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# *Message from the President*

## New Chairman for Amalgamated Life Insurance

*By David J. Walsh, President and Chief Executive Officer*

*I have an important announcement to make on behalf of our flagship company, Amalgamated Life Insurance. The Company has elected a new Chairman of the Board. She is Lynne Fox, International President of Workers' United and the Manager of the Philadelphia Joint Board for Workers' United. Lynne succeeds Noel Beasley, who has retired. Noel has served as the President of Workers' United and the Manager of its Chicago and Midwest Regional Joint Board, as well as the Vice President of the Service Employees International Union (SEIU).*

Lynne, a previous Board Member of Amalgamated Life, brings to her new role as Chair strong values, professional integrity, extensive labor experience and a longstanding commitment to fair and equal treatment of all working people. We anticipate exceptional contributions in her new leadership role. She does have big shoes to fill. Noel was an exemplary Chairman of our Board, whose insights, direction and ability to build consensus will have a lasting impact on our organization. He will be greatly missed. We wish him a well-deserved, fulfilling retirement.

Lynne is our first female Chair at Amalgamated Life; an historical milestone for our organization. Based on her many contributions to our decision-making as a Board Member, our expectations are that Lynne will be a strong leader of our Board, leveraging her experience across the labor markets and her commitment to core values in support of working Americans which we fully share.

Her affiliations include: President of the Philadelphia Jewish Labor Committee, Vice President on the Philadelphia AFL-CIO Council, and member of the Philadelphia Airport Advisory Board.

Lynne earned her Bachelor of Science from Pennsylvania State University and a Juris Doctor from Gonzaga University, School of Law, where she served on the Law Review and was published, and Temple University School of Law.

*She is a native Philadelphian.*

# *Broker's Corner*—Raising Awareness of Disability Insurance and Its Importance

When it comes to believing they will suffer a serious disability, most Americans shrug and adopt the "It won't happen to me" mentality. This is particularly true of younger people, who might be surprised to learn that one in four 20-year-olds will suffer a disability before they retire, according to the Social Security Administration's estimates. If you think that these disabilities occur largely from serious accidents, you are wrong. Social Security Disability Insurance statistics indicate that over one third of workers receive benefits for musculoskeletal issues such as back problems, joint pain and muscle pain. Further, the data shows that only 9% of long-term disabilities occur as a result of a serious accident.

So, what can brokers and other advisors do to convince the 75% of working Americans who don't have any disability insurance (Source: LIMRA) of its importance? The Council for Disability Awareness suggests that education and greater awareness are essential. Following are some key points to share with plan sponsors and participants regarding disability insurance and why every working American should have this vital coverage:

- Consider the financial impact of having one's income interrupted by disability. The majority of Americans would suffer serious financial consequences and be unable to sustain their lifestyles for even a period of six months if they were not receiving a paycheck due to a disability. Additionally, based on a Bankrate survey, just 38% of Americans would be able to cover a $500 repair bill.
- Recognize the most common income-interrupting disabilities are of a musculoskeletal nature, while many disabilities also stem from illnesses such as cancer, heart attacks and strokes.
- Despite what most Americans believe, disability insurance is not that costly. The cost for most individual disability insurance plans is between 1% and 3% of the individual's salary. Therefore, for a manager earning $75,000 annually, a disability insurance policy would cost approximately $750 to $2,250 per year or $63 to $187 per month.
- Consider that for every 17 working Americans of any age, one is currently disabled and at any given time 1 out of every 20 people will suffer an income-interrupting disability at some point in their working lives.

Amalgamated Life Insurance offers competitive Group Disability Insurance and Worksite Individual Disability Insurance. Both short-term and long-term disability coverage is available. Amalgamated Life's Group Disability Insurance offers income protection for non-worksite related events such as accidents, illnesses and pregnancies with benefits and duration tailored to meet a client's needs. It is offered on either a contributory or non-contributory basis and includes an optional Vocational Rehabilitation Benefit in some states. Amalgamated's Worksite Short-Term Disability Policy offers portability so that when individuals change jobs, their coverage goes with them. It is renewable to age 72 (age 65 in Massachusetts), features flexible benefit periods and disability payment amounts based on income. For complete information about Amalgamated disability insurance policies, contact your Amalgamated sales representative.

# *Amalgamated Life Insurance*—Best Practices in Claims Handling

*By Nina Chakraborty, Vice President, Claims*

One of the most important components of an insurance company's operations is its claims handling procedure. It is critical that claim determinations are prompt and accurate based on the plan provisions for ERISA self-funded medical plans or the policy for fully-insured disability plans. At Amalgamated Life Insurance and AliCare, our Claims Division has always operated under the culture of customer-focused claims handling, and puts a high priority on quality and completeness of each claim. We strive to process the claim correctly the first time so that the member receives the appropriate benefit due under the plan.

To achieve the highest standards in quality claims handling, the Claims Division at Amalgamated Life Insurance and AliCare has departmental claims training manuals that include processes and procedures on how to review and adjudicate medical claims, as well as disability claims. The medical training manual contains specific guidelines on how to handle certain claim situations, such as accident investigations and coordination of benefits. It also contains specific instructions by each Fund/group, since there are different plans and coverages for each of the self-funded plans that we administer. Additional guidelines are documented for JAA Blue Cross Blue Shield claims handling, and other preferred provider organizations that require designated procedures. The Disability Claims manual is specific to the handling of disability claims and includes an outline of the numerous steps involved to review and make a decision on finalizing the claim. These manuals are available on-line for easy access to pertinent information.

Achieving quality claims handling and customer satisfaction often requires educating the customer and dispelling any misconceptions they may have regarding their claim. The type of issues that arise on medical claims may relate to a member's lack of familiarity with their benefits. This occurs if they have medical care, and then receive a balance due statement from a provider. The balance due could be the deductible, co-pay, or coinsurance on the benefit plan of which they were unaware. If the service was rendered out-of-network, then the member may have a large balance. If the use of an out-of-network provider

*(continued)*

was not in the control of the patient, such as an anesthesiologist, then this issue becomes a problem that the member could not anticipate. We attempt to help lessen the balance due by contacting the provider; however, this isn't always possible. In other instances, our explanation of the benefit coverage will suffice in addressing the issue. On disability claims, the biggest misconception is that the member will receive a benefit check immediately after the claim is filed. Since the claimant is disabled, they are expecting to get a check, but the policy may be for a monthly check, not a weekly check. We attempt to clarify this for the claimant by sending a letter or verbally explaining how the process works.

In order to have a successful claim operation, competent staff, good systems and IT support are critical. The Claims Division employs knowledgeable and dedicated staff to handle and process claims. All staff members who make claim decisions hold New York State Accident & Health Adjuster licenses and are put through a rigorous training program. Amalgamated also has top-notch, dedicated IT professionals who ensure that the claim system, and other pertinent applications, such as workflow and imaging, operate efficiently. These systems are upgraded annually to provide additional enhancements to the claim operations. The IT staff provides a high level of support to the operational areas. Once a claim has been paid, whether a medical claim or disability claim, it is scanned and the image is stored. We are required to maintain all claim documents for at least seven years, but continue to retain many for longer than that. Any related documentation, such as letters and correspondence, are also scanned and stored in an on-line image folder by member/claimant. The claims system also contains a place to document any notes that need to be retained.

Another important element for ensuring high quality claims handling is effective customer communications. It is key to achieving customer satisfaction. It starts with a well-documented Summary Plan Description (SPD) and other benefit plan design documents that are given to members or claimants. Once a claim is adjudicated, the Explanation of Benefits (EOB) should also be clear and concise. If a member or claimant contacts the Customer Service Department, the representatives are able to provide clear explanations and responses to the caller. The representatives are knowledgeable about health benefit and disability plans and have on-line documents to assist them with providing accurate responses.

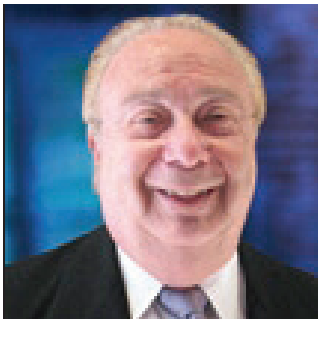
In the case of more complex claims, which are to be expected in a high volume claims operation, the claims staff must be experienced in identifying claims that require a higher level of review. The purpose of the additional review is to ensure that the claims are accurately priced and necessary edits, such as medical necessity, are applied. We are responsible to the Funds to make sure that only legitimate services are paid, and we are also responsible to the member/claimant that they receive the benefits to which they are entitled. These claims go through multiple levels of review, including supervisory and quality analyst review. Certain claims that meet additional high dollar thresholds are not only reviewed by the management team, but our medical case management nurses at AliCare Medical Management (AMM) as well, during a weekly meeting to discuss the high dollar or complex claims. Our focus on complex and high dollar claims minimizes the follow-up or any complaints, while ensuring that we have met our duty to process claims correctly.

The Claims Division has many regulations that impact the handling of claims. Medical claims must be handled in accordance with preferred provider (PPO) contractual requirements. ERISA requires uniformity in claims procedures for self-funded plans and requires that these plans conform to HIPAA provisions and other Acts, such as the Mental Parity Act. With the advent of the Affordable Care Act of 2010 (ACA), plans also had to make changes in plan design, and adhere to new standards on appeals and other procedures that impacted the claims training and processes. Insured Disability claims are subject to state laws, including provisions on timeliness and benefits.

By taking a structured approach to the proper processes and procedures, applying effective systems, and having dedicated staff members who are committed to the highest standards of customer satisfaction, Amalgamated Life has earned the AM Best "A" (Excellent) rating for the last 40 consecutive years, in which its excellent claims management are specifically cited.

# *Amalgamated Agency*—Why ERISA Bonds Matter

*By Ira Schwartz, Consultant*



The Employee Retirement Income Security Act (ERISA) was passed to prevent the mismanagement and abuse of funds associated with private pensions and other employee benefit plans. It establishes the rules and standards governing those who manage the assets and investments for private sector employee benefit plans. To ensure that its standards are upheld, ERISA requires that individuals who handle plan funds and assets be covered by what is known as an ERISA Fidelity Bond. These individuals include every person who "handles funds or other property" associated with the plan. That includes individuals who: have physical contact with cash, checks or similar property; have the power to transfer plan funds and negotiate plan property such as securities; have disbursement authority; have authority to sign checks or other negotiable instruments; and/or have supervisory or decision-making responsibility over these activities that require bonding. The ERISA bonding requirement also applies to service providers such as third-party administrators and investment advisors if they handle funds or other property of the plan.

The ERISA Fidelity Bond is intended to protect a plan from losses incurred as a result of fraud or dishonesty. Following is a Q&A with Amalgamated Agency's ERISA Bond specialist Ira Schwartz to provide a broader understanding of this vital coverage.

**Q:** What acts of fraud and dishonesty are covered by an ERISA bond?

**A:** *Among the acts of fraud or dishonesty by those responsible for managing an employee benefit plan's funds and assets are larceny, theft, embezzlement, forgery, misappropriation of funds, wrong conversion and willful misapplication.*

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**Q:** Besides protecting a plan from losses stemming from these various acts of fraud and dishonesty, what are the other stipulations regarding ERISA bonds intended to protect plan participants?

**A:** *ERISA strictly prohibits the use of deductibles to cover losses with the maximum amount for which the person causing the loss is required to be bonded. Further, it requires the employee benefit plan to be named as an insured party on the bond in order for the plan to recover losses covered by the bond.*

**Q:** What is the difference between an ERISA Fidelity Bond and Fiduciary Liability Insurance?

**A:** *Many people think they are the same, but they are not. Whereas an ERISA Fidelity Bond is specifically intended to insure a plan against losses due to acts of fraud or dishonesty, Fiduciary Liability Insurance insures fiduciaries against losses caused by breaches of fiduciary responsibilities. For example, the Department of Labor just passed its "Conflict of Interest Fiduciary Rule." Breaches of fiduciary responsibility under its requirements would be covered under a Fiduciary Liability Insurance policy.*

**Q:** Where does one purchase an ERISA Fidelity Bond?

**A:** *These bonds must be obtained through a surety or reinsurer named on the Department of Treasury's listing of Approved Sureties, Department Circular 570. It is available at: https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570.htm. There are also select circumstances for which these bonds can be obtained from the Underwriters at Lloyds of London. A stipulation is that neither the plan nor any interested party may have any control or significant financial interest in the surety and/or agent or broker from whom the bond is purchased.*

**Q:** For which types of employee benefit plans does the ERISA bond requirement apply?

**A:** *The bonding requirement applies to most ERISA retirement plans and many funded welfare benefit plans. It does not apply to employee benefit plans that are unfunded and for which benefits are paid directly out of an employer's or union's general assets, or for plans that are not subject to Title I of ERISA, which includes church plans and various governmental plans. Additionally, some regulated financial institutions (e.g., certain banks, insurance companies, and registered broker-dealers) are exempt if they meet the exemption conditions.*

**Q:** What amount of coverage must the ERISA Fidelity Bond provide?

**A:** *Coverage is typically assessed as follows: Each person must be bonded in an amount that is equal to a minimum of 10% of the amount of funds he/she handled in the prior year, but cannot be less than $1,000. Further, each required person must be bonded for more than $500,000 or $1,000,000 for each of those plans holding employer securities. Here is an example the Department of Labor provided: If a company's plan has funds totaling $1,000,000, and the plan trustee, named fiduciary and administrator are each employees of different companies that have access to the full $1,000,000 and each has the power to transfer plan funds, approve distributions and sign checks, then under ERISA, each person must be bonded for at least 10% of the $1,000,000 or $100,000.*

**Q:** Can the plan pay for the ERISA Fidelity Bond out of the plan's assets?

**A:** *Yes.*

**Q:** If a service provider such as a third-party administrator or investment advisor must be bonded under ERISA, must the plan purchase the bond?

**A:** *No. The service provider and advisor must purchase their own separate bonds insuring the plan.*

For more information, visit: https://www.dol.gov/ebsa/publications/erisafidelitybondplanprotection.html

**Online Member and Provider Portals**
**Check Claims Status and EOBs**
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**Customer Service Hours**

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|---|---|
| Monday–Thursday | 8:00 a.m. to 8:00 p.m. |
| Friday | 8:00 a.m. to 6:00 p.m. |
| Saturday | 9:00 a.m. to 2:00 p.m. |

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