

**D. Level Two Appeal Item Number Four (4)**

**The adverse benefit determination on review dated January 30, 2007 fails to follow DOL 29 CFR 2560.503-1 (Claims Procedure). Pursuant to ERISA, the plan therefore “has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.”**

The adverse benefit determination on review letter dated January 30, 2007:

1. Does not contain a statement pursuant to DOL 29 CFR 2560.503-1 (Claims Procedure) that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section
2. Was not received within the ninety (90) day timeframe prescribed by DOL 29 CFR 2560.503-1 (Claims Procedure). On December 27, 2006 Mr. Gary Person, Cigna wrote Ms. XXXX “...that would make the applicable decision date January 19, 2007”. Cigna sat on the appeal and did not seek a medical review until January 4, 2007 (over eighty days after receiving the appeal). When the peer review was received by Cigna’s Registered Nurse Ms. Karen Haley on January 11, 2007 and deemed by Ms. Haley to support Mr. XXXX’s disability claim Cigna’s administrative staff contrived a plan to disregard the findings of Ms. Haley and to have a transferable skills analysis by a non-independent Cigna employee, Ms. XXXXX. Cigna withheld the findings of Cigna’s own Registered Nurse, Ms. Karen Haley and Cigna’s Independent Vocational Expert, Ms. XXXX from Ms. XXXX in the process. The appeal decision was not made until January 30, 2007, eleven days beyond the ninety (90) day ERISA mandated window. Cigna’s dilatory and contrived tactics represent a last-ditch 11th hour attempt to fabricate some evidence based on a logical fallacy and the intentional misconstruction of the peer review report to create any appearance of propriety in denying benefits due to the paucity of any legitimate basis to do so based upon the record.
3. Breaches Cigna’s own correspondence and requirements to delineate communication regarding two separate coverages with differing terms and conditions. On November 13, 2006 Ms. Johnson stated in a letter to Ms. XXXX “Although these appeals involve a review of the same subject matter, issues and information, you will be provided duplicate letters on each step of the process with one addressing the WOP adverse determination and one addressing the Long Term Disability adverse determination.” Only one adverse determination letter, for both policies, was sent to Mr. XXXX’s attorney.
4. Utilizes an incorrect definition of disability. The correct definition of “disability” set forth in the controlling policy document, as well as in the

Summary Plan Description and numerous additional documents, is defined on Page 18: “An employee will be considered Totally Disabled if he is totally and continuously disabled so that he is completely prevented from performing the duties of his occupation or employment. It is provided, however, that if monthly benefits has been paid for 26 weeks and the employee remains so disabled, he will subsequently be considered Totally Disabled only if such disability completely prevents him **from engaging in any gainful occupation or employment** for which he is, or becomes, reasonably qualified by training, education, or experience.” (Emphasis added)

- The word “duties” is removed from the second part of the definition and replaced by the words “engaging in”. Cigna’s repeated use of the word “duties” in the adverse determination letter is inconsistent with the correct definition of disability in the contract.
- The adverse determination letter says Cigna “based our decision to deny Mr. XXXX’s claim for benefits on Policy language”. How did Cigna accomplish this if it was analyzing the wrong definition of disability?

Pursuant to ERISA, Cigna “has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.” Cigna’s decision is therefore arbitrary and must be reversed.