Frequently Asked Questions
Short-term disability (STD) Insurance

What is short-term disability?

Short-term disability (STD) is a coverage that pays a defined benefit to an insured member of an employer for a period of disability due to accident or sickness. After a claim is approved, benefit payments begin once the insured has satisfied an elimination period and are paid until the insured returns to work, or when they have exhausted their maximum benefit period.

What is a complete claim?

A complete claim includes complete employer information, complete employee information, the Attending Physician Statement (APS) and authorization for release of additional medical records if necessary.

Do all questions regarding other income need to be answered?

Yes. To avoid a delay in the processing of a claim, all questions on the claim form should be fully answered. A signed authorization is also needed and will help expedite the claim processing.

What are the next steps after the initial claim submission?

Once the initial claim submission process is completed, Lincoln proceeds with the following steps:

- Lincoln assigns the employee's leave to a short-term disability claims examiner.
- The STD claims examiner will reach out to the employee, employer and physician's office to gather any additional information needed to make the STD benefits determination.
- The STD claims examiner will continue the claim management process throughout the duration of the disability, even reviewing for the likelihood of a transition to long-term disability and initiating that process, if necessary.

What steps will be taken if there are problems obtaining completed paperwork and documentation?

- Day 1—during the telephonic intake call, the Attending Physician Statement is sent to doctor's office
- Within 3 business days—Claims Examiner completes an initial review to approve, deny or pend the claim (initial call to the claimant is attempted)
- 7 days from the initial review date—Claims Examiner reaches out to the claimant and doctor's office
- 10 days from the initial review date—If missing employer information, the Claims Examiner will follow up with the employer
- 15 days from the initial review date—Claim is closed and letter is sent to the claimant and employer

Will Travel Nurse across America, LLC receive copies of all letters sent to employees, such as initial claim letters, approvals, denials, and extension letters?

Yes, Travel Nurse across America, LLC will receive copies of all letters to employees. However, the program is subject to Gramm-Leach-Bliley privacy regulations, requiring private health information be removed from letters copied to the employer.

Turnaround times

Short-term disability

- Initial claim review—within 3 business days
- Correspondence—within 3 business days
- Email/Phone—within 24 business hours

Expedited claims processing: Fast Track (FT) diagnosis

We offer an expedited claim process for the following conditions: Maternity, Hysterectomy, Appendectomy, Cholesyctectomy, Bunionectomy, or Hernia. Once we confirm eligibility and the surgery or delivery date, we make the disability payment within 24 hours. Payment is based upon the usual and customary duration (based on MD Guidelines). For example, maternity claims are lump sum paid—6 weeks from normal delivery minus elimination period & 8 weeks for c-section deliveries minus the elimination period.

My employee's salary has changed and the check does not reflect the current salary, how can I get this corrected?

If the claim was incurred prior to the date of increase, the increase would not be reflected in the benefit. If the increase was effective prior to the date of disability and meets contract requirements for reporting salary increase Human Resources must audit all of the insured employee's salary information, provide the amount and date of the increase and pay back premium on any increased amounts. After we receive the premium for the increased amounts, we will make the adjustment to the benefits, and any retroactive benefits due would be paid to the employees.

Where will disability checks be mailed?

Unless otherwise indicated, all claim checks are mailed directly to the employee's home.

How often are short-term disability benefit checks issued?

The standard procedure is to issue short-term disability checks every other week.

How does Travel Nurse across America, LLC notify Lincoln of a return to work?

We prefer to take this information over the phone as we could expedite the final payment. The employer may also provide a Return to Work Notification or the employee may provide a doctor's release form. If the information is being given over the phone, the following information is required regarding the return to work:

- Date the employee returned to work?
- Did the employee return to the same occupation?
- Did the employee return to work full or part time?

Our policy has a pre-existing condition clause. How is this applied? What does this mean?

This provision stipulates that disabilities caused by, or contributed to, a pre-existing condition are excluded from coverage under the contract unless certain conditions have been met. A pre-existing condition applies to a sickness or injury from which the employee received medical treatment, consultation, care or services including diagnostic measures or prescribed drugs or medicines during a specific period of time prior to the employee's effective date. An investigation based on the Pre-Existing language will be conducted, if applicable.

Example: A 3/6 pre-existing clause means that any disabling condition which the Insured received treatment during the 3 months immediately prior to the effective date of coverage is excluded. Once the Insured has been covered for 6 months the pre-existing clause no longer applies. Travel Nurse across America, LLC has a 3/6 pre-existing clause.

Can a claim for pregnancy be considered pre-existing under short term disability?

Yes, maternity is considered in the same manner as any other illness and it can be deemed pre-existing, if the person was treated for, diagnosed with or took prescription drugs for a condition during the three months prior to the employee's effective date for STD coverage. For example: A 3/6 pre-existing clause means that any disabling condition which the Insured received medical treatment, consultation, care or services including diagnostic measures or prescribed drugs or medicines during the three months prior to the employee's effective date is pre-existing and will not be covered for benefits, until the person has been insured on the plan and actively at work (performing all normal job duties at the employer's usual place of business) for at least 6 consecutive months.

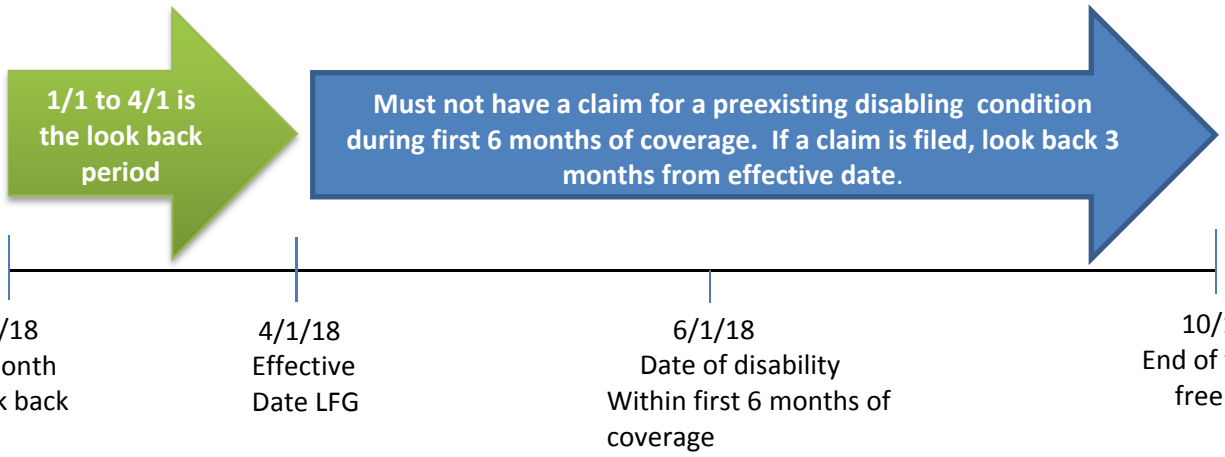
Establishing date of disability with a pregnancy claim and how it impacts the pre-existing clause

- Your due date is not the date of disability.
- Your date of disability occurs when you are medically unable to work due to your pregnancy.

Examples:

1. Your due date is 7/1/18 and you are on bed rest as of 6/1/18. The date of disability is 6/1/18 and any pre-existing investigation would be established based off the 6/1/18 disability date and not the 7/1/18 due date.
2. Your due date is 7/1/18, however you deliver early on 6/15/18. Provided you worked up until your delivery date of 6/15/18, your date of disability would be 6/15/18. Any pre-existing investigation would be established based off the 6/15/18 date of disability.
3. If covered under the plan for less than 6 months before your date of disability, then your claim is subject to the pre-existing clause.
4. If your due date is after you have been on the plan for 6 months, however your date of disability is BEFORE you have been on the plan for 6 months, then your claim is subject to the pre-existing clause.
5. If your date of disability is AFTER you have been on the plan for 6 months, then the pre-existing clause would not apply.

Example:



How does the elimination period work?

The elimination period is 14 days. This means that a person must meet the definition of disability and be unable to work due to a covered injury or sickness for 14 consecutive days before benefits can begin.

Example: John Doe is in a car wreck and is seriously injured. No STD benefits are payable for the first 14 days, while John satisfies his elimination period. Benefits can begin on the 15th day following the car wreck/injury. John could be eligible for benefits from the date he meets the elimination period and while he meets the definition of disability – not to exceed 11 weeks. At the end of the STD period, if John is still disabled, he may be eligible for Long Term Disability benefits.

Are work related injuries or illnesses covered by Short Term Disability?

No. The short term disability plan covers non-occupational injuries and illnesses only. Work related injuries and illnesses should be filed in the usual process.

If an employee is approved for FMLA leave, does this mean that he/she is approved for Short Term Disability Benefits?

No. FMLA and STD benefits are separate and independent of one another. The employee must file a claim for FMLA job protection within the time limits specified in the regulation. FMLA does not include income replacement, only job protection. Short Term Disability is income replacement insurance and STD guidelines and provisions are outlined in the insurance policy. It is possible to be approved for FMLA leave and denied for STD benefits, just as it is possible to be approved for STD benefits and denied for FMLA leave. The time period approved for STD benefits is dependent on the insured person's ability to perform their occupational duties and the definitions in the policy.

A claimant is receiving other income during a period of Short Term Disability - how does this change their STD benefit?

Some sources of income are "offsets" meaning that they reduce the STD benefit, while others are not.

Example: Salary continuation is an offset – if an employee receives salary continuation during a period of disability, the STD benefits will be reduced by the amount of salary continuation received. This may result in no payable STD benefit until the salary continuation has been exhausted.

Example: Paid Time Off (PTO) is not an offset, meaning that it is possible to collect PTO and STD, until the PTO is exhausted, if permitted by Travel Nurse across America, LLC.

What Social Security assistance is provided?

Lincoln employs former Social Security Administration experts to assist claimants throughout the initial application and the appeal process. We will pay the cost of attorney fees for appeal representation. Additionally, claimants who sign our indemnity agreement and show evidence that they've applied for SSDI will receive full benefit until an award is received. Claimants not expected to qualify for Social Security are not required to go through the application process; in fact, these claims are often recommended as return-to-work or case management candidates.

What are the guidelines for duration of disability?

Lincoln uses Medical Disability Advisor, published by Presley Reed, the industry-leading program for determining disability duration. It incorporates diagnosis, age, and strength demand of the job and type of treatment, to establish an optimum return to work date. Duration guidelines serve as benchmarks or starting points, for determining what is reasonable; they are not rigid rules. Many claims are not "typical", and in such cases, we gather additional medical information to substantiate or refute additional days of disability beyond what the duration guidelines suggest. The approved duration of disability takes into account the Medical Disability Advisor guidelines and factors listed above, as well as the duties of the claimant's occupation, and the medical and clinical information submitted.

How do registered nurses and doctors participate in the case management process?

Lincoln's clinical staff is an integral part of the claims team, and available to our Claims Examiners for consultations or medical reviews of entire files. Our RN's and other clinical team members call physicians to discuss detailed medical information as needed. Our staff is experienced in a variety of specialties, including mental health issues.

In the event of complicated or conflicting medical information who makes the claim determination and what is the process?

Travel Nurse across America, LLC's assigned claims examiner retains ultimate decision-making authority for claims. However, the claims examiner also has a wide array of resources available to assist in making the best decision possible. Our clinical team has various specialties available for medical reviews. The RN's, physicians and clinical staff may also contact a physician to discuss or clarify medical information. Other resources include peer reviews (an independent specialist reviews medical information in the claim file), Independent Medical Exams, and Functional Capacity Assessments—during which safe working tolerances are established based on the employee's functional limitations. More complicated claims are typically reviewed by senior claims examiners and managers in addition to reviews conducted by clinical staff.

Who does Human Resources or the employee contact for status or additional information regarding the STD claim?

- 800-423-2765 - Our telephonic service hours are: 7 a.m. to 7 p.m. CST Monday-Thursday and 7 a.m. to 5 p.m. CST on Fridays
- Disabilityclaims@lfg.com
- The claim examiner – the name, phone number and email address will be located on correspondence from the claim examiner.

What is required to appeal a denied claim?

In most instances, a written appeal must be received within 180 days from the date of denial to reconsider a denied claim. A written response will be completed within 45 days, advising the employee if additional information is needed or if a decision has been reached.

Send a written appeal to:

Claims Shared Services
The Lincoln National Life Insurance Company
P. O. Box 2337
Omaha, Nebraska 68103
Fax number (402) 361-1460

The letter should indicate the reason the claim should be reconsidered. If the denial was due to a waiting period or effective date issue, proof will be required to support employee position such as enrollment form or copies of payroll deductions. For disability, employee should also provide any additional information to support the appeal. Such information could include:

- Medical records
- Test results
- Payroll records
- 1 Appeal review for ATP/ASO
- 2 Appeals reviews for STD
- 180 days to request a review of an adverse decision

LINKS process

Lincoln offers a variety of programs and services to assist disabled employees and help them return to full productivity. One such program is LINKS — a highly efficient claims process for those covered by Lincoln Financial short-term disability (STD) and long-term disability (LTD) plans. LINKS goes beyond usual expectations to provide a smooth transition from STD to LTD without claim filing. It is a proactive, integrated claims management system that provides early intervention with the insured to identify potential LTD claims.

How the LINKS process works:

• When an STD claim is received, the Claims department determines whether the claimant is also covered under a Lincoln Financial LTD plan. If so, the integration process begins. A team approach is used and, when deemed appropriate, a nurse and a vocational counselor are consulted for return-to-work planning. The LINKS program was designed by Lincoln Financial to blend technology with the personal touch of our disability Claims Examiners. All claims information resides together in our system for more efficient access and coordination. Claims Examiners work closely together to manage claims and monitor the progress of the disability. This approach benefits both the employee and employer by helping the employee get back to productive work and full earning potential as quickly as possible.

• Employees who have Lincoln Life Insurance coverage, and who meet all of the policy provisions, are eligible for the Life Waiver Benefit. Through the LINKS process, a claim for waiver of life insurance premiums is automatically set up and coordinated with the Life Insurance department. This extra step in our integrated process means the employee will not have to submit a separate claim.