Disability Insurance and ERISA FAQs

The following publication offers general guidance for employees who are considering disability insurance options offered by their employer as an optional benefit. If you are in that situation, do your best to understand and compare policy benefits, triggers, waiting periods, exclusions and dispute resolution rules that will apply if you and the insurer disagree over a claim or coverage.

If I have choices between disability insurance plans offered by my employer – what should I look for?

Most employers who offer disability insurance coverage to their employees usually offer group policies by one insurer for short-term disability claims and long-term disability claims. Sometimes employers will offer optional supplemental long-term disability coverage which provides greater income replacement in the event you experience an extended period of disability. Even if you do not have a choice between two or more policies, it is important to understand the benefits and limitations of your disability insurance. You should look for the following:

• ***Who pays the cost of coverage?*** The manner in which your or your employer pays the premium for the insurance coverage may determine whether or not the benefits you receive under the disability policies will be taxable. If your employer pays the entire premium or you pay all or part of the cost of your disability insurance with pre-tax dollars, then your benefits will likely be taxable. If you pay all of the cost of your disability insurance premium with after-tax dollars then your benefits will likely not be taxable. If you and your employer share the cost of the disability insurance, the amount non-taxable is based on your portion paid with after-tax dollars. If you have the option to pay for the disability insurance premium with after-tax dollars it is recommended that you do so.

• ***How is the benefit amount determined?*** It is important to know how much of your pre-disability income will be paid while you are out on disability. Most policies do not provide 100% income protection and most policies do not take into account extra-compensation you receive in the form of bonuses or overtime in calculating your pre-disability earnings. In addition, most policies "offset" for other income and benefits you receive, including government provided disability benefits (i.e., California State Disability Insurance and Social Security Disability Insurance, Workers' Compensation), benefits your

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family members receive on account of your disability (i.e., Dependent Social Security Disability Insurance), retirement benefits, and wages earned from other employment. For example, if your policy provides you 60% of you pre-disability earnings which comes out to $5,000/month and you receive $3,000/month in State Disability Insurance benefits, then the benefit you will receive under the disability policy is $2,000.

• ***For how long will you receive benefits?*** Most short-term disability policies provide income protection following the 7th day of disability and up to 6 months or 1 year. Most long-term disability policies provide income protection from after 6 months or 1 year to age 65 or your Social Security Retirement Age, which can be found here: http://www.socialsecurity.gov/retire2/agereduction.htm. However, some policies will only provide coverage for a certain number of years which would not provide income protection until you are eligible for retirement.

• ***What are the policy's limitations on coverage?*** Most policies do not cover all kinds of disabilities. As a general matter, most policies exclude coverage for disabilities caused by pre-existing conditions where you received care or treatment for the medical condition in the 3, 6, or 12 months preceding the date you became covered under the policy. However, most policies will not deny a claim on the basis of a pre-existing condition if you have been insured for more than 12 months before becoming disabled. California law prohibits insurers from applying a pre-existing condition limitation to a claim where the insured has been covered by the policy for 24 months. Additionally, most policies will only pay benefits for 24 months where the disability is classified as being caused by a "Mental Illness," the definition of which varies from policy to policy. Other conditions sometimes limited in disability policies include neuromusculoskeletal conditions, chronic fatigue syndrome, fibromyalgia, drug addiction and alcoholism, and certain self-reported disabilities not supported by "objective medical evidence."

If a dispute arises over benefits under a policy I got through my employer, what do I need to know?

Most employer-provided disability plans that are funded by group insurance policies are governed by a federal law known as the Employee Retirement Income Security Act of 1975 (ERISA). ERISA will not apply, however, if your employer is a church or government entity. If ERISA governs your claim and the claims administrator denies your benefits, it is important to be aware of the following considerations:

• ***The Plan's Appeal Procedure***. You should immediately request the Summary Plan Description and

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the Plan documents for the disability plan from your employer. These documents should outline the claims and appeals process that you must pursue (known as “exhausting administrative remedies”) before you will be allowed to file a lawsuit to enforce your rights under the Plan. The claims administrator should give you 180 days from the date you receive the denial letter to submit an appeal. It is very important that you appeal the decision by the deadline because failing to do so may prohibit you from seeking judicial review of your claim if the claims administrator refuses to overturn its decision.

• ***Your Claim File.*** If your claim is denied you are entitled to a complete copy of your claim file, which should include all of your records and other internal notes created by the administrator in reviewing your claim. You should send the administrator a letter requesting your claim file as soon as you get the denial letter. The claim file will contain important information, including medical reviews done on your claim and surveillance reports and videos in some cases.

• ***Establishing a Complete Record.*** The denial letter should set forth the reasons your claim was denied as well as what information you need to submit to perfect your claim. It’s important to review this carefully. Your claim file, including documents you submit with your appeal, and other documents generated before a final appeal decision, is typically the only information a court will consider when determining whether or not you are entitled to benefits under the Policy. Therefore, you should make sure to submit every piece of medical and other evidence supporting the reasons you cannot work. A letter simply stating that you are appealing, without more, will likely result in a further denial of your claim. You should also consider consulting with an ERISA attorney for representation in the appeal as soon as you receive the denial letter as it often takes close to the 180 days to put together a strong appeal.

• ***Judicial Review.*** If the claims administrator upholds the denial of your claim and you have exhausted your administrative remedies, your next recourse is to file a lawsuit in federal district court. It is important to review the Plan document to determine whether the Plan requires you to file a lawsuit within a certain period of time. If you do not file suit within by the applicable deadline, or statute of limitations, a Court will likely find your claim time-barred.

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