Teamsters Western Region & Local 177 Health Care Plan

IMPORTANT NOTICE

FOR HEALTH COVERAGE TO CONTINUE WHILE DISABLED...

Please contact the Administrative Office at (855) 215-2039 or

see the reverse side of this document for important steps to follow when you are disabled.

Please note:

If you do not timely notify The Hartford (formerly Aetna) at (866) 825-0186 of your leave of absence and file the appropriate documents, your health coverage may be terminated and will not be reinstated until your leave of absence is reported or your disability benefit is approved. You MUST call The Hartford immediately at (866) 825-0186 to report your leave of absence. In addition, you MUST report your actual return to work date to The Hartford ASAP by calling (866) 825-0186.

You may also go to https://abilityadvantage.thehartford.com and use your UPS ID to register. From this portal, you may manage your leave of absence; check status of your leave; and submit documents electronically.

Administrator: Southwest Service Administrators, Inc.
P.O. Box 43110, Phoenix, AZ 85080-3110 • Phone: 855-215-2039 • Fax: 602-324-0555• www.wr177healthcare.com

To continue health coverage while you are unable to work due to:

A) An **on the job injury**, your employer may contribute to the plan for up to 52 weeks of eligibility.

B) A **non-work related illness or injury**, your employer may contribute to the plan for the first 4 weeks of your disability. You ***MUST*** first contact The Hartford at 1-866-825-0186 to report your leave of absence and you ***MUST*** also notify UPS HR (or your direct manager). UPS will then determine if you are eligible for four weeks of contributions to the health plan while you are disabled. You ***MUST*** also report your actual return to work date to The Hartford **ASAP** by calling (866) 825-0186.

   a. If eligible and approved for Short-Term Disability (STD) benefits, your health benefits will be extended with a disability waiver for the duration of your approved disability up to a maximum of 26 weeks.

      i. If you work in NJ, NY, or HI, you will need to file your short-term disability claim with The Hartford at *https://abilityadvantage.thehartford.com* or call 1-866-825-0186 to reach a disability representative at The Hartford. Additionally, you may submit documents via facsimile at 1-833-357-5153 or by email at GBIinformationUpload@thehartford.com.

      ii. For all other states, Disability Filing Procedures and Forms are available at www.wr177healthcare.com or you may also contact the Fund Office at (855) 215-2039.

      iii. If you reside in CA, you should also file a claim with the State of CA. For CA benefits, go to https://www.edd.ca.gov/Disability/DI_Claim_Process.htm.

   b. If eligible (must be Full-time) and approved for Long Term Disability (LTD), your employer may contribute to the health plan for up to 52 weeks of your LTD leave of absence. You ***MUST*** contact The Hartford at 1-866-825-0186 with at least sixty (60) days' notice to initiate your LTD Benefits.

      PLEASE NOTE: LTD benefits are not automatic and are not guaranteed simply because you were approved for Short-Term Disability. If The Hartford denies your LTD claim, you will be provided appeal rights and you should be prepared to elect (and pay for) COBRA continuation coverage while your appeal is pending.

   c. If your disability continues beyond 26 weeks and you are a Part-time employee, you will be offered COBRA continuation coverage.

   d. You may be eligible for a ***Family Medical Leave*** of Absence. If approved, your employer may contribute to the health plan for up to 12 weeks of your approved FMLA leave.

   e. You ***MUST*** report your actual return to work date to The Hartford **ASAP** by calling (866) 825-0186.

It is very important to contact the Administrative Office at (855) 215-2039 if your benefits were terminated due to a disability and you need guidance on getting your benefits reinstated.

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HOW TO FILE FOR SHORT-TERM DISABILITY BENEFITS*

Step 1 – Teamsters Western Region & Local 177 Health Care Plan

Getting Started - Employees must complete and submit the STD Disability Claim Form to initiate a disability claim. The employee can download and print the claim from the website at www.wr177healthcare.com or the employee can call 1-855-215-2039 to request a claim form be mailed or faxed to them. **Disability Claims must be received within 180 days** of the injury or illness. If not received timely, your claim may be denied.

Completion of the Form: The following parts of the claim form must be completed:
Part A – Must be completed by the Employee
Part B – Must be completed by the Employer/HR Department
Part C – Must be completed by a Physician. *Please refer to the definition of Physician in Article 10 of the Summary Plan Description.*

Where to send the completed Form: Once the claim form is filled out in its entirety, the form can be mailed to:

Southwest Service Administrators, Inc., P.O. Box 43110, Phoenix, AZ 85080-3110

or the claim form can be faxed to the Disability Fax Line: **Disability Fax Line: 602-324-0553**

Updates: Physician updates for continuing disability and/or final release to work should be mailed and/or faxed to the above address and/or Disability Fax Line. Responses to administrative requests for information **must be received within 45 days of the request**, otherwise your claim or continuation of your claim may be denied.

Step 2 – The Hartford – Leave of Absence Notice

Getting Started - Employees ***MUST*** call The Hartford at 1-866-825-0186 to initiate his/her leave of absence with UPS. Additionally, a disability claim will need to be filed with Teamsters Western Region & Local 177 Health Care Plan or with The Hartford if you work in HI, NJ, or NY*. The Hartford will gather basic information to begin the leave of absence and send a letter to the employee which includes their responsibilities while on STD.

Medical Documentation - A medical note supporting the leave of absence must be provided to The Hartford within 48 hours of the initial phone call. It is not necessary for the employee to wait for the letter to send the medical note. Once on leave, medical documents must be sent to The Hartford every 90 days to recertify the leave.

Questions - Employees with questions about their disability claim should contact Teamsters Western Region & Local 177 Health Care Plan at 855-215-2039. These questions can include inquiries about claim status, payments, denial of benefits or similar issues. The Hartford can answer questions about an employee's leave of absence. Contact The Hartford at 866-825-0186.

Return To Work (RTW) – When you are ready to return to work, you ***MUST*** call The Hartford at 866-825-0186 to report your return to work. This is an important step to ensure that you do not experience issues with benefits and/or pay. The Hartford does not require a letter authorizing your return.

Transition to Long Term Disability – Full-time employees may be eligible for Long Term Disability (LTD) benefits and should start a transition to LTD around the 20th week of your disability. To initiate LTD benefits, you must call The Hartford at 866-825-0186 regarding your extended leave and to file an LTD Claim which may be completed online at https://abilityadvantage.thehartford.com.

If you work in NY, NJ or HI and are filing a claim for a disability, you **MUST file your claim with The Hartford. You may file a claim online by going to https://abilityadvantage.thehartford.com where you can register using the email address you prefer to have claim updates while on leave. You may also call The Hartford at 866-825-0186 to reach a disability representative.*

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In addition to completing and returning this form to Southwest Service Administrators, Inc., you ***MUST*** call The Hartford at 866-825-0186 to initiate your leave with UPS. UPS Employees ***MUST*** also report their actual return to work date to The Hartford ***asap*** by calling 866-825-0186.

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P.O. Box 43110, Phoenix, AZ 85080-3110
Disability Fax Line: (602) 324-0553 • Toll Free Customer Service: (855) 215-2039 • www.wr177healthcare.com

SHORT TERM DISABILITY INCOME CLAIM FORM

PART A EMPLOYEE'S STATEMENT *(MUST BE COMPLETED BY EMPLOYEE)*

1. EMPLOYEE NAME (PLEASE PRINT)	2. BIRTH DATE MO DAY YEAR	3. SOCIAL SECURITY NO. / /
4. ADDRESS ☐ CHECK HERE IF NEW ADDRESS CITY STATE ZIP		5. PHONE NO. ( )
6. EMPLOYER (Or Company you work for) UPS ☐ Other ☐:		
6 a. EMPLOYER ADDRESS CITY STATE ZIP		7. PHONE NO. ( )

8. IS DISABILITY DUE TO A WORK-RELATED CONDITION? ☐ YES ☐ NO	9. IS THIS CLAIM FOR A NON-WORK-RELATED ACCIDENT OR INJURY? ☐ YES ☐ NO
10. WHERE DID THE INJURY OCCUR?	11. WHEN DID THE INJURY OCCUR? MO DAY YEAR

12. BRIEF DECRIPTION OF HOW THE INJURY OCCURRED:

13. NAME AND CONTACT INFORMATION OF PERSON RESPONSIBLE FOR INJURY:

14. RESPONSIBLE PERSON'S INSURANCE INFORMATION:

15. a. ARE YOU RECEIVING A MONTHLY (RETIREMENT OR DISABILITY) BENEFIT FROM SOCIAL SECURITY? ☐ YES ☐ NO
15. b. ARE YOU RECEIVING A MONTHLY PENSION BENEFIT FROM A PENSION PLAN UNDER A COLLECTIVE BARGAINING AGREEMENT? ☐ YES ☐ NO
15. c. ARE YOU RECEIVING A MONTHLY DISABILITY INCOME BENEFIT FROM ANY OTHER HEALTH PLAN? ☐ YES ☐ NO
IF YOU ANSWERED YES, TO ANY OF THESE QUESTIONS, PLEASE ATTACH A COPY OF YOUR MONTHLY INCOME STATEMENT FROM THE APPLICABLE SOURCE(S).

16. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.

Employee Signature _____ Date _____

***** DISABILITY INCOME BENEFITS CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE *****

PART B HUMAN RESOURCE STATEMENT *(MUST BE COMPLETED BY EMPLOYER / HR DEPARTMENT)*

1. LAST DAY WORKED / /	2. DATE RETURNED TO WORK-**IF APPLICABLE:** Complete this section if the employee has returned to work. If beginning of disability please check "Unknown/NA": Date:____/____/____ ☐ Unknown/NA	3. DID INJURY **(IF APPLICABLE)** OCCUR ON THE JOB? ☐ YES ☐ NO
4. SIGNATURE OF EMPLOYER		5. PRINTED NAME
6. DATE	7. TITLE & PHONE NUMBER	

PART C PHYSICIAN'S STATEMENT OF DISABILITY *(MUST BE COMPLETED BY PHYSICIAN)*

1. PATIENT'S NAME: (PLEASE PRINT)		2. SOCIAL SECURITY NUMBER / /
3. ICD.10 CODE WITH DESCRIPTION:		4. IF DIAGNOSIS IS PREGNANCY, PLEASE LIST DUE DATE:
5. DATE PATIENT DISABLED FROM WORK:	6. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: (REQUIRED)	7. DATE PATIENT RELEASED TO RETURN TO WORK:
8. DATES PATIENT WAS FIRST SEEN FOR THIS DISABILITY:		IS THIS A SCHEDULED SURGERY? ☐ YES ☐ NO IF YES, PLEASE PROVIDE THE DATE:
8a. PLEASE LIST THOSE DATES FOR WHICH THE PATIENT WAS TREATED **IN-PERSON** FOR THIS DIAGNOSIS:		8b. PLEASE LIST THOSE DATES FOR WHICH THE PATIENT WAS TREATED **VIRTUALLY** FOR THIS DIAGNOSIS:
9. FEDERAL TAX ID NUMBER:	10. PHONE NUMBER:	11. FAX NUMBER:
12. PHYSICIAN NAME: (PRINT)	13. PHYSICIAN CREDENTIALS: (PRINT)	14. DATE:
15. PHYSICIAN'S ADDRESS:		16. PHYSICIAN'S SIGNATURE