condition Limitation

“The Insurance Company will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-Existing Condition. A 'Pre-Existing Condition' means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after an Employee is covered for

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at least 12 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits."

Takeover Provision

"C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-Existing Condition Limitation will not apply to an Employee covered under a Prior Plan who satisfied the pre-existing condition limitation, if any, under that plan. If an Employee, covered under a Prior Plan, did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied.

Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy."

3.0 Applying the PCL

PCL language varies. Review the policy at hand to determine the scope and applicability of the PCL. Although the wording of most policies is similar, the timeframes for investigation vary. For example, in Short Term Disability (STD) policies the timeframes are much shorter.

Certain timeframes that may be considered during the PCL investigation include the Investigation Period and the Hurdle Period:

- Investigation Period: The timeframe before the effective date of coverage, or before the effective date of any added or increased benefits, in which the customer may have originally been treated, or should have treated, for the condition.

- Hurdle Period: The period of time after the effective date of coverage, or after the effective date of any added or increased benefits, that the customer must be in Active Service before becoming disabled for a condition that may be the same or related to the condition in the Investigation Period in order to avoid potential application of the PCL.

To determine whether a claim is subject to a PCL investigation, review the policy to see if it contains a PCL provision. If it does, compare the incur date (reported date of disability) to the customer's effective date of coverage.

If the policy contains a buy-up option, or has been amended to add or increase benefits, obtain the effective date of the increased coverage. The buy-up portion may be subject for PCL even if the basic is not.

If the customer became disabled within the Hurdle Period outlined in the policy, the PCL may apply.

Determine if the customer was covered under a prior plan with the client (Employer or Policyholder) immediately prior to the effective date under the current policy. If the customer was not covered under the prior plan immediately prior to their effective date under our policy, the PCL may apply, depending on the incur date and diagnosis. Check the policy's PCL

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provision and eligibility language to determine if the customer's effective date of coverage is correct. Review the policy's Takeover Provision as it may be applicable when considering PCL.

Depending upon the applicable policy provision, the Investigation Period may be 3, 6, 12 or 24 months prior to the most recent effective date of insurance. Similarly, the Hurdle Period may be 6, 12 or 24 months as of the most recent effective date of insurance. PCL provisions may be expressed in terms of a combination of these numbers.

For example, a 3/12 PCL means that we would investigate if the customer was treated at any time during the 3 months prior to their most recent effective date of coverage if he/she went out of work within 12 months after the effective date of their coverage.

If the policy has a treatment free period in the PCL provision, refer to section 4.0

Once we have determined that a reported incur date falls within the policy's Hurdle Period, contact the Employer to determine:

- Was the Employee in Active Service on the effective date of this policy?
- Was the Employee insured on the day before the effective date of this policy under another group policy that is sponsored by the Employer and is replaced by this policy?
- Has the Employee completely satisfied the requirements of any PCL provision under the prior policy? Obtain the prior policy for review.
    - If not, does the period of time that the Employee was covered under the prior policy, when added to the time that the Employee has been covered under our policy prior to commencement of Total Disability equal or exceed our policy's PCL time period requirements?

If the answers to all of the above questions are "yes" and the benefit through our policy is less than or equal to the prior plan, the PCL will be waived. However, if the answers to all of the above questions are "yes" and the benefit through our policy is greater than the prior plan, then a PCL investigation with respect to the difference between the two benefits should be completed. If the answer to any of the above questions is "no," then re-evaluate the customer's eligibility and consider if a PCL investigation should be performed.

4.0 Treatment Free Period

For policies with a treatment free period, the investigation period defined by the policy may reflect a combination of 3, 6, 12 or 24 months. Based on a 3/3/12 PCL provision, an investigation to determine whether the disabling conditions is pre-existing is needed if the customer's incur date is within 12 months of the most recent effective date.

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If between EDOC and LDW, the customer has a 3-month period where they did not treat for their disabling conditions, then the PCL does not apply. This 3-month period is floating and may occur any time during the period of EDOC to LDW. If there is not a treatment free period, then investigate the 3 months prior to EDOC for treatment of the disabling conditions.

Example of a 3/3/12:

EDOC = 1/1/2022

LDW = 9/1/2022

ID = 9/2/2022

PCL investigation is needed if customer's incur date is 1/1/2022 – 12/31/2022. If the customer has a 3 month period where they did not treat for their disabling conditions between 1/1/2022 – 9/1/2022, no additional investigation is required. Otherwise, the period of 10/1/2021 – 12/31/2021 should be investigated for treatment of disabling conditions.

5.0 Added or Increased Benefits

A PCL can apply to "any added benefits or increases in benefits." This can refer to any increases to the benefit payable under the policy, such as increases to the benefit percentages, the maximum and minimum benefit, as well as added benefits such as a Cost of Living Adjustment.

Added/Increased benefits include Employee-elected increases in coverage, such as buy-up elections, as well as Employer-elected increases. Employer-elected increases can include differences between a new policy and the prior plan, as well as policy amendments. If the change is the result of a new policy, obtain necessary information from the prior plan so that coverage levels can be compared.

If a policy amendment includes any increase in benefits, a customer becoming disabled within the Hurdle Period from the date of the amendment would be subject to a PCL investigation. The PCL would only apply to the benefit increase or addition. When conducting a PCL investigation for an increased benefit, if we determine that benefits are otherwise payable, but the customer's disability was found to be pre-existing, then benefits would be payable at the lower amount.

For example, if the prior plan contained a 50% benefit, and the new policy contains a 60% benefit, as long as the customer satisfied the requirements of the PCL under the prior plan, the PCL would apply only to the additional 10% increase.

6.0 State Restrictions

Some states regulate the way we administer PCL provisions. These requirements will supersede policy language that does not adhere to the state's requirements.

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Texas: For any Texas situsued policies, "reasonable person" language is not allowed. In the event this wording is contained in a Texas situsued policy that has not yet been updated, it should not be relied on to determine PCL. This guidance applies to all customers covered under Texas situsued policies, regardless of their state of residency or employment.

New York: For any New York situsued policies, if the customer becomes disabled due to a pre-existing condition during the Hurdle Period, then they cannot be excluded from benefits. Instead, no benefits will be payable during the Hurdle Period. Benefits will be pended until the later of the end of the Hurdle Period, or the end of the contract's Elimination Period. Once the Hurdle Period is satisfied, the claim will be evaluated to determine if the customer is entitled to benefits per the other provisions of the policy. If yes, and the policy's Elimination Period has also been satisfied, benefits will then be payable. For more details regarding the application of this statute, refer to "Pre-Existing Condition Limitations Under Policies Delivered in New York".

Maryland: For Maryland situsued policies, there are different exclusionary periods for different sets of applicants: those who are not underwritten and those who are medically underwritten with a Waiver Rider. New policy language has been inserted into Maryland situsued policies to support the requirements. Refer to "Maryland Requirements for Pre-Existing Condition Limitation and Investigation" for details.

Minnesota: for Minnesota residents the Hurdle Period may not be longer than 24 months from the customer's most recent effective date of insurance.

7.0 Accident and Acute Injuries

When the disabling condition is the result of accidents or acute injuries, you may be able to quickly recognize that PCL won't be applicable given how the incident occurred. For example:

- Ankle fracture sustained in a motorcycle accident
- Spinal cord injury resulting from a skiing accident
- Broken leg after being hit by a car

In these types of circumstances, the customer could not have received treatment during the PCL Investigation Period for an injury that hadn't occurred yet. Your PCL review may reasonably conclude that the disabling condition is not Pre-Existing given how the incident occurred. When this circumstance is applicable, document the file with the rationale for coming to this conclusion.

There are other types of accidents/injuries where a more in-depth PCL investigation may be warranted (e.g. repetitive, prolonged or overuse injuries related to chronic muscle or joint conditions). You also need to consider whether the customer has any other conditions that might complicate their recovery from the incident.

Every claim is unique and should be evaluated based on the individual facts of the claim.

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When evaluating accidents and injuries, if it is unclear as to whether or not an in-depth PCL investigation is warranted, contact a Senior Claim Manager, Technical Coach, Team Leader and/or Quality Review Specialist.

8.0 PCL Investigation

Once you have determined that the customer became disabled during the Hurdle Period and that an in-depth PCL investigation is warranted, determine if the customer treated for a Pre-Existing condition (consistent with the policy's definition of a 'Pre-Existing Condition') during the Investigation Period.

Consider the following actions during the Initial Investigation.

- Review the policy's PCL provision to determine the specific dates to be investigated (Investigation Period). Review the existing information on file to determine what medical information has been received, and what additional information may be relevant to the condition and investigation.

- It may also be useful to seek medical information *prior* to the start of the Investigation Period. Use your judgment to determine how far back to seek records.

- Contact the customer by phone. Gather information to help you understand the history of the reported disabling condition. Ask about all medications prescribed/refilled, names and contact information for all providers, hospitals, etc. Also notify the customer that their claim is being investigated for a possible Pre-Existing Condition. Describe the specific type of information needed and the applicable dates per the PCL policy provision. Gather PCL-related information from the customer to understand their treatment not only within the Investigation Period, but also the treatment and the history leading up to that period.

- Document the system with the customer's response. Indicate that requests will be sent directly to the appropriate providers and/or other persons. Use the LTD Initial Review with PCL letter or the STD Initial Review with Pre-ex Delay letter to provide the customer with written PCL notice. If you were unable to obtain PCL related information over the phone, or to validate information gathered over the phone, attach to your written correspondence the PCL questionnaire in the correspondence tool.

- Send requests to all treating providers, physicians, hospitals, clinics or other medical providers for all dates of treatment, office notes, test results, medical records, medications prescribed, and specific conditions treated for during the applicable period (that is, prior to, during and after the Investigation Period) to address prior treatment as well as current treatment and functionality.

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- Include a request for the names, addresses, and phone numbers of other treating or referring physicians, and hospitals, clinics or other medical providers where the customer received or requested treatment.

- If the customer indicates they have more than one condition/diagnosis, ask the treating providers if the conditions are related. If they are not, two completely different investigations may be required.

- Request an IntelliScript Report. Refer to "IntelliScript Pharmacy Records Request" for instructions on this procedure.

- As each response is received, review the information to determine if the responding party provides the names of additional sources that have not already been contacted. Write to these sources as well. If a treating provider replies by phone, use your judgment to determine if it's necessary to ask for validation in writing.

- Whenever it is necessary to follow-up, advise the customer in writing of the additional information needed to decide the claim, that it is their obligation to provide it, and that follow up requests will also be sent directly to the appropriate providers. This provides the customer with an opportunity to assist in the investigation. Refer to "State Compliance Guidelines for Policies Providing Disability Benefits" for additional information.

- Once the requested information is received, review each response to determine if the medical source has provided the information requested. As necessary, contact the treating providers to clarify their responses or obtain missing information.

- Further contact with the treating providers may be necessary if the customer is claiming to be disabled from a condition that may be related to, caused by, or resulting from a condition for which they were treated during the Investigation Period. If the condition is complex or the relationship between conditions is unclear, review with the appropriate expert resource: Nurse Case Manager, Behavioral Health Specialist, Pharmacist or Medical Director.

- Once all requested and necessary information is received and the appropriate reviews have been completed, document the outcome of the PCL investigation in the Claim Strategy Task. If the decision is to make an adverse claim determination because we have established that the Disabling condition(s) is Pre-Existing, the procedures in "Adverse Claim Determination Guidelines for Policies Providing Disability Benefits" and "Adverse Determination Letter Content for Policies Providing Disability Benefits" should be followed.

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- It may be determined that one or some of the customer's conditions are Pre-Existing and others are not. If the claim is approved, the approval letter should identify the condition(s) that are Pre-Existing and therefore not considered in the approval determination. Include appeal language for those conditions determined to be Pre-Existing. Please see section 9.0 for more information on this topic.

9.0 PCL and Co-Morbid and Co-Existing Conditions

When conducting a PCL investigation, you may determine that the customer received treatment for multiple conditions during the Investigation Period.

According to policy language, benefits will not be payable for "any period of Disability caused or contributed to by, or resulting from, a Pre-Existing Condition," The focus of the PCL investigation should be on the conditions reported as Disabling by the customer and treatment providers.

If the customer is reporting multiple Disabling conditions, or has significant co-morbid conditions that are impacting ability to function, all the conditions should be considered in the PCL investigation.

There are times when one or more of the Disabling conditions may be found pre-existing. If benefits are payable, the customer should be informed of which conditions were found to be pre-existing, and are excluded from further consideration. This information should be included in the approval letter and documented in the Claim Strategy. Include appeal language in the approval letter for those conditions determined to be Pre-Existing.

> **For example:** A customer may be reporting a psychiatric condition and a physical condition. Records obtained during the investigation may support that the psychiatric condition was pre-existing, but the physical condition was not. If benefits are approved based on the physical condition, the customer should be advised that the psychiatric condition was found pre-existing, and no benefits will be paid for that condition.

If records obtained during the Investigation Period note treatment for other, unrelated conditions, you should consider if the customer has any functional limitations related to these conditions. If the customer does not have functional limitations related to the treatment during the Investigation Period, the PCL provision would not apply to these conditions and no further action should be taken in regard to this information.

> **For example**: A customer is reporting they are unable to work due to a psychiatric condition. Records obtained during the Investigation Period note that the customer received treatment for neck and back pain. The customer and the treatment providers are not reporting any limitations due to the neck and back pain. No further action should be taken in regard to this information and you should move forward with your review of the claim.

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10.0 Proving Pre-Existing Condition

In order to render an adverse claim decision under the PCL provision, the claim file must contain proof the condition/disability was caused/contributed to by/resulted from a Pre-Existing Condition. However, there may be claims where we are unable to definitively establish whether or not the disabling condition was Pre-Existing. For example:

- Customer did not provide us with the necessary information or authority to conduct or complete our PCL review
- Medical sources did not respond to requests for records
- Medical records available are insufficient to prove or rule out PCL

Customer Not Cooperating

If the reason for our inability to confirm or rule out PCL is because we are missing information directly within the customer's control (e.g. Disclosure Authorization, PCL questionnaire, etc.), then the Claimant Cooperation provision may apply. Check the policy to determine if it contains this provision. Consider the following factors:

- Have meaningful attempts been made to gather the information or obtain authorization from the customer, utilizing both written and telephonic communication?
- Have we been unable to gather the necessary information by other means (e.g. Verbal Authorization, obtaining PCL information over the phone, etc.)?
- Is the missing information material to our PCL investigation?
- Have we allowed a reasonable amount of time for the customer to respond?

If we determine that the Claimant Cooperation provision applies, the adverse decision rationale is not based on the PCL provision. Rather, the rationale should cite the failure of the customer to cooperate with providing the necessary information or documents needed to determine whether the PCL provision applies.

Insufficient or Incomplete Medical Records

If the reason for our inability to confirm or rule out PCL is beyond the customer's direct control (e.g. we are missing treating provider's office notes, hospital records, etc.), then the Claimant Cooperation provision would likely not apply. Consider the following factors:

- Have meaningful efforts been made to gather the medical information, utilizing both written and telephonic communication?
- Have we considered utilizing a vendor (e.g. Genex) to obtain the records?

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- Has a pharmacy canvas been requested?
- Has the customer been notified of the information we are missing?
- Is the missing information material to our PCL investigation?
- Have we allowed a reasonable amount of time for the medical source(s) to respond?
- Have we been unable to gather the necessary information by other means (e.g. validating over the phone the dates and/or type of treatment)?

Upon reaching a point in the PCL investigation where we have exhausted efforts to establish whether the disabling condition was Pre-Existing, the information available should be reviewed to determine if we have enough evidence on file to make a PCL decision. Review the claim file as a whole and consider all available records, including those contained in the customer's STD file (if applicable), as well as any information that can reasonably be gained from the "History" section of any office notes on file.

- If we determine there is enough evidence to reasonably conclude that the customer's disabling condition is not Pre-Existing, then PCL should be ruled out, even if we haven't gathered all the requested records. Move forward with the decision of whether or not the customer meets the definition of Disability and follow the standard guidelines for approval or denial once the Disability determination has been made.

- If we determine there is insufficient evidence to reasonably rule out PCL or to definitively prove PCL, move forward with the decision of whether or not the customer meets the definition of Disability. If the customer satisfies the definition of Disability, the claim should be approved. Notify the customer that, due to not receiving all the records we requested, we were unable to establish whether or not the condition was Pre-Existing, but that all other applicable policy provisions were met. The approval letter should provide notice that if we later receive information that validates the customer's Disabling condition was Pre-Existing, we reserve the right to re-evaluate the customer's entitlement to benefits. The Approval Letter templates contain guiding language to be selected in order to provide the required notice to the customer.

  Since PCL would be considered unresolved, any subsequent medical information that is received should be evaluated under all applicable policy provisions, including PCL. For the ongoing management of the claim, flag this issue by documenting it in both the Claim Strategy task and in an open General Follow-Up task. Sample claim file documentation: "*PCL is unresolved because {insert reason we were unable to rule out PCL}. Any future medical records should be reviewed to determine if PCL applies*." Throughout the life of the claim following the approval, if we receive information that validates the Disabling condition was Pre-Existing, refer the claim to the DMS Policies/Procedures Referrals mailbox for guidance.

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If it is unclear as to whether the information on file is sufficient to reasonably rule out PCL or to definitively establish PCL, contact a Senior Claim Manager, Technical Coach, Team Leader and/or Quality Review Specialist for guidance.

11.0 Time Limits

The need to conduct a PCL investigation does not change the deadline by which a claim determination must be made. Refer to “ERISA Guidelines for Policies Providing Disability Benefits” and “State Compliance Guidelines for Policies Providing Disability Benefits” for details about those time limits, and how and when they may be extended.

Back to Table of Contents

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Pregnancy Leave Guidelines

1.0 Purpose/Overview

2.0 Pregnancy Duration

3.0 Pregnancies Without Complicating Medical Conditions or Work Environments

4.0 Pregnancies With Exceptional Circumstances

5.0 Pregnancies With Other Complicating Conditions

6.0 Reasonable Accommodations

7.0 Post Partum Duration

8.0 State Requirements

9.0 Coding Pregnancy Claims

10.0 References

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1.0 Purpose/Overview

The purpose of these guidelines is to assist in evaluating normal and exceptional pregnancy claim situations. Also provided is information regarding employment considerations during pregnancy.

2.0 Pregnancy Duration

There are several factors which may influence the length of time a customer can continue to work during pregnancy. These factors vary from customer to customer, and must be considered on a case-by-case basis. Consider all relevant medical records, information gathered during customer and provider outreaches, and the customer's history and job duties during claim evaluation.

The next four sections will help determine a customer's abilities during their pregnancy and after delivery.

3.0 Pregnancies Without Complicating Medical Conditions or Work Environments

Most customers with sedentary occupations and/or normal pregnancies should be able to work until the date of delivery. However, we may pay these claims up to 2 weeks prior to and including the Estimated Date of Confinement (EDC) if the customer ceases working.

4.0 Pregnancies with Exceptional Circumstances

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Some customers may have complicating medical conditions or work environments that may necessitate additional time off. These claims should have medical and occupational information documented in the file and may be paid up to 4 weeks prior to the EDC if the customer ceases working. Consider these factors:

- Customers who were underweight before pregnancy and whose weight gain during pregnancy have been below target.
- Hypertensive customers (Absolute BP>140/85, or an increase of 30 mmHg in systolic BP or 15 mmHg in diastolic BP, or any increase in BP with proteinuria or edema).
- Customers carrying twins or more (multiple gestation)
- Customers whose jobs require prolonged, continuous, or intermittent standing of more than 3 hours in an eight hour work day, e.g. cashiers, bank tellers, physicians, nurses, waitresses, etc.
- Customers whose jobs belong to moderate to heavy physical demand job categories.
- Customers with previous pregnancy complications such as low birth weight infants, intrauterine growth retardation, pre-eclampsia/eclampsia, etc. should minimize physical work.
- Customers who work in extreme temperature environment (above 78F or below 50F).
- Customers whose jobs involve working with chemicals, heavy metals, ionizing radiation, infectious agents (rubella virus, cytomegalovirus), solvents, or pesticides, e.g. laboratory chemists, petroleum refinery workers, lead-acid or cadmium battery assembly workers, automobile tire makers, x-ray technicians, oncology nurses, automobile repair technicians, anesthetists, farm workers, exterminators, hospital sterilizing personnel, sewer workers, dry cleaners, electronics industry, etc.
- Conditions which may require bed rest or early pregnancy leaves include: Hyperemesis Gravidarum, Incompetent Cervix, Antepartum Hemorrhage/Placenta Previa, Preterm Labor, Pregnancy-Induced Hypertension/Pre-Eclampsia, Intrauterine Growth Retardation, Multiple Gestation, Pre-Existing Medical Conditions, Infection or Communicable Disease.

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5.0 Pregnancies With Other Complicating Conditions

The customer's physician may prescribe extended leave for conditions that may not fall into either category above. If a customer has an extended leave prescribed, consultation with the

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Nurse Case Manager (NCM) and/or Medical Director (MD) should be considered to determine if cessation of work is warranted, and how far along in the pregnancy it is appropriate.

The following are examples of conditions which may be complicating during pregnancy:

- Two premature deliveries with infants weighing less than 4.41 lbs. (2,000 g).
- Incompetent cervix and history of previous fetal loss or cervical cerclage.
- Uterine anomalies with loss of a fetus.
- Cardiac status greater than Class II, which affects the ability to tolerate the massive increase in cardiac output and blood volume imposed by pregnancy.
- Marfan's syndrome.
- Hemoglobinopathies including thalassemia.
- Pulmonary or arterial hypertension.
- Retinopathy greater than stage I, renal changes with abnormal creatinine clearance, preeclampsia, or polyhydramnios.
- Gestational pemphigoid (herpes gestation), if discomfort is great.
- Severe anemia - 8 g/dl of hemoglobin or less.
- Insulin Dependent diabetes with poor/labile control and complications of syncope.
- Hypothalamic - Pituitary axis endocrinologic disorders (Thyroid Disorders).
- Renal Failure – Chronic Kidney Disease
- Sickle Cell Disease.
- Back Pain/Radiculopathy.

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The medical condition should be evaluated in conjunction with the customer's occupation to determine if the length of leave is reasonable.

6.0 Reasonable Accommodations

Work during pregnancy is typically considered to be safe. In order to qualify for disability, there needs to be a complicating condition requiring a medical necessity for restrictions. An example

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of such a condition could be lower back pain for a pregnant customer in a medium to heavy occupation.

The Pregnant Workers Fairness Act requires employers to provide reasonable accommodations to employees with known limitations related to pregnancy, childbirth, or related medical conditions; disability is not required. States may have additional requirements to provide reasonable accommodations related to pregnancy, childbirth or related medical conditions.

7.0 Post-Partum Duration

Post-partum duration will vary depending on the type of delivery and whether there are complications present. For a normal vaginal delivery with no complications, post-partum disability duration may typically be up to 6 weeks. For cesarean delivery with no complications, post-partum disability duration may typically be up to 8 weeks. Consult the policy or plan documents as some policies/plans may define post-partum duration for vaginal and cesarean deliveries. Follow the policy/plan instructions if different than what is defined here.

Claim situations that have post-partum complications should be considered on a case by case basis, reviewing relevant medical records and occupational requirements.

In claim situations with miscarriage, post-partum duration is based on the trimester in which the miscarriage occurs:

- Miscarriage in the 1st Trimester – For all occupations is 3 days expected duration.

- Miscarriage in the 2nd or 3rd Trimester – May approve to the earlier of the Estimated Return to Work (ERTW) or 2 weeks. With supporting medical documentation, including restrictions/limitations (R&Ls), may approve up to 3 weeks post-partum for sedentary and light occupations and 4 weeks post-partum for medium to very heavy occupations. Medical documentation and R&Ls should be reviewed for consideration of benefits beyond 4 weeks post-partum.

8.0 State Requirements

Certain states have Statutory or Private Plans with requirements that exceed the expected durations we have outlined above. For example, certain states may require payment of up to 4 weeks prior to the EDC as a 'normal' delivery, not 2 weeks, as indicated above. Adhere to the Private or Statutory requirements on claims submitted under Statutory or Private Plans. Please refer to any Statutory or Private plan documents for additional information regarding these requirements. Additional information on Statutory and Private plans may be found in the statutory plan releases.

9.0 Coding Pregnancy Claims

ICD-10 Codes for Short Term Disability (STD) Claims:

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O80 – when a customer goes out on disability for pregnancy no more than 2 weeks prior to the EDC and delivery is normal vaginal. (Note: This should also be used for Statutory claims where the plan allows 4 weeks prior to EDC and the delivery is normal vaginal).

If cesarean section delivery is confirmed after initial claim submission, update code O80 to code O82.

O82 - when a customer goes out on disability for pregnancy no more than 2 weeks prior to the EDC and the delivery is a cesarean section. (Note: This should also be used for Statutory claims where the plan allows 4 weeks prior to EDC and the delivery is a cesarean section)

O99.89 – when a plan or policy allows a customer to stop working greater than 2 weeks prior to the EDC due to occupational requirements or other special handling instruction.

O99.89 – for 1st, 2nd and 3rd trimester miscarriage.

Complication Prior to EDC or After Delivery - Pregnancy claims falling outside the normal guidelines defined above should be coded using the ICD-10 code appropriate for the complication.

Document the file with the delivery date/type once it is confirmed.

ICD-10 Codes for Long Term Disability (LTD) Claims:

New LTD Claims (includes both Stand Alone and transitioned STD claims): Pregnancy claims should be coded as O80 for the first 12 months from the incur date. A secondary ICD-10 code may be input if there are complicating or concurrent conditions.

12 Months Past Incur Date: Most pregnancy-related conditions should have either resolved, or the condition should have evolved into another primary condition by 12 months after the incur date. If the claim continues, an ICD-10 code appropriate to the complication or new primary condition should be used.

10.0 References

American College of Obstetrics and Gynecology: Employment Considerations During Pregnancy and the Postpartum Period. 2021

Back to Table of Contents

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Proof of Loss for California-Issued Long Term Disability Policies

1.0 Purpose/Overview

2.0 California-Issued LTD Policies

3.0 Proof of Loss Requirements for Initial and Ongoing LTD Evaluations

4.0 Proof of Loss Requirements for LTD Appeals

1.0 Purpose/Overview

The purpose of this procedure is to review the state-mandated timeframe for submission of Proof of Loss for California-issued Long Term Disability (LTD) policies.

2.0 California Issued LTD Policies

The state of California has issued specific guidelines relating to Proof of Loss for LTD claims governed by California-issued policies. These requirements apply only to group LTD policies issued in California.

The issue state can be found on the face page of the policy, and is usually identified by the following language:

"This Policy describes the terms and conditions of coverage. It is issued in California and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address."

3.0 Proof of Loss Requirements for Initial and Ongoing LTD Evaluations

In relevant part, the Proof of Loss provision governing LTD claims under California-issued policies states:

"*Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss.*"

During both the initial investigation and the ongoing management of an LTD claim governed by a California-issued policy, if additional information is needed to make a claim determination or to support periods of continuing Disability, we must allow the customer a minimum of 90 days to provide this information. In correspondence with the customer, they should be notified of this 90-day timeframe. The customer is responsible for obtaining the requested information from providers, the employer, or others, but you should assist the customer as part of our procedures. Nothing in these procedures should prevent you from making a decision prior to 90 days, if there is information sufficient to support a determination that benefits are payable.

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4.0 Proof of Loss Requirements for LTD Appeals

Refer to release “Requirements for Handling Disability Appeals” for guidelines relating to Proof of Loss on LTD appeals governed by California-issued policies.

Back to Table of Contents

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Proof of Loss Provision in Disability Policies

1.0 Purpose/Overview

2.0 Proof of Loss Defined

3.0 Initial Investigation Proof of Loss Considerations

4.0 Ongoing Investigations Proof of Disability Considerations

5.0 Impact to Claim Evaluation

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the Proof of Loss (POL) provision in disability policies.

2.0 Proof of Loss Defined

Policy language varies so, it is important to consult the specific policy provision for each claim. Standard policies define POL as:

"Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity."

"Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company."

If applicable, refer to "Proof of Loss for California-Issued Long Term Disability Policies" for additional information.

3.0 Initial Investigation Proof of Loss Considerations

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Standard policies include a filing requirement that outlines the POL standard. Generally, the required time period for submission is one year and 90 days from the date of loss or last day worked.

For initial investigations, the information needed from the customer to satisfy POL requirements is minimal, and only require a claimed loss within the timeframe outlined in the policy. Examples of a claim for loss may include but are not limited to:

- Phone call from customer/client/authorized representative stating they are unable to work due to a disability.
- Submission of documentation (e.g., Claim Form, Intake Form, Disability Questionnaire, etc) by customer/client/authorized representative making claim for benefits due to a disability.

Standard language states that If written POL, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of the time limits, the claim will be denied."

To determine if POL has been established or whether information was submitted timely based on state and contractual requirements, refer to "Late Submittals".

Once a claim for loss has been received, the claim should be evaluated following normal claim procedures. It is the responsibility of the Claim Manager (CM) to evaluate whether the information on file satisfies the Definition of Disability and other applicable requirements defined by the policy.

4.0 Ongoing Investigation Proof of Disability Considerations

While initial investigations require documentation to support POL, ongoing investigations require proof of continued Disability and Appropriate Care by a Physician.

For ongoing investigations, standard policies state that proof of continued Disability and Appropriate Care by a Physician should be given within 30 days of the Insurance Company's request.

Since POL has already been satisfied during the initial investigation, the ongoing investigation should focus on establishing proof of continued Disability and Appropriate Care as referenced above in section 2.0.

There may be instances when the information on file is sufficient enough to support continued disability (MMI, progressive/terminal medical conditions). The information on file should be assessed to determine whether additional documentation is needed based on the facts of the specific claim.

If it is determined that additional information is necessary to make a disability determination for continued benefits, the CM should work with the customer and their provider(s) to gather the

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necessary information. Once it has been determined that additional information is needed, the CM should follow the process outlined in “Ongoing Claim Request for Information”.

5.0 Impact to Claim Evaluation

If it is determined that information is needed to make claim decision during the initial investigation or ongoing management of the claim, POL states that we must allow the customer the minimum number of days outlined in the policy to provide this information.

Standard policy language referenced below does not include POL in the Definition of Disability or the Termination of Benefits provisions.

POL outlines when proof of continued Disability and Appropriate Care by a Physician must be received, however, standard policy language below does not include POL in the Definition of Disability or in the Termination of Benefits provision. If the requested information is not received within a specified timeframes, it should serve as an indicator that additional action is needed.

“Definition of Disability/Disabled:

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and

2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and

2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability”

Termination of Disability Benefits

Benefits will end on the earliest of the following dates:

1. the date the Employee earns from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to him or her at that time;

2. the date the Insurance Company determines he or she is not Disabled;

3. the end of the Maximum Benefit Period;

4. the date the Employee dies;

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5. the date the Employee is no longer receiving Appropriate Care;

6. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due."

With the exception of Late Submittals and non-standard policy language, POL should not be used as the sole basis for making an adverse determination once the customer has asserted a claimed loss.

If there is a continued claim for loss by the customer as referenced above, the POL provision has been satisfied. If an additional evaluation is needed to support proof of disability as defined by the policy, the CM should follow the normal claim process and continue the investigation.

Claim Managers (CM) should work with the clinical resources (e.g. Nurse Case Manager, Behavioral Health Specialist, Medical Director) staff to determine whether additional information is needed based on the facts of the claim. If requested information is not received within the specified timeframe, after reasonable exhaustive attempts, the CM should refer to "Claimant Cooperation" and "Appropriate Care" to determine next steps.

Back to Table of Contents

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Receipt of Claim for Linked Life Waiver of Premium

1.0 Overview

2.0 Assumed Receipt of a Linked Waiver of Premium Claim

3.0 Date of Receipt of Appeals

1.0 Overview

These guidelines define Date of Receipt for Linked Waiver of Premium claims to ensure compliance with timing standards and Employee Retirement Income Security Act (ERISA) regulations.

A Linked Waiver of Premium claim exists when a customer has Long Term Disability (LTD) coverage and Group Term Life Insurance coverage that includes a Waiver of Premium provision with us. The LTD is managed by the LTD team and the Linked Waiver of Premium is managed by the Waiver of Premium team.

2.0 Assumed Receipt of Linked Waiver of Premium Claims

ERISA regulations provide that the period of time within which a benefit determination is required to be made begins when "a request for a plan benefit or benefits [is] made by a claimant in accordance with a plan's reasonable procedures for filing benefit claims."

The Date of Receipt for a Linked Waiver of Premium Claim will be used as the basis for all required state compliance and ERISA timing standards for claim acknowledgment and claim administration letters.

When a customer is approved for LTD benefits, assume that the customer has made claim for Linked Waiver of Premium. The Date of Receipt of a Linked Waiver of Premium claim is the date of the "LTD to LWOP" task to the LWOP Referrals Queue in the system.

Even if the claim is referred to the Linked Waiver of Premium team after the Waiver of Premium start date, the Date of Receipt is the "LTD to LWOP" task.

Refer to "State Compliance Guidelines for Policies Providing Disability Benefits" to ensure timely acknowledgement from the Linked Waiver of Premium Date of Receipt. Refer to "ERISA Guidelines for Policies Providing Disability Benefits" for additional information regarding ERISA requirements.

We will not assume receipt of a Linked Waiver of Premium claim under the following circumstances:

- The customer is over the Waiver of Premium limiting age on the date of disability (typically age 60);
- An adverse determination has been made on the LTD claim based on the LTD Definition of Disability, eligibility, policy exclusion, or limitation;
- The LTD claim has been closed due to return to work in a covered class; or

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- The LTD claim has been permanently settled.

For life policies with an Extended Death Benefit provision, refer to “Extended Death Benefit with Waiver of Premium”.

3.0 Date of Receipt of Appeals

The Date of Receipt for appeals is the date that we receive the customer’s request in writing to appeal the adverse determination on the Linked Waiver claim. If a customer calls requesting that an adverse claim decision be reviewed, advise them to submit their request in writing. The appeal does not commence until their request is received in writing.

If the customer sends a written appeal on the adverse determination on the LTD claim, the customer should be called to clarify if the Linked Waiver claim is also being appealed. If the customer confirms they are appealing the Linked Waiver claim, then the Date of Receipt for the Linked Waiver appeal is the date of the phone call. Document the details of the phone call; a separate written appeal is not required.

If the customer’s written request for appeal of a claim is submitted late (more than 185 days after the date of the adverse determination letter), then the Date of Receipt will be the date that the Senior Appeal Specialist determines that Good Cause exists to excuse the late submission.

Back to Table of Contents

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Receipt of Claim or Appeal

1.0 Purpose/Overview

2.0 Date of Receipt of Initial Claims

3.0 Early Intent to File

4.0 Pre-Filed Claims

5.0 Date of Receipt of Appeals

1.0 Purpose/Overview

The purpose of these guidelines is to define the date of our Receipt of Claim and/or Receipt of Appeal to allow us to ensure compliance with timing standards and ERISA regulations.

For guidance on receipt of Linked Waiver of Premium claims refer to “Receipt of Claim for Life Waiver of Premium.”

2.0 Date of Receipt of Initial Claims

ERISA regulations provide that the period of time within which a benefit determination is required to be made begins when “a request for a plan benefit or benefits [is] made by a claimant in accordance with a plan’s reasonable procedures for filing benefit claims.”

The Date of Receipt will be used as the basis for all required state compliance and ERISA timing standards for claim acknowledgment and claim administration letters. The Date of Receipt does not change if the claim is misrouted to the wrong office or team.

The Date of Receipt is defined as the date we first receive, in writing or by telephone (through our Intake Department), notice that a particular customer is seeking disability benefits under a particular policy. The notice must provide the information specified below.

- Date of disability/loss
- Customer’s name and address
- Client’s (Employer) name and address

Without this information, we generally will not have sufficient basis to begin a claim investigation. Therefore, if a client or a customer provides information which appears to provide some, but not all, of the necessary information, and the investigation cannot be started without the missing information, the acknowledgement letter should specifically state why the investigation is being delayed, and what the customer must provide for it to commence.

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If the submission is not complete, but we have enough information to begin the claim investigation, then the Date of Receipt has been satisfied, and we should begin the investigation and follow up for what information may be missing or incomplete.

The Claim Manager will be responsible for determining if the information received is sufficient to satisfy the definition of Date of Receipt.

3.0 Early Intent to File

We may receive information that otherwise satisfies the definition of the Date of Receipt, but it is submitted too long before the policy's benefit start date (e.g. customer attempts to file a claim 180 days before the policy's benefit start date). In that circumstance, we may determine that it is not possible to reasonably investigate and determine the customer's disability status as of that future date. If the information is received too early, this contact is not considered a Receipt of Claim. However, we want to keep the customer informed. Send the customer a letter acknowledging the advance notification of intent to file a claim, including a brief explanation of why we are unable to begin our investigation at that time. This letter should include the items outlined in the "State Compliance Guidelines for Policies Providing Disability Benefits." The letter should explain why the initiation of the investigation premature as well as the timeframe the customer can next expect to be contacted.

4.0 Pre-Filed Claims

If a customer notifies us of the intention to stop working at some future point (see "Pre-Filed Claims"), we should still accept this as notification of the upcoming absence. Though the state compliance and ERISA clock for processing a claim would not start until the employee stops working, we should still acknowledge this notification with a letter, as described in "Pre-Filed Claims."

5.0 Date of Receipt of Appeals

The Date of Receipt for appeals will be the date that we receive the customer's request in writing for appeal of a claim (date of fax or date stamp). If a customer calls us requesting that an adverse claim decision be reviewed, we should send the appropriate letter, but the appeal does not commence until their request is received in writing. If the customer's written request for appeal of a claim is submitted late (more than 185 days after the date of the adverse determination letter), then the Date of Receipt will be the date that the Senior Appeal Specialist determines that Good Cause exists to excuse the late submission.

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Back to Table of Contents

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Receipt of New Information on Adversely Determined Claims When No Appeal has Been Filed

1.0 Purpose/Overview

2.0 Adverse Determination

3.0 Receipt and Review of New Information

4.0 Review of New Information Alters Prior Decision

5.0 Review of New Information Does Not Alter Prior Decision

6.0 New Information Received After Appeal Deadline has Expired

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the actions that may be taken when we receive new, timely information for an adversely determined claim.

2.0 Adverse Determination

An adverse benefit determination refers to any negative decision on an individual's claim for benefits, including but not limited to a denial, reduction, termination of, or failure to make payment (in whole or in part) for, a benefit.

Refer to “Adverse Claim Determination Guidelines for Policies Providing Disability Benefits” for additional information about adverse determinations.

In an adversely determined claim, the customer would have been provided with appeal rights as outlined in “Adverse Determination Letter Content for Policies Providing Disability Benefits.”

3.0 Receipt and Review of New Information

Information received late (e.g. outside the timeframe within which to timely file an appeal) is considered an attempt to file an appeal and a response is required. Refer to Section 6.0 for additional guidance in handling new information that is received outside the timeframe within which to timely file an appeal.

New Information, related to our prior adverse determination received by us during the time within which an appeal may be timely filed, will be reviewed. In the absence of a written request for an appeal review, such information will not be considered an appeal.

The new information should be reviewed:

- Within established timeframes for handling incoming calls and correspondence

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- With sole focus on the merits of the new information itself, not prompting additional steps
- With additional resources, as appropriate (e.g. review new medical information with a nurse)

Document your review in the claim system and follow the applicable procedures in 4.0 or 5.0 below.

4.0 Review of New Information Alters Prior Decision

If the new information alters the prior claim decision, reopen the claim, pay any benefits due, and send the New Information – Reopen letter.

The letter should indicate that a review was completed in response to the new information received and include an explanation of benefits payable. If the claim being reopened has not been previously paid, include the same detailed explanation of benefits that would be included in a standard approval letter, in addition to the information contained in the New Information – Reopen Letter.

5.0 Review of New Information Does Not Alter Prior Decision

If the new information does not alter the prior claim decision, send the customer the New Information – Remain Closed letter. The letter should:

- Indicate a review was completed in response to the new information that was received.
- Identify what new information was received.
- Explain that the new information did not include a request for appeal.
- Advise the customer to review the adverse determination letter for instructions on filing an appeal, including the deadline within which to file an appeal.
- Emphasize that an appeal must be requested in writing within the timeframe outlined in the adverse determination letter.

6.0 New Information Received After Appeal Deadline has Expired

If the new information was not received by the deadline outlined in the adverse determination letter, it should be rejected as a late filed appeal. This rejection would include standard adverse on appeal ERISA rights.

Refer to “Requirements for Handling Disability Appeals” and “Claim Manager Appeal Workflow” for additional guidance in handling late appeals.

Back to Table of Contents

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Receipt of New Information on Closed Claims

1.0 Purpose/Overview

2.0 Closed Claims

3.0 Receipt and Review of New Information

4.0 Review of New Information Alters Prior Decision

5.0 Review of New Information Does Not Alter Prior Decision

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the actions that may be taken when we receive new information for a claim that has been closed.

2.0 Closed Claims

A claim may be closed because:

- The customer returned to work after receiving benefits
- The customer returned to work during the benefit waiting period
- The customer requested that the claim be closed
- The claim was Advance Paid and Closed (AP&C)
- The claim was medically approved through a defined time frame and closed (for example: pregnancy)

A closed claim is not an adverse determination, therefore no appeal rights are provided to the customer upon the claim closure.

If you receive new information on an adversely determined claim, with no written request for appeal, refer to "Receipt of New Information on Adversely Determined Claims When No Appeal has Been Filed."

3.0 Receipt and Review of New Information

There are times when new claim related information is received following the claim closure. Each claim is unique and the new information should be reviewed on a case by case basis to determine next steps.

Review the new information:

- Within established timeframes for handling incoming calls and correspondence.

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- Within the normal claim process and with the sole focus on the merits of the new information.

- With additional resources, as appropriate (e.g. review new medical information with expert resources).

Document your review in the claim system.

4.0 Review of New Information Alters Prior Decision

If the new information alters the prior claim decision, the claim should be reopened, paying any benefits due.

Send the New Information – Reopen letter.

The letter should indicate that a review was completed in response to the new information that was received.

The letter should include an explanation of benefits payable. If the claim being reopened has not been previously paid, include the same detailed explanation of benefits that would be included in a standard approval letter, in addition to the information contained in the New Information – Reopen Letter.

5.0 Review of New Information Does Not Alter Prior Decision

If the new information does not alter the prior decision and an adverse decision was not previously communicated, the Clam Manager should follow the process for Adverse Claim Determination Guidelines for Policies Providing Disability Benefits.

Back to Table of Contents

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Release of Information from Group Operations Policies and Procedures

1.0 Purpose/Overview

2.0 Purpose of Group Operations Policies and Procedures

3.0 Disclosure in the Adverse Benefit Decision Letter

4.0 Release of Standard Policies and Procedures

5.0 Release of Non-Standard Disability Claim Policies and Procedures

6.0 Requests for Paper Access

7.0 Responding to Customer/Attorney Relevant Document Demand Request for Policies and Procedures

8.0 Customer Requests for Specification

9.0 Responding to Requests from Employees

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1.0 Purpose/Overview

This document explains the purpose of Group Operations “Policies and Procedures” (P&Ps) and explains the criteria for their release in different circumstances.

2.0 Purpose of Group Operations Policies and Procedures

P&Ps are intended to serve as a resource for Group Operations staff to manage claims. They contain administrative processes and safeguards designed to promote the goal of consistent claim administration across similarly situated claims in accordance with applicable federal and state regulations and the governing policy/plan provisions. P&Ps are housed in the knowledge management tool.

The P&Ps are not intended to be a set of absolute rules. Each claim is unique, and should be managed using the expertise and judgment of the reviewer, taking into account the specific details of that claim, and consulting P&P’s as a resource when appropriate.

Although Group Operations P&Ps are considered confidential and proprietary information and are not authorized for distribution beyond Group Operations employees, there are occasions during claim administration that may require their production.

3.0 Disclosure in the Adverse Benefit Decision Letter

Beginning with ERISA Disability claims received on or after April 1, 2018, the U.S. Department of Labor ERISA regulations require an adverse benefit determination letter to include "the

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specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied on in making the adverse determination, or, alternately, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist."
Consistent with their purpose noted above in 2.0, P&Ps do not dictate or determine a particular claim's outcome. Rather, Claim Manager's (CM) rely upon the provisions of the governing plan/insurance policy and the information received in support of and developed during review of the claim. However, for ease of administration, we will provide disability customers routine online access to its standard Disability Claim P&Ps.

4.0 Release of Standard Disability Claim Policies and Procedures

For Disability claims received on or after April 1, 2018, the adverse determination letter template in the Correspondence Tool includes language advising the customer how to access the Disability Claim P&Ps online.

For adverse claims received prior to April 1, 2018, upon customer request, you may provide instructions for access by referring the customer to Disability Claim P&Ps located at nyl.com/disability-claim-policies-and-procedures.

Standalone Waiver and third parties with appropriate authorization from the customer (i.e., attorneys, etc.) can also access this information at nyl.com/disability-claim-policies-and-procedures.

When a customer accesses P&Ps online, they are accessing the P&Ps as they exist on the date the customer accesses and views them.

5.0 Release of Non-Standard Disability Claim Policies and Procedures

If the CM consults guidance provided in any P&Ps not appearing in the Standard Disability Claim P&Ps noted above in 4.0, then the CM should consult with the Senior Claim Manager (SCM), Technical Coach (TC) and/or Legal Referral Specialist (LRS) for direction on how to provide additional disclosures. Typically, this additional information will be specifically disclosed within the analysis provided in the customer's benefit determination letter.

6.0 Requests for Paper Access

If a customer says they do not have access online, and they request paper access, then send via hard copy.

7.0 Responding to Customer/Attorney Relevant Document Demand Requests for Policies and Procedures

Under ERISA, after any adverse benefit determination, a customer is entitled to copies of "relevant" documents, upon request, and free of charge. A "relevant" document is:

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"A document, record, or other information shall be considered 'relevant' to a claimant's claim if such document, record, or other information (i) Was relied upon in making the benefit determination; (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of [the regulation] in making the benefit determination;"

For claims received on or after April 1, 2018, determining relevancy is not an issue for the standard Disability Claim P&Ps since we are making these available online to our disability customers at the time of their adverse benefit determination. However, if the CM made a benefit determination that involved reference to any policies, procedures, or guidelines not appearing in the standard Disability Claim P&Ps noted above in 4.0, the CM needs to ensure that they are, or have been disclosed. Typically, this additional information will have been specifically disclosed within the analysis provided in the customer's adverse benefit determination letter. You should check to determine if that is the case, and, if confirmed, then you may simply refer the customer/attorney to the adverse determination letter (in addition to the standard Disability Claim P&Ps disclosed online).

Otherwise, for unusual situations where such information was not previously disclosed, the LRS will work with the Policies and Procedures Department to draft a response. The response will include instructions for accessing the information deemed relevant to the handling of the claim. Information disclosed in this fashion will be the information that was effective on the date immediately preceding the date of the adverse determination.

Sample letter language for routine responses is included below:

Sample language for ERISA Claims

Consistent with the ERISA claims regulations, {customer name} is entitled to reasonable access to relevant documents that were relied on in reaching the adverse benefit determination on the claim; were submitted, considered or generated in the course of making the adverse benefit determination; demonstrate compliance with administrative processes and safeguards designed to ensure plan provisions are applied consistently; or constitute a statement of policy or guidance with respect to the plan under which {customer name} was insured and concerning the denied benefit for {customer name}'s diagnosis.

In reaching the adverse determination on {customer name}'s claim, LINA did not rely upon any specific rule, guideline, protocol, standard or criterion. Rather, it relied on the relevant provisions of the governing plan document and the information received in support of and developed during review of the claim. We have provided you with a copy of the claim file, including relevant plan documents. Requests for any other plan documents should be directed to the plan administrator. Administrative processes and safeguards applied to {customer name}'s claim are reflected in the claim file including the insurance certificate and policy. Our standard Disability Claim Policies and Procedures are currently available to you and your client

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online, as indicated in the decision letter. Any additional non-standard Policies and Procedures relevant to LINA's handling and determination of {customer name}'s claim, if any, are specifically disclosed in the claim decision letter.

Any information provided from our Policies and Procedures Manual is considered to be confidential and proprietary information, and is not intended for duplication or distribution.

These Disability Claim Policies and Procedures are not relied upon to determine claim outcome. The Disability Claim Policies and Procedures provide guidelines for the manner in which we administer disability claims. Our claim staff is trained on our Disability Claim Policies and Procedures, which describe how we process claims, unless the circumstances of the particular claim or the policy/plan provisions make an exception necessary. The Disability Claim Policies and Procedures disclosed to you include the guidelines generally applicable to processing {customer name}'s claim.

Depending upon the experience of the Claim Manager and/or the issues presented in any given claim, the Claim Manager may or may not have needed to actually review any part of these Policies and Procedures during claim management. Generally, our claim decisions are based upon the Claim Manager's judgment and review of the claim file as a whole, including any information and medical documentation obtained, provided or gathered. Such information is then evaluated and considered in light of applicable policy or plan provisions.

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Sample language for Non-ERISA

In reaching the adverse determination on {customer name}'s claim, LINA did not rely upon any specific rule, guideline, protocol, standard or criterion. Rather, it relied on the relevant provisions of the governing plan document and the information received in support of and developed during review of {customer name}'s claim. We have provided you with a copy of the claim file, including relevant plan documents. Requests for any other plan documents should be directed to the plan administrator. Administrative processes and safeguards applied to {customer name}'s claim are reflected in the claim file including the insurance certificate and policy. Our standard Disability Claim Policies and Procedures are currently available to you and your client online, as indicated in the decision letter. Any additional non-standard Policies and Procedures relevant to LINA's handling and determination of {customer name}'s claim, if any, are specifically disclosed in the claim decision letter.

Any information provided from our Policies and Procedures Manual is considered to be confidential and proprietary information, and is not intended for duplication or distribution.

These Disability Claim Policies and Procedures are not relied upon to determine claim outcome. The Disability Claim Policies and Procedures provide guidelines for the manner in which we administer disability claims. Our claim staff is trained on our Disability Claim Policies and Procedures, which describe how we process claims, unless the circumstances of the particular claim or the policy/plan provisions make an exception necessary. The Disability Claim

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Policies and Procedures disclosed to you include the guidelines generally applicable to processing {customer name}'s claim.

Depending upon the experience of the Claim Manager and/or the issues presented in any given claim, the Claim Manager may or may not have needed to actually review any part of these Policies and Procedures during claim management. Generally, our claim decisions are based upon the Claim Manager's judgment and review of the claim file as a whole, including any information and medical documentation obtained, provided or gathered. Such information is then evaluated and considered in light of applicable policy or plan provisions.

8.0 Customer Requests for Specification

On occasion, a customer may ask a CM to identify which specific sections of the standard Disability Claims P&P were "relied on" in making a claim determination. If that request is included with a request for "relevant" documents, the CM should follow the procedure in section 7.0. If not, the CM should provide the following response:

Our Policies and Procedures are not relied upon to determine claim outcome. The Disability Claim Policies and Procedures provide guidelines for the manner in which we administer disability claims. Our claim staff is trained on our Disability Claim Policies and Procedures, which describe claim processes, unless the circumstances of the particular claim or the policy/plan provisions make an exception necessary. The Policies and Procedures disclosed to customers include the guidelines generally applicable to processing their claim. Depending upon the experience of the Claim Manager and/or the issues presented in any given claim, the Claim Manager may or may not have needed to actually review any part of these Policies and Procedures during claim management. If the CM reviewed a particular part of the Policies and Procedures, that part has been disclosed. Generally, our claim decisions are based upon the CM's judgment and review of the claim file as a whole, including any information and medical documentation obtained, provided or gathered. Such information is then evaluated and considered in light of applicable policy or plan provisions.

9.0 Responding to Requests from Employees

We do not release P&Ps to employees who are not part of the claims organization. If an employee from another department (such as Sales or Products) requests information from the P&Ps, do not provide it.

Review the request with your Team Leader, SCM and/or TC and if necessary with a member of the Policies & Procedures Department, for assistance with the response. You may be able to clarify the information in question or provide a stand-alone document that addresses the specific issue under discussion.

Back to Table of Contents

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Requirements for Handling Disability Appeals

1.0 Purpose/Overview

2.0 Appeal Reviews

3.0 Expert Resources

4.0 Timeframe and Communication

5.0 Tolling

6.0 LTD Policies Issued in California

7.0 Review and Respond

8.0 Number of Appeal Reviews

9.0 Appeal Decision Review and Communication

10.0 Access to Information

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1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the process for appeals on disability claims, including specific state-mandated requirements for Long Term Disability (LTD) policies issued in California. For required letter content, refer to “Appeal Affirmation Letter Content for Policies Providing Disability Benefits.”

2.0 Appeal Reviews

The Department of Labor issued regulations in 2000 that governed appeals for disability benefits under ERISA plans, and revised these regulations in January 2017. The revised regulations apply to disability claims filed on or after April 1, 2018. These guidelines are intended to set forth appeal procedures that provide customers a reasonable opportunity to have an Adverse Benefit Determination fully and fairly reviewed. An Adverse Benefit Determination refers to any negative decision on an individual's claim for benefits, including but not limited to a denial, reduction, termination of, or failure to make payment (in whole or in part) for a benefit. It also includes any adverse determination based on a customer’s eligibility for coverage under the applicable policy, and any rescission, cancellation or discontinuation of disability coverage that retroactively affects any customer, even if there is no immediate adverse effect on any particular benefit at that time.

Appeals will be reviewed without deference to the initial Adverse Determination. Appeal reviews will be conducted by members of the Appeal Team, a business unit maintained for such reviews, to ensure that someone other than the initial decision-maker or that person’s subordinate completes the appeal evaluation.

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It is our policy and practice that all customers have an opportunity to obtain a full and fair review of any adverse benefit determination, including those made on non-ERISA claims. Therefore, this procedure is a guideline for the handling of all disability appeals unless specifically stated otherwise.

If it is unclear if ERISA governs a particular plan or claim, ERISA status should be confirmed. See release "ERISA Guidelines for Policies Providing Disability Benefits" for guidance on how to confirm an account's ERISA status.

Failure to follow these procedures in ERISA claims may result in a customer being considered to have exhausted their administrative remedies. Customers may be entitled to bring legal action based on our failure to provide reasonable claim procedures that would yield a decision on the merits of the claim, and may result in loss of the opportunity for further internal claim review.

3.0 Expert Resources

If the Adverse Determination was based, in whole or in part, on a medical judgment, a medical review must be completed by a health care professional who was not the professional consulted in connection with the original decision or a subordinate of that person. The health care professional should have the appropriate training/experience in a field of medicine reasonably related to the medical condition in question.

The regulations do not explicitly state that the health care professional must be a party outside of the Company, therefore, our Nurse Case Managers, Medical Directors, and other internal staff can satisfy this requirement.

Any Medical and/or Vocational experts whose consultation was obtained should be documented in the claim file.

The review must include consideration of all comments, records, documents, and information submitted by the customer even if they were not submitted or considered during the initial decision.

4.0 Timeframe and Communication

Receipt Timeframes:

Customers covered under an ERISA policy have at least 180 days (calendar days) to file an appeal following the date of receipt of the Adverse Determination letter. We allow the customer up to 185 days from the date of the determination letter to account for reasonable delivery time of the letter.

We may accept an appeal after the 185th day at our discretion, but only if we feel that the delay was due to Good Cause. Examples of Good Cause may include, but are not limited to reasons such as medical inability to respond (due to hospitalization, coma, unconsciousness,

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etc.), or mental incapacity (due to a psychiatric condition, neurological deficit, stroke, etc.), or unusual circumstances preventing the customer from obtaining medical records (i.e. death or relocation of physician, difficulty meeting with a specialist, etc.).

If the customer does not provide an explanation within 30 days (90 days for LTD policies issued in CA), from the date of the Late Submission Appeal Letter, the Senior Appeal Specialist (SAS) may send a letter advising that the appeal request has been denied due to the late submission.

Upon receipt of a written explanation the SAS or Team Leader (TL) of the Appeal Team will review the request for appeal review and determine whether Good Cause exists. Customers covered under a Non-ERISA policy do not have a standard amount of time to file an appeal. Policy-specific language may provide a restriction on the time for appeals. This wording is typically located under the section titled "Legal Actions" in standard policies.

If it is determined Good Cause exists to excuse the late appeal submission, the appeal will be assigned to an Appeal Team member, and the file should be documented to confirm that the Date of Receipt for the appeal is the date that it is determined Good Cause exists. If it is determined good cause does not exist, the appeal request will be denied.

Acknowledgement Timeframes:

Acknowledgment of appeal letters should be sent to customers within 10 calendar days from the date of receipt of an appeal.

ERISA Decision & Communication Timeframes:

On appeal, a decision to affirm or overturn the prior claim determination must be made within 45 days of the date of receipt. Our practice is to provide a status update to the customer within 30 days from date of receipt of an appeal.

One 45 day extension is allowed during the appeal process, if eligible. To be eligible for this extension, special circumstances must be present AND we must advise the customer in writing by the 45th day from the date of receipt of the appeal:

- that special circumstances exist and what the special circumstances are (the letter should identify each special circumstance that exists),
- that we are taking an extension,
- and the date by which we expect to render a decision.

Non- ERISA Decision & Communication Timeframes:

Policy-specific language may provide a restriction on the time we have to complete an appeal. This wording is typically located under the section titled "Legal Actions" in standard policies. Where there is no restriction in the policy, the procedures set forth in ERISA Decision &

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Communication Timeframes should be followed to the extent possible, but those procedures and timeframes are not mandatory, and can be modified as appropriate.

5.0 Tolling

During the appeal process, we may toll (i.e., stop the clock) when the customer has failed to submit information necessary to decide the appeal. If a customer tells us that they refuse to provide the requested additional information that is considered a "response" and ends the tolling period.

In order to toll:

- We must advise the customer in writing that we are missing information that is necessary to decide the appeal. Whenever it is the customer's ultimate responsibility to provide the necessary information to the Company (even if the customer previously provided a Disclosure Authorization), we should advise the customer that the information is required, and that, though we are also requesting the information directly from the appropriate source, it is the customer's responsibility to provide the information to us.

- Our letter should state that we are tolling our time to decide the appeal until the earlier of: (a) the date the customer responds to the request; or (b) the date the entity(ies) provides the necessary information we requested from them; (c) the amount of time we are required to give the customer to provide information under any governing state procedure (such as California); or (d) the date the customer otherwise responds to the request for information. A "response" occurs when the customer provides some of the requested information (and tells us that no more will be provided), or the customer tells us that the information will not be provided.

- The toll runs from the date on which the notification is sent to the customer until the earliest date set forth in the previous bullet.

If it is determined that an Independent Medical Examination (IME) or Functional Capacity Evaluation (FCE) is required, the IME/FCE is "information necessary to decide the claim" that the customer has failed to provide, and tolling is appropriate. A letter must be sent to the customer that includes the information specified in the bullets above. The toll runs from the date on which the notification of the need for an IME/FCE is sent to the customer, until we receive the IME/FCE report or the earlier of the date the customer:

- notifies us they will not be attending an examination

- asks us to reschedule the examination without providing a reasonable excuse

- fails to attend the examination without a request to reschedule the examination

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If customer does not attend IME/FCE, refer to "Independent Medical Evaluations and Peer Review Referrals" for guidance on when it may be appropriate to reschedule. Additional tolling may be applicable if the IME/FCE is rescheduled.

We may also toll when the customer requests additional time to provide information to us. In that situation, you should:

- Confirm in writing the customer's request, identifying the specific information the customer wants to provide.
- State that we are agreeing to the request.
- State that our time to decide the appeal will be tolled until the earlier of: (a) the date the customer provides the information; or (b) the date the customer advises that they do not want us to wait for the receipt of information.
- The toll runs from the date on which the notification is sent to the customer until the earlier date set forth in the previous bullet.

Excluding days tolled, the overall required timeframe for a decision to be made on an appeal is 90 days from the Date of Receipt.

- Initial 45 days + allowed extension 45 days, as eligible = 90 Days total

See section 6.0 for tolling guidelines specific to LTD policies issued in California.

6.0 LTD Policies Issued in California

California Issued LTD Policies

The state of California has issued specific guidelines relating to Proof of Loss for claims governed by California issued LTD policies. The requirements in section 6.0 apply only to group LTD policies issued in California.

The issue state can be found on the face page of the policy, and is usually identified by the following language:

"This Policy describes the terms and conditions of coverage. It is issued in California and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address."

Proof of Loss

In relevant part, the Proof of Loss provision governing LTD claims under California issued policies states, "*Proof of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent*

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upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss."

Appeal Claim Processing

During the appeal claim process of an LTD claim governed by a California issued policy, if we need additional information in order to make an appeal determination, or the customer has additional information to submit, we must allow the customer a minimum of 90 days to provide this information, and we should follow the tolling procedure set forth above to toll our time to make a determination until that 90 days has elapsed (or until the customer provides the information or otherwise responds). The customer is responsible for obtaining the requested information from providers, the employer, or others, but you should assist the customer as part of our procedures. Nothing in these procedures should prevent you from making a decision prior to 90 days, if you have information that supports a determination that benefits are payable.

7.0 Review and Respond

This requirement applies to claims received on or after April 1, 2018. During an appeal, and before reaffirmation of a denial, we must provide the customer with any new or additional evidence considered, relied upon or generated during the appeal process, and any new or additional rationale for our decision, and give the customer a reasonable opportunity to respond.

- The customer should be allowed 14 days to respond to the information provided (90 days for LTD policies issued in California). The Appeal Specialist (AS) will attempt to reach out (i.e. phone, email…) to the customer during this period of time to determine whether or not any customer response is forthcoming.

- Tolling will apply while awaiting a response from the customer.

A customer's response should be considered in the final appeal determination. Depending on the nature of the response the AS may need to determine if additional action(s) are needed to address the information received.

8.0 Number of Appeal Reviews

Customers covered under an ERISA policy must appeal once through the Company's administrative review process and cannot proceed with filing a lawsuit until this mandatory review process is exhausted.

The mandatory appeal review process is not required for customers covered under a Non-ERISA policy. However, we do make this review process available. For Non-ERISA customers, there is no fixed number of appeals that will be permitted, though we may advise a customer who has submitted multiple appeals that we will not accept any more. Any additional Non-ERISA appeals are subject to the following provisions:

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- Each appeal must be made in writing.
- New information must be provided with each subsequent appeal.
- While a customer may submit multiple appeals, there may be a limit on how many years we will accept them as referenced in the policy.

9.0 Appeal Decision Review and Communication

A Second Eye Review of all appeal determinations should be completed by the TL, SAS, or a mentor who has been authorized to conduct the review prior to finalizing the decision. Upon completion of the review the AS will:

- Communicate determination verbally (as appropriate) and in writing, to the customer and client (if applicable).
- Complete the Appeal Process Task.
- Return the claim file to the Core Team for ongoing claim management on overturn determinations.

10.0 Access to Information

When requested by the customer, we will provide reasonable access to all documents, records or other information relevant to the claim. Information is considered relevant if it was submitted, considered, or generated in the course of making the benefit determination, even if it was not relied upon as part of the basis for the determination. We should not release any information labeled as attorney/client communications or any information prohibited by the applicable state law.

For information on how the customer is afforded access to policies and procedures, refer to "Adverse Determination Letter Content for Policies Providing Disability Benefits" and "Appeal Affirmation Letter Content for Policies Providing Disability Benefits."

Back to Table of Contents

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Second Eye Reviews Long Term Disability

1.0 Purpose/Overview

2.0 LTD Adverse Determinations

3.0 Other Claim Decisions

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the Second Eye Review process for Long Term Disability (LTD) claims. Second Eye Reviews will be completed by a Technical Coach (TC), Team Leader (TL), or a mentor who has been authorized to conduct a Second Eye Review (i.e. reviewer).

2.0 LTD Adverse Determinations

A Second Eye Review should be completed by a TC for all LTD Adverse Claim Determinations. An Adverse Claim Determination refers to any negative decision on an individual's claim for benefits, including but not limited to a denial, reduction, termination of, or failure to make payment (in whole or in part) for, a benefit. It also includes any adverse determination based on a customer's (claimant) eligibility for coverage under the applicable policy, and any rescission, cancellation or discontinuation of disability coverage that retroactively affects any customer, even if there is no adverse effect on any particular benefit at that time.

Prior to the referral to the reviewer for the Second Eye Review, appropriate expert resource review should have already occurred, where applicable.

The following may be reviewed by the Second Eye Reviewer:

- Appropriateness of determination
  - Resource utilization
  - Functionality established
  - Determination rationale clearly documented
- System coding
- Written communication

As part of the Second Eye Review, the reviewer should complete either the Pending Claims Second Eye Review Checklist or the Active Claims Second Eye Review Checklist. The Second Eye Reviewer should document the task in the claim system with the overall result of the review and may include additional comments regarding the claim determination, as needed.

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3.0 Other Claim Decisions

A Second Eye Review may be completed on other claim decisions such as approvals and closures due to customer's death, return to work or reaching maximum duration of benefits.

When reviewing other claim decisions the Second Eye Reviewer may review the following:

- Appropriateness of determination.
- Claim documentation:
  - Return to work plan
  - Ongoing claim management plan
  - System coding
- Accuracy of calculation of benefits due and future benefits payable (offsets, return to work benefits, etc.)
- Written communication
- Appropriate follow up tasks and referrals established

As part of the Second Eye Review, the reviewer should complete either the Pending Claims Second Eye Review Checklist or the Active Claims Second Eye Review Checklist. The Second Eye Reviewer should document the task in the claim system with the overall result of the review and may include additional comments regarding the claim determination as needed.

The CM's TL may determine a CM is not required to follow the above Second Eye Review process for claim approvals and/or closures due to customer's death, return to work or reaching maximum duration of benefits.

Back to Table of Contents

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Second Eye Reviews Short Term Disability

1.0 Purpose/Overview

2.0 Second Eye Review Guidelines

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the second eye review process for Short Term Disability (STD) adverse determinations.

2.0 Second Eye Review Guidelines

A Second Eye Review by a Senior Claim Manager (SCM) or Team Leader (TL) should be completed for all STD Adverse Claim Determinations by all Claim Managers (CM). An Adverse Claim Determination refers to any negative decision on an individual's claim for benefits, including but not limited to a denial, reduction, termination of, or failure to make payment (in whole or in part) for, a benefit. It also includes any adverse determination based on a customer's (claimant) eligibility for coverage under the applicable policy, and any rescission, cancellation or discontinuation of disability coverage that retroactively affects any customer, even if there is no adverse effect on any particular benefit at that time.

Prior to the referral to the SCM or TL for the Second Eye Review, appropriate expert resource review should have already occurred, where applicable.

The following may be reviewed by the Second Eye Reviewer:

- Appropriateness of determination
  - Resource utilization
  - Functionality established
  - Determination rationale clearly documented
- System coding
- Written communication

As part of the Second Eye Review, the SCM or TL should complete the Short Term Disability "Second Eye Review Checklist," which should be documented in the claim. The reviewer may also provide additional comments regarding the claim determination.

At the discretion of the CM's TL, certain eligibility determinations may not be subject to the Second Eye Review process.

Back to Table of Contents

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Short Term Disability and Social Security Awards

1.0 Purpose/Overview

2.0 Social Security Award and Records

3.0 Adverse Determination Letter

1.0 Purpose/Overview

The purpose of this guideline is to review how to evaluate a Social Security Disability Insurance (SSDI) award for a Short Term Disability (STD) claim and how to document the result of that evaluation if there is an adverse claim determination. This guideline applies to STD claims received on or after April 1, 2018.

2.0 Social Security Award and Records

If the customer or the customer's representative notifies us that an SSDI award has been issued, request a copy of the award. If the customer does not provide us with a copy of the SSDI award, and if there is an adverse determination on the STD claim, the letter should state that no SSDI award was provided and therefore this information could not be considered in the claim determination.

Where an SSDI award has been presented by the customer or the customer's representative, the award should be reviewed to determine if it supports the customer's STD claim.

If we are aware of or notified that the Social Security Administration (SSA) has medical information that may be relevant to our claim determination, the Claim Manager (CM) should make reasonable efforts to gather this information from the customer, physician and/or SSA. We cannot request information directly from the SSA without an SSA consent form completed by the customer. The SSA consent form should, where possible, specify the information being requested (i.e., provider name and/or date of treatment).

3.0 Adverse Determination Letter

When there is an adverse determination on an STD claim where a copy of the SSDI award was provided to us, the adverse determination letter should provide a summary of the reasons for disagreeing with, or not following, the disability determination made by the SSA.

Listed below are some factors to consider:

- Is the SSDI award relevant to the reasons for our Disability Determination, or was our adverse determination based on policy/plan requirements that preclude STD benefits regardless of Disability status? (e.g. Pre-existing Condition Limitation, Work Related Exclusion, Eligibility, etc.)

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- Does the SSDI award outline the reasoning behind SSA's decision to award benefits? (this is typically seen only in Administrative Law Judge award letters). If so, is the SSA's reasoning not sufficient to satisfy policy/plan requirements?

- If we were notified about SSA-related information, such as an SSA exam, did the customer provide us with those records, or cooperate by providing us with for the SSA consent form (i.e. authorization)?

- If the customer signed and returned the SSA Consent form to us, did the SSA respond to our requests for SS records in a timely manner?

Back to Table of Contents

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Short Term Disability Expert Resource Medical Review

1.0 Purpose/Overview

2.0 Guidelines for Referral to the NCM/BHS

3.0 Guidelines for the NCM/BHS Upon Referral

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of the roles for the Claim Manager (CM) and Nurse Case Manager (NCM)/Behavioral Health Specialist (BHS) during the medical review of Short Term Disability (STD) claims.

2.0 Guidelines for Referral to the NCM/BHS

The CM should consider the following when referring a file to the NCM/BHS.

- Customer does not plan to return to work (RTW) within duration guidelines and medical information does not appear to support restrictions and limitations (R&Ls) beyond the duration guidelines.
- Clarification of R&Ls is needed or medical records are unclear.
- Multiple claims exist for this customer
- Multiple diagnoses are indicated.
- Conflicting medical information with multiple providers.
- Claims prior to STD transition to Long Term Disability (LTD).

3.0 Guidelines for the NCM/BHS Upon Referral

If, after reviewing the file, the NCM/BHS finds that no further clarification of the customer's functionality is needed, they will document their findings and recommendations, and return the file to the CM.

If the NCM/BHS finds that additional clarification or outreach is needed, they will retain the file. The NCM/BHS may contact the customer and/or provider to clarify functionality, RTW plan or conflicting medical information. The NCM/BHS may also contact the employer to discuss possible accommodations or RTW. The NCM/BHS may reach out to a Vocational Coach (VC) to assist in RTW efforts. As needed, the NCM/BHS will review the file with a Medical Director (MD). Once all clarification and/or outreach efforts are completed, the NCM/BHS will document their findings and recommendations, and return the file to the CM.

Back to Table of Contents

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Social Security Awards and Disability Determinations

1.0 Overview

2.0 Gather Social Security Records

3.0 Consider the Social Security Award and Assess its Relevance

4.0 Document and Communicate the Consideration of the Social Security Award

1.0 Overview

This procedure reviews how to gather, consider and document Social Security Disability Insurance (SSDI) award information during a Long Term Disability claim evaluation.

For Waiver of Premium claims, see “Social Security Awards and the Waiver of Premium Evaluation.”

2.0 Gather Social Security Records

When a customer has received an SSDI award, a Claim Manager (CM) should gather and consider SSDI information and document the claim file accordingly.

Upon receipt of an SSDI award, the CM will make a reasonable effort to obtain SSDI records from the Social Security Administration (SSA). To obtain the customer’s consent for release of these records, ask the customer to sign and return to us the SSA’s Consent for Release of Information (Form SSA-3288). The file documentation should fully record the Claim Manager's efforts to obtain the customer’s consent and the SSDI file.

If SSDI records are unavailable after reasonable efforts to obtain them, the CM should proceed with the claim evaluation.

In cases of SSDI denials, information included as part of the SSA file may be useful to our evaluation. This may include, among other items, consultative exams and information resulting from an Administrative Law Judge (ALJ) hearing. This information can be requested from the SSA as part of the claim process.

3.0 Consider the Social Security Award and Assess its Relevance

An SSDI award, and the information related to it, should be considered as part of the overall Disability analysis under the applicable disability plan/policy. Consideration of the SSDI award involves an assessment of its relevance to our evaluation. Under certain circumstances – where the SSDI award provides useful information or insight into the customer’s current functional capacity – the SSA’s judgement finding the customer disabled is an essential factor and should be given significant weight in a customer's favor in making a disability analysis.

To assess the award’s relevance, consider the degree to which it offers useful insight into the question or issue before us. Various factors will determine the relevance of an SSDI award to our evaluation.

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Relevant

Where an SSDI award finding the customer disabled provides useful information or insight into the customer's current functional capacity, it can be highly relevant to the Disability analysis. This may occur when the SSA's award is time-concurrent with our evaluation, and there are no factors that would reduce the award's relevance.

Lesser or of No Relevance

In some cases, the SSDI award may have little or no relevance to the claim decision. For example, the SSDI award should not be given significant weight if:

- the SSDI award is aged (6 months or older) and/or inconsistent with other information relevant to the Disability determination, including more current medical information and/or vocational and financial/earnings information.
    - for aged awards, determine if the SSA has reassessed the customer's condition since its initial decision.
- the award is based on the SSA's use or application of internal administrative standards that may reduce the standard of proof required for certain customers or are different from the standards for disability under the applicable plan/policy. Examples include:
    - the transferability of skills for customers aged 50+
    - compassionate allowances based on diagnosis only
- the claim decision is based on contractual provisions in our plan/policy that preclude a customer from receiving benefits regardless of Disability status:
    - eligibility
    - exclusions
    - pre-existing conditions
    - contract limitations
    - customer's earnings have exceeded the maximum allowed under the policy.
- the customer has refused to provide and/or timely respond to reasonable requests for authorization to obtain the SSDI file and records relevant to the timing and/or basis of the SSDI award are not otherwise available.

4.0 Document and Communicate the Consideration of the Social Security Award

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In Claim Strategy documentation, the CM should acknowledge consideration of the SSDI award and outline its relevance (if any) to the claim decision:

- Where the award is highly relevant, document how it was given significant weight in the Disability decision
- Where the award is of less or no relevance:
  - Document the reason that the award is of lesser or no relevance
  - Include the basis(es) for the assessment of the award's reduced relevance. The explanation should provide detailed information, relevant circumstances, and applicable policy language pertaining to the determination.
- Document your review of SSDI records, if applicable
- If you arrive at a different benefit determination than the SSA, explain why

If our decision is an adverse determination, document consideration of the SSDI award within the adverse determination letter using the guidelines above. Explain to the customer how the SSDI award was considered in the claim review, and why our decision differs from the decision made by the SSA.

Back to Table of Contents

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Social Security Awards and the Waiver of Premium Evaluation

1.0 Overview

2.0 Considerations for Requesting Information from Social Security Administration

3.0 Requesting the SSA File

4.0 Documenting Consideration of the SSDI Award

1.0 Overview

These guidelines provide an overview for considering Social Security Disability Insurance (SSDI) award information during a Waiver of Premium claim evaluation.

2.0 Considerations for Requesting Information from Social Security Administration

If a customer has been awarded SSDI, the Waiver Specialist should consider requesting Social Security's file. The SSDI file should be requested when there is a reasonable likelihood it contains medical or vocational evidence not already in our claim file and is likely to be relevant to our claim evaluation.

Indicators that the SSDI file should be requested include:

- Social Security Administration (SSA) obtained an independent medical, psychological, or vocational examination not in our file.
- There is a reasonable basis to believe the SSDI file may contain medical or functional evidence not currently in our file.
- Treating provider records relevant to our evaluation have not been obtained and may be included in the SSDI file.

In cases of SSDI denials, information included as part of the SSA file may be useful to our evaluation. This may include, among other items, consultative exams and information resulting from an Administrative Law Judge (ALJ) hearing. This information can be requested from the SSA as part of the claim process.

3.0 Requesting the SSA File

Once it is determined that the SSA file should be requested, follow these steps:

Customer Outreach:

- Ask the customer to sign and return SSA's Consent for Release of Information (Form SSA-3288).
- Make at least one phone call to explain the request and clarify whether SSA arranged an independent exam.

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- Send two written requests for the Consent for Release of Information with 14-day response deadlines.

SSA Requests:

- Submit two written requests to SSA with 30-day response deadlines.
- If payment is required, submit promptly and allow 30 days after payment for records to be produced.

4.0 Documenting Consideration of the SSDI Award

Employee Retirement Income Security Act of 1974 (ERISA) regulations require consideration of a Social Security Disability award provided by the customer. If there is an adverse determination on a Waiver of Premium claim the adverse determination letter should include an explanation for disagreeing with the Social Security Administration determination of disability.

Claim file documentation should include:

- Consideration of the SSDI award regardless of whether the SSDI file was obtained.
- The rationale that explains why the SSDI file was requested or was not requested.
- How the SSDI award impacted the determination.
- Document review of the SSDI file, if obtained, and if you arrive at a different Disability decision than Social Security, explain why.
- If an adverse decision is made, document consideration of the SSDI award in the adverse determination letter using the above guidelines. Explain how the SSDI award was considered in the claim review and why our decision differs from SSA's decision.

Reasons why an SSDI award may have less relevance to a Waiver of Premium claim determination:

- The SSDI award is aged (6 months or older) and/or inconsistent with other information relevant to the claim determination, including more current medical information and/or vocational and financial/earnings information.
    - For aged awards, determine if the SSA has reassessed the customer's condition since its initial decision.
- The award is based on the SSA's use or application of internal administrative standards that may reduce the standard of proof required for certain customers or are different from the standards for disability under the applicable plan/policy. Examples include:
    - The transferability of skills for customers aged 50+.
    - Compassionate allowances based on diagnosis only.
- The claim decision is based on contractual provisions in our plan/policy that preclude a customer from receiving benefits regardless of Disability status:
    - Eligibility
    - Contract limitations.

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- The customer has refused to provide and/or timely respond to our reasonable requests for authorization to obtain the SSDI file and records relevant to the timing and/or basis of the SSDI award are not otherwise available.

Back to Table of Contents

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State Compliance Guidelines for Policies Providing Disability Benefits

1.0 Purpose/Overview

2.0 State Compliance Guidelines

3.0 State Required Language

4.0 Correspondence Tool Acknowledgement

5.0 Oral Acknowledgement

6.0 Notification of Status/Delay

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview of state compliance requirements for acknowledging disability claims and providing status updates to customers. These guidelines are based on regulations and guidelines set forth by individual states. To ensure compliance nationally, we adhere to the strictest state guidelines, even if those guidelines may not apply to a particular claim.

These guidelines apply to both ERISA and Non-ERISA claims. Refer to “ERISA Guidelines for Policies Providing Disability Benefits” for additional notice requirements for ERISA claims.

For state compliance guidelines on non-disability policies, see “State Compliance Guidelines for Non-Disability Policies”.

2.0 State Compliance Guidelines

Upon receipt of notice of a new claim, within 10 calendar days, acknowledge receipt of the claim and do one of the following:

- Pay the claim - provide full explanation
- Make an adverse claim determination - provide full explanation
- Pend the claim - notify of the reason the claim cannot be resolved and as applicable provide a description of information needed to make a claim decision

While the claim decision is pending; provide status updates to the customer every 30 calendar days until a decision is reached.

Respond to communication from the customer or customer representative within 10 calendar days. "Communication" means any type of communication which reasonably indicates a response is requested.

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Respond to Insurance Commissioner complaints within 10 calendar days (7 calendar days in North Carolina). All complaints should be referred immediately to your Team Leader (TL) or Customer Response Specialist (CRS) in accordance with “Customer Complaints.”

Compliance requirements count calendar days as opposed to business days. In addition, there are no allowances made for legal holidays and weekends or other non-work days. If an acknowledgement or status letter is due on a holiday or a weekend, the letter must be sent prior to the holiday or weekend to meet compliance requirements.

Document the claim file to demonstrate compliance with these guidelines.

3.0 State Required Language

Some states require specific language in adverse claim determination letters, claim delay (extension) letters, and appeal delay letters.

The specific language can include:

- Insurance Commissioners' address and telephone number for Fully Insured Accounts
- Any additional state contact information as required

The states requiring additional language for adverse determination, delay and appeal extension letters can be found in “State-Required Language for Letters.”

4.0 Correspondence Tool Acknowledgement

In general, the correspondence tool should be used to provide claim acknowledgment and status notifications. When completed appropriately, these letters contain all necessary state compliance wording. In all cases however, claim acknowledgment letters should be reviewed prior to mailing/finalization, to include additional claim/account-specific required wording (e.g. Family Medical Leave), or additional forms inserted.

5.0 Oral Acknowledgement

Written acknowledgment is the preferred method of communication, but in some circumstances (e.g. customer is hospitalized, or acknowledgment has been delayed), a claim may be orally acknowledged.

The initial call can include oral claim acknowledgment if necessary under the circumstances. The call should be documented in the claim system. If the call includes claim acknowledgment, the documentation should include the details of each requirement set forth in the acknowledgment letter, and state what you told the customer, including what additional information is needed to make a claim decision.

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The call should be made to the customer within the same time frame as written acknowledgment (10 calendar days from the date of claim receipt). This timeframe matches our customer service goal for the initial phone call to the customer.

If all of the information listed above has been discussed and documented, then an additional written acknowledgment is not required. However, if you cannot speak directly to the customer or a message is left, a written acknowledgment should still be sent to the customer within 10 calendar days of claim receipt to ensure proper documentation of communications in absence of any approval or adverse determination decision.

6.0 Notification of Status/Delay

While you are encouraged to call the customer to notify them of the reason that a claim decision delay is necessary and update them verbally on claim status, a phone call does not satisfy status/delay communication standards. To ensure compliance requirements, a written status letter should be sent to the customer in addition to any conversation(s) that you may have had with them. In general, the correspondence tool should be used to provide claim status notifications. When completed appropriately, these letters contain all necessary state compliance wording.

Make every attempt to resolve the claim and make a decision within 30 days from the date of receipt. If more than 30 days is needed to make a claim decision, a written claim decision delay letter should be sent to the customer explaining the reasons that a claim decision delay is necessary. The letter should be sent as close to 30 calendar days from receipt of the claim as possible, but not later. If the investigation continues beyond 30 days, subsequent status/claim delay letters should be sent at 30 calendar day intervals from the date of the previous status/claim delay letter. This status/claim delay letter is separate from the initial status/claim decision delay notification sent with the acknowledgment letter.

State regulations generally include a requirement that if a determination cannot be made until some event, process, or third party determination is made, then the insurer should advise the customer of the situation and provide an estimate as to when the determination can be made. It can be difficult to estimate the date by which a third party will provide information, so in most claim situations, you should use a standard timeframe of 30 days for the next written status update. While it is permissible to use a shorter estimated timeframe than 30 days in our letter, update the customer by the date provided.

To satisfy both ERISA and various state requirements, the following items should be included in all claim decision delay letters:

- The circumstances causing the delay in decision
- The date a decision can be expected
- An explanation of standards on which entitlement to a benefit is based (policy language)

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- The unresolved issues that prevent a decision
- The additional information needed (specifically naming from which sources information is needed).

It is important to be as specific as possible when describing what information is needed and who we need information from, so that the customer may also contact those sources to request the information.

Since our acknowledgment and delay letters act as our first explanation and written communication with the customer about the claim decision process, the letters should include sufficient information to determine exactly who requests have been sent to, including the name of each source. Other acceptable options would be: "We have requested information from the medical sources listed on your claim form," or "We have requested information from your attending physician" (if there is only one). General statements that we have requested additional information should be avoided.

If a claim requires a subsequent claim decision delay letter because, at least in part, the providers from whom information has been requested are causing or contributing to the delay in the claim decision, the providers should be specifically identified in the letter. Also, if we have requested new information since the last communication, these sources should also be identified in the letter.

Back to Table of Contents

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Transferrable Skills Analysis and Labor Market Survey Referral Process

1.0 Purpose/Overview

2.0 Prior to Referral

3.0 Referral Process

4.0Transferable Skills Analysis Results

5.0 Labor Market Survey, Relocation and Job Availability Surveys

1.0 Purpose/Overview

The purpose of these guidelines is to provide guidance for referral of a claim for a Transferrable Skills Analysis (TSA) and/or a Labor Market Survey (LMS).

2.0 Prior to Referral

The Claim Manager (CM) is responsible for gathering information about the customer's relevant work history and documenting it in the claim file. General guidelines for relevant work are 15 years prior to the date of referral to the Vocational Coach (VC)/Rehabilitation Specialist (RS) for non-technical fields and 10 years prior to the date of referral to the VC/RS for technical fields. Relevant work history is determined by the VC/RS based on various vocational factors. The responses on the Disability Questionnaire (DQ) may be helpful in gathering this information.

Obtain a job description or completed Job Requirements Form from the employer (ER) prior to referral where possible. The job description may include:

- the major/material job responsibilities
- the physical/mental demands
- additional information (e.g. environmental conditions, materials/equipment/machinery used)

Medical information clearly outlining the customer's functional ability, including restrictions and limitations, should be summarized in the claim file.

3.0 Referral Process

The claim, including relevant work history and restrictions and limitations should be sent to the expert resource via the Internal Resource Referral (IRR) task. The task should provide the basis for the referral and include the TSA/LMS Referral Form. The TSA/LMS Referral Form includes certain policy information which may be relevant in this regard.

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Where information concerning Indexed Earnings (as defined) is provided:

Indexed Earnings as of this date: For Long Term Disability, if the TSA is conducted prior to the "Any Occupation" date, enter the "Any Occupation" date in this field. If the TSA is conducted after the "Any Occupation" date, enter the date the TSA is being referred.

Initial Covered Earnings (Basic Monthly Earnings, or BME) as of: Use either the Benefit Start Date (BSD) or the Incurred Date (ID). Review the policy language and select the appropriate drop box under the field. If the policy language indicates that indexing begins after 12 Monthly Benefits are payable, use the BSD. If the policy language indicates that indexing begins after 12 months of Disability, use the ID.

If the Rehab Specialist (RS) determines more information is required, the RS should note the date received and any missing data in the IRR. Referrals with incomplete data are generally returned to the CM to obtain the missing information. Similarly, if clarification is needed the RS may contact the CM to gather the information from the ER or Customer. Once the information is received or the clarification is provided, the CM routes the file back to the RS by completing a new IRR task.

If a vendor is used to complete the TSA, the RS is responsible for appropriate follow up with the vendor, reviewing the finished report, and documenting the IRR task.

The guideline for completion of the TSA and report in the IRR task is 5 business days from the date the referral is received. If a TSA is needed prior to this time frame, the CM should indicate this on the referral form.

Refer to Any Occupation Investigation Guidelines for any state-specific variations.

4.0 Transferable Skills Analysis Results

The RS will generate a report after performing a TSA indicating one of the following:

- No Occupations Identified - If no occupations are found, the RS will provide a summary to explain and review the factors limiting the customer from performing other occupations based on the information provided on the referral form.
- Occupations Identified - If occupations are identified the RS will provide a chart with the occupations identified and (where applicable) the salary information.

5.0 Labor Market Survey, Relocation and Job Availability Surveys

Depending on the facts of the claim and the applicable policy requirements, the RS may recommend a Labor Market Survey (LMS), based upon the TSA results. The CM has the discretion to determine whether to proceed with a LMS, explaining the basis for the decision in the IRR task to the RS.

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If a LMS is sought and the customer has moved to a new location in a different city or state after the incurred date, the primary search may be performed in either the customer's new location, or in the labor market where the customer was originally employed. The most reasonable location should be selected based on the facts of the claim, taking into account the labor market in both the customer's old and new residence.

Document the rationale for the location used to conduct the LMS in the claim system. Once a location has been selected, a second LMS is typically not conducted in a different location. Unless the factors used to make the LMS determination change, were made in error, or were not known, the original LMS is typically the guideline for ongoing claim management. If the customer moves again at a later date, an updated LMS may be conducted at the customer's new location.

The RS will conduct the LMS based on the parameters given by the CM, typically within the specified radius/commuting time from the customer's home, or former residence if the customer has moved. Refer to the policy for specific parameters and reasonableness when determining a commuting distance.

- The resultant LMS should specify any parameters used.

In the case of occupations in which traveling is considered the norm (e.g., flight attendant), incumbents typically move/relocate frequently, or an employment search is typically accomplished on a national basis (e.g., college President or corporate President), if a Labor Market Survey is warranted, the Labor Market Survey will typically be conducted on a national basis. Claims may be referred to the RS to determine if the customer falls into this category based on the customer's prior occupation and work history.

Job Availability Surveys (JAS) are an expanded option of the LMS to see if jobs are available in a specific labor market if required by the policy. The RS should determine whether a JAS is warranted based on the facts of the claim, and should document the reason for conducting a JAS.

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Workers Compensation and the Long Term Disability Evaluation

1.0 Purpose/Overview

2.0 Policy Language

3.0 Determine if the Claim is Work-Related

4.0 WC Investigation

5.0 WC Follow-up and Award

6.0 Follow up on Appealed and Denied Claims

7.0 Estimation of WC Benefits

8.0 WC from Other Employment

1.0 Purpose/Overview

The purpose of these guidelines is to provide an overview for handling a Long Term Disability (LTD) claim where the customer has made a Workers' Compensation (WC) claim known to us.

2.0 Policy Language

The first step in evaluating the relevance of a WC claim to the disability determination is to review the policy.

Standard LTD policy language lists WC benefits as an offset to the disability benefit under the Other Income Benefits provision in the policy. Such standard language may read as follows:

> *"An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.*
>
> *5. any amounts received (or assumed to be received*) by the Employee or his or her dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted."*

However, review each specific policy to ensure that the language exists, and to determine what it says, before pursuing WC as an offset.

3.0 Determine if the Claim is Work-Related

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Once it is confirmed that the policy integrates with WC benefits, investigate the specific claim and condition to determine if it was work-related.

Review the available claim information for indicators that the disability may be the result of a workplace accident or while travelling for work, or an illness triggered by work.

Question the employer and employee as to the nature of the condition, and if a WC claim has been or will be filed.

If a claim has been or will be filed:

- Confirm if benefits from the WC carrier have been approved or received as a result of the condition
- Obtain the name, address, phone number, and fax number of the WC carrier
- If WC has been awarded, seek the WC award letter from the customer, WC carrier, or employer. Confirm WC benefit amount to determine appropriate offset
- If WC has been denied, confirm intent to appeal WC decision with the customer
- If WC has been denied, and customer is appealing, confirm if a hearing date has been set
- Seek the WC denial letter if applicable
- Request medical records from the WC carrier as well as from the treating provider(s)

If the customer reports that their condition is work-related, but has not filed for WC, suggest the customer consider filing for WC benefits. Depending on the claim situation and policy language, an estimated offset for WC benefits may be applied while the WC claim is pending. See section 7.0 for further guidance.

Workers' Compensation requirements related to mental health diagnosis vary by state.

- Some states do not allow worker compensation to cover any mental health conditions.
- Other states only cover mental health conditions that occurred due to a traumatic events in the workplace.
- Other mental health conditions may be covered in certain circumstances which varies by state. These could include examples such as first responders, mental illness related to a physical injury.

If customer is advising that their mental condition is not covered by workers' compensation in their state, gather the documentation that is available if any, and refer the claim to DMS

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Policies/Procedures Referral Mailbox by completing the DMS Policies and Procedures Referral form.

4.0 WC Investigation

Disability evaluations are based on conclusions drawn from multiple sources including medical, vocational, and financial documentation applied to the provisions of the governing policy. WC records are an element of this analysis. The WC file may contain additional medical records, test results, and information regarding the customer's treatment. The WC file may also contain information on the customer's functional capacity based on examination or other sources. Various factors will determine the relevance and impact of WC information on the Disability determination. Analyze and address the WC information within the context of considering the claim file as a whole, and document the file accordingly.

Request that the WC Carrier provide all information, if possible. This includes all benefit information, including the amount paid and payment period, as well as any medical information that the WC Carrier may have. If the WC claim is under appeal, request the status of the appeal so we can follow up appropriately. A current Disclosure Authorization should be included with the request.

If the WC Carrier is uncooperative, or cannot provide this information, request the information from the employee or employer. Another option is to contact the state directly to request information. The Offset Specialist in your office can provide these contact numbers, as well as resources to locate additional state-specific WC information about benefit percentages and maximums.

When WC records are obtained, review the records in conjunction with all other information gathered, and document your consideration of the WC records in the Disability evaluation. If it is determined that the information received is not relevant to the Disability determination, explain in the claim file the basis for this determination. Your explanation should refer to the specific information, circumstances and/or policy language you considered in deciding whether the WC records contain information bearing upon the Disability decision.

If it is determined that it is not necessary to seek WC records, document the claim file with the specific information or circumstances supporting the determination that WC records were not necessary in evaluating the Disability claim. For example:

> The customer had a WC claim where WC benefits terminated in 2020. The customer filed an LTD claim on November 1, 2023, indicating a last day worked of June 1, 2023. The Claim Manager does not seek the WC records, as he/she reasonably believes that the information contained in the WC file would not be pertinent to the current Disability analysis. Records from 3 years prior to the Incurred Date would not provide information to clarify functionality for the relevant time period.

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5.0 WC Follow-up and Award

Once a request has been sent to the WC carrier, set a task to follow up for the requested WC information.

If we receive confirmation of a WC Award or Settlement, determine the appropriate manner to apply the offset.

- If the WC award provides a given date span and amount for the award, then this should be used as the basis for our offset calculation if the policy language permits.
- If a lump sum settlement is received, refer to the language in the policy to determine how this will be prorated over the life of the claim. Further information concerning lump sum settlements can be found in the release "Lump Sum Payment Integration." Ensure we offset only for the portion of the settlement that concerns lost wages.

If a WC claim exists, ensure system coding is updated to reflect the WC offset and/or estimation.

6.0 Follow up on Appealed and Denied Claims

Once the customer has confirmed that WC has denied the claim:

- Request a copy of the denial notice from the customer and/or WC carrier.
- Confirm with the customer that they have or will be appealing the WC denial.
- If the customer is appealing the denial, follow up for an appeal decision in a timely manner.
- Confirm with the WC carrier that the appeal has been received, and question the carrier for the expected timeframe for resolution of the appeal.
- Suggested timeframes to follow up on an appeal would be approximately every 3-6 months. A general follow-up task should be set for this timeframe to check on the appeal status with the carrier/customer.

7.0 Estimation of WC Benefits

Most LTD policy versions include WC benefits under the Assumed Receipt of Benefits provision. This means that an estimated WC offset can be applied unless the customer has applied for the WC benefit, proved the benefit has been denied, has pursued any and all appeals (unless we determine they are not likely to succeed) and signs our Reimbursement Agreement. Policy language may vary, so consult the individual policy provisions for each claim.

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Deciding when to place an estimated WC offset may vary from claim to claim. WC laws vary from state to state, and may affect the decision times on WC claims. Similarly, some WC appeals may take longer than others depending on the courts' scheduling and backlog. If the reason for the delay in obtaining information or claim status is a result of these factors, it may not be reasonable to apply an estimated offset.

However, if we know that the customer has already been awarded WC benefits, and the customer is uncooperative or we are unable to confirm the actual offset amount from either the WC carrier, the employer, or the customer, an estimate may be appropriate. As a result, consult with your Technical Coach or Team Leader prior to placing an estimate for WC offsets. The following are general examples of when an estimate may be appropriately placed on a claim:

- We have confirmed the customer is receiving WC Benefits and/or a settlement occurred, but we do not currently have documentation of the amount.
- We have received confirmation that a claim was filed but the customer is uncooperative in providing documentation of the status of the case.

If an estimated WC offset has been applied based on the Assumed Receipt of Benefits provision, a follow-up task should be set for 30 days from the estimation date to follow-up for the requested documentation to confirm the actual offset amount. Upon receipt of the requested information, the system coding should be updated appropriately, and any necessary benefit calculation adjustments should be made.

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Policies issued in New York

Per New York only government benefits the insured actually receives can be offset from the benefit. Government benefits include the following:

- Social Security Disability,
- Workers' Compensation,
- Employers' Liability, and
- Occupational Disease Law Benefits

8.0 WC from Other Employment

Occasionally, there are scenarios where a customer may be entitled to WC from other employment. To determine if this WC benefit should be offset, refer to the policy language referencing WC in the Other Income Benefits.

If the plan/policy references WC benefits payable for "*Injury or Sickness arising out of work with the Employer,"* then the offset only pertains to WC payable through the plan/policyholder. The term "Employer" is defined in the plan/policy, so reference the definition available in the plan/policy.

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If the Other Income Benefits offset language does not reference the “Employer,” then the WC benefits payable from another employer may be offset.

Back to Table of Contents

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Workers Compensation and Work-Related Exclusions and the Short Term Disability Evaluation

1.0 Purpose/Overview

2.0 Policy Exclusion

3.0 Interpretation of Policy Language

4.0 Determine if the Claim is Work Related

5.0 Workers Compensation Related to Other Employment

6.0 Denied/Controverted WC Claims under Fully Insured STD Policies

7.0 Recovery of Overpayment where Workers Compensation Denial is Reversed under Fully Insured STD Policies

8.0 State Specific Guidance

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1.0 Purpose/Overview

The purpose of this procedure is to review the process for handling a Short Term Disability (STD) claim when the policy contains a Workers' Compensation (WC) or work-related exclusion and there are indicators that the disability may be work-related.

2.0 Policy Exclusion

The first step in investigating the relevance of a WC claim to the STD evaluation is to check the policy language.

Many STD plans and policies contain an exclusionary clause for WC. This means that if the customer is entitled to or is receiving benefits from WC, or if the condition is work-related, Disability Benefits may not be payable. An example of this policy language can be found below:

> *"The Insurance Company will not pay any Disability Benefits for a Disability that results directly, or indirectly, from:…*
>
> *7. an Injury or Sickness for which the Employee is entitled to benefits from Workers' Compensation or occupational disease law.*
>
> *8. an Injury or Sickness that is work-related."*

Some plans may include one or both of the above-noted exclusions depending on the Employer's choice and the policy filing state requirements. Policy language may vary, and not all plans/policies contain this exclusion. Consult the individual policy provisions for each claim.

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Note: See State Specific Guidance section 8.0 below for guidance on how the WC exclusion should be applied for policies issued in North Carolina and New York. Section 8.0 also outlines a process, for customers who work in Maine, for asserting a lien on the WC award.

3.0 Interpretation of Policy Language

The first component of the exclusion noted in typical policy language references employees who are "entitled to benefits from Workers' Compensation." This exclusion applies to customers who are receiving income replacement from WC due to their work-related condition.

The second component of the exclusion refers to injuries or sicknesses that are "work-related." This exclusion may apply not only to customers who are receiving WC, but also in some situations where the customer is not eligible for WC. Some examples are:

- WC denied due to late filing
- Customer was not working enough hours to qualify for WC
- Employer did not have WC coverage
- Work-related injury occurred during self-employment or other job
- Employee's job category is exempted from WC laws

However, if WC has denied a claim due to not being work-related, do not rely on the second "work-related" component of the exclusion. See Section 6.0 for additional guidance on this scenario.

4.0 Determine if the Claim is Work Related

Investigate the specific claim and condition to determine if it was work-related.

- Review the available claim information for indicators that the injury or sickness may be the result of an accident at the workplace or an illness triggered by work.
- Question the employer and employee as to the nature of the condition, and if a WC claim has been or will be filed.
- If a WC claim has been or will be filed:
    - Confirm if benefits from the WC Carrier have been approved or received as a result of the condition.
    - Obtain the name, address, phone number, and fax number of the WC carrier, if needed.
    - If WC has been denied, confirm intent to appeal WC decision with the customer.

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- If WC has been denied, and customer is appealing, confirm if a court date has been set.
- Seek the WC award or denial letter if applicable

- If the customer reports that their condition is work-related, but has not filed for WC, suggest the customer file for WC benefits. In some circumstances, the work-related exclusion may be applied until a denial from WC is issued stating that the condition is not work-related.

Workers' Compensation requirements related to mental health diagnosis vary by state.

- Some states do not allow worker compensation to cover any mental health conditions.
- Other states only cover mental health conditions that occurred due to a traumatic event in the workplace.
- Other mental health conditions may be covered in certain circumstances which varies by state. These could include examples such as first responders, mental illness related to a physical injury.

If customer is advising that their mental condition is not covered by workers' compensation in their state, gather the documentation that is available if any and refer the claim to DMS Policies/Procedures Referral Mailbox by completing the DMS Policies and Procedures Referral Form.

5.0 Workers' Compensation Related to Other Employment

Occasionally, a customer may be receiving WC through a different employer, either a prior job or a second job. In these cases, the policy exclusion may apply. Check the policy language to see if it references WC received through a specific Employer. If the exclusion does not reference the specific Employer, and the customer is receiving WC benefits through another employer, the exclusion may be applied. Review specific situations with your Senior Claim Manager or Team Leader as needed to determine if the exclusion applies.

In situations where a customer has a prior WC claim related to the current condition that is no longer paying benefits, the exclusion may not apply. For example, a customer may have a prior work-related back injury that was exacerbated through recreational activity. In this case, the work-related exclusion would not apply. However, if the prior work-related injury was exacerbated by another work-related injury, then the exclusion may apply. Review these situations with your Senior Claim Manager, Team Leader or Legal Referral Specialist.

6.0 Denied/Controverted WC Claims under Fully Insured STD Policies

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If we are notified that a WC claim has been denied (i.e., controverted) on the grounds that the employer or WC carrier is contesting the work-relatedness of the customer's condition, we evaluate a customer's eligibility for provisional STD payments, without considering the work-related exclusion.

An employer or WC carrier "controverting" a WC claim on the grounds that they do not consider the condition to be work-related is the same as a denial, and triggers an administrative review process under the authority of the WC Board. A Notice of Controversy is filed by the employer or WC carrier with the WC Board, informing it that the customer's request for WC benefits is being denied. If the customer notifies us that the WC claim has been denied, the CM should request a copy of the denial notice/Notice of Controversy from the customer and/or Workers' Compensation carrier. Upon receipt, review the letter to determine the basis for the denial. If the documentation indicates that the WC claim is denied/controverted on the grounds that the injury or sickness is not work-related, request a Reimbursement Agreement (RA) from the customer, and evaluate the claim by reviewing and considering the other policy provisions. If all other policy provisions necessary to approve coverage are satisfied, the work-related exclusion should not be applied at this time, and the claim should be paid according to the other terms of the policy. The customer should be advised that if the WC decision is reversed, the STD claim would be overpaid. The RA should be received prior to issuing benefits.

The CM should also confirm that the customer has or will be appealing the WC denial. If the customer is appealing the denial, the CM should follow up for an appeal decision in a timely manner. Suggested timeframes to follow up an appeal would be approximately every 3-6 months. A general follow-up task should be set for this timeframe to check on the appeal status with the carrier/customer. Customers are not required to appeal the WC decision in order to receive provisional benefits as outlined above.

If the customer works in Maine, please see State Specific Guidance section below. For all other states, refer the claim to the Legal Referral Specialist to determine whether a lien can be asserted. If it is determined that it is permissible to assert a lien, send the WC carrier the letter called "WC Lien Letter to WC Carrier."

Note that the provisional payments outlined above only apply when the employer or WC carrier asserts that the injury or sickness is not work related. If the WC claim is denied for some other reason (e.g., customer was working a sufficient number of hours as to not qualify for WC, the medical condition did not prevent the customer from working, late filing, etc.), the exclusion for "an Injury or Sickness that is work-related" would still apply, and should be evaluated under Section 4.0.

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7.0 Recovery of Overpayment where Workers' Compensation Denial is Reversed under Fully Insured STD Policies

If the WC board determines that the customer's condition is work-related, or if the Employer or WC carrier makes or agrees to make any payment to, or for the benefit of the customer in settlement of the WC claim, the customer would not be entitled to STD benefits if the policy

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contains the WC or work-related exclusions. If STD benefits have been paid, the WC board reversal would result in an overpayment.

Most states do not grant a lien against WC benefits, which means we are limited to pursuing the overpayment from the customer directly. For states in which a lien cannot be asserted (per the verification process outlined in Section 6.0), follow the standard overpayment recovery guidelines.

If the customer works in Maine, or any other state where it is permissible to assert a lien, refer the claim to the Legal Referral Specialist.

8.0 State Specific Guidance

Maine:

If the customer works in Maine, there is an additional notification that should be sent to the WC carrier. Maine law permits us to assert a lien on the WC award if the WC denial is reversed and we have paid benefits. Maine law provides for the ability to recover out of any eventual WC award. If the customer works in Maine, the CM should send the WC carrier the letter called "WC Lien Letter to WC Carrier", which puts the WC carrier on notice of our payments subject to recovery out of the WC proceeds if the WC denial is reversed. See 02-031 CMR Chptr. 530 sec. 5(A). As noted in section 6.0, customers are not required to appeal the WC decision in order to receive provisional STD benefits.

North Carolina:

Policies issued in North Carolina contain the following language:

> *"The Insurance Company will pay Disability Benefits for a Disability that results, directly or indirectly, from an Injury or Sickness that is work related, unless benefits are paid or payable under Worker's Compensation or occupational disease law."*

If the policy is issued in North Carolina, the WC exclusion should not be applied unless confirmation of WC payments is received.

New York:

Policies issued in New York:

Per New York only government benefits the insured actually receives can be offset from the benefit. Government benefits include the following:

- Social Security Disability,
- Workers' Compensation,
- Employers' Liability, and
- Occupational Disease Law Benefits

Back to Table of Contents

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Back to Table of Contents

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