STRIS & MAHER LLP

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March 24, 2015

VIA EXPRESS MAIL (RETURN RECEIPT REQUESTED)
AND FACSIMILE

Plan Administrator

[redacted]

Plan Supervisor

[redacted]

PATIENT: [redacted]
CLAIMANT: [redacted]
SS NO.: [redacted]
PLAN: [redacted]
SPONSOR NO.: [redacted]
CLAIM NO.: [redacted]

To Whom It May Concern:

My colleagues and I represent [redacted], a participant in the [redacted] ("Plan") who is quadriplegic. You have denied his claim for medical benefits. I write in the hope that we can resolve this matter without judicial intervention.

I was shocked and disappointed when I learned of the Plan's behavior regarding [redacted]'s claim. As you may know, my firm and I regularly represent plan participants, beneficiaries, and medical providers in important, high-stakes disputes involving the Employee Retirement and Income Security Act of 1974 ("ERISA"). *See, e.g.*, *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013) (co-counsel); *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013) (co-counsel); *Conkright v. Frommert*, 559 U.S. 506 (2010) (lead counsel, argued); *LaRue v. DeWolff, Boberg & Associates, Inc.*, 552 U.S. 248 (2008) (lead counsel, argued); and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006) (lead counsel, argued). This case presents one of the most egregious examples of fiduciary misconduct that I have witnessed in my career.

Having reviewed the relevant hospital and police records; the Plan Document and Summary Plan Description, Exh. A ("Written Instrument"); and correspondence between [redacted]'s prior counsel and multiple Plan fiduciaries, it is clear to me that you have wrongfully refused to pay [redacted]'s medical expenses. It is equally clear to me that you have flagrantly violated your procedural obligations under ERISA and Department of Labor regulations.

Your misconduct has forced [redacted] to retain our firm to vindicate his rights under ERISA and the Plan. While we are prepared to bring suit in federal court if necessary, I expect that you

will reverse your adverse benefit determination after carefully reviewing and considering this letter. At a minimum, I am confident that you will provide [redacted] the "full and fair review" to which he is entitled under 29 U.S.C. § 1133.

## RELEVANT FACTS

[redacted] is a heroin addict who, for years, has received treatment at the [redacted]. *See, e.g.*, Exh. B (Medical Records of [redacted]). On [redacted], 2014, [redacted] visited the [redacted] where he received a prescribed 95mg dose of methadone. *Id.* at [redacted]. Less than 24 hours later, he was involved in a horrific traffic accident which has rendered him quadriplegic.

### I. [redacted] Suffers a Catastrophic Accident Leaving Him Quadriplegic.

Around [redacted] on [redacted], 2014, [redacted] began to drive toward the [redacted] in [redacted] where he worked. *See* Exh. C ([redacted]. According to a police report, in a "dark" area "without any street lighting," the rear driver's side tire of [redacted] "rapidly deflat[ed]" and blew out. *Id.* at [redacted]. [redacted] lost control of his car, which crossed into the opposing lane and "spun in a counter clockwise direction." *Id.* at [redacted]. The [redacted] then skidded off the side of the road and flipped three times, scattering debris at each impact, before settling upside down 42 feet away. *Id.* at [redacted].

As the [redacted] tumbled across the desert, [redacted]'s head smashed against the interior of the car. *Id.* at [redacted]. When the car finally stopped, [redacted] "[redacted] noticed that he was unable to move his limbs and immediately felt a severe pain coming from his neck." *Id*. When a police officer arrived at approximately [redacted], [redacted] was immobile, still strapped by his seatbelt into the overturned vehicle. *Id.* at [redacted].

The officer on the scene described [redacted] as lethargic, and his speech as "weak, slow, and slurred." *Id.* at [redacted]. The officer later found "three small baggies of what appeared to be heroin" and "five hypodermic needles" in [redacted]'s vehicle. *Id.* at [redacted]. The officer speculated that the accident may have resulted from a number of factors, including the tire blowout and heroin intoxication. *Id.* at [redacted]. He arrested [redacted] for possession of contraband and "for suspicion of driving under the influence of a controlled substance." *Id.* at [redacted]; *see also id.* at [redacted] (selecting "IMPAIRMENT NOT KNOWN" as opposed to "UNDER DRUG INFLUENCE" when recording officer's assessment of [redacted]'s sobriety).

After receiving on-site emergency medical treatment, [redacted] was airlifted to [redacted] in [redacted]. *See id.* at [redacted]. While rendering aid, doctors took blood tests indicating that [redacted] had opiates in his system. [redacted]'s doctors determined that he had sustained severe injuries, including a broken neck and a damaged spinal cord, and that as a result of those injuries, [redacted] was now quadriplegic. *Id.* at [redacted].

### II. [redacted] Incurs Over $1 Million in Covered Medical Expenses.

Unsurprisingly, the treatment of [redacted]'s injuries has been extraordinarily costly and involved numerous medical providers. I understand that each medical provider has submitted its

bills to you directly to request reimbursement. In an abundance of caution, I have attached all medical billing records in [redacted]'s possession as exhibits to this letter. [redacted] has incurred medical expenses of over $1 million relating to his injuries to date, as reflected below.[1]

| Medical Provider | Your Responsibility | Exhibit |
|---|---|---|
| [redacted] | $[redacted] | D |
| [redacted] | $[redacted] | E |
| [redacted] | $[redacted] | F |
| [redacted]roup | $[redacted] | G |
| [redacted] | $[redacted] | H |
| [redacted] | $[redacted] | I |
| [redacted] | $[redacted] | J |
| [redacted] | $[redacted][2] | K |
| [redacted] | $[redacted] | L |
| [redacted] | $[redacted] | M |
| [redacted] | $[redacted] | N |
| [redacted] | $[redacted] | O |
| [redacted] | $[redacted] | P |
| [redacted] | $[redacted] | Q |
| [redacted] | $[redacted] | R |
| [redacted] | $[redacted] | S |
| [redacted] | $[redacted] | T |
| [redacted] | $[redacted] | U |
| [redacted] | $[redacted] | V |
| [redacted] | $[redacted] | W |
| **TOTAL** | **$1,387,430.74** | |

[redacted] will continue to incur substantial medical expenses relating to the car accident and his resulting quadriplegia.

### III. [redacted] Submits a Claim for Benefits, Which You Ignore for Months.

Naturally, [redacted] expected that his medical expenses would be paid by you. When that expectation became frustrated, [redacted] enlisted the help of attorney [redacted] to pursue a benefits claim on his behalf.

As you know, Section [redacted] of the Written Instrument sets forth the procedures for filing a claim for benefits with the Plan. *See* Exh. A at [redacted]. In compliance with those procedures, [redacted] sent

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[1] As a result of his quadriplegia, [redacted] has relied almost entirely on the assistance of his traumatized wife, [redacted] ("[redacted]"), to gather documentation associated with his claim. Accordingly, the above table may be incomplete. I ask that you notify us of any additional expenses beyond those identified above.

[2] [redacted] has offered to settle its $[redacted] contractual claim for an immediate payment by you of $[redacted].

a letter to the Plan Administrator and Plan Supervisor on [redacted], 2014 describing [redacted]'s accident and resulting medical treatment. *See* Exh. X ("Claim Letter") at [redacted]

The Claim Letter disclosed [redacted]'s history of heroin use and explained that "the day before the accident, [redacted] took a prescribed dose of methadone at approximately [redacted]" *Id.* at [redacted]. The Claim Letter requested that the Plan send all "communications regarding this matter" directly to [redacted]. *Id.* at [redacted]. And it emphasized that "Time is of the essence" because of [redacted]'s need for ongoing treatment. *Id.* at [redacted].

*You ignored the Claim Letter*. You then proceeded to contact the hospital where [redacted] was receiving treatment – and not [redacted]'s attorney – and told it that you "would no longer pay for [redacted]'s treatment . . . ." *See* Exh. Y at [redacted]. [redacted] and his counsel only learned of your position when [redacted]'s wife was informed by the hospital that the Plan had denied his claim. *See id.*

[redacted] sent a follow-up letter on [redacted] 2014 ("Second Claim Letter"). *Id.* The Second Claim Letter formally requested copies of all the information that you considered when processing [redacted]'s claim. *Id.* It reiterated that "**Time is of the essence**." *Id.* at [redacted] (emphasis in original). And it reminded you that "all communications regarding this matter should be directed to [counsel for [redacted]]." *Id.* at [redacted].

*You also ignored the Second Claim Letter.* After hearing nothing for yet another week, [redacted] sent another follow-up letter on [redacted], 2014 ("Third Claim Letter"). Exh. Z. Once again, [redacted] requested information about the denial of [redacted]'s claim. *Id.* at [redacted]. And, once again, [redacted] emphasized that "**TIME IS OF THE ESSENCE**," *id.* at [redacted] (emphasis in original), as [redacted] faced imminent involuntary discharge from his hospital due to his outstanding claim and inability to pay. *Id.*

## IV. You Formally Deny [redacted]'s Claim Based Solely on an Inapplicable Provision from the Wrong Plan.

The next day ([redacted], 2014), you finally acknowledged and formally denied [redacted]'s benefits claim. *See* Exh. AA ("Denial Letter").

At that point, you had had *months* to consider [redacted]'s claim and had, *many weeks earlier*, already informed one hospital that the claim was denied. Thus, read in context, the Denial Letter embodies a complete abdication of the most basic fiduciaries duties set forth in ERISA.

Your 2-page Denial Letter is largely comprised of boilerplate statements about ERISA and the Plan. *See* Exh. AA at [redacted]. Indeed, the entire substantive analysis of your denial consists of one paragraph. *See id.* at [redacted]. And that one-paragraph denial is predicated entirely on an "Illegal Acts" exclusion *that is not contained in the Plan*.[3]

[3] You did not rely on, or even mention, any other Plan exclusion. *See generally* Exh. AA. Nor did you dispute that [redacted] was eligible for benefits as a Dependent Participant or that his claim was otherwise adequate. *Id.*

You attached an incomplete document to the Denial Letter purporting to excerpt the Plan's Written Instrument. Exh. AB at [redacted]. According to your "excerpt," the Plan's Illegal Acts exclusion reads as follows:

> [redacted] Care, supplies, treatment, and/or services for any Injury or Sickness which is incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. . . .

Exh. AA at [redacted]. When [redacted] later contacted you yet again to request a complete copy of the Written Instrument, you provided a copy of the written instrument governing an AAON, Inc. employee benefit plan from which the "Illegal Acts" provision had been excerpted. Exh. AB at [redacted]. Of course, [redacted] is not a participant in that plan. *Id.*

You eventually provided the applicable Written Instrument of the [redacted] which contains a *materially different* "Illegal Acts" exclusion. It provides:

> [redacted] Charges for services received as a result of illness or injury occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one (1) year could be imposed . . . .

Exh. AB at [redacted]. This exclusion clearly does not apply to [redacted]. Among other reasons, see *infra* 7-9 (discussing the illegality of a source of injury exclusion based on a medical condition such as chemical dependence), that is true because (i) [redacted] is not alleged to have committed any act which could result in "a sentence to a term of imprisonment in excess of one (1) year" and (ii) the illegal acts mentioned in the Denial Letter (*e.g.*, *possession* of a controlled substance and *possession* of hypodermic needles) could not possibly have *caused* "directly or indirectly" the injuries suffered by [redacted]. *See, e.g.*, *id.* at [redacted] (explaining that "there is absolutely no evidence that [redacted]'s injuries from the car accident resulted, indirectly or directly, from any alleged criminal offense," much less a "serious" illegal act).

In light of your overall conduct to date, it appears unlikely that your initial reliance on a seemingly disqualifying provision from *the wrong plan* was merely the result of incompetence. Should this case proceed to litigation, we will have no choice but to seek discovery on this subject.

## V. You Decline to Reconsider Your Denial of [redacted]'s Medical Benefits.

On [redacted], 2014, you, by and through your attorney, [redacted], Esq., wrote to [redacted], notifying her that you would not reverse your adverse benefit determination. *See* Exh. AC ("[redacted] Letter") at [redacted].

In your [redacted] Letter, you did not purport to affirm [redacted]'s benefits denial under the "Illegal Acts" provision that was improperly quoted and relied upon in the Denial Letter. *See generally* Exh. AC. Nor did you suggest that you were relying on the "Illegal Acts" provision actually contained in the Plan. *See id.* Instead, you affirmed denial on a new and independent basis

– a plan exclusion that [redacted], [redacted] *'s lawyer*, had mentioned out of an abundance of caution in her Claim Letter. Exh. AC at [redacted] (referencing [redacted]'s Claim Letter and identifying "Exclusion [redacted] . . . of the applicable [redacted] Plan" as the applicable Plan exclusion); *see also* Exh. X at [redacted].

That provision, entitled "Illegal Drugs or Medications," purports to exclude:

> [redacted] Services, supplies, care or treatment to a Participant for an Illness or Injury resulting from that Participant's voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician whether or not it is determined that the illegal substance was the cause of the Illness or Injury. This includes treatment of a Substance Abuse required by a court or in lieu of a conviction. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Exh. AC at [redacted].

In affirming your denial, you stated that "it is not arbitrary for the Plan to deny [[redacted]'s] claims based on the appropriate exclusion above." *Id.* at [redacted]. You explained that [redacted]'s vehicle contained heroin and syringes and that [redacted]'s toxicology screen at the hospital indicated a positive result for opiates. *Id.* You rejected the possibility that [redacted]'s methadone treatment caused the positive results as unsubstantiated. *Id.* And while you acknowledged the limitations of a police officer's on-the-scene observations, you emphasized that there was no information "indicating that the cause of the accident was officially determined to be the blown tire . . . ." *Id.* As such, you concluded that there were facts "sufficient to suggest that the Plan Participant may have been under the influence of illegal drugs at the time of the accident brought on by the usage of heroin." *Id.*

## VI. You Engage in Undisclosed Communications with [redacted]'s Medical Providers.

We have learned that you recently entered into settlement negotiations with [redacted] ("[redacted]"), one of [redacted]'s medical providers, after [redacted] sent you a meet-and-confer letter last month. *See* Exh. AD ("[redacted] Letter").[4]

[4] We received a copy of the letter, which criticizes your "arbitrary and capricious" handling of [redacted]'s claim. *See id.* at [redacted] ("It is not clear whether the Plan's denial considered or arbitrarily and capriciously ignored this evidence."); *id.* ("It also is not clear whether the Plan's denial considered or arbitrarily and capriciously ignored the fact that the Patient was administered methadone on the advice of a physician."). The letter also observes that the application of the [redacted] exclusion here could "violat[e] the ERISA non-discrimination rules" because "the Patient suffered from the potential medical condition of substance abuse addiction." *Id.* at [redacted]. For reasons described below, we agree with [redacted]'s conclusions.

I understand that [redacted] offered to settle its $[redacted] claim against you for $[redacted]. *Id.* at [redacted]. You appear to be seriously considering this offer and have requested an extension of time.

Obviously I welcome the news that you might finally be willing to honor your obligations under the Plan. I am also pleased to find that you consider [redacted]'s Post-Service Claim still pending. That said, I am deeply troubled by your choice to exclude [redacted] and his counsel from your attempts to settle *his* claim for benefits.

As you know, the default under the Plan is payment of benefits to the relevant participant. Exh. A at [redacted] ("All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury or whose covered Dependent's Sickness or Injury, is the basis of a claim."). In addition, regardless of the existence of any assignment of benefits to a medical provider, the Plan fulfills its obligations whenever it pays benefits directly to the participant. *See id.* And the Plan specifically precludes the assignment of a participant's right to sue to recover benefits. *Id.*

You have known for the better part of a year that [redacted] is represented by counsel in connection with his efforts to obtain Plan benefits. His attorney has written you several letters demanding information and urging you to reconsider your refusal to pay his eligible medical expenses. Yet when you began interacting with [redacted] about these expenses, you made no effort whatsoever to notify [redacted] or his counsel. Instead, [redacted] learned from [redacted]'s lawyers of the existence of these negotiations.

## ANALYSIS

### I. Your Benefits Denial Was Arbitrary and Capricious.

[redacted] is the husband of [redacted], a "Participant" in the Plan. *See* Exh. A at [redacted] (defining "Participant" as "A Full-Time Employee . . . who has met the requirement for participation in the Plan, and has elected to participate in the Plan . . . ."). As her spouse, [redacted] is a "Dependent Participant." *See* Exh. A at [redacted] (defining "Dependent Participant" as an "eligible Dependent who has met the requirement for participation in the Plan. . . ."). [redacted] was covered under the plan at all times relevant to his claim.

As a result of his accident, [redacted] incurred "Eligible Medical Expenses." The Plan provides for the payment of Eligible Medical Expenses under the following circumstances:

> The Plan Administrator will pay following satisfaction of the applicable Deductibles and Copayments, the Percentage Payable of the Expenses Incurred during a Calendar Year by the Employee Participant or Eligible Dependent due to an Injury[5] or Illness, provided:

[5] [redacted] unquestionably suffered an "Injury" within the meaning of the Plan. *See, e.g.*, Exh. A at [redacted] ("ACCIDENT / INJURY: Any bodily Injury caused by an Accident (a happening that is not expected, foreseen or intended, and is exact as to time and place) and which results directly from the Accident, independent of all other causes."); *id.* at [redacted] (same).

1. The expenses is incurred while covered for this benefit;
2. The expense is included in the following items of Eligible Expenses;
3. The expense is not paid or payable under another coverage of the Plan; and
4. The expense is deemed Medically Necessary as defined here.

*Id.* at [redacted].

The medical expenses associated with [redacted]'s injuries meet the four criteria for Eligible Medical Expenses under the Plan. *See id.* at [redacted]; *id.* at [redacted] (defining "Eligible Expenses"). Each expense was incurred while [redacted] was covered by the Plan and each expense was included in the Plan's list of Eligible Expenses. *Id.* at [redacted]; *see also id.* at [redacted] (including seventeen different "HOSPITAL SERVICES" as well as, *inter alia*, "Diagnostic X-ray and Laboratory," "Physical Therapy," and "Physician Services"). None of his expenses was "paid or payable under another coverage of the Plan." *Id.* at [redacted]. And each expense was indisputably medically necessary. *See id.* at [redacted], [redacted].

After incurring Eligible Medical Expenses, [redacted] properly submitted a claim for benefits "within thirty (30) days after the occurrence or commencement of any incurred expenses covered by the Plan," *id.* at [redacted], to the Plan Supervisor, [redacted]. *Id.* at [redacted], [redacted].

After submitting timely notice, [redacted] learned that the Plan Supervisor wanted additional information about his accident. *See* Exh. K ([redacted], 2014 invoice from [redacted]). As a result, [redacted] sent her [redacted], 2014 Claim Letter, which described in detail the circumstances of [redacted]'s accident, see Exh. B at [redacted], and provided her legal analysis of the validity of [redacted]'s claim, *id.* at [redacted].

You eventually produced your [redacted] Letter. As you make clear, your sole grounds for refusing to pay [redacted]'s covered medical expenses is your stated belief that [redacted] "may have been under the influence of illegal drugs at the time of the accident," and that according to a police report his possible intoxication "may have had a causative impact on the accident." Exh. AC at [redacted]. You have asserted at various times that the Plan's "[redacted]" or "[redacted]" exclusions applies as a result, see Exh. AA at [redacted]; Exh. AC at [redacted]; or at least that it was not arbitrary or capricious to conclude that the latter exclusion applies, Exh. AC at [redacted].

Your analysis is wrong.

Assume for the sake of argument that [redacted] consumed heroin before the accident and that the accident would not have occurred but for his intoxication. You assert that the Plan would not be required to pay [redacted]'s medical expenses under those circumstances because they "result[ed] from that Participant's voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not yet administered on the advice of a Physician . . . ." Exh. AC at [redacted] (quoting "[redacted]" exclusion of Plan).

That assertion is unlawful. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") forbids plans to deny benefits when an injury arises from a specified cause or activity

(a "source-of-injury exclusion") that results from a medical condition.[6] It is no secret that [redacted] is a heroin addict. *See, e.g.*, Exh. X at [redacted] ("[redacted] has been a long-time heroin user."); Exh. AB at [redacted] (same). Substance dependence is an Axis 1 primary psychiatric disorder – *i.e.*, a "medical condition" – characterized by, among other things, withdrawal and "a persistent desire or unsuccessful efforts to cut down or control substance use." Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. And consuming an opiate as a result of substance dependence is therefore by definition a "cause or activity that results from a medical activity" under HIPAA.

But of course, there is no need to analyze the Plan or the law so carefully in this case. You have made no showing whatsoever that [redacted] had consumed heroin before the accident, nor that such intoxication in any way caused his car accident. *See, e.g.*, Exh. AB at [redacted] (explaining that "there is absolutely no evidence that [redacted]'s injuries from the car accident resulted, indirectly or directly, from any alleged criminal offense," much less a "serious" illegal act); Exh. AC at [redacted] (your assertion that "sufficient information has not been provided to show that [the exclusion] does not apply here."). Indeed, you do not even *assert* causation. *See* Exh. AC at [redacted] (Plan had facts "sufficient to suggest that the Plan Participant *may have been* under the influence of illegal drugs at the time of the accident brought on by the usage of heroin") (emphasis added).

As [redacted] explained in her Claim Letter and again when she asked you to reconsider your denial, you must establish causation to apply an exclusion. *See* Exh. X at [redacted]; Exh. AB at [redacted]. You rely exclusively on the responding police officer's incident report memorializing his initial impressions of the scene. Exh. AC at [redacted]. That report is self-evidently inadequate to support the conclusions you draw from it.

## II. Your Handling of [redacted]'s Claim Was Unlawful.

Regardless of your perspective on the merits of [redacted]'s claim, the procedure by which you reached that view is both troubling and illegal.

As I am sure you are aware, ERISA requires that you provide every plan participant – even one who is an admitted heroin addict – adequate notice of the reasons for denial, 29 U.S.C. § 1133(1), and "full and fair review" of his or her claim. 29 U.S.C. § 1133(2). *See also* 29 C.F.R. § 2560.503-1(b) (describing your "[o]bligation to establish and maintain reasonable claims procedures.").

As explained above, [redacted] was in a horrific accident that rendered him quadriplegic. When he submitted a claim for benefits, you ignored him.

[redacted] prepared and submitted a five-page letter with information and arguments, and attached supporting documents. When that letter failed to elicit a response, she was forced to write two

[6] The "[redacted]" provision that you relied on in affirming [redacted]'s benefit denial also imposes such a requirement, providing that "This exclusion does not apply (a) [*sic*] if the Injury . . . (b) resulted from a medical condition (including both physical and mental health conditions)." Exh. AC at [redacted]. Tellingly, you did not consider how this limitation on the "[redacted]" exclusion might apply in [redacted]'s case.

more letters, pleading with you to respond because [redacted]'s doctors had threatened to discharge him.

After two months, you finally acknowledged receipt of those communications. When you did so, it was in the form of a claim denial letter predicated entirely on *an inapplicable provision from the wrong plan*. You provided one paragraph of analysis about why that inapplicable provision barred [redacted]'s $1+ million benefit claim. And given the timing of your response, and the fact that you failed to reference the right plan, it is clear that you either (1) gave no meaningful consideration to [redacted]'s claim or, worse, (2) intentionally cited the wrong plan.

[redacted] then sought reconsideration of your adverse benefit determination. In so doing, she explained why neither the provision from the wrong plan that you had relied on, nor the analogous provision contained in the right plan, were a reasonable basis for denying [redacted]'s claim.

Nearly two months later, your lawyer, [redacted], mailed [redacted] a letter effectively conceding that point. In affirming the denial of [redacted]'s claim, [redacted] *did not even attempt* to justify the position taken by the Plan Supervisor. Instead, he relied on a completely different basis for affirmance. And rather than engage in a "full and fair review" process by requesting additional evidence sufficient to make factual findings in support or denial of [redacted]'s claim, [redacted] merely noted each area in which he believed there was a lack of evidence and proceeded to construe that lack of evidence in favor of an exclusion.

Your behavior is hardly what one would expect of an administrator acting in good faith. Although you invoke *Firestone* like a talisman in your two letters, you must no doubt be aware that deferential review is forfeitable. Indeed, I am confident that if [redacted] is forced to file his suit in federal court, your decision will be reviewed *de novo*, you will lose on the merits, and my firm will recover substantial fees pursuant to 29 U.S.C. § 1132(g). *See, e.g.*, *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. 2006) (en banc) ("When an administrator tacks on a new reason for denying benefits in a final decision, thereby precluding the plan participant from responding to that rationale for denial at the administrative level, the administrator violates ERISA's procedures."); *Saffon v. Wells Fargo & Co.*, 522 F.3d 863, 871 (9th Cir. 2008) (holding final denial letter's reliance on the lack of evidence that the insurance company had not identified as necessary to successful disposition of the claim was a procedural violation denying claimant full and fair review); *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.*, 125 F.3d 794, 798-99 (9th Cir.1997) (holding that court should review *de novo* decision of plan administrator that gave one reason in its initial denial, but changed reasons in its final denial).

**NEXT STEPS**

We seek immediate payment in full of the Post-Service Claim. In addition, we request clarification about how to resolve [redacted]'s ongoing claims for medical benefits. As you know, [redacted] continues to incur eligible medical expenses and will probably do so for the foreseeable

future. To ensure that there is no confusion or delay in processing his claims, we would appreciate clarification regarding the Plan's procedure for filing claims under these circumstances.[7]

At a minimum, we request written acknowledgment from you that [redacted]'s Post-Service Claim is pending. Your recent interactions with [redacted] suggest that you remain willing to engage in an interactive process with respect to this long overdue claim for benefits. *See supra* 6-7. Given the extent of your mishandling of the Post-Service Claim to date, I anticipate that you will welcome this opportunity to start afresh and provide [redacted] the "full and fair" review he is entitled to under ERISA.

If instead you choose to view this matter as closed, please state in writing that [redacted] has exhausted his administrative remedies under the Plan. If you are unwilling to continue to engage in an interactive process with [redacted] concerning his Post-Service Claim, then by definition [redacted] has exhausted his remedies under the Plan and must seek redress elsewhere.

Finally, I once again formally exercise [redacted]'s right to access "all documents, records, and other information relevant to [his] claim for benefits" pursuant to sections 503 and 505 of ERISA, 29 U.S.C. §§ 1133, 1135, and their implementing regulations, 29 C.F.R. § 2560.503-1. *See* 29 C.F.R. § 2560.503-1(j); *see also* 29 C.F.R. § 2560.503-1(m)(8) (defining "relevant" to mean information that "(i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination . . . ; (iii) demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or (iv) . . . constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis . . . .").

These materials include but are not limited to:

- All documents you or anyone acting on your behalf considered during the course of making the initial adverse benefit determination with respect to [redacted]'s claim.
- All documents you or anyone acting on your behalf generated during the course of making the initial adverse benefit determination with respect to [redacted]'s claim, as well as the name and title of any individuals involved in creating the documents, the dates of their creation, and any sources cited in them.

[7] As you may be aware, [redacted] recently purchased health insurance coverage for her husband on California's exchange. Your misconduct left her with no other choice. As [redacted] and [redacted] repeatedly warned you, [redacted]'s medical providers threatened to involuntarily discharge him unless they received payment, and you repeatedly refused to pay. You should be unsurprised to learn that [redacted]'s quadriplegia and ongoing unpaid medical care have been financially ruinous to the [redacted]. In light of their distress, [redacted] was only able to afford a policy that covers a fraction of the medical expenses covered by the Plan. Under these circumstances, your potential liability is significant.

- All official or unofficial records that you or anyone acting on your behalf considered during the course of making the initial adverse benefit determination with respect to [redacted]'s claim.

For each document provided pursuant to the above request, please provide a physical or electronic copy and a brief description of its contents. In addition, please identify any expert or other third party that you consulted to review or interpret such documents on your behalf. Please state the name, contact information, qualifications, and any compensation arrangement between you and such experts. Finally, please indicate the extent to which you relied upon the contents of any document provided pursuant to the above request in denying [redacted]'s claim.

To further facilitate resolution of this dispute, I also request the following information about your processes to date:

- The identity of all individuals and organizations involved in the initial adverse benefit determination with respect to [redacted]'s claim.
- The identity of all individuals and organizations involved in the decision not to reverse the initial adverse benefit determination with respect to [redacted]'s claim.
- The identity of all individuals and organizations involved in drafting or sending any correspondence to [redacted] regarding [redacted]'s claim.
- A description of your process for selecting individuals or organization to review claims, and a detailed description of your process for selecting the individuals or organizations involved in reviewing [redacted]'s claim.
- The length of time spent by any individuals in reaching the initial adverse benefit determination with respect to [redacted]'s claim.
- The length of time spent by any individuals in deciding not to reverse the initial adverse benefit determination with respect to [redacted]'s claim.
- The identity of any third parties that you contacted during the course of reaching the initial adverse benefit determination or deciding not to reverse the initial adverse benefit determination.
- The identity of any of [redacted]'s medical providers with whom you are in contact regarding [redacted]'s medical expenses, as well as any written correspondence between you and such providers.

With respect to any individual identified in response to the above questions, please state his or her name, job title, employer, experience level, and any other relevant qualifications. In the case of non-[redacted] employees or organizations, describe the nature of the relationship between the employer or organization and [redacted] and the compensation arrangement between the parties. Please also provide any documents that describe or govern the relationship between the employer or organization and [redacted], and any other relevant records that you have retained.

In addition, to the extent that you are in contact with any medical providers other than [redacted] with respect to [redacted]'s medical expenses, please copy me on all correspondence on a going-forward basis so that I can ensure [redacted]'s interests are protected.

Lastly, [redacted] requests additional information about the Plan, including:

- Any and all documents that support your claimed status as a self-funded plan; and
- Any and all stop-loss insurance or reinsurance purchased by [redacted] in connection with its operation of the Plan, as well as any documents describing or governing the relationship between you and any stop-loss insurers or reinsurers.

After you have had a chance to review this letter and the enclosed materials, please contact our co-counsel [redacted] to coordinate next steps. He looks forward to speaking with you.

Sincerely,

Peter K. Stris

PKS/keh
Enclosures

cc: [redacted]