ADMINISTRATIVE APPEALS OF LONG-TERM DISABILITY AND HEALTH CLAIMS

2017 ABA LTD Litigation

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NOW WHAT?

- The claimant receives a written adverse benefit determination – either a denial of an initial claim or termination of ongoing benefits.

- NOW WHAT?

LTD PLANS IN GENERAL

- General characteristics of LTD Plans
  - Generally provide benefits after 6 months of disability until retirement age representing approximately 2/3 of pre-disability earnings.
  - Many have an own occupation standard of disability that shifts to any occupation standard of disability after 24 months.
  - Almost all plans will offset other income or benefits including WC, SDI, SSDI, retirement benefits, etc.
  - Many plans have a 2-year limitation for mental illnesses and other conditions.

TYPES OF LTD PLANS

- Insured Plans
  - Employer purchases insurance policy from insurer to provide benefits to employees who become disabled from work.
  - Often, the insurer who is responsible for paying the benefits also determines eligibility for benefits.
  - The Supreme Court recognizes this as a structural conflict of interest. *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008).

"What conflict of interest?!

TYPES OF LTD PLANS

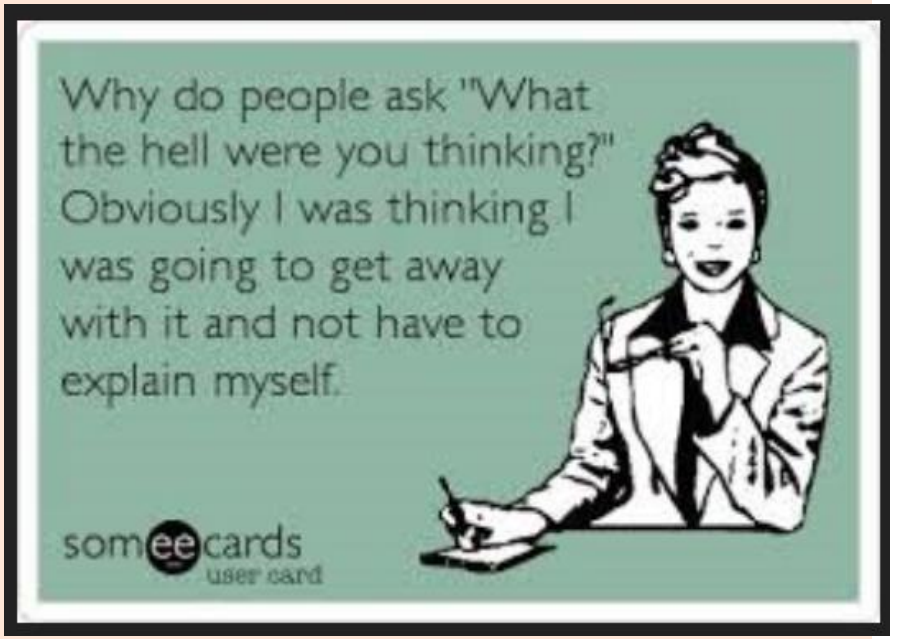
- Self-Funded Plans
  - Employer sets aside funds for qualified participants.
  - Usually big employers like AT&T or Johnson & Johnson.
  - Many hire third-party administrators (often insurance companies) to determine eligibility for benefits.
  - Protections afforded by state's insurance laws do not apply.

ADVERSE BENEFIT DECISION

- Notification of an adverse benefit determination. 29 C.F.R. §2560.503-1(g) -- **Every employee benefit plan must:**
  - Provide **adequate notice in writing** when claim is denied;
  - Set forth the specific reasons for such denial, referring to the relevant plan provisions;
  - Describe what information is necessary to perfect the claim and why;
  - Describe the plan's review procedures and the time limits applicable to such procedures;
  - Describe what **internal rules, guidelines, or protocols** the administrator relied on in making the adverse decision

ADVERSE BENEFIT DECISION

- What is the plan thinking when it writes the denial letter?
  - What plan provision(s) is the plan relying on?
  - What facts did the Plan Administrator consider?
  - What medical evidence is there?
  - Surveillance of the claimant?



ADVERSE BENEFIT DECISION

- What is the plan thinking when it writes the denial letter?
  - Any contrary evidence indicating that the claimant is not disabled? If so, did the Plan Administrator consider such evidence when making its decision?
  - What is the job description of the claimant?
  - Any *Glenn* or *Amara* concerns?
  - Internal or external review process?

REQUEST FOR REVIEW PROCESS

- ERISA requires a "full and fair review." ERISA § 503.

- **PRACTICE TIP:** This Review constitutes your evidence in litigation

REQUEST FOR REVIEW DEADLINE

The claimant has 180 days to appeal.

The clock is running!

REQUEST FOR REVIEW PROCESS

- 29 C.F.R. §2560.503-1(h) -- Every plan must:
  - Provide claimants the opportunity to submit written comments, documents, records, and other information;
  - Provide that copies of all documents and other information relevant to the claim
  - Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim;
  - Provide claimants at **least 180 days** following receipt of a benefit denial to appeal;
  - Provide for a review that does not afford deference to the initial adverse benefit determination;
  - Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in making the adverse benefit determination.
  - If the plan does not follow these statutory requirements, the time limits to appeal are not enforced against the claimant. *Counts v. American General Life and Accident Ins. Co.*, 111 F.3d 105 (11th Cir. 1997).

REQUESTING PLAN DOCUMENTS

- Request Plan Documents
- Don't limit it just to the plan – ask for anything relevant and be specific!

5. Any and all documents reflecting communications, either oral or written, between [Claim Administrator] and Ms. _____, including, but not limited to, all handwritten notes of such communications;

6. Copies of all correspondence or communications from physicians, attorneys, accountants, or other service providers employed or retained to render advice on behalf of the Plan or its fiduciaries regarding Ms. _____'s claim. Please note that no attorney-client privilege attaches to these communications. *Wildbur v. ARCO Chemical Co.*, 974 F.2d 631 (5th Cir. 1992); *Smith v. Jefferson Pilot Financial Ins. Co.*, 245 F.R.D. 45, 47-29, NO. CIV A 07-10228-PBS (D. Mass., Aug. 02, 2007).

7 Identification of any medical or vocational experts whose advice [Claim Administrator] sought for Ms. _____'s claim; copies of the experts' resumes and/or curriculum vitae; a disclosure of the compensation arrangement between [Claim Administrator] and those experts; a disclosure of the number of claims per year that each expert has reviewed for [Claim Administrator] in the last three years; and a disclosure of the number of claims per year for which each expert recommends a finding of "disabled" per year for the last three years.

8. Any other document, record, or any other information relevant to Ms. _____'s claim for benefits.

RESPONDING TO A DOCUMENT REQUEST

- What do plans do when they receive a document request?
  - What documents, records, or other information are "relevant?"
  - 29 C.F.R. § 2560.503-1(m)(8)
    - If it was relied upon in making the benefit determination;
    - Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
    - Demonstrates compliance with the administrative processes and safeguards required under ERISA;
    - Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination

REQUEST FOR REVIEW PROCESS: REVIEW THE PLAN DOCUMENTS

- Review the Plan documents for
  - Definition of disability ("own occupation" vs. "any occupation" and whether % of pre-disability earnings is a factor)
  - Grant of discretion
  - Offsets (may make it unfeasible to take a claim)
  - Whether STD is a prerequisite to LTD
  - "Objective Evidence" requirements
  - Exclusions and Limitations

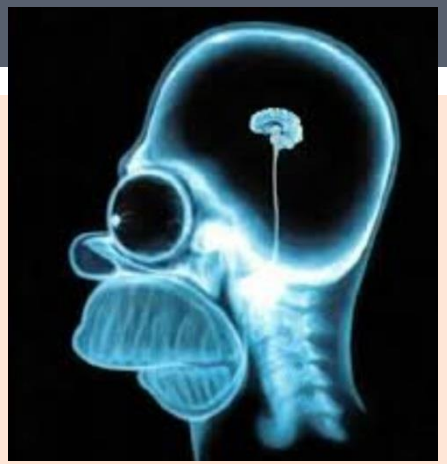
REQUEST FOR REVIEW PROCESS: REVIEW THE CLAIM FILE

- Review the claim file for:
  - Internal notes
  - Evidence of procedural irregularities
  - Evidence of conflict of interest
  - Medical reviews
  - Vocational reviews
  - Surveillance reports and videos

ADDRESSING AN ADVERSE MEDICAL REVIEW

- Carefully read the medical reviewer's report
  - Did the medical reviewer speak with the treating physician?
  - What records did the plan provide to the medical reviewer?
  - What records did the plan fail to provide?
  - Did the medical reviewer consider the claimant's job description?
- Try to obtain the treating physician's response to the medical reviewer's report

REQUEST FOR REVIEW PROCESS: PREPARE YOUR APPEAL



- What to Submit
  - Medical records
  - Letters from medical providers
  - Address adverse medical reviews
  - "Objective" evidence
    - current symptom[s];
    - other medical conditions that might affect or lengthen the recovery period;
    - existing abnormalities or deficiencies;
    - results from physical examinations;
    - observations made by the treatment provider during office visits/therapy sessions;
    - diagnostic tests and their results (for example, lab results, x-rays and MRIs);

REQUEST FOR REVIEW PROCESS: PREPARE YOUR APPEAL

- Address surveillance
  - Diminish utility of surveillance
  - Review surveillance videos – watch time stamps carefully and compare with surveillance report.
  - Watch for contradictory statements made by claimant regarding the surveillance
  - Review claim file for contradictions/consistencies with activities seen on surveillance.
  - Review medical reports for possibly flawed interpretations of surveillance
  - Obtain client and other statements to "fill in the gaps" of surveillance.
  - Have treating physician or IME review surveillance and render opinion.
  - Investigate whether surveillance was done lawfully.

REQUEST FOR REVIEW PROCESS: PREPARE YOUR APPEAL

- Declarations (claimant, friends, co-workers, etc.)
- Functional Capacity Evaluations and Independent Medical Examinations
- Vocational Analysis
- Medical literature
- Social Security file for supporting information

RESPONDING TO THE REQUEST FOR REVIEW

- Appeal procedures and administrative review must comply with plan documents
  - NO FEES!
  - Have there been similarly situated claimants in the past?
- What does the plan look for in an appeal?
  - Timeliness of the appeal
  - What aspect of the denial letter is the claimant appealing?
  - Did claimant provide additional material or information that was requested?
  - Has claimant requested any new evidence from plan on appeal? If so, has claimant reserved the right to supplement or address the new evidence?

RESPONDING TO THE REQUEST FOR REVIEW

- What does the plan look for in an appeal?
  - Who reviewed the initial claim for benefits and made decision to deny benefits?
  - Was the claim initially denied based in whole or in part on a medical judgment?
    - This includes determinations on whether treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate
    - Must consult with a health care professional who has appropriate training and experience and was not involved in the initial determination to deny benefits

RESPONDING TO THE REQUEST FOR REVIEW

- If the appeal is denied, how does the plan prepare the appeal denial letter?
  - Compliance with plan's claims procedure
  - Was the time period for claimant to respond to request for additional information tolled?
  - Must provide identification of medical or vocational experts whose advice was obtained
  - Do the plan documents further provide for a second appeal, voluntary appeal, or arbitration?

RESPONDING TO THE REQUEST FOR REVIEW

- Several Courts have articulated that appeal denial letters must provide a clear and prominent statement of any applicable contractual limitations period and its expiration date in the final notice of adverse benefit determination on appeal – Already required? See, *Santana-Diaz v. Metro. Life Ins. Co.*, 2016 WL 963830 (1st Cir. March 14, 2016); *Mirza v. Ins. Admin. Of Amer., Inc.*, 800 F.3d 129 (3d Cir. 2015); *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014)

DOL NPRM

- On November 18, 2015, the Department of Labor issued proposed regulations specifically modifying the current claims regulations to address disability benefit claims and appeals. The proposed regulations adopt procedural protections implemented for health care claimants under the ACA, including:

DOL NPRM

- Minimizing financial conflicts of interest
- Full disclosure of all reasons supporting a claim denial
- Claimants have access to their entire claim file, as well as any claim processing guidelines, standards, and protocols, and are allowed to present evidence and testimony during the review process;
- Claimants are notified of and have an opportunity to respond to any new evidence reasonably in advance of an appeal decision
- Final denials at the appeals stage are not based on new or additional rationales unless claimants first are given notice and a fair opportunity to respond
- If plans do not adhere to the claims rules, the claimant is deemed to have exhausted administrative remedies available under the plan (with certain exceptions)
- Notices are written in a culturally and linguistically appropriate manner

DOL NPRM—AVOIDING CONFLICTS OF INTEREST

- Builds on independent review standards for avoiding conflicts of interest – "full and fair" review
- Decisions regarding hiring, compensation, termination, promotion, or similar matters involving individuals involved in making a claim decision must not be based upon the likelihood that the individual will support the denial of disability benefits
- Ex. Plan would not be permitted to provide bonuses based on the number of denials made by claims adjudicator
- Ex. Plan would not be permitted to contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than on the expert's professional qualifications

DOL NPRM—ENHANCED DISCLOSURES

Adverse benefit determinations on disability claims would have to contain:

- a discussion of the decision, including the basis for disagreeing with the disability determination by the Social Security Administration, by a treating physician, or other third party disability payor
- internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying the claim

A notice of adverse benefit determination *at the claim stage* would have to contain a statement that the claimant is entitled to receive relevant documents (current regulations require such statement only in notices of adverse benefit determination denied on appeal)

DOL NPRM—REVIEW AND RESPOND TO NEW INFORMATION

- Claimants would have a right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal (*as opposed to having a right to such information on request only after the claim has already been denied on appeal*)
- Prior to a plan's decision on appeal, a claimant must be provided:
  - with any new or additional evidence considered (free of charge), relied upon, or generated by the plan as well as any new or additional rationale for a denial,
  - a reasonable opportunity for the claimant to respond

DOL NPRM—REVIEW AND RESPOND TO NEW INFORMATION

Example. Plan denies claim and claimant appeals. Plan causes a new medical report to be generated by a medical specialist who was not involved in developing the first report. Proposed regulations would require that this new report be furnished to claimant prior to the expiration of the decision period (45 days).

- Plan would be required to consider any response from the claimant
- Must allow claimant reasonable opportunity to respond
- Special tolling rules so that a claimant has a reasonable opportunity to respond

DOL NPRM—EXHAUSTION

- Expands on the "deemed exhaustion" provision in the existing DOL regulations in three respects:
- No deemed exhaustion based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant.

DOL NPRM—EXHAUSTION

- Not available if the violation is part of a pattern or practice of violations by the plan
- Claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted
- If a court rejects the claimant's request for immediate review on the basis that the plan met the *de minimis* standards, the claim shall be considered re-filed on appeal upon the plan's receipt of the decision of the court
  - Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of resubmission

DOL NPRM—RESCISSIONS

- Proposed regulations would treat rescissions as adverse benefit decisions
- Rescission include cancellation or discontinuance of disability coverage that has retroactive effect
- By treating rescissions as adverse benefit decisions, participants and beneficiaries would be able to utilize the administrative claims procedures under the plan

DOL NPRM—LINGUISTICALLY APPROPRIATE NOTICES

- Proposed regulations would require that adverse benefit determinations be provided in a culturally and linguistically appropriate manner
- If claimant's address is in a county where 10% or more of the population residing in that county, as determined based on data published by the U.S. Census Bureau, are literate only in the same non-English language, notices of adverse benefit determinations would have to include a prominent one-sentence statement in the relevant non-English language about the availability of language services
- Plan would be required to provide a customer assistance process (such as a telephone hotline) with language services in the non-English language and provide written notices in the non-English language upon request

HEALTH CLAIMS – URGENT CARE

- Plan Administrator shall render a decision of a claimant on the initial receipt of a Claim involving Urgent Care as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the such claim.
- A "Claim Involving Urgent Care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

HEALTH CLAIMS – URGENT CARE

- If a Claim Involving Urgent Care requires additional information in order for the plan administrator to render a decision, the plan administrator must notify the claimant of the specific information necessary to complete the claim within twenty-four (24) hours of receipt of the Claim Involving Urgent Care. The plan administrator shall permit the claimant at least forty-eight (48) hours to provide the specified information. The plan administrator must render a decision on a Claim Involving Urgent Care that required additional information no later than the earlier of forty-eight (48) hours after receipt of the additional information or by the end of the time period the plan administrator gave the claimant to provide the additional information.

HEALTH CLAIMS – URGENT CARE

- In the event the Claim Involving Urgent Care is denied, the claim denial must include:
- (i) the specific reason or reasons for the adverse determination;
- (ii) reference to the specific plan provisions on which the determination is based;
- (iii) a description of any additional materials or information necessary for the claimant to perfect the claim;
- (iv) an explanation of why such information is necessary;
- (v) a description of the plan's expedited review process for Claims Involving Urgent Care and applicable time limits on such review and a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination; and

HEALTH CLAIMS – URGENT CARE

- (vi) in the event an internal rule, guideline, protocol, or similar criterion was relied upon in making the determination on the claim, either a copy of such rule or guideline or a statement that a copy of the rule or guideline, etc. will be provided to the claimant free of charge upon request, or if the determination was based on medical necessity, experimental or a similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge.

HEALTH CLAIMS – URGENT CARE

- If a claimant fails to follow the Plan's claims procedures properly, the plan administrator must notify the claimant within twenty-four (24) hours of receipt of notice of the improperly filed claim of the proper procedures to be followed to file the claim. A claim is not filed properly when there is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unity customarily responsible for handling benefit matters and it is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval was requested.

HEALTH CLAIMS – PRE-SERVICE CLAIM

- (1) The plan administrator shall render a decision and notify the claimant on a Pre-Service Claim no later than fifteen (15) days after such claim is filed and within a reasonable period of time considering the medical circumstances. Such decision may be provided in writing or electronically. In the event the plan administrator denies a Pre-Service Claim, the denial must include the information in the adverse benefit determination below. In the event circumstances outside of the plan administrator's control require an extension of the period for rendering a decision and provided the plan administrator notifies the claimant of the need for the extension, the period for determining the Pre-Service Claim may be extended one time for up to fifteen (15) days.

HEALTH CLAIMS – PRE-SERVICE CLAIM

- For purposes of these claim procedures, “Pre-Service Claim” means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

HEALTH CLAIMS – PRE-SERVICE CLAIM

- (2) In the event additional information is needed to process the claim, the plan administrator shall notify the claimant of the additional information needed and request the fifteen (15) day extension for processing the claim for circumstances outside of the plan's control. The plan administrator shall permit the claimant at least forty-five (45) days to provide the specified information. When the additional information is received, the plan administrator shall decide the claim in no more than fifteen (15) days from the receipt of the additional information.

HEALTH CLAIMS – PRE-SERVICE CLAIM

- The fifteen (15) day extension period for deciding the claim shall commence running upon the plan administrator's receipt of the additional information. In the event the plan administrator denies a Pre-Service Claim, the denial must include the information in the adverse benefit determination below.

HEALTH CLAIMS – PRE-SERVICE CLAIM

- (3) If a claimant fails to follow the Plan's claims procedures properly, then the plan administrator shall notify the claimant of the failure to follow the plan's claims procedures properly and of the proper procedures to file within five (5) days of receipt of the communication from the claimant. This notice may be given orally to the claimant unless the claimant requests the notice be provided in writing.

HEALTH CLAIMS – POST-SERVICE CLAIM

- The plan administrator shall notify the claimant within a reasonable period of time and no later than thirty (30) days after receipt of the Post-Service Claim of the decision on the Post-Service Claim. Any adverse benefit determination on a Post-Service Claim shall include the information shown below. The initial period for determination on a Post-Service Claim may be extended one time by the plan administrator for up to fifteen (15) days provided the plan administrator both determines that an extension is necessary due to matters beyond the control of the plan, and notifies the claimant prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the expected date by which the plan expects to render a decision.

HEALTH CLAIMS – POST-SERVICE CLAIM

- If such extension is necessary due to the need for additional information, the notice to the claimant must specifically describe the additional information needed and provide the claimant with at least forty-five (45) days in which the claimant may respond. In the event a claimant is notified of the need for additional information, the time period for processing the Post-Service Claim shall not begin to run again until the additional information is received from the claimant or his authorized representative. For purposes of these claims procedures, "Post-Service Claim" means any claim for a benefit under a group health plan that is not a Pre-Service Claim.

HEALTH CLAIMS – CONCURRENT CARE CLAIM

- (1) In the event the plan administrator determines to reduce or terminate a course of treatment or a series of treatments, the plan administrator must notify the affected participant or beneficiary of the intended termination or reduction (the adverse benefit determination) sufficiently in advance of the reduction or termination so that the participant or beneficiary may appeal the adverse benefit determination. The adverse benefit determination on a Concurrent Care Claim shall include the information specified below. Any decision on the appeal of the adverse benefit determination on the reduction or termination must be rendered before the reduction or termination of the care or course of treatment. For purposes of these claims procedures, "Concurrent Care Claim' means a claim that is reconsidered after an initial approval has been made and results in a reduction, termination or extension of a benefit.

HEALTH CLAIMS – CONCURRENT CARE CLAIM

- (2) If a participant or beneficiary requests an extension of the course of treatment beyond the period of time or number of treatments, the claim will be decided as soon as possible, taking into account medical exigencies. The plan administrator will notify the participant or beneficiary of the outcome of the claim, whether adverse or not, within twenty-four hours after the receipt of the claim by the plan, provided that the claimant made the claim at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

HEALTH CLAIMS – DENIAL OF URGENT CARE CLAIM

- Explanation of a claim denial shall be sent to the claimant and shall set forth, in a manner calculated to be understood by the claimant, the following information:

  (1) The plan administrator's adverse determination.

  (2) The specific reason or reasons for the adverse determination.

  (3) Specific reference to the pertinent plan provisions on which the denial is based.

  (4) A description of any additional materials or information necessary for the claimant to perfect the claim, and an explanation of why such information is necessary.

HEALTH CLAIMS – DENIAL OF URGENT CARE CLAIM

(5) A description of the plan's review process for claims and applicable time limits on such review and a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination.

(6) In the event an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, either a copy of such rule or guideline or a statement that a copy of the rule or guideline, etc. will be provided to the claimant free of charge upon request.

(7) In the event the adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limit, the claim denial must include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

HEALTH CLAIMS – APPEAL FOR DENIAL OF MEDICAL BENEFITS CLAIM

- (1) *Claimant's Appeal Requirements and Rights*: If a claimant's claim for medical benefits is denied, either in whole or in part, the claimant shall have one hundred eighty (180) days from receipt of an adverse benefit determination on a claim for benefits to submit a written request for appeal to the plan administrator. If a claimant disagrees with the claim denial, the claimant must file a written request for appeal. A claimant should submit written comments, documents, records and all other information relating to the claim for benefits. A claimant may request reasonable access to and copies of all documents, records, and other information relevant to the claim.

HEALTH CLAIMS – APPEAL FOR DENIAL OF MEDICAL BENEFITS CLAIM

- The claimant shall be provided this information free of charge. The review of the initial adverse determination will take into account all comments, documents, records and other information that is submitted, regardless of whether such information was submitted and considered in the initial determination of the claim. The claimant will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

HEALTH CLAIMS – APPEAL FOR DENIAL OF MEDICAL BENEFITS CLAIM

- (2) *Appeals Involving Medical Judgment in Whole or in Part*: If the appeal involves a determination based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment or other item is experimental, investigational or not medically necessary or appropriate), a health care professional with the appropriate training and experience in the field of medicine at issue in the appeal will be appointed. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the appeal.

HEALTH CLAIMS – APPEAL FOR DENIAL OF MEDICAL BENEFITS CLAIM

- (2) *Appeals Involving Medical Judgment in Whole or in Part*: If the appeal involves a determination based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment or other item is experimental, investigational or not medically necessary or appropriate), a health care professional with the appropriate training and experience in the field of medicine at issue in the appeal will be appointed. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the appeal.

HEALTH CLAIMS – SECOND LEVEL OF APPEAL FOR DENIAL OF MEDICAL BENEFITS CLAIM

- If, after reviewing the first level of appeal and any further information that the claimant has submitted, the plan administrator denies the claim for medical benefits either in whole or in part, and the claimant disagrees with the denial, the denial must be appealed by requesting a review of the claim for medical benefits by the plan administrator. The plan administrator must receive a written request for an appeal within ninety (90) days of the date the claimant received notice that the claim for medical benefits was denied.

The remainder of the second level appeal for a denial of a claim for medical benefits will be handled as discussed above. The request for a second level appeal should be mailed to the plan administrator.

HEALTH CLAIMS – INDEPENDENT REVIEW OF MEDICAL NECESSITY DETERMINATIONS OR COVERAGE RESCISSIONS

- If an appeal involves a medical necessity determination or a coverage rescission determination, a claimant may request an independent external review of his or her claim. Any such external review shall comply with applicable state or federal law and other rules and procedures for non-grandfathered plans as set forth in Department of Labor Regulation § 2590.715-2719.

HEALTH CLAIMS – SECOND LEVEL OF APPEAL FOR DENIAL OF MEDICAL BENEFITS CLAIM

- If, after reviewing the appeal and any further information that the claimant has submitted, the plan administrator denies the second level appeal, either in whole or in part, a notice (which will be provided to the claimant in writing by mail or hand delivery, or through e-mail) will be provided to the claimant within a reasonable period of time, but not later than either fifteen (15) days for a Pre-Service Claim or thirty (30) days for a Post-Service Claim, from the day the request for a review was received by the plan administrator.

- The notice describing the decision shall include the information described above.