# Scottsdale Lincoln Health Network

# Short-Term Disability

## Program Description

*Restated and Effective January 1, 2015*

## SUGGESTIONS FOR USING THIS GUIDEBOOK

*Read through the **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the **Definitions** chapter, which explains many technical and medical terms that appear in the text.*

*This guidebook contains a **Frequently Asked Question** section on page 14. This is a handy resource for general information about the program.*

# TABLE OF CONTENTS

## *Short-Term Disability*

Introduction..... 4

Eligibility and Participation..... 5

Short-Term Disability Benefits..... 6

Termination of Coverage..... 7

General Exclusions..... 7

Proof of Disability..... 9

Claims and Denial Procedures..... 10

Definitions..... 12

Frequently Asked Questions.....14

General Information.....15

Program Information.....16

# INTRODUCTION

## *WHAT THIS GUIDEBOOK TELLS YOU*

This booklet describes the Short-Term Disability Program for Scottsdale Lincoln Health Network (referred to as SLHN) restated June 1, 2014. Except for provisions that specifically indicate other effective dates, this guidebook replaces all other booklets previously provided to you.

This guidebook will help you understand and use the benefits provided to you. It describes the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to support your claim. Be sure to read the General Exclusions and Definitions chapters. Remember, not all disabilities are covered by this program.

All provisions of this guidebook contain important information. If you have any questions about your coverage or your obligations under the terms of this program, be sure to seek help or information. A Frequently Asked Questions section appears on page 15 of this document.

SLHN is committed to maintaining this coverage for eligible staff members to provide income protection should you become disabled; however because future conditions cannot be predicted, this program may be amended from time to time. The most up to date information on this program can be found on the websites www.shc.org/benefits or JCL portal, https://rjjclhn.jcl.com. If the later program description describes a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with any program changes, in a safe and convenient place where you and your family can find and refer to them.

This program is a salary continuation program and as such does not constitute a welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA). A claims management company is contracted by SLHN and is responsible for administration of the program according to the provisions detailed in this guidebook. This means that all claims are submitted by staff members to the claims management company. Approved claims are communicated back to the Employee Benefits Department for payment processing through the regular payroll system and payroll schedule. Payments are considered taxable income.

SLHN reserves the right to perform case management in order to coordinate cost-effective options for health care delivery, treatment and return to work.

Coverage under this program is only for non-occupational accidental injuries and illnesses. Coverage for occupational injuries and illnesses will be determined under the workers' compensation program.

Short-term disability refers to how or if you will be paid while you are on a leave of absence.

Please note that this program runs concurrently with the federal Family and Medical Leave Act (FMLA). FMLA is defined as job protection for up to 12 weeks while on a leave of absence. See

the FMLA policy and the Department of Labor website www.dol.gov/whd/fmla.gov for detail information on this federal law.

In the event of a misstatement of any information affecting your coverage under this program, the true facts will be used to determine benefits coverage.

# ELIGIBILITY AND PARTICIPATION

## *Eligibility in the Program:*

All staff members who are in a budgeted position working 32 hours or more per pay period.

## *Effective Date of Coverage*

Coverage is effective the 1st of the month after one year of employment or eligibility. Coverage for physicians, managers, directors and associate vice presidents is effective the 1st of the month following employment or eligibility. Eligibility is determined by the staff member's hire date or the date of a transfer to an eligible position.

## *Actively at Work Requirement*

If you are not actively at work on the day your coverage under this program is to begin, you will not be covered until the day you return to active work.

Actively at work means that you are performing all of the regular duties of your job at the location where you normally work. You will still be considered actively at work if you are absent from work due to approved time off, whether paid or unpaid that may include PTO, vacation, holiday, or a regular day off, as long as you were actively at work on your last regularly scheduled workday before the absence.

## *Personal Leave of Absence and Break in Benefit Eligible Status*

During an approved personal (which includes family and education) leave of absence your coverage will be suspended until you return to work in an active status.

If a break in benefit eligible status exceeds 30 calendar days, a staff member must re-meet any service requirements before coverage can begin again.

A break in benefit eligible status of 30 calendar days or less will, upon return to active work in an eligible status, result in either:

- reinstatement with no loss in benefits; or
- for those who have not yet met their service requirement, a resumption of service accrual toward the satisfaction of the service requirement.

Approved season and staffing leaves are not considered a break in service.

# SHORT-TERM DISABILITY BENEFITS

## *When Disability Benefits Begin*

Short-term disability benefits provide income protection to you if you are a covered staff member who, as a result of a non-occupational injury or illness, become disabled and are unable to work in your job. The disability must start while you are covered under this program and you must be under the regular care of a physician who certifies that you are disabled. You will receive benefits under this program after you have satisfied the 7-day elimination period of disability. Benefits are paid through the payroll department at the normal payroll schedule.

## *Recurrence of Disability*

If you become disabled, return to active work, and become disabled again due to the same or a related cause, your disability will be considered a continuation of the previous period of disability, as long as you return to active work for less than 14 days.

If during your disability, you become disabled for an unrelated disability, your new disability will be considered the start of a new disability period and you do not need to satisfy an additional 7-day elimination period.

If you have returned to active work for more than 14 days, then become disabled again, regardless it is for the same disability or unrelated, it will be considered the start of a new period of disability. In this case, benefits will not begin until the eighth consecutive day of the new period of disability.

If diagnosed with cancer, no additional waiting period will be required for time missed for chemo or radiation treatment received within six months of surgery or diagnosis.

If previously approved for long-term disability (LTD) with the same claims management company and your disability is a recurrent claim within 6 months, your LTD claim will be reconsidered as a continuation and you will not be eligible to file a short-term disability claim.

***Summary***

*The disability must start while you are covered under this program and you must be under the regular care of a physician who certifies that you are disabled. The term physician means a person (other than you, your spouse, child, brother, sister or parent, or the child, brother, sister or parent of your spouse) who is properly licensed as a M.D., D.O., D.P.M., D.D.S., D.M.D., or PMHNP and recognized by the state in which treatment is provided, and* ***who is qualified to treat the condition or injury*** *for which you are applying for benefits.*

*Benefits will not be covered if you are under the care of a chiropractor, naturopath or acupuncturist.*

***Payment of Short-Term Disability Benefits will stop on:***

1. *The date you are no longer disabled; or*
2. *The date you return to work in any gainful occupation; or*
3. *The date you exhaust the maximum number of days for which benefits will be paid; or*
4. *The date sufficient medical evidence expires; or*
5. *The date of your death*

## How a Disability is Determined

The claims management company determines if you are disabled because of an illness or injury where you are prevented from or unable to wholly and continuously perform the essential functions of your job, even with reasonable accommodation. You are not considered disabled unless you are under the care and treatment of a licensed physician who is practicing within the scope of his/her license during the entire period of disability. An attending physician statement (as part of the application) from your physician is required and reviewed by the claims management company.

## How Much the Program Will Pay

The amount of your benefit will be 60% of your basic weekly salary. Basic weekly salary means your hourly rate of pay just prior to the date your disability begins multiplied by the number of hours you are regularly scheduled to work per week. The amount of the benefit will not exceed 40 hours in a week. Paid Time Off (PTO), vacation and/or sick leave must be used to supplement the 60% pay but at no time will it extend beyond 100% of pay. Employed physicians that do not have a vacation bank cannot supplement the other 40%.

The claims management company uses a guideline to determine the number of recovery days necessary to recover from most injuries and illnesses. These guidelines are used to determine how long your short-term disability benefits are approved and paid. If additional time is requested, medical information may be required from your physician to substantiate the additional time requested. Benefits will cease if sufficient medical information is not received.

## Maximum Benefit

The maximum number of days which benefits will be paid is 180 days in a rolling calendar year.

## When Benefit Payments Stop

Payment of Short-Term Disability Benefits will stop on:

- The date you no longer are employed with SLHN; or
- The date you are no longer disabled; or
- The date you return to work in any gainful occupation; or
- The date you exhaust the maximum number of days for which benefits will be paid; or
- The date sufficient medical evidence expires; or
- The date of your death.

# TERMINATION OF PROGRAM COVERAGE

You will cease to be covered under this program on the earliest of the following dates:

- The date you cease to be in an eligible status;
- The date your employment with SLHN ends; or
- The date SLHN discontinues this program.

# GENERAL EXCLUSIONS

Short-term disability benefits will not be provided for:

- That portion of any period of disability during which you:
  - are not under the direct care of a legally qualified physician; or
  - engage in any work for remuneration or profit; or
  - are incarcerated.
- Any period of disability caused by:
  - any elective cosmetic procedures; or
  - intentionally self-inflected Injury of any kind; or
  - accidental bodily injury which arises out of or occurs in the course of any occupation or employment for wage or profit; or
  - illness or injury for which you are entitled to any benefits under any workers' compensation law or similar legislation; or
  - war or act of war (declared or not); or
  - any case where your being engaged in an illegal occupation was a contributing cause to your disability; or
  - commission of an assault or felony by you.

Short-term disability benefits may be reduced by other income you receive or are eligible to receive due to your disability, such as:

- The residual benefit for pay received as part of temporary transitional duty (TTD) work. Total STD benefit, plus TTD pay, plus any paid time off (PTO, vacation, sick) shall not exceed 100% of pre-disability income;
- Settlements or judgments received for income loss;
- Unemployment benefits.

# PROOF OF DISABILITY

***Summary***

*An application for disability benefits and proof of disability must be received by the claims management company before benefits can be paid.*

*You can call you claim in telephonic, online or paper forms. Refer to page 10 for more information.*

An application for disability benefits, an authorization for release of medical information, and proof of disability medical certification must be received by the claims management company before benefits can be approved and paid. Proof of disability may be satisfied by evidence of disability from your physician with a course of treatment that is appropriate for your condition and consistent with evidence based medicine. Such evidence should include subjective symptoms and objective findings of your health and disability that prevents you from performing the essential functions of your job.

Proof of disability may consist of records from the physician, written reports, x-rays and any other medical records, as well as evidence that you continue to be under the appropriate care and treatment of a physician. In the absence of such proof, the claims management company may elect to not approve or suspend benefits until such proof is received.

Your disability must be supported by current medical evidence. You must be under the continuous care of a qualified physician, with a course of treatment that is appropriate for your condition.

If your physician cannot substantiate your disability by objective findings, you may be required to see a physician selected by the claims management company for an independent evaluation. Failure to cooperate with such requests may result in an interruption in benefits.

Subsequent proof of continuing disability will be requested from you by your physician at reasonable intervals determined by the extent and severity of your injury or illness. It is your responsibility to provide medical evidence of continuing disability.

## *Right to Examine*

SLHN reserves the right to request an examination by an independent physician, vocational expert or other health care practitioner as often as is reasonably necessary, if, in its judgment or that of the claims management company, the information submitted is not sufficient to support your claim of disability.

If you fail to comply with such a request, the result may be an interruption in or suspension of benefits. Benefits may also be suspended if the results of the independent examination determine that you are not disabled under the definition of this program.

# CLAIMS AND DENIAL PROCEDURE

## *Disability Benefit Claims and Denial Procedures*

This section explains how initial claim determinations are made and the process for denied benefits. These procedures ensure the program provisions are applied consistently with respect to you and all other program participants. The claims process outlined in this section is designed to provide you a full, fair and fast review of your claim.

## *Authorized Representative*

You may authorize a representative to act on your behalf to file a claim for short-term disability benefits. An authorized representative includes the staff member's health care provider, legal spouse, dependent child age 18 or over, parents or adult siblings, grandparent, court ordered representative (such as an individual with durable power of attorney or legal guardian), or other adult over the age of 18.

You must provide a written statement indicating that you have designated an individual as an authorized representative along with their name, address and phone number. If you are unable to provide a written statement, an individual may act as your authorized representative if written proof, such as a notarized power of attorney for health care purposes or court order of guardianship/conservatorship, is provided that specifies that the proposed individual may act as your authorized representative.

Once an authorized representative is named, the claims management company will route all future claims and denial-related correspondence to the authorized representative and not the staff member until the designation is revoked or as mandated by a court order. You may revoke a designated authorized representative by notifying Scottsdale Healthcare Hospitals Employee Benefits Department in writing.

The claims management company and SLHN reserve the right to withhold information from a person who claims to be the authorized representative if there is suspicion about their qualifications to act as your authorized representative.

## *Filing an Initial Disability Claim*

If you become disabled from a non-occupational Illness or Injury, you must file a claim for disability benefits no later than 30 calendar days after the date on which the illness or injury begins. You have several options for filing an initial disability claim.

- Call Mutual of Omaha directly to file your claim with a disability customer service rep at 866-379-9525 Select option 3, then option 2, and then option 1.

- Online at www.mutualofomaha.com/customer-service choose "I am a plan member", then click go; choose the state Arizona; then select the *Online Short-Term Disability Claim* form.
- Claim form packet can be found on the Employee Benefits website www.shc.org/benefits, JCL portal, https://rjjclhn.jcl.com, call your Employee Benefits Department at 480-323-4540 (SHC) and 623-434-6174 (JCL) or by email employeebenefits@shc.org and jcldisabilityclaim@jcl.com.

## *Initial Claim Determination*

**Initial Claim Determination** – The claims management company will make an initial claim decision regarding your disability claim within 3 business days after receipt of the claim.

**Extensions –** This 3 business day period may be extended for up to 30 days, if the claims management company (1) determines that such an extension is necessary due to matters beyond their control; and (2) notify you, prior to the expiration of the initial 3 business day, of the circumstances requiring the extension and date a decision is expected. If, prior to the end of the first 30 day extension period, the claim management company determines that, due to matters beyond their control, a decision cannot be rendered within that extension period, the period for making the decision may be extended for up to an additional 30 days; provided that you are notified prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date a decision is expected.

**Notice of Extension –** A notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a claim decision and the additional information needed to resolve those issues. You will have 30 days within which to provide the specified information.

**Time Periods –** The period of time within which a claim decision is required to be made will begin at the time a claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. If a period of time is extended as described above due to your failure to submit information necessary to decide a claim, the period for making the claim decision will be "tolled" or suspended from the date on which notice of the extension is sent to you until the earlier of: 1) the date on which the claims management company receives your response; or (2) the date established by the claims management company in the notice of extension for the furnishing of the requested information.

## *If your claim for Disability Benefits is denied*

If your claim for disability benefits is denied, a notice of an adverse benefit determination will be provided to you in writing or electronically. This notice will:

- Provide the specific reason(s) for the denial;
- reference the specific program provision(s) on which the denial is based; and
- provide information regarding the procedure for reconsideration of your claim.

If the denial was based on a medical judgment, (medical necessity, experimental or investigational) information regarding the scientific or clinical judgment for the denial will be provided free of charge upon request.

If the claim is denied and you disagree with that decision, you or your authorized representative may, upon request and without charge, request copies of all relevant documents, records, and other information relevant to your claim for benefits.

You may request a reconsideration of your claim by submitting updated medical records or chart notes that have not been previously submitted, to the claims management company. The additional information must be submitted within sixty (60) days from the date of the original denial letter. The claims management company will review the information and forward its recommendation and the additional materials to Scottsdale Healthcare or John C. Lincoln who will make the final determination and will notify you of their decision. This decision by Scottsdale Healthcare or John C. Lincoln will be considered final.

# DEFINITIONS

ACTIVE WORK/ACTIVELY AT WORK means you are performing all the regular duties of your job either at your usual place of business or at a location to which business requires you to travel. You will be considered actively at work on any day you are absent from work whether paid or unpaid due to PTO (paid time off), vacation, holiday, or a regular day off provided you were actively at work on your last regularly scheduled work day before such absence.

ADVERSE BENEFIT DETERMINATION means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of eligibility to participate in the program.

AUTHORIZED REPRESENTATIVE means the individual who can act on behalf of a staff member (because of the staff member's death, disability or other reason acceptable to the program) to file a claim. An authorized representative includes the staff member's health care provider, legal spouse, dependent child age 18 or over, parents or adult siblings, grandparent, court ordered representative (such as an individual with durable power of attorney or legal guardian), or other adult over the age of 18.

BASIC WEEKLY SALARY means your hourly rate of earnings in effect just prior to the date disability begins, multiplied by the number of hours regularly scheduled to work each week. The amount of the benefit will not exceed 40 hours in a week. Basic weekly salary does not include shift differential, commissions, bonuses, overtime pay and other extra compensation.

CLAIM means a request for a program benefit made by a staff member or the staff member's authorized representative in accordance with the program's reasonable claims procedures.

CLAIMS MANAGEMENT COMPANY is the organization contracted by Scottsdale Lincoln Health Network to administer the Short-Term Disability program.

DISABILITY/DISABLED means, as determined by the Claims Management Company, that because of illness or injury you are prevented from wholly and continuously performing the essential functions of your job, even with reasonable accommodation. See also the definition of essential functions and reasonable accommodation. You are not considered disabled unless there is objective medical evidence to support the claim, you are you are under the regular care and with the appropriate levels of treatment by a licensed physician with the appropriate level of specialty involvement and the treatment program follows the best practice treatment protocols.

DISABILITY BENEFITS/BENEFITS means money that is paid as a weekly benefit when your claim for disability benefits has been approved.

EMPLOYER means Scottsdale Lincoln Health Network and includes any division, subsidiary, or affiliated company named in the program.

ESSENTIAL FUNCTIONS means the fundamental job duties of the position you hold and detailed in your position's job description.

ILLNESS and INJURY means sickness, disease, or other medical conditions including pregnancy, bodily injury resulting directly from a non-work related accident and independently of all other causes.

MANAGERS, DIRECTORS AND PHYSICIANS include staff members employed by SLHN in a Leadership capacity on a salaried basis including Directors, Associate Vice Presidents and Residents.

PHYSICIAN means a person (other than you, your spouse, child, brother, sister or parent, or the child, brother, sister or parent of your spouse) who is properly licensed as a M.D., D.O., D.P.M., D.D.S., D.M.D., Psychiatrist or Psychiatric Nurse Practitioner, and recognized by the state in which treatment is provided, and who is qualified to treat the condition or injury for which you are applying for benefits. Chiropractors, neuropaths and acupuncturists are not physicians as that term is used in this program.

REASONABLE ACCOMMODATION means making adjustments or modifications in the work, job application process, work environment, job structure, equipment, employment practices or the way that job duties are performed so that an individual can perform the essential functions of the job.

REGULAR CARE means you personally visit a physician as frequently as is medically required according to generally accepted standards to manage and treat your disabling

condition(s) and you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards by a physician whose specialty or experience is the most appropriate for your disabling condition.

STAFF MEMBER means anyone employed by SLHN.

YOU and YOUR means you, the staff member.

# FREQUENTLY ASKED QUESTIONS

### *When do I need to file a claim?*

As soon as you know you are going to be off work or as soon as possible. You must provide proof of your claim before your disability benefit can be considered for payment. You must also provide proof of continued disability and regular treatment by a physician.

### *How do I file a claim?*

Telephone or online directly with the claims management company or obtain the claim form packet at www.shc.org or JCL portal, https://rjjclhn.jcl.com. Refer back to page 10 for more detailed instructions.

### *When will my STD benefits begin?*

Once claim is approved and after the seven calendar day waiting period has been fulfilled, and you are in an eligible status, STD pay begins.

### *What is my STD rate of pay?*

STD benefits are based on your hourly base pay in effect just prior to the date disability begins, multiplied by the number of your weekly status hours. Basic weekly salary does not include shift differential, commissions, bonuses, overtime and any other extra compensation.

### *How are benefits paid?*

Benefits are paid through the regular payroll system and follow the biweekly payroll schedule.

### *Will taxes be withheld from my STD payment?*

Yes, Federal and employment taxes are withheld from STD payments. Employment taxes (Social Security and Medicare) will also be withheld from your check.

### *Will I be paid during the seven day waiting period?*

PTO, vacation or sick leave must be used in order to receive your normal income during the seven day waiting period.

### *Can I use PTO, vacation, sick leave during my STD leave?*

PTO, vacation and sick leave must be used to supplement the 60% benefit level.

### *How are my benefit premiums and other deductions paid while I am on leave?*

Because you are being paid through payroll at the normal payroll schedule, all benefit premiums and other deductions will be deducted from your paycheck. If at any time during your disability you do not receive a paycheck, or your paycheck does not cover your benefit contributions, you must contact the Employee Benefits department on how to make your premium payments.

### *Do I have to have a urinary drug screen to return to work?*

Yes, policy states that if you are off work for more than seven (7) calendar days, you must go to Corporate Health for a urinary drug screen. You cannot return to work until you are cleared. This process can take two to five days, so be sure to have your drug screen taken at least one week prior to your return to work. If you are released to return to work and have not completed the required drug screen, your STD benefit will not be extended, resulting in a possible loss of income or additional use of PTO or vacation leave.

### *If I am able to return to work on a modified schedule, will disability benefits continue?*

Yes, if your physician releases you to work on a modified work schedule, and your department is able to accommodate your modified work schedule, short-term disability payment will continue for your missed work hours (not to exceed your budgeted weekly hours).

# GENERAL INFORMATION

### *FUNDING*

The program is funded through the general revenues of SHLN, which pays the full cost of the program. Staff members are not required to contribute to the program.

### *Amendment and Termination of the Program*

SHLN may at any time, without giving prior notice make changes or modify the program. The program has been established with the expectation that it will be continued indefinitely, but there is no obligation to maintain the program for any given time and may, without prior notice, make changes, discontinue or terminate the program at any time.

# PROGRAM INFORMATION

## *Name of Program*

Scottsdale Lincoln Health Network Short Term Disability Program

## *Name and Address of Employer and Corporate Employee Benefits Department*

Scottsdale Lincoln Health Network
8125 N. Hayden Road
Scottsdale, Arizona 85258-5199

## *Who Pays for the Program?*

The cost of this Program is paid entirely by SLHN.