

F. Level Two Appeal Item Number Six (6)

Ms. Johnson's letter dated November 13, 2006 and Cigna's ACCLAIM note February 1, 2007 indicate that ERISA 29 CFR 2560.503-1 (Claims Procedure) regarding Cigna's fiduciary obligation to provide a "full and fair" review apparently do not apply to Cigna. Cigna's Appeal Team has provided blank authority to Cigna's claim management staff to commit fiduciary "wrongs" or breaches when pursuing benefit denials and foisted the adjudication of such "wrongs" onto the Federal Court system.

Ms. Karol Johnson's letter to Ms. XXXX dated November 13, 2006 was Cigna's initial attempt to compartmentalize the appeal when Ms. Johnson stated "the issue that will be reviewed on appeal is your client's level of functionality, as developed by the medical records and his vocational capabilities...." Then on February 1, 2007 (two days after the level one appeal decision) Ms. Karol Johnson entered a note into Cigna's ACCLAIM system referencing an undated phone conversation she allegedly had with Mr. XXXX's attorney XXXX. The note states that "Atty [XXX] primarily wants to talk about the alleged wrongs that have occurred in past mgmt. Told her my decision is a review of the medical records and functionality and **not those things that are alleged to have occurred.**" (Emphasis added)

These statements by Ms. Johnson are inconsistent with Cigna's requirement, pursuant to ERISA 29 CFR 2560.503-1 (Claims Procedure), to "provide for a review that takes into account **all** comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination." (Emphasis added) The requirement does not say "medical records and functionality" it says "all documents and comments" and that would include alleged fiduciary "wrongs" or breaches.

Cigna is legally bound to review and adjudicate these alleged fiduciary "wrongs" as mandated by controlling ERISA "full and fair" claim procedure. Failure to do so essentially grants Claim Management staff a blank check to act in a self-interested manner that eviscerates Cigna's fiduciary obligations to Mr. XXXX's best interests and denies Mr. XXXX a "full and fair" review. Mr. XXXX has been denied benefits since May 1, 2006. Many of these alleged "wrongs" represent material breaches of Cigna's fiduciary duty and may be grounds for reversal on their own merit. It is absolutely shocking that Ms. Johnson admits that the alleged fiduciary "wrongs" or breaches have not been reviewed and adjudicated to date.

The alleged fiduciary "wrongs" contained in Level One appeal items numbers 1, 5, 9, 10, 13 & 17 including applying an incorrect definition of disability, bad faith offers and lying about medical record requests, gamesmanship, acting with premeditation to deny benefits, modifying diagnoses in the Ascenza system, failure to produce documents, acting to retaliate and failing to delineate separate policy language are hereby resubmitted with this level two voluntary appeal for review and adjudication according to ERISA "full and fair" requirements.