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Submitted via: e-ORI@dol.gov

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Dept. of Labor
200 Constitution Avenue NW
Washington D.C. 20210

**Re: Claims Procedure Regulations for Plans Providing Disability Benefits
(RIN 1210-AB39)**

Dear Assistant Secretary Borzi:

I write to comment on the proposed regulations to amend the claims procedure regulations at 29 C.F.R. 2560.503-1 applicable to disability benefits. I am an attorney whose practice for 35 years has been devoted to the representation of workers and retirees who have been denied benefits from ERISA-governed benefit plans. I am well-situated to comment on these regulations based on my experiences in this field, including writing *Pension Claims: Rights and Obligations* (1988 and 1993), and representing individuals and classes of employees and retirees in some of the largest and most significant actions under ERISA, including *Amara v. CIGNA Corp.*, 563 U.S. 421 (2011), and *Page v. PBGC*, 968 F.2d 1310 (D.C. Cir. 1992) (which resulted in a \$1 billion recovery).

Approximately 140 million current and former employees and their families are eligible for employee benefits as part of the consideration for their labor. Because health, disability and retirement benefits are so essential to their well-being, ensuring “full and fair review” of denied benefit claims is critical to their welfare. As the Department recognizes, the denial of benefits is a “severe hardship for many individuals.” 80 F.R. 72015 (Nov. 18, 2015).

As the Supreme Court has recognized, the fundamental structural problem with employee benefit claims is that “the entity that administers the [employee benefit] plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket [and] this dual role creates a

conflict of interest.” *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 108 (2008). Not only does this dual role mean that critical decisions about benefits are being made by individuals who lack neutrality or independence, but it also means that the experts retained by the sponsoring companies or insurance companies are also conflicted and biased in favor of the entities who retained them.

When Congress enacted ERISA on Labor Day of 1974, it delegated the responsibility to the Department of Labor to issue regulations under ERISA §503, 29 U.S.C. §1133, to ensure a “full and fair review by the appropriate named fiduciary of the decision denying [a] claim” for benefits under an employee benefit plan. In May 1977, the Labor Department issued benefit claims regulations codified at 29 C.F.R. 2560.503-1 to enforce ERISA’s requirements. 42 F.R. 27426. The regulations were “in response to concerns that predated enactment of ERISA, in particular the lack of any uniform procedural standards for benefit claims resolution and participants’ lack of information about claims procedures generally.” 63 F.R. 48390 (Sept. 9, 1998).

By 1998, the Department had already recognized that the 1977 benefit claims regulations were “no longer adequate to protect participants and beneficiaries.” 63 F.R. 48390. The Department acknowledged what the case law was already showing: The 1977 regulations were not ensuring “full and fair review” of denied benefit claims, and were allowing review procedures to persist that were obviously conflicted and biased in favor of upholding benefit denials, such as by allowing the same person to “review” a benefit denial who originally denied the claim, or allowing company-appointed “committees” to “defer” to the persons who originally denied the claims. *See, e.g., Springer v. Wal-Mart Assocs. Group Health Plan*, 908 F.2d 897, 901 (11th Cir. 1990).

The Department took important steps to address some of these deficiencies for group health and disability plans in 2000, and it took further steps for “non-grandfathered” group health plans in the 2011 interim final regulations under the Affordable Care Act (which were finalized without reservation on the same day as these proposed regulations). However, the Department has never amended the 1977 regulations for pension plans, severance plans, or life insurance plans. And the Department has not amended the 2000 regulations for disability plans or grandfathered health plans. *See, e.g.,* 66 F.R. 35886 (July 9, 2001) (recognizing that “the rules applicable to pension plans (and welfare plans other than group health and disability) have remained essentially unchanged from the 1977 regulation”).

The Department is to be applauded for proposing these regulations to improve the existing claims regulations for disability benefits and bring them into line with the regulations for non-grandfathered health claims. But there is no reason why reforms for

pension, severance, life insurance benefits, and grandfathered health benefits should continue to be delayed as the 1977 regulations approach their 40th anniversary and the 2000 regulations have already passed their 15th anniversary.

As described below, the Department also needs to take immediate steps to protect participants and beneficiaries in disability and all other employee benefit plans from the rapidly escalating efforts by company sponsors and insurers to gut the Department's claim procedures and ERISA's procedural protections by redrafting the claims and appeals procedures in SPDs and plan documents. Even as this notice and comment process proceeds, plan sponsors and insurers are attempting to unilaterally write ERISA's protections out of the law, the regulations, and court decisions, and also to discourage and even intimidate benefit claimants from pursuing internal appeals and court actions by imposing new, burdensome requirements.

I. Comments Requested in the Proposed Regulations

Comments on Redrafting of SPDs and Plan Documents to Defeat Procedural Rights of Participants and Beneficiaries

The DOL has invited comment on the unilateral shortening of statutes of limitations by plan sponsors and insurers that is occurring since the Supreme Court's decision in *Heimeshoff v. Hartford Life & Accid. Ins Co.*, 134 S.Ct. 604 (2013). This is certainly a critical issue because the Supreme Court has effectively encouraged such redrafting in *Heimeshoff*. But the problem of redrafting claim procedures in order to defeat the rights of participants and beneficiaries cannot be confined to statutes of limitations.

I respectfully submit that DOL's regulations should, without delay, address the ways in which companies, insurers and TPA's are aggressively trying to limit, through drafting, the benefit claim procedures and judicial review, not only for disability benefits but also pensions, severance and life insurance benefits, as well as both grandfathered and non-grandfathered health benefits. Unless DOL addresses this, DOL will carefully be making reforms in certain areas, while a freight train bears down not only on those reforms but also the modest rights that participants and beneficiaries have secured over the years by virtue of the 1977 and 2000 regulations, the statutory provisions and the case law.

Articles in the trade press, blogs and defense-side listserves trumpet the profound change that is already underway. In an October 20, 2015 interview for *Fiduciary News*, Stephen Rosenberg, who represents Aetna and other companies, speaks of a "profound

change to the benefit plan environment”:

There is more and more a focus in plan draftsmanship on including terms that could limit, either substantively or tactically, the ability of participants or beneficiaries to successfully bring suit, such as the increased use of contractual limitations periods and venue selection clauses, which are both issues that have garnered the attention, to varying degrees, of the Supreme Court. I think plaintiffs’ successes in ERISA litigation over the recent past have really driven plan sponsors and their lawyers to think proactively about what they can do, in writing their plans, to raise the level of difficulty for plaintiffs and their lawyers in ERISA litigation.

See also “View from Sidley: Steps for Employers to Consider to Mitigate ERISA Litigation Risk” in the October 10, 2015 issue of Bloomberg BNA’s *Pension & Benefits Daily* (advocating redrafting of plan provisions on statute of limitations, including “anti-tolling language,” forum selection, releases and arbitration); “View from Proskauer: Liability Through ERISA Plan Design: Statute-of-Limitations Periods, Venue Provisions and Anti-Assignment Clauses” in the March 15, 2015 issue of *Pension & Benefits Daily* (same).

To illustrate this trend, Exelis, a large defense contractor which was formerly a part of ITT, recently adopted similar provisions as “Legal Action Provisions” in the same Resolution that Exelis adopted to terminate a longstanding retiree life insurance plan, thereby attempting to:

- (a) Make “the exclusive venue for any action arising under this plan ... the Middle District of Florida,”
- (b) Impose a “one year” limitations period on actions by claimants, while allowing the plan or its fiduciaries to “recover[] overpayments of benefits” or to “bring any legal or equitable action against any party” outside of that period; and
- (c) Limit any award of attorneys’ fees against the plan to “the lowest amount of fees” while simultaneously providing for an award of fees against a participant “unless the court specifically finds that there was a reasonable basis for the action.”

Attachment 1.

The claims and appeals section of the SPD for the Kodak Company (Attachment 2) goes even further and epitomizes the new aggression to defeat procedural rights by unilateral plan draftsmanship. Kodak's "summary" description of its "claims and appeals procedures" extends for 16 pages and contains the following efforts to defeat participant rights and procedural protections:

The plan administrator's authority is fully discretionary in all matters related to the discharge of his or her authority under the plan including, without limitation, his or her construction of the terms of the plan, his or her determination of eligibility for coverage or benefits, the interpretation and application of legal requirements and precedents, and whether or not to compel binding or non-binding arbitration or mediation.

IF YOU DO NOT FILE YOUR CLAIM BY THE APPLICABLE DEADLINE AND IN THE PROPER MANNER, YOUR CLAIM WILL EXPIRE AND IT WILL BE AUTOMATICALLY DENIED IF SUBSEQUENTLY FILED. YOU WILL NEVER BE ABLE TO PROCEED WITH A LAWSUIT BASED ON THAT CLAIM.

If your claim involves a plan change or amendment, you are deemed to know about your claim as it relates to the change or amendment when the change or amendment is first communicated to plan participants, whether or not the change or amendment has taken effect by that date. The 60-day period for filing a claim regarding a plan change or amendment starts to run as of the date the change or amendment is first communicated to plan participants.

If you do not receive notice of a decision or an extension notice within 90 days of filing your claim, you must assume that your claim has been denied. If you receive an extension notice, but you do not receive notice of a decision within 180 days of filing a claim, you must assume that the claim is being denied.

The claims reviewer has full discretionary authority to determine the type of claim being processed.

No form of communication other than a letter (for example, telephone or e-mail) will constitute an appeal ...

If you do not file your appeal by the deadline in an appropriate format, your

claim will expire and the claim denial or assumed denial will be FINAL. You will not be able to pursue an appeal or a lawsuit in connection with that claim.

IMPORTANT! ... if you do not appeal properly and on time, your claim cannot be raised in subsequent litigation. You cannot avoid this rule by filing a new initial claim on the same subject with different arguments.

Your appeal letter must be in the form directed by the claims reviewer, and must include all information required by the claims reviewer as well as the reasons why you believe the claim was improperly denied ...

[A]ny arguments not made and evidence not filed on appeal CANNOT BE RAISED in subsequent litigation.

If you do not object to any perceived conflicts on appeal, you will be considered to have agreed that the claims reviewer does not have a conflict of interest, and you cannot raise this issue in a lawsuit.

If you do not receive notice of the decision regarding an appeal within the applicable review period, you must assume that the appeal has been denied. [T]he plan administrator for the plan in question retains the right to compel binding or non-binding arbitration or mediation. Also, in some cases, a plan may require or permit a second level of appeal ... If the second level of appeal is mandatory, you must complete the second appeal process before you will be entitled to file suit.

If you want to file suit, you must do so by the earlier of: 1. The date that is 90 days after the date that your claim is denied on appeal ...; or 2. The date that is 90 days after a cause of action accrued....

If the applicable 90-day deadline for filing a lawsuit ... is, for any reason, not applied by a court, then the deadline for filing the suit will be no longer than one year from the earlier of the date the claim was denied on appeal or the date the cause of action accrued.

**IF YOU DO NOT FILE SUIT BY THE APPLICABLE DEADLINE,
YOUR CLAIM WILL EXPIRE AND YOU WILL NEVER BE ABLE TO
PROCEED WITH A LAWSUIT IN CONNECTION WITH THAT CLAIM
OR A RELATED CLAIM.**

All lawsuits against or involving one or more of Kodak's plans must be filed in the Federal Court for the Western District of New York located in Rochester, New York, unless the plan administrator agrees to a different forum.

If you file a lawsuit and the court or arbitrator rules against your claim, you will be responsible for the attorney's fees and other expenses incurred by the plan, its fiduciaries, Kodak and other related parties in defending against your action, unless otherwise agreed to by the plan administrator or otherwise ordered by the court or arbitrator. If you file a lawsuit and the court rules in your favor, the plan, its fiduciaries, Kodak and other related parties will not be responsible for your attorney's fees and other expenses unless otherwise ordered by the court or arbitrator.

If your lawsuit is successful, the applicable plan, its representatives and fiduciaries, Kodak, and related parties will not be liable for extracontractual or punitive damages, and will only be liable for pre-judgment interest if ordered by a court or arbitrator. You will not be entitled to benefits in excess of those promised by the terms of the written plan document, regardless of what oral or written statements may have been made to you.

As Kodak's 16-page SPD and Exelis' Resolution illustrate, this is a freight train bent on destroying the protective rules for venue, statute of limitations, attorneys' fees, arbitration, choice of law, evidence, assignment of claims, and practically anything else that can be redrafted to gain an advantage for the plan sponsor or insurer. Obviously, the movement to destroy through unilateral redrafting as many of the reforms in ERISA, the regulations, and the case law has been fueled by *Heimeshoff* and the Supreme Court's decisions on arbitration clauses. But regardless of the fuel, this is a train that is picking up steam. If no action is taken by the Department, this Administration will be the one under whose watch "full and fair review" deteriorated even more than in the long 40 years since the admittedly inadequate 1977 regulations were issued.

Under the authority of ERISA §503, the Department has already issued the rule in 29 C.F.R. 2560.503-1(b)(3) that "The claims procedures for a plan will be deemed to be reasonable only if — ... (3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits." The 1977 regulatory preamble states that "[A] claims procedure which meets the minimum requirements set forth in this regulation nevertheless may be deemed not reasonable if it contains other provisions which unduly inhibit or hamper the initiation or processing of plan claims. For example, a claims procedure may be deemed

unreasonable if it requires a claimant to file a complicated claim form before the claim is considered properly filed, or if it requires the payment of a fee as a condition for filing a claim or obtaining review of a denied claim. It should be noted that a procedure which is reasonable on its face may be deemed unreasonable if it is administered in such a way as to unduly inhibit or hamper the initiation or processing of plan claims.” 42 F.R. 27426-27 (5/27/1977) (the same examples are in the regulation itself).¹

Although the 1977 regulation is prescient, the Department has never brought an action to enforce this provision. Besides strengthening the rule by bringing enforcement actions to face the challenges brought on by the redrafting that Kodak and other companies are presently engaged in, the Department could strengthen this regulation by connecting it with the rule in ERISA §404(a)(1)(D), 29 U.S.C. §1104(a)(1)(D), that a fiduciary may only lawfully follow a plan provision “insofar as [it is] consistent with the provisions of this title” I of ERISA, which includes ERISA §§502 and 503, and that a plan provision that inhibits or hampers judicial redress for a breach of fiduciary duty in the claim procedure is “void” under ERISA §410(a), 29 U.S.C. §1110(a), as an exculpation “against public policy” of “a fiduciary from responsibility or liability for any responsibility, obligation or duty.” In addition to the policy embodied by ERISA §503, ERISA §2(b), 29 U.S.C. §1001(b), declares it “the policy” of the Act “to protect ... the

¹ Two decisions have relied on this regulation. In *Bond v. Twin Cities Carpenters Pension Fund*, 307 F.3d 704, 706 (8th Cir. 2002), the Twin Cities Carpenters’ plan provided that arbitration was the sole remedy for a participant who was not satisfied with a benefit determination, with a presumption that the participant would bear half the costs. The Eighth Circuit held this violated the regulations which “unequivocally prohibit plans from using procedures that hinder the processing of claims.” “Under the ERISA plan in Bond’s case, if a Plan participant wants to appeal an adverse board determination, they are faced with the presumption that they will have to shoulder half of the costs of arbitration. The threat of having to pay the arbitrator’s expenses no doubt discourages the pursuit of many legitimate claims by those who cannot afford such costs. A claims system such as this is unduly burdensome, and not permitted by ERISA.” *See also Booth v. Hartford Life & Accident Ins. Co. of Am.*, 2009 U.S. Dist. LEXIS 130887, *33 (D.Conn. 2/4/2009) (provision that a claim was not considered complete unless the employer completed an applicable section of the claim form violated 29 C.F.R. 2560.503-1(b)(3); the defendant “administered the requirement that an Employer Form be provided in a manner that unduly inhibited the initiation of Booth’s claim for benefits. Particularly in a situation in which the employer refused to furnish the necessary form, Hartford’s obligation to avoid hindering claims and to decide claims promptly meant that it could not delay processing of Booth’s claim indefinitely while it waited for an Employer Form that would not arrive for almost two years”).

interests of participants in employee benefit plans and their beneficiaries ... by providing for appropriate remedies, sanctions and ready access to the Federal courts.”

The Department could also strengthen the regulation by expanding the examples of inhibiting or hampering claims to address the ways that plan sponsors and insurers are presently attempting to unilaterally override protections, e.g., through shortened statutes of limitations, restricted exclusive venue, and intimidating provisions about paying the company’s or insurer’s attorneys’ fees. Another baseline that the Department could adopt immediately is that any limiting provision has to be in both the plan document and the SPD. The regulation could also specifically state that the Department will apply a totality of the circumstances test to determine whether a combination of limiting provisions “unduly inhibits or hampers the initiation or processing of claims.” Finally, the Department can make clear that actions under ERISA §§409 and 510 are available to secure redress for interference with the exercise of rights under ERISA to obtain a full and fair review.

Comments on Unilaterally Shortened Statute of Limitations Periods

Because the expiration of a statute of limitation bars any access to the courts for review of a denied benefit claim, statutes of limitation are a critical area for the Department to address in ensuring a full and fair review of denied benefit claims, including “ready access” to the courts.

As stated, the Supreme Court’s 2013 *Heimeshoff* decision obviously encouraged the shortening of statutes of limitations. *Heimeshoff* ruled that the plan document for an employee benefit plan may contractually shorten the limitations period that otherwise applies under borrowed state law (which is often three or six years) and that the plan document may also specify that the shortened limitations period, e.g., one year or even less, commences “at a particular time.” 134 S.Ct. at 611-12. Although the Court hedged that the limitation must always be “reasonable, *id.* at 610, *Heimeshoff* clearly means that an employee’s or a non-ERISA lawyer’s common understanding of how much time is allowed to file a lawsuit, including when the limitations commences to run, may not be accurate. Even before *Heimeshoff*, lower courts sometimes upheld unilateral plan provisions drastically shorter than any analogous state law period for breach of contract. *See, e.g., Davidson v. Wal-Mart Assocs. Health & Welfare Plan*, 305 F.Supp.2d 1059, 1068-73 (S.D. Iowa 2004) (upholding Wal-Mart’s shortening of the limitation period for a benefit claims denial to “45 days from the decision on appeal”).

To address this issue, the Department should first rule that both the SPD and any denial letter must disclose any limitations period for instituting a court action shorter than

the period in ERISA §413, 29 U.S.C. §1113, or the State statute of limitations for written contracts (e.g., a 180-day filing deadline when the state limitations period for written contracts is three years). The denial letter should also identify the specific date on which the limitations period will expire in order to create a safe harbor for anyone who files suit before that date. Because any shortened limitations period is a plan term, as the DOL's preamble points out, plan administrators are in much a better position to compute the date of expiration of the limitations period and should not be hiding the ball from claimants about what position they will take in litigation. If plan administrators are functioning as fiduciaries, they will want the participant or beneficiary to be fully apprised of the date by which any suit must be filed from the plan administrator's perspective.

The First, Third, and Sixth Circuit have already interpreted the existing regulations to require the denial letter to provide notice of when any limitations period will expire. *Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675, 680 (1st Cir. 2011); *Mirza v. Ins. Admin. of Am., Inc.*, 800 F.3d 129, 133-136 (3^d Cir. 2015); *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503, 505-7 (6th Cir. 2014); accord, *Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis, No. 4:12CV53 HEA*, 2014 WL 562557, at *4 (E.D. Mo. Feb. 13, 2014), *aff'd sub nom. Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 790 F.3d 799 (8th Cir. 2015). *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282, 1295 (9th Cir. 2014) also holds that the SPD must disclose the "limitation of the time for bringing suit" in "close conjunction" with the description of the benefits because it "qualifies as a circumstance 'which may result in disqualification, ineligibility, or denial or loss of benefits.'" Because of the confusion produced by *Heimeshoff*, the DOL should do more than interpret its existing rules; it should revise them to eliminate any possible ambiguity about the obligation to disclose any shorter period.

Since *Heimeshoff* left open the possibility that an internal limitations period could start running even before the internal claim process is complete, 134 S.Ct. at 614-15, DOL should also step in and exercise its authority to ensure reasonableness and a full and fair review by clarifying that any limitations period is tolled while a claimant is exhausting the internal review process and that any plan provision that does not provide for such tolling violates the "full and fair review" mandated by 29 U.S.C. §1133. The Fourth Circuit has already held that limitations periods should be tolled during the internal appeal process. See *White v. Sun Life Assur. Co. of Canada*, 488 F.3d 240, 252 (4th Cir.), *cert. denied*, 552 U.S. 1022 (2007). And the 2000 regulations already contain a tolling provision while a dispute is in a voluntary process. 65 F.R. 70254 (Nov. 21, 2000); 29 C.F.R. 2560.503-1(c)(3)(ii). Guidance from the Department on what is a reasonable plan-based limitations provision is entirely consistent with the 2000 regulations and the Department's previous decisions to allow generous deadlines for the

claims process, e.g., routine 90 day extensions for initial decisions on claims and routine 60-day extensions for decisions on appeal simply by asserting “special circumstances.” See 29 C.F.R. 2560.503-1(f)(1) and (i)(1).

In light of the generous time periods already built into the claims regulations, the Department could also give plan sponsors and insurers the choice of tolling and then allowing a limitations period equal to the ERISA §413 period or the analogous state contract period or tolling with a shortened time period for both the initial decision and any decision on appeal, reduced from the current 180-day period (with an extension) for the initial decision and the current 120-day period (with an extension) for the decision on appeal. There is no reason why the generous periods in the regulations should ever be combined with a shortened limitations period.

Comments on Unilateral Venue Selection Provisions

As indicated above, there is a serious issue related to *Heimeshoff* that the proposed regulations do not address. In *Smith v. Aegon Companies Pension Plan*, 769 F.3d 922, 930 (6th Cir. 2014), a Sixth Circuit panel, over a dissent from Judge Clay, allowed a unilaterally-added forum selection clause which required the plaintiffs to travel to a distant venue (Cedar Rapids, Iowa) in contravention of the liberal venue provision in ERISA §502(e)(2), 29 U.S.C. §1132(e)(2). The panel majority ruled that the plan provision was “presumptively valid and enforceable” even though it was “not the product of an arms-length transaction” and restricted the venue available under §502(e)(2). Judge Clay pointed out that going to Cedar Rapids to sue was not a viable option for “retirees on a limited budget, sick or disabled workers, widows and other dependents—[who] are often the most vulnerable individuals in our society, and are the least likely to have the . . . wherewithal to litigate in a distant venue.” 760 F.3d at 935.

Certiorari in *Smith v. Aegon* (14-1168) was denied on January 11, 2016. In an invitation brief before the Supreme Court in *Aegon*, the Solicitor General recommended that certiorari be denied because there was no circuit conflict while explaining that the *Aegon* majority was wrong because the text of ERISA §502(e)(2) is clear and Congress expressly recognized that this would provide participants and beneficiaries with a “liberal” choice of venue, see S.Rep. 93-383 (1973), available at 1974 U.S.C.C.A.N. 4889, 4989. The Solicitor General also pointed out that under the analytical framework in *The Bremen v. Zapata Off-Shore Co.*, 407 U.S. 1, 15 (1972), unilateral forum selection clauses are “unenforceable” as against “public policy.”

Obviously, forum selection clauses like the one in *Aegon* are being used to disadvantage ERISA claimants and place burdens on their right to sue. In *Turner v.*

Sedgwick Claims Mgmt. Servs., 2015 WL 225495 at *21 (N.D. Ala. Jan. 16, 2015), the court encouraged the Department to regulate in this area as opposed to using “the ad hoc, highly informal means of amicus briefs.” To ensure that there are no more circuit decisions like *Aegon*, the Department’s regulations should make clear that the venue provision in ERISA §502(e)(2), which not only Congress but the courts have long recognized as “liberal,” *see, e.g., Varsic v. United States District Court for Central District of Calif.*, 607 F.2d 245, 248 (9th Cir. 1979), cannot be overruled by a unilateral plan or policy provision. Not only is this contrary to ERISA’s policy, but it also violates the ERISA §404(a)(1)(D) requirement that the fiduciary follow a plan provision only “insofar as [it is] consistent with the provisions of this title” I of ERISA, which includes ERISA §502(e)(2).

Comments on Unilateral Attorneys’ Fee Provisions

Like the unilaterally redrafted venue provisions, the redrafted provisions by Exelis, Kodak and others on attorneys’ fees are at odds with the discretion Congress granted the courts in ERISA §502(g)(1), 29 U.S.C. §1132(g)(1), and with the Supreme Court’s decision on the exercise of that discretion in *Hardt v. Reliance Standard Life Ins.*, 560 U.S. 242 (2010). Even though Supreme Court decisions bind all lower federal and state courts, these unilateral provisions seek to overrule the factors set forth in *Hardt*. Obviously, the effort to override *Hardt* by private unilateral action is doomed to fail. But in the meantime, without Department action, these provisions are discouraging and even intimidating participants and beneficiaries from filing suit to obtain the “ready access” to the courts that Congress promised. Anyone with experience in litigation knows how discouraging and intimidating even the remote prospect of having to pay a corporation’s high-priced law firm is to an individual who would be bankrupted by the payment of litigation expenses. As indicated above, an ERISA §510 action is available to redress efforts to “fine,” “discipline” or “discriminate” against an individual for the exercise of rights under ERISA and the plan. *Inter-Modal Rail Emples. Ass’n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 515 (1997), holds that ERISA §510 extends to plan amendments.

Comments on Unilateral Forced Arbitration Provisions

The Department should also clarify and provide further guidance on its position on the role of arbitration in a “full and fair review.” As Judge William Young recently wrote, “forced arbitration bestrides the legal landscape like a colossus, effectively stamping out the individual’s statutory rights wherever inconvenient to the businesses which impose them.” *In re Nexium (Esomeprazole) Antitrust Litig.*, 309 F.R.D. 107, 146-147 (D. Mass. 7/15/2015). A December 2013 Baker & McKenzie article entitled “A Sea

Change for ERISA Litigation” encourages companies with benefit plans to take advantage of recent Supreme Court decisions on arbitration and class action waivers by adopting mandatory arbitration provisions for ERISA claims (including statutory claims) with express waivers of class actions.² The article touts that “[t]wenty years from now there may no longer be Employee Retirement Income Security (“ERISA”) class actions.” See also “Arbitration of ERISA Claims: Yes You Can!” in the July 20, 2015 issue of Bloomberg BNA’s *Pension & Benefits Daily*.

The Baker & McKenzie article inexplicably fails to take into account that the DOL has a longstanding position, first taken in 1977, that arbitration cannot be a mandatory part of a “full and fair” review procedure unless it has been adopted in a collective bargaining agreement. 29 C.F.R. 2560.503-1(b)(2); DOL Adv. Op. (AO) 82-46A (Sept. 3, 1982); 42 F.R. 27427 (May 27, 1977). The 2000 regulations reiterate the position taken in the 1977 regulatory preamble and the regulation for plans established pursuant to collective bargaining agreements that mandatory arbitration cannot be part of the internal review and appeal procedure for group health or disability benefit claims unless it has been the subject of collective bargaining. 29 C.F.R. 2560.503-1(c)(4) and (d); 65 F.R. 70253-54. (While the 2000 regulations prevent arbitration from being a “mandatory” part of the claims procedure for these benefits, an exception allows a plan to make claimants go through a “non-binding” hoop with ensuing delays and no prospect of attorneys’ fees. 29 C.F.R. 2560.503-1(c)(4)(i)). The regulation that prevents arbitration from being mandatory should be extended to all employee benefit claims and the exception should be removed. Arbitration should only be allowed on a mutually agreed basis and should not be allowed to become an excuse for delay.

Even more fundamentally, Baker & McKenzie’s article failed to take into account that the Supreme Court’s recent decisions on arbitration are predicated on agreements to arbitrate *by both sides*. Even though the degree of substantive agreement by an employee benefit plan participant may in some respects be comparable to a consumer’s agreement to a consumer contract, there still must be at least a pro forma agreement by a consumer. Mandatory arbitration cannot be unilaterally written into the terms of the plan’s claims procedure without even a pro forma agreement by the participant or beneficiary consistent with decisions in the First, Second, Third, Fourth, Sixth, Seventh and Ninth Circuits holding unilateral arbitration provisions to be unenforceable.³

² Available online at <http://www.bakermckenzie.com/ALNAASeaChangeDec13/>.

³ *Campbell v. Gen. Dynamics Gov’t Sys. Corp.*, 407 F.3d 546, 557-58 (1st Cir. 2005) (affirming denial of motion to compel arbitration when employer failed to provide notice of agreement to arbitrate; mass email about the General Dynamics’ new dispute

The Baker & McKenzie article also inexplicably fails to recognize that DOL's regulations prohibit imposing the costs of arbitration on the participant. *See* 29 C.F.R. 2560.503-1(b)(3). Indeed, the Senate-passed version of ERISA would have required all plans to include arbitration as a voluntary option for employee benefit plan participants, but the conferees rejected that provision because it would be "too costly" for plan sponsors. III ERISA Leg. Hist. 4769 (explanation of Senator Javits). Many arbitration procedures also do not provide for awards of attorney's fees, whereas ERISA §502(g) expressly provides the courts with discretion to make such awards as part of ERISA's enforcement scheme.

Because more advocacy pieces like Baker & McKenzie's can be expected and because of widespread misperceptions about the Supreme Court's jurisprudence on arbitration, the Department of Labor should again clarify its position on the role of arbitration in a full and fair review of all denied benefit claims and provide guidance to the public that addresses the points described above, including explaining again the Department's longstanding regulatory position and addressing the circuit decisions prohibiting the unilateral imposition of forced arbitration.

II. Comments on Proposed Regulations

The undersigned also offers the following comments on the proposed regulations for disability benefits that are principally carried over from the 2011 ACA regulations for non-grandfathered group health benefits:

resolution policy "did not state directly that the Policy contained an arbitration agreement that was meant to effect a waiver of an employee's right to access a judicial forum," did not "contain anything to put the recipient on inquiry notice of that possibility by conveying the Policy's contractual significance," and did not require an "affirmative response of that sort would have signaled that the Policy was contractual in nature"); *Schnabel v. Trilegiant Corp.*, 697 F.3d 110, 120 (2d Cir. 2012); *Cardionet, Inc. v. CIGNA Health Corp.*, 751 F.3d 165, 171 and 177 (3d Cir. 2014); *Hooters of Am., Inc. v. Phillips*, 173 F.3d 933, 938-40 (4th Cir. 1999); *Floss v. Ryan's Family Steak Houses, Inc.*, 211 F.3d 306, 315-16 (6th Cir. 2000); *Gibson v. Neighborhood Health Clinics*, 121 F.3d 1126, 1132 (7th Cir. 1997); *Comer v. Micor, Inc.*, 436 F.3d 1098, 1101-04 (9th Cir. 2006).

The proposed fiduciary regulation at 80 F.R. 21,973, 21,985 (April 20, 2015) would also ban waivers of participation in class actions from any arbitration agreement concerning investment recommendations by a fiduciary under ERISA.

1. Independence and Impartiality—Avoiding Conflicts of Interest

The Department's 2000 claims procedure regulations established that full and fair review of an adverse benefit determination for health or disability benefits must be by a named fiduciary "other than the person who made the initial determination" and must not afford deference to an initial adverse determination. 29 C.F.R. 2560.503-1(h)(3)(ii) and (h)(4); 65 F.R. 70252 (Nov. 21, 2000). This is a very important reform, but as Professor Katherine Vukadin has pointed out, "few plan participants ever access the appeal processes." "Unfinished Business: The Affordable Care Act and the Problem of Delayed and Denied ERISA Healthcare Claims," 47 J. Marshall L. Rev. 1, 10 (Spring 2014). As a result, it is important that the Department's regulations ensure that the initial decision is unbiased, and not just that conflicts are not blatantly present on appeal.

The 2000 regulations applicable to group health and disability benefit claims also already required that experts who have been consulted by the plan administrator who made the initial determination or by the named fiduciary conducting a review must be identified, without regard to whether their advice was relied upon. 29 C.F.R. 2560.503-1(h)(3)(iv) and (h)(4). In addition, any healthcare professional consulted on review must not be the individual consulted in connection with the initial adverse determination. 29 C.F.R. 2560.503-1(h)(3)(v).

To foster independence and impartiality in claims adjudication, the 2011 ACA regulations add that for non-grandfathered health benefits, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, must not be based on the likelihood that the individual will support the denial of benefits. 75 F.R. 43333; 29 C.F.R. 2590.715-2719(b)(2)(ii)(D).

The proposed regulations for disability claims on the impartiality of claims decision-makers and reviewers are important as a continuation of the DOL's efforts to lessen the effect that bias has in the claims and appeals process. However, everyone in the disability field knows that the medical reviewers hired by insurance companies are biased in favor of the insurer's position. And everyone knows, too, that a modest rule like the Department has proposed that the retention of medical reviewers should not be contingent on the likelihood that they support the insurer's position is going to be largely ineffective. It is time for the Department to take bolder action and accept the Supreme Court's decade-old invitation in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831-32 (2003), to issue a treating physician rule addressing the weight to be accorded opinions of the claimant's treating physician vis a vis the opinions of medical reviewers retained by the insurer. *Nord* holds that:

ERISA empowers the Secretary of Labor to “prescribe such regulations as he finds necessary or appropriate to carry out” the statutory provisions securing employee benefit rights.... If the Secretary of Labor found it meet to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference.

As the Supreme Court observed in *Nord*, Social Security already utilizes the treating physician rule for determinations of disability. 20 C.F.R. 404.1527(c)(2). And DOL’s 2011 rule on urgent care determinations already requires deference to the treating physician’s opinion on whether a claim is for urgent care. 76 F.R. 37212; 29 C.F.R. 2590.715-2719(b)(2)(ii)(B). Accordingly, the Department’s final regulations should provide that in any benefit claim involving issues of medical judgment, the Plan administrator and the named fiduciary responsible for reviewing adverse benefit determinations should defer to the opinions of the claimant’s treating physician. This is the only effective counter to the bias of medical reviewers hired by insurance companies.

The related authority against bias that the Department has never fully utilized is the authority to clarify the scope of ERISA preemption in the context of insurance claims. The Department’s 2000 regulations address preemption by providing that State insurance laws on processing benefit claims and denials are not superseded unless they “prevent[] the application of a requirement of the regulation.” 65 F.R. 70254 (Nov. 21, 2000); 29 C.F.R. 2560.503-1(k). The Department should clarify that the phrase “law of any State which regulates insurance” in ERISA §514(b) includes state insurance laws and state laws and judicial decisions of general application relating to the processing of insurance claims, including notice-prejudice rules, and to bad faith denials of claims under insurance policies or contracts. Those State laws and decisions should only be preempted if their enforcement prevents the application of an ERISA regulation.

The proposed regulation on conflicts also needs clarification in four areas:

First, the proposed regulation should make clear that impartiality must be ensured, even where the plan, itself, is not directly responsible for hiring or compensating the individuals involved in deciding or reviewing a claim. This clarification is necessary because plans frequently delegate the selection of experts to third-party vendors who, in turn, employ the experts.

Second, clarification is needed concerning which individuals are “involved.” Claims administrators often protest that physicians, or other consulting experts, were not “involved in making the decision” but merely supplied information (such as an opinion on physical restrictions and limitations) that the claims adjudicator considered. Under this

logic, plans may argue that consulting experts are not affected by the impartiality regulation. The 2000 regulations on consulting experts should be used to clarify which individuals are “involved.”

Third, the proposed regulation should make unmistakable that it is not only claims adjudicators and physicians who must be impartial. Vocational experts and accountants are also frequently consulted in the claims process and should be included in the scope of the impartiality requirement.

Fourth, the proposed regulation should address mixed motives for using an individual by making clear that if the conflict plays any part in the decision to retain, hire, or compensate the claims handler or other expert, the decision violates the regulations.

2. Improvements to Basic Disclosure Requirements

The 2011 ACA regulations require notices to claimants in non-grandfathered health plans to offer additional content, which the Department has now proposed be extended to disability benefits. Specifically, the ACA regulations provide that:

- Any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, the claim amount, the date of any service (if applicable), and, on request and if applicable, any diagnosis code and its corresponding meaning and any treatment code and its corresponding meaning.
- The plan or issuer must ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes any classification or denial code and its corresponding meaning, as well as a description of the plan’s or issuer’s standard, if any, used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.
- The plan or issuer must disclose the availability of, and contact information for, any applicable office of participant/consumer assistance.

The proposed regulation on disability benefits would amend the current disclosure requirements in three significant respects, each of which is addressed below.

a. Discussion of the Decision and Its Relationship to SSDI or other Disability Awards

The proposed regulation for disability benefit claims requiring the claims administrator to meaningfully discuss and distinguish the views of treating physicians or other entities that are paying benefits, proposed 2560.503-1(g)(1)(vii)(A), will be helpful in addressing arbitrary, but unfortunately common practices. *See, e.g., McDonough v. Aetna Life Ins. Co.*, 783 F.3d 374, 382 (1st Cir. 2015) (“Aetna’s failure to articulate the contours of the own occupation standard, apply that standard in a meaningful way, and reason from that standard to an appropriate conclusion regarding the appellant’s putative disability renders its benefits-termination decision arbitrary and capricious”). Generally, if an administrator pays any attention to contrary opinions, the attention is in the form of boilerplate paragraphs in the denial letters. Reasons and evidence that is favorable to the claimant are often ignored. Claimants are thereby hampered in responding, which stands in the way of full and fair review. Sometimes courts do not understand the difference between these boilerplate paragraphs and the type of explanation mandated by ERISA. The regulations should be clarified to ensure that it will change reliance on this sort of explanation or a failure to address contrary evidence.

The proposed regulation requiring a discussion about the difference between the plan’s decision and awards made by other systems, such as Social Security, should also be expanded to explain how deference has been accorded to the decision of the Social Security Administration. As a model, the regulation could utilize the language in regulatory settlement agreements reached by insurers and state insurance commissioners in response to concerns about disability claims processes by insurers like UNUM. For example, in the regulatory settlement agreement UNUM is required to follow, this language was used:

The Companies must give significant weight to evidence of an award of Social Security disability benefits as supporting a finding of disability, unless the Companies have compelling evidence that the decision of the Social Security Administration was (i) founded on an error of law or an abuse of discretion, (ii) inconsistent with the applicable medical evidence, or (iii) inconsistent with the definition of disability contained in the applicable insurance policy.

b. Disclosure of Internal Rules

The DOL's proposed regulation regarding disclosure of the internal rules or criteria used to make a disability benefit decision, proposed 2560.503-1(g)(1)(vii)(B), is helpful because internal rules, guidelines, protocols, standards, claims manuals, and similar materials often create hidden plan terms that the claimant is unable to learn of in order to address them in the appeal. As in the healthcare context, plans sometimes argue that internal criteria are proprietary or confidential. Keeping the rules that are used to administer a plan a secret is inconsistent with the most basic promise of ERISA: Benefits must be administered "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104.

Much litigation will be avoided if the claimant knows from the outset what criteria he or she needs to meet in an appeal. *See e.g., Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111, at *10 (S.D.N.Y. Jan. 30, 2004); *Craig v. Pillsbury*, 458 F.3d 748, 754 (8th Cir. 2006) (decrying the use of "double-secret" plan terms); *Samples v. First Health Group Corp.*, 631 F. Supp. 2d 1174, 1183 (9th Cir. 2007). This requirement will also promote the dialogue between claimant and plan that ERISA contemplates. *Booten v. Lockheed Med. Ben Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) ("in simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries").

To fulfill the requirement that "the claims procedures contain administrative processes and safeguards designed to ensure and to verify that ... plan provisions have been applied consistently with respect to similarly situated claimants," 29 C.F.R. 2560.503-1(b)(5), the regulation should also make clear that the Plan administrator must maintain records of claims for benefits that have been granted or denied, indexed by plan provision and subject matter, in a manner that allows claimants to have access to the documents, records or other information that were submitted, considered, or generated in making other benefit determinations.

c. Notice of Right to Request Relevant Documents

DOL is to be commended for clarifying that "relevant" documents must be produced with the initial denial of a claim, and not just with the denial of an appeal. The regulation concerning notice of the right to request relevant documents contained in proposed 2560.503-1(g)(1)(vii)(C) is an improvement since it was formerly omitted from the regulation on the contents of initial denials. *Compare* 29 C.F.R. 503-1(g)(1) *with* 503-1(h)(2)(iii) and (j)(3). It would be helpful to claimants, however, to include the words "claim file," which is plain language and consistent with the amendment at 29

C.F.R. 2560.503-1(h)(4)(i) [proposed regulation]. Attorneys may understand the language of (g)(1)(vii)(C), but lay persons, who are often unrepresented at the claims stage, may not realize what rights are given here. The regulations should also expressly reject court decisions that require claimants to prove prejudice to obtain their claim file. *See, e.g., DiGregorio v. Hartford Comprehensive Employee Benefit Serv. Co.*, 423 F.3d 6, 15-17 (1st Cir. 2005).

29 C.F.R. 2560.503-1(g)(1)(iii) already requires the “description of any additional material or information necessary for the claimant to *perfect* a claim.” The proposed regulations should reiterate this requirement and connect it with the production of “relevant” documents. This is consistent with the principle that “the claims process must be collaborative not adversarial, especially in light of the fact that claimants must often proceed without the aid of legal counsel.” *Harrison*, 773 F.3d at 24; *accord, Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). The Department’s proposed regulations should also define the information necessary to “perfect” a claim to mean the “relevant” material or information for the participant or beneficiary to take action and turn the claim into a successful claim.⁴

The regulations should also make clear that a full and fair review requires plan administrators and named fiduciaries to gather and consider the readily available evidence and relevant plan terms that might confirm eligibility. *See, e.g., Harrison v. Wells Fargo Bank*, 773 F.3d 15, 21-22 (4th Cir. 2014); *Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807 (10th Cir. 2004). The Department of Labor has specifically adopted this position in its amicus brief in the *Harrison v. Wells Fargo Bank* litigation.

3. Right to Review and Respond to New Information Before Final Decision

The 2011 ACA regulations clarified that plans and issuers are required to provide claimants (free of charge) with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with a claim, as well as any new or additional rationale for a denial at the internal appeals stage, in time for the claimant to have a reasonable opportunity to respond to such new evidence or rationale. 75 F.R.

⁴ Comparable to the identification of any applicable office of participant/consumer assistance for help with a non-grandfathered health benefit denial at 29 C.F.R. 2590.715-2719(b)(2)(ii)(E)(4), the denial letter for a disability claim should also notify participants or beneficiaries that they have the right to be represented in the administrative appeal process, and that in addition to private attorneys there are regional EBSA offices and other agencies that may help. The Social Security Administration already does this.

43333; 29 C.F.R. 2590.715-2719(b)(2)(ii)(C). This rule reversed *Midgett v. Washington Group Int'l Long Term Disability Plan*, 561 F.3d 887, 896 (8th Cir. 2009), and similar decisions⁵ which have denied claimants the opportunity to review and rebut medical opinions generated during the appeal. 75 F.R. 43333.⁶

Obviously, the DOL wishes to improve things for disability claimants who have been sandbagged by new rationales or evidence during review on appeal. Sandbagging has been a persistent problem in the ERISA appeals process and some courts have voiced their disapproval of such “gamesmanship.” In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), the court articulated the problem as follows:

[w]ithout knowing what “inconsistencies” the Plan was attempting to resolve or having access to the report the Plan relied on, Abram could not meaningfully participate in the appeals process. . . This type of “gamesmanship” is inconsistent with full and fair review.

Id. Given that it is often difficult for a claimant to supplement the record in litigation, the proposed change offers some assurance that a claimant will be able to contribute his or her relevant evidence to the record that the court will review. There is, however, a countervailing consideration that while the opportunity to submit proof to the plan is offered, the time for processing the claim will be extended without benefit payments. Claimants cannot continue a process *ad nauseum* while they need to pay their mortgages and feed their families. A second consideration is that while the *claimant* may be ready to respond in a matter of days, the type of evidence needed to respond to new evidence or rationale offered by the plan may require hiring an expert or asking for another report from a physician, psychologist, or vocational consultant. To allow claimants to respond while limiting the time added to the process, claimants should have at least 60 days to respond to new evidence or rationales provided by the plan on appeal, with a 60 day extension if there are special circumstances.

⁵ *Metzger v. UNUM Life Ins. Co.*, 476 F.3d 1161, 1167 (10th Cir. 2007), *Glazer v. Reliance Standard Life Ins. Co.*, 524 F.3d 1241, 1245-46 (11th Cir. 2008), *Killen v. Reliance Standard Life Ins. Co.*, 776 F.3d 303, 310-311 (5th Cir. 2015).

⁶ In addition to the Department’s rejection of *Midgett*, the reasoning of the decision has been rejected in *Grossmuller v. Auto Workers*, 715 F.2d 853, 858 (3d Cir. 1982), *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 696 (7th Cir. 1992), and *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 871-72 (9th Cir. 2008).

There is also some uncertainty about what the new regulations contemplate by “testimony.” In the regulatory preamble, the DOL states: “the proposal would also grant the claimant a right to respond to the new information by explicitly providing claimants the right to *present evidence and written testimony* as part of the claims and appeals process.” But the proposed regulation says: “[the processes for disability claims must] allow a claimant to review the claim file and to *present evidence and testimony* as part of the disability benefit claims and appeals process.” Proposed 2560.503-1(h)(4)(i). The current regulation, by comparison, provides that “[the process must] provide claimants the opportunity to *submit written comments, documents, records, and other information* relating to the claim for benefits.” 29 C.F.R. 2560.503-1(h)(ii)(2)[current regulation].

The inconsistencies between the preamble and the proposed regulation and the current regulation could lead to disagreements over what the intended change is and whether the proposed regulation contemplates the right to a hearing with live testimony. The proposed regulation’s language about “evidence and testimony” could be interpreted to contemplate courtroom evidentiary standards for claimants submitting proof of their claim – something that is not normally applied in the ERISA context. Some plans are in a position to observe rules of evidence as they have in-house counsel and other legal resources to rely upon to assure compliance, while others are not. And claimants who are not represented by counsel are not prepared to deal with courtroom evidentiary standards. The Department needs to make clear that it is not curtailing or narrowing the types of information that claimants may submit to the administrator.

Under the current regulation, claimants sometimes submit testimony in the form of an audio or video CD. This is particularly useful in cases where the claimant cannot write so that a written statement is difficult or impossible. It is also helpful in those cases where seeing and hearing the claimant may be important. The reference to “written testimony” in the preamble might give plans the ammunition to disallow any audio or video submissions on the grounds that these forms of evidence do not represent “written testimony.” The proposed regulation should make clear that it is not intended to put claimants in a worse position than they face at present.

A related issue is the opportunity for the claimant to supplement the record even when the plan maintains that it has not changed its rationale or offered new evidence. Many meritorious disability claims are denied and affirmed by the courts based on the scope of the record on review before the court. For instance, Social Security Disability Insurance decisions, which are the focus of some of the proposed rules, are often crucial to proving disability claims. However, SSA is notorious for taking along time to reach its decisions and a favorable SSA ruling may come after the final denial on appeal of the disability plan. This is true as well for other kinds of favorable medical and vocational

evidence. Even where it would not be a problem to do so, plan administrators often refuse to consider this type of evidence, choosing instead to shut the door on a meritorious claim. There is a clear solution to this which tracks the Fifth Circuit's *en banc* holding in *Vega v. National Life Ins. Serv., Inc.*, 188 F.3d 287, 300 (5th Cir. 1999), where the Court wrote:

We hold today that the administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it. Thus, if the information in the doctors' affidavits had been presented to National Life before filing this lawsuit in time for their fair consideration, they could be treated as part of the record. Furthermore, in restricting the district court's review to evidence in the record, we are merely encouraging attorneys for claimants to make a good faith effort to resolve the claim with the administrator before filing suit in district court; we are not establishing a rule that will adversely affect the rights of claimants.

Id. In light of *Vega's* holding, the proposed regulation on responding to new rationales should require the plan administrator to accept and review a claimant's evidence and treat it as part of the record, so long as it is sent in time for the administrator to consider the evidence before litigation is commenced.

4. Deemed Exhaustion of Claims and Appeals Processes

Shortly after ERISA became effective, courts implied a requirement to exhaust internal claims and appeals procedures based on ERISA §503's provision for "full and fair review." *See, e.g., James A. Wooten, A Reflection on ERISA Claims Administration and the Exhaustion Requirement, 6 Drexel L. Rev. 573, 579-81 (2014).* Because Congress specifically assigned the authority to interpret this section of ERISA to DOL, the DOL has not only the authority, it has the responsibility to issue regulations governing any exhaustion requirement associated with a "full and fair review."

The Department's 1977 regulations provided that a claim would be deemed exhausted if "the decision on review is not furnished within" the appropriate time period. 29 C.F.R. 2560.501(h)(4). The preamble to DOL's 1998 proposal expanded on this by stating that "claimants should not be required to continue to pursue claims through an administrative process that fails to meet the minimum standard of the regulation." 63 F.R. 48397. This "specif[ied] more clearly the consequence that the Department believes flow from a failure to provide procedures that meet the minimum regulatory standards." *Id.*

The 2000 regulation on deemed exhaustion has generally been followed. *See, e.g., Nichols v. Prudential Ins. Co.*, 406 F.3d 98, 106-08 (2d Cir. 2005) (“failure to adhere literally to the regulatory deadlines renders the claimant’s administrative remedies exhausted by operation of law”). But some courts have held that deemed exhaustion will not apply if there is substantial compliance and the claimant does not establish prejudice or substantive harm. *See, e.g., Holmes v. Colo. Coalition for the Homeless Long Term Disability Plan*, 762 F.3d 1195, 1212-13 (10th Cir. 2014) (citing other cases).

The interim final ACA regulations in 2010 provided that if a plan or issuer “fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was *de minimis*.” 75 F.R. 43334. This reflected the Department’s “continu[ed] belief that claimants should not have to follow an internal claims and appeals procedure that is less than full, fair, and timely.” 76 F.R. 37213. The final ACA regulation, however, allowed an exception for “errors that are minor and meet certain other specified conditions.” 76 F.R. 37213. Under that final regulation, if a plan or issuer “fails to adhere to all the requirements” of the internal claims and appeals process, a claimant is “entitled to pursue any available remedies under section 502(a) of ERISA or under State law,” except in the case of a “*de minimus* violation.” 76 F.R. 37213; 29 C.F.R. 2590.715-2719(b)(2)(ii)(F). To qualify for the exception, the error must not only be *de minimus*, but it must be non-prejudicial, attributable to “good cause or due to matters beyond” the plan’s or issuer’s control, not reflective of a “pattern or practice” of non-compliance, and be made in the context of an “ongoing, good faith exchange of information.” *Id.* The plan or issuer must provide an explanation of the basis for asserting that the non-compliance is subject to this exception upon written request of the claimant. *Id.*

The final 2011 ACA regulation on deemed exhaustion, including the exception for a *de minimus* violation, should be adopted (and should be extended to all employee benefits, including grandfathered group health benefits). To avoid unnecessary litigation issues, however, the Department should illustrate what “minor errors” are (and are not) and address the impact of more than one minor error.

There are also three areas that could be improved in the proposal:

First, the Department’s regulations should make it very clear that this rule is not subject to any exception for “substantial” compliance. Nor should forfeiture of deferential review be confined to “flagrant violations” of the Department’s benefit claims regulations with “flagrant” to be defined by the courts, contrary to *Gatti v. Reliance Standard Life*

Ins. Co., 415 F.3d 978, 985 (9th Cir. 2005).

Second, the standard of judicial review that will apply requires clarification to address a potential inconsistency between the preamble and the proposed regulation. The preamble says: “in those situations when the minor errors exception does not apply, the proposal clarifies that the reviewing tribunal *should not give special deference to the plan’s decision, but rather should review the dispute de novo.*” However, the regulation says: “if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review *without the exercise of discretion by an appropriate fiduciary.*” Proposed 2560.503-1(1)(2)(i). It can be expected that, without clarification, some plans will argue that the italicized language in the regulation does not require a court to affirmatively exercise *de novo* review. The Department should clarify its intent. The Department should also clarify that *de novo* review includes factual determinations as well as the application of plan provisions to facts.

Third, the proposed regulation on deemed exhaustion should be clarified to ensure that the provision applies to both claims and appeals, not just the initial claim review. If there is a violation of the regulations, the claimant can seek review regardless of whether the claim is in the “claim” or the “appeal” stage.

5. Coverage Rescissions—Adverse Benefit Determinations

The 2011 ACA regulations make clear that adverse benefit determinations include a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time). This definition is broader than the definition in the 2000 regulations, which provided that a denial, reduction, or termination of, or a failure to provide payment (in whole or in part) for a benefit is an adverse benefit determination eligible for internal claims and appeals processes. 75 F.R. 43332; 29 C.F.R. 2590.715-2719(a)(2)(i) and (b)(2)(ii)(A). Continued coverage is also required pending the outcome of an internal appeal. 75 F.R. 43334; 29 C.F.R. 2590.715-2719(b)(2)(iii).

The proposed regulation should make clear that a rescission includes any recoupment claim by the plan sponsor or issuer based on overpayments or subrogation. The regulation should also make clear that an adverse benefit determination includes an adverse decision on coverage. It is possible that the definition of “rescission” in proposed 2560.503-1(m)(4)(ii) is not sufficient to cover the situation where the plan asserts that coverage never existed in the first place.

The proposed language about treating rescissions as adverse benefit

determinations should also be expanded to address the situation where an insurer defers the right to appeal until the date that benefits end, which imposes significant economic hardship on claimants who may be deprived of benefits for several months while appeals proceed. The claimant should have the option to appeal that determination immediately to avoid economic hardship.

6. Culturally and Linguistically Appropriate Notices

The “average plan participant” standard in ERISA §102 has never referred to the understanding of a single participant but is based on “typical participants in the plan.” 29 C.F.R. 2520.102-2(a). The SPD regulations already require assistance if “10% or more of all plan participants [in a plan with 100 or more participants] are literate only in the same non-English language.” 29 C.F.R. 2520.102-2(c).

The ACA required notices to be provided in a culturally and linguistically appropriate manner, which was spelled out further in paragraph (e) of the final regulations. 76 F.R. 37213-14; 29 C.F.R. 2590.715-2719(b)(2)(ii)(E). To reflect our nation’s diverse workforce and make notices understandable to the “average plan participant,” the ACA’s rule should be extended to all employee benefits.

The Department clearly has authority to update the notice requirements consistent with the ACA’s rules. But the Department should clarify that the protection applies whether the plan *or* the county meets the 10% standard. As drafted, the proposed regulation might reduce the protection in instances where 10% of the plan but not 10% or more of the residents of a county are literate only in the same non-English language.

* * * *

I appreciate the opportunity to present these comments on the proposed regulations. If you have any questions or want me to do anything more, please contact me at 202-289-1117. Thank you.

Sincerely,



Stephen R. Bruce

ATTACHMENT 1 EXELIS RESOLUTION

WRITTEN CONSENT OF THE BOARD OF DIRECTORS OF EXELIS INC.

The undersigned, being all of the directors (each, a "Director") of the Board of Directors (the "Board") of Exelis Inc. (the "Corporation"), an Indiana corporation, hereby waive the giving of any and all notice of the holding of a meeting of the Directors, and acting in lieu of a meeting pursuant to § 23-1-34-2 of the Indiana Business Corporation Law, hereby unanimously consent to, adopt and approve the following resolutions and the actions taken thereby, and a copy of this unanimous written consent (the "Unanimous Written Consent") hereby is ordered to be filed with the minutes of the proceedings of the Board:

WHEREAS, the Corporation heretofore has adopted and maintains (i) the Exelis Salaried Retiree Life Insurance Plan on behalf of certain retirees of the Corporation and its subsidiaries or predecessors thereto (the "Salaried Plan") and (ii) life insurance arrangements on behalf of certain retirees and certain disabled former employees of the Corporation's Space Systems Division or predecessors thereto, including Eastman Kodak Company, which arrangements include without limitation the Kodak Group Life Insurance/Survivor Benefit Insurance Plan, the Kodak Family Protection Program, the Kodak Supplementary Group Life Insurance Plan, the Kodak Life Insurance Plan and the Kodak Life Insurance Plus Plan (collectively, the "SSD Plan") and with the Salaried Plan, the "Plans" and individually, a "Plan");

WHEREAS, the Board desires to amend the Plans in various respects, effective as of the date hereof; and

WHEREAS, the Board desires to terminate the Plans, effective as of January 1, 2016.

Plan Amendment

NOW, THEREFORE, BE IT RESOLVED, that effective as of the date hereof, the Salaried Plan hereby is amended to add the following provisions (collectively, the "Legal Action Provisions") to page 12 of the ITT Salaried Retiree Life Insurance Plan Summary Plan Description, dated January 1, 2010 (which document serves, in part, as the official plan document for the Salaried Plan, provided that effective October 31, 2011, all references therein to the plan sponsor, plan administrator or entity with amendment and termination authority shall be deemed to be references to the Corporation):

Applicable Law and Venue

This plan and all rights hereunder shall be governed by and construed in accordance with the laws of the State of Florida (without regard to principles of conflicts of law) to the extent such laws have not been preempted by applicable federal law. The exclusive venue for any action arising under this plan shall be in the United States District Court for the Middle District of Florida.

Limitation Period for Actions Involving the Plan

Except for claims to which the periods prescribed by section 413 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") apply, (a) no legal or equitable action under section 502 of ERISA (including an action that could have been brought under section 502 of ERISA) may be commenced later than one year after the date the claimant receives a final decision in response to the claimant's request for review of an adverse benefit determination under this plan's administrative claims and appeals procedure (or if later, November 1, 2016) and (b) no legal or equitable action (including a legal or equitable action under section 502 of ERISA) involving this plan may be commenced later than two years after the date the person bringing an action knew, had or was provided notice, or otherwise had reason to know, of the circumstances giving rise to the action (or if later, November 1, 2017). Notwithstanding the foregoing, in no event shall the filing of a claim or appeal under this plan's administrative claims and appeals procedure toll, delay, or otherwise impact in any manner the running of the time period set forth in provision (b) above or the time periods prescribed by section 413 of ERISA. This provision shall not bar the plan or its fiduciaries from (x) recovering overpayments of benefits or other amounts incorrectly paid to any person under this plan at any time or (y) bringing any legal or equitable action against any party.

Legal Fees

Any award of legal fees in connection with an action involving this plan shall be calculated pursuant to a method that results in the lowest amount of fees being paid, which amount shall be no more than the amount that is reasonable. In no event shall legal fees be awarded for work related to: (a) administrative proceedings under this plan; (b) unsuccessful claims brought by a participant or any other person; or (c) actions that are not brought under ERISA. In calculating any award of legal fees, there shall be no enhancement for the risk of contingency, nonpayment or any other risk, nor shall there be applied a contingency multiplier or any other multiplier. In any action brought by a participant or any other person against this plan, any current or former committee or other body tasked with administering this plan, any current or former fiduciary of this plan, the Company or any of their current or former affiliates or their or their current or former affiliates' respective officers, directors, trustees, employees, or agents (current or former) (collectively, the "Plan Parties"), legal fees of the Plan Parties in connection with such action shall be paid by the participant or other person bringing the action, unless the court specifically finds that there was a reasonable basis for the action.

FURTHER RESOLVED, that effective as of the date hereof, the SSD Plan hereby is amended to add the Legal Action Provisions to its official plan document (whether in the form of a summary plan description, certificate of insurance, combination thereof or otherwise);

FURTHER RESOLVED, that to the extent that any provision of the Plans is inconsistent with the Legal Action Provisions, the Legal Action Provisions shall supersede such inconsistent provision with respect to legal or equitable claims filed against any person or entity other than the company underwriting an insurance policy under which a benefit under a Plan may be payable. In the event that a legal or equitable claim is asserted against both (i) an insurance company underwriting such a policy and (ii) any other person or entity, the Legal Action Provisions shall supersede such inconsistent provision with respect to the claim asserted against such other person or entity, and the inconsistent provision shall apply solely to the extent the claim is asserted against such insurance company;

Plan Termination

FURTHER RESOLVED, that effective as of January 1, 2016, the Plans hereby are terminated, such that no benefit (whether a basic life, supplemental life, optional life, dependent life or survivor income benefit or otherwise) shall be payable under the Plans upon the death of a retiree or disabled former employee (whether a retiree or disabled former employee as of the date hereof or an active employee as of the date hereof who subsequently terminates employment from the Corporation and its subsidiaries) occurring after December 31, 2015; provided, however, that for the avoidance of doubt, this provision in no event shall be interpreted to limit any conversion rights which may inure to a retiree or disabled former employee under any insurance policy maintained in connection with a Plan; and

General

FURTHER RESOLVED, that all corporate actions and all actions taken by the officers, directors or other authorized agents of the Corporation, or any of them, in connection with the foregoing resolutions, whether taken before or after the effective dates of those resolutions, hereby are approved, ratified and confirmed as the duly authorized acts of the Corporation.

This Unanimous Written Consent may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same Unanimous Written Consent. A facsimile or electronic mail transmission of a counterpart hereof bearing the signature of a Director will be legal and binding upon that Director.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the undersigned, being all of the Directors of the Corporation, have executed this Unanimous Written Consent as of this 6th day of November, 2015.

[REDACTED]

[REDACTED]

[REDACTED]

**ACTION WITH RESPECT TO
CERTAIN RETIREE LIFE INSURANCE ARRANGEMENTS**

**ATTACHMENT 2
KODAK SPD**

YOU & KODAK



Benefits Handbook

Kodak

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CLAIMS AND APPEALS PROCEDURES

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Introduction

This summary describes the administrative procedures used to file and process claims and appeals pertaining to the benefit plans described in this handbook. You must follow these administrative procedures before you can bring a lawsuit to challenge a decision or action taken under a plan (including, without limitation, a claim denial, a plan procedural rule or a plan amendment).

The plan administrator of a plan generally has decision-making authority with respect to that plan's claims and appeals. The plan administrator's authority is fully discretionary in all matters related to the discharge of his or her responsibilities and the exercise of his or her authority under the plan including, without limitation, his or her construction of the terms of the plan, his or her determination of eligibility for coverage or benefits, the interpretation and application of legal requirements and precedents, and whether or not to compel binding or non-binding arbitration or mediation. Under some plans, the plan administrator has delegated his or her authority to a claims administrator or another person or entity. In this summary, the term "claims reviewer" is used to refer to the plan administrator or other person or entity with decision-making authority under a plan with respect to that plan's claims and appeals.

It is the intent of each plan that the decisions of the plan administrator (or the party to whom the

decision-making authority was delegated), and his or her actions with respect to the plan, will be conclusive and binding upon all persons having or claiming to have any right or interest in or under the plan, and that no such decision or action will be modified by a court unless such decision or action is proven to be arbitrary or capricious.

The plan administrator for all benefit plans except those listed below is the Director, Global Benefits and Employee Services, Eastman Kodak Company, 343 State Street, Rochester, New York 14650-0901 (telephone number: 585-724-4800)

Benefit Plan	Plan Administrator
Kodak Retirement Income Plan	Kodak Retirement Income Plan Committee (KRIPCO)
Eastman Kodak Employees' Savings and Investment Plan	Savings and Investment Plan Committee (SIPCO)

Communications with the above committees should be addressed in care of the Director, Global Benefits and Employee Services, at the above address.

Filing Claims

Under each benefit plan, a claimant must follow the claims procedure in order to receive benefits or challenge any aspect of the plan or plan administration. In this summary, the "claimant" may be you, one of your covered Dependents, or your beneficiary, depending on the plan. In order to keep this summary as easy to read as possible, this summary generally uses the words "you" and "your" to refer to the claimant. All such references extend to participants, Dependents and beneficiaries, regardless of who is actually reading this summary or filing the claim.

Steps to Take: If you have a claim, you should take the following steps:

Initial Claim:

1. Identify the plan or plans involved.
2. Consult the benefit summary for the plan(s) found

elsewhere in this handbook and this section to determine what rules apply to the filing of your claim.

3. Identify the type of claim involved (see “Type of Claim”).
4. Identify the deadline for filing your claim (see “Deadlines for Filing Claims”).
5. Determine how and where to file your claim (see “Brief Overview of Plan-Specific Claim Rules”).
6. File the claim by the deadline, following the procedures set forth in the relevant benefit summary and this section.
7. If your claim is approved, the plan will take action to pay or otherwise resolve your claim (depending on the type of claim involved and the action your claim requested).
8. If your claim is denied, review the explanation provided by the claims reviewer and decide whether you are satisfied with the reasons for the denial or whether you wish to appeal. If you are dissatisfied with the decision, you should take the following steps:

Appeals:

1. If you decide to appeal a denied claim, determine when, where and how to file your appeal (see “Appeals”).
2. File your appeal by the deadline, following the procedures set forth in the relevant benefit summary and this section (see “How to File an Appeal”).
3. If your appeal is approved, the plan will take action to pay or otherwise resolve your claim (depending on the type of claim involved and the action your claim requested).
4. If your appeal is denied, review the explanation provided by the claims reviewer and decide whether you are satisfied with the reasons for the denial or whether you wish to file a lawsuit (or pursue other methods of dispute resolution, if available or required under the plan).

Note: *Some plans require two levels of appeal, in which case you would repeat steps 2-4 if your first appeal is denied.*

5. If you decide to file a lawsuit, file your lawsuit by the deadline in the Federal Court for the Western District of New York in Rochester, New York, by the deadline (see “Limits on Legal Actions”).

These steps are just a summary. They are explained at greater length in the following pages and the benefit summaries for the individual plans located elsewhere in this handbook. You should review this entire section and all of the plan benefits summaries carefully.

Type of Claim: Claims under Kodak’s benefit plans fall into one of two categories: “Routine Claims for Payment of Benefits” and “Other Claims.”

A “*Routine Claim for Payment of Benefits*” is a claim that asserts that you are entitled to receive a specific payment under the terms of the Plan.

Example 1: *You are a participant in a Kodak dental plan and you incur an expense for covered dental care. You (or your dentist) would file a Routine Claim for Payment of Benefits. If the claim meets all of the dental plan’s requirements, the plan will pay the claim.*

Example 2: *You are a participant in a Kodak life insurance plan and you die. Your beneficiary files a Routine Claim for Payment of Benefits seeking payment of your life insurance benefit. If the claim meets all the requirements of the life insurance plan, the plan will pay the claim.*

All claims that are not Routine Claims for Payment of Benefits (including, without limitation, claims about eligibility for plan coverage or the reduction or elimination of plan coverage or company contributions) are “*Other Claims.*” Under the Kodak Medical Assistance Plan, your appeal of a rescission of coverage is also treated as an Other Claim. A rescission of coverage means a cancellation or discontinuance of coverage that is effective retroactively and that is not due to a failure to timely pay required contributions toward the cost of coverage. You do not need to file a claim regarding a rescission of coverage. If you are notified by the plan administrator or his or her delegate that your coverage under KMAP or KRx is being rescinded, that notification is considered to be a claim denial and you may appeal the rescission within 180 days following your receipt of the notice of rescission of coverage. An appeal of a rescission of coverage is treated as an “Other Claim.”

Example 3: *You are a participant in a Kodak life insurance plan. Kodak amends the plan to provide that smokers will be required to pay higher premiums than non-smokers. You want to file a claim objecting to the higher premiums. This is not a claim for a specific payment due to you or your beneficiary under the terms of the plan. Therefore, this is an “Other Claim.”*

Deadlines for Filing Claims: The amount of time that you have to file a claim may depend on the type of benefit and whether your claim is a “Routine Claim for Payment of Benefits” or an “Other Claim,” as described below:

Plan Name	Routine Claims for Payment of Benefits	Other Claims
Accidental Death Insurance	Within 90 days of death, dismemberment or other covered injury, or within one year if it is unreasonable to submit such claim within 90 days.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Dental Plan (Kdent)	Within one year from the date the dental service was rendered.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Dependent Accidental Death Insurance	Within 90 days of death, dismemberment or other covered injury, or within one year if it is unreasonable to submit such claim within 90 days.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Dependent Care Reimbursement Account (DCRA)	After covered services have been rendered, but prior to April 30th following the end of the calendar year in question.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Dependent Life Plus Insurance Plan	Within one year from the date of death.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Employee Assistance Program	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Flexible Benefits Plan	Within 60 days from the date that you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Health Care Reimbursement Account (HCRA)	After covered services have been rendered, but prior to April 30th following the end of the calendar year in question.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Life Insurance Plus Plan	Within one year from the date of death.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.

(continued on next page)

Plan Name	Routine Claims for Payment of Benefits	Other Claims
Long-Term Disability	Within one year after the earlier of (1) the date that you cease to be an STD Recipient or (2) the date your employment is terminated.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Medical Assistance Plan	Within one year from the date the health service was rendered, or if the claim involves inpatient care, within one year of the date of discharge.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Occupational Accidental Death Insurance	Within one year from the date of death.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Prescription Drug Plan (KRx)	Within one year from the date the expense was incurred.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Retirement Income Plan	Within one year from the earlier of (1) the date you become eligible for a plan distribution (whether or not you elect to receive one) or (2) the date you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within one year from the earlier of (1) the date you become eligible for a plan distribution (whether or not you elect to receive one) or (2) the date you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.
Savings and Investment Plan	Within one year from the earlier of (1) the date you become eligible for a plan distribution (whether or not you elect to receive one) or (2) the date you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Short-Term Disability	Within 60 days from the date that you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Termination Allowance Plan	Within 60 days from the date that you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Vacation Buy	Within 60 days from the date that you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.
Workers' Compensation Supplement Plan	Within 60 days from the date that you know or should have known that there is an issue, dispute, problem or other claim with respect to your benefit.	Within 60 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the plan.

If a plan is not listed in the above table, see the benefit summary for that plan to find out what time limits apply. **IF YOU DO NOT FILE YOUR CLAIM BY THE APPLICABLE DEADLINE AND IN THE PROPER MANNER, YOUR CLAIM WILL EXPIRE AND IT WILL BE AUTOMATICALLY DENIED IF SUBSEQUENTLY FILED. YOU WILL NEVER BE ABLE TO PROCEED WITH A LAWSUIT BASED ON THAT CLAIM.**

You do not need to file a claim regarding a rescission of coverage under the Kodak Medical Assistance Plan. When you are notified by the plan administrator or his or her delegate that your coverage under the Kodak Medical Assistance Plan is being rescinded, that notification is considered to be a claim denial and you can appeal the rescission in accordance with the appeal procedure described below.

If your claim involves a plan change or amendment, you are deemed to know about your claim as it relates to the change or amendment when the change or amendment is first communicated to plan participants, whether or not the change or amendment has taken effect by that date. The 60-day period for filing a claim regarding a plan change or amendment starts to run as of the date the change or amendment is first communicated to plan participants.

Example 1: *You are a participant in a Kodak dental plan, and you incur a claim for a dental service that meets the requirements for payment by the plan. That type of claim is a Routine Claim for Payment of Benefits. If you do not file your claim within one year of incurring the expense, as required by the plan, your claim will have expired. If you try to claim the expense after this one-year time period, your claim will be denied. In other words, if you miss an applicable filing deadline, you will never be eligible to obtain payment for the services described in your claim.*

Example 2: *You are a participant in a Kodak life insurance plan. Kodak amends the plan to provide that smokers will be required to pay higher premiums than non-smokers. You want to submit a claim to challenge that amendment. That type of claim is an Other Claim so you must file your claim within 60 days after the date the amendment is first communicated by Kodak. If you do not file your claim within this 60-day time period, you will never be able to challenge the amendment through either the claims procedure used by the dental plans and/or a lawsuit in court.*

Brief Overview of Plan-Specific Claims Rules:

Medical, Dental, HCRA and DCRA: You must complete the appropriate claim form, attach the required supporting documentation, and mail it to

the appropriate claims processing unit as noted in the “Claims and Payment of Benefits” portion of the applicable plan’s benefit summary. Be sure to file your claim by the proper deadline. In some cases, a physician or a hospital may “file” the claim for you by billing the carrier or other claims reviewer directly.

EAP: To use the EAP, you should contact the EAP office as described in the plan’s benefit summary.

Life, ADI, OAD: In the case of life insurance, ADI, Dependent ADI and OAD, on receiving notice of an event (such as a death or dismemberment), Metropolitan Life Insurance Company (MetLife) will send the beneficiary a letter and self-explanatory forms to be completed and returned. When completed and returned, these forms constitute a Routine Claim for Payment of Benefits.

In the event you or your Dependent suffer an accidental injury that is covered under ADI or Dependent ADI, you can file a claim with MetLife as noted under “Claims and Payment of Benefits” in the ADI and Dependent ADI summaries.

Retirement Plans: When you leave the Company for any reason (except death), you will have to contact the SIP-Line to request distribution of any funds you have in SIP. You also must complete the appropriate forms for the eventual distribution of any retirement income benefit you may receive under KRIP.

LTD: If you wish to apply for LTD benefits, you should apply when you receive notification from the Kodak Employee Service Center that your STD or WCS benefits will be exhausted. You should also contact the Kodak Employee Service Center to apply for LTD benefits if you are laid off while on STD or WCS and your benefits under that plan will be ending.

Note: *Additional information regarding how to file claims is included in each of the benefit summaries contained in this handbook or provided to you under separate cover.*

Review the “Claims and Payment of Benefits” section in the benefit summaries. For life insurance, ADI and OAD, you should also review the “Beneficiaries and Assignments” sections in those summaries. For KRIP and SIP, you should also review the “Survivor Benefits” sections in those summaries. Kodak also maintains certain plans that are no longer open to new enrollment by Employees in general but which continue to cover certain Employees and/or former Employees and their Dependents and beneficiaries. If you are a participant, Dependent, or beneficiary under one of those plans, you should consult the

supplement to the handbook that you were provided in connection with that plan in addition to reading this section.

Use of Authorized Representatives: You can designate, by means of a power of attorney, an authorized representative to act on your behalf in connection with the submission or processing of plan claims. A court-appointed legal guardian or custodian may also be appointed to act as the authorized representative on your behalf.

Note: *An assignment of benefits by a claimant does not by itself function as an authorized representative designation.*

If you are a Dependent Child, your parents or legal guardian will automatically be considered your authorized representative if you are a minor under applicable state law, and to the extent permitted or required by state or other law.

In the event that you are covered under a benefit plan providing medical or dental coverage and need urgent care, the plan will recognize a health care professional with knowledge of your condition as your authorized representative.

In the absence of a power of attorney, court-appointed designation or automatic designation as discussed above, an individual will not be permitted or authorized to act on your behalf. For example, a participant will not be permitted to act on behalf of his or her spouse without a valid power of attorney or a court-appointed designation.

If you are deceased, your estate or a person with appropriate legal authority may act on your behalf.

Written designation of an authorized representative is necessary to protect against disclosure of information about you to unauthorized persons or entities. When you have an authorized representative, all notices and other communications pertaining to your claim will be furnished to the authorized representative only, unless you make a written request to the claims reviewer that a copy of all notices and other communications be sent to you.

Initial Claims Determinations

When you initially file a claim, be sure to file all of the arguments and evidence that you would like the reviewer to consider. Although you will be able to file additional arguments and evidence in support of your claim on appeal if your initial claim is denied, it is obviously in your best interest to give the reviewer all of the arguments and information necessary to approve your claim initially so that you do not need to file an appeal.

If you have questions about any notice you receive regarding the approval, denial, payment or non-payment of your claim, you should contact the claims reviewer with whom the claim was filed (for example, the plan administrator, insurance carrier or other claims administrator), since there may be a simple solution to your problem. However, if you cannot resolve your questions through this informal process and wish to appeal, you must file your formal appeal by the deadline described below, even if you have previously discussed your questions informally with the claims reviewer. Therefore, keeping track of deadlines is very important.

Routine Claims: Routine claims for payment of benefits will be processed according to the following rules:

Separate Procedures for Medical Benefits: If your claim is for medical benefits (other than prescription drug benefits) the claim will be processed according to the procedures described in the most recent benefits booklet available for that option. If no benefits booklet is in effect for your medical plan when the claim is filed, your claim will be processed according to the procedures described below.¹

Claims for Benefits other than Medical, Dental, HCRA, EAP or Disability Benefits: If your claim is for benefits other than medical, dental, HCRA, EAP or disability benefits, the claims reviewer with whom your claim was filed has to make a decision whether to approve or deny the claim within a reasonable period of time. Generally, the claims reviewer will make the initial determination within 90 days of the reviewer's receipt of the claim. In special situations, an extension for an additional 90 days may be required to process the

¹ State laws generally have special rules governing the processing of claims for insured health care benefits. These laws usually include claim determination processes similar to the procedures described in this summary. However, if a rule described in this summary is more favorable to a claimant than the rule under state law, this summary's rule may supersede the rule required by state law. As a result, the rules used to process an insured health care claim should be determined at the time that the claim is filed.

claim. In such a case, the claims reviewer will provide you with written notice of the extension within the original 90-day period, explaining the reason for the delay and the date by which you can expect a decision.

If your claim is approved by the claims reviewer, payment of the claim will be made as described under the “Claims and Payment of Benefits” part in the applicable plan’s benefit summary.

If your claim is denied by the claims reviewer, you will receive written or electronic notification from the claims reviewer of the specific reason or reasons for the denial. The notice will also include specific reference to applicable plan provisions on which the denial was based, a description of any additional information needed to complete the claim with an explanation of why it is necessary, instructions to be followed if you wish to appeal the denial, and a statement about your right to bring a civil lawsuit under ERISA following the appeal. The denial notice will be mailed within 90 days of the claim’s filing unless the 90-day processing extension applied to the claim. In that case, the denial notice will be mailed within 180 days of the claim’s filing.

If you do not receive notice of a decision or an extension notice within 90 days of filing your claim, you must assume that your claim has been denied. If you receive an extension notice, but you do not receive notice of a decision within 180 days of filing a claim, you must assume that the claim has been denied.

Claims for Medical, Dental, HCRA or EAP Benefits:

The procedures for processing medical (including prescription drug), dental, HCRA or EAP claims (i.e., “health care claims”) vary depending on the type of health care claim. Health care claims are divided into 4 types:

- **Concurrent Care Claims:** Any health care claim previously approved as an ongoing course of treatment to be provided over a period of time or over a number of treatments where you request that the care be extended, or the care is either reduced or terminated by the health plan. Concurrent care claims may also be classified as urgent care claims, pre-service care claims or post-service care claims and, if so, the claim will be processed using the other claim classification rules unless a specific concurrent care claim rule pertains to the claim.
- **Pre-service Care Claims:** Any health care claim for non-urgent care that must be decided before you will be given access to the care (that is, pre-authorization of the claim). A pre-service care claim may also be classified as an urgent care claim and, if so, the rules applicable to urgent care claims supersede the rules applicable to pre-service care claims.
- **Post-service Care Claims:** Any health care claim for non-urgent care that has already been provided involving the payment or reimbursement of costs for the care.

The claims reviewer has full discretionary authority to determine the type of claim being processed.

When making an initial determination, the claims reviewer must decide whether to approve or deny the health care claim within the following time frames:

- **Urgent Care Claims:** Any health care claim where your life or health, or your ability to gain maximum function is in jeopardy or, in the opinion of your doctor, you are subject to severe pain which cannot be adequately managed without the care or treatment proposed in the claim.

Type of Claim	Timeframe for Making an Initial Claim
Urgent Care Claims	A decision must be made as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the claims reviewer receives the claim, unless more information is needed to process the claim. If more information is needed, the claims reviewer has 24 hours to notify you of the specific information needed, you have 48 hours from receipt of the notice to provide the information, and the claims reviewer must make a decision within 48 hours after the earlier of the receipt of the needed information or the end of your 48-hour period to provide the information.
Concurrent Care Claims	If the claim is a request to extend a course of treatment involving an urgent care claim, a decision must be made as soon as possible, not to exceed 72 hours, taking into account the medical circumstances, but not later than within 24 hours of your request for an extension of care if the request was made at least 24 hours before the treatment is to end. If urgent care is not involved, the claim will be processed as a pre-service or post-service care claim, as appropriate. If the claim pertains to a premature reduction or termination of a course of treatment by the plan, you must be given sufficient advance notice of the reduction or termination to permit you to appeal and obtain a determination on review before the reduction or termination goes into effect.
Pre-Service Care Claims	A decision must be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claims reviewer receives the claim, except that an extension of an additional 15 days may be taken in circumstances beyond control of the claims reviewer with notice to you before the initial 15-day period expires. If the circumstances involve the need for more information, you have 45 days from receipt of notice to provide the information, and the claims reviewer must make a decision within 15 days after the earlier of the receipt of the needed information or the end of your 45-day period to provide the information.
Post-Service Care Claims	A decision must be made within a reasonable period of time, but not later than 30 days after the claims reviewer receives the claim, except that an extension of an additional 15 days may be taken in circumstances beyond control of the claims reviewer with notice to you before the initial 30-day period expires. If the circumstances involve the need for more information, you have 45 days from receipt of notice to provide the information, and the claims reviewer must make a decision within 15 days after the earlier of the receipt of the needed information or the end of your 45-day period to provide the information.

If you do not receive notice of a decision or an extension notice within the applicable time period described above, you must assume that the claim has been denied. If you received an extension notice, but do not receive notice of a decision within the applicable time period described above, you must assume that the claim has been denied.

Whenever a health care claim is denied, the claims reviewer must give notice of the denial to you in writing or electronically. The denial notice will identify the claim and include the specific reason(s) for the denial (including an explanation of the scientific or clinical basis used to support a finding that the proposed care is not medically necessary or experimental), specific reference to applicable plan provisions on which the denial was based (including disclosure of any internal rule, guideline

or protocol relied on in making the determination), a description of any additional information needed to complete the claim with an explanation of why it is necessary, instructions to be followed if you wish to appeal the denial (including how to appeal on an expedited basis if the denial pertains to an urgent care claim), information regarding the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman, and statements about your rights to request the applicable diagnosis and treatment codes and their corresponding meanings and bring a civil lawsuit under ERISA following the appeal.

Claims For Disability Benefits: If your claim is for disability benefits (e.g., STD or LTD benefits), the claims reviewer has to make a decision whether to

approve or deny the claim within a reasonable period of time, not to exceed 45 days following the reviewer's receipt of the claim. An extension of an additional 30 days may be taken in circumstances beyond the reviewer's control so long as written notice is given to you before the initial 45-day period expires. This notice will explain the reason(s) for the delay and the date by which a decision can be expected. If a reason for the delay involves the need for more information, you have 45 days from receipt of the extension notice to provide the needed information, and a determination will then be made within 30 days after the earlier of the date that the claims reviewer receives the needed information or the end of your 45-day period to provide the information.

A second extension of an additional 30 days may be taken in circumstances beyond the claims reviewer's control so long as written notice is given to you before the first 30-day extension period expires. The notice will also explain why the delay is necessary and the date by which a decision can be expected, and if a reason for the delay involves the need for more information, you again have 45 days from receipt of the extension notice to provide the information. A determination will be made within 30 days after the earlier of the date that the claims reviewer receives the needed information or the end of your 45-day period to provide the information.

If the claim is denied, you will be given written or electronic notice of the denial. The denial notice will include the specific reason(s) for the denial, specific reference to applicable plan provisions on which the denial was based (including disclosure of any internal rule, guideline or protocol relied on in making the determination), a description of any additional information needed to complete the claim with an explanation of why it is necessary, instructions to be followed if you wish to appeal the denial, and a statement about your right to bring a civil lawsuit under ERISA following the appeal.

If you do not receive notice of a decision or an extension notice within 45 days of filing your claim, you must assume that your claim has been denied. If you receive an extension notice, but you do not receive notice of a decision within the applicable time period described above, you must assume that the claim has been denied.

Other Claims: All Other Claims must be filed, in writing, with the plan administrator of the relevant plan by the deadline stated above. The claims reviewer will make a decision on your claim within

90 days of its receipt of the claim. However, in special situations, an extension for an additional 90 days may be required to process the claim. In such a case, written notice of an extension will be furnished within the original 90-day period, explaining the reasons for the delay and the date by which a decision can be expected.

If your claim is approved by the claims reviewer, the plan administrator will take appropriate action to resolve your claim. You will be informed of the action the plan administrator decides to take. If you are not satisfied that the plan administrator's action will resolve your claim, you may file an appeal as described below.

If your claim is denied by the claims reviewer, you will receive written or electronic notification from the claims reviewer of the specific reason or reasons for the denial. The notice will also include specific reference to applicable plan provisions on which the denial was based, a description of any additional information needed to complete the claim with an explanation of why it is necessary, instructions to be followed if you wish to appeal the denial, and a statement about your right to bring a civil lawsuit under ERISA following the appeal. The denial notice will be mailed within 90 days of the claim's filing unless the 90-day processing extension applied to the claim. In that case, the denial notice will be mailed within 180 days of the claim's filing.

If you do not receive notice of a decision or an extension notice within 90 days of filing your claim, you must assume that your claim has been denied. If you receive an extension notice, but you do not receive notice of a decision within 180 days of filing a claim, you must assume that the claim has been denied.

Appeals

How to File an Appeal: If the claims reviewer denies your claim, or if the claims reviewer approves your claim but, in the case of a Routine Claim for Payment of Benefits, you are not satisfied with the payment promised or made, or in the case of an Other Claim, you are not satisfied with the action the plan administrator then takes to resolve your claim, you should contact the claims reviewer. The claims reviewer may be able to answer questions or otherwise satisfy your concerns about the handling of the denied claim. As noted above, if you receive notification of a rescission of your coverage under the Kodak Medical Assistance Plan, that notification

is considered a claim denial and you may appeal it in accordance with the appeal procedure described in this section.

If you remain dissatisfied and wish to appeal your claim denial, you must write a letter (as described below) to the claims reviewer within the time specified as follows:

For a Routine Claim for Payment of Benefits:

- *Within 60 days following your receipt of the claim's denial notice (or within 60 days of the date the claim is assumed to be denied) if the claim involved is not a medical (including prescription drug), dental, HCRA, EAP or disability claim.*
- *Within 180 days following your receipt of the claim's denial notice (or within 180 days of the date the claim is assumed to be denied) if the claim involved is a medical (including prescription drug), dental, HCRA, EAP or disability claim. If the denial notice pertains to an urgent care claim (including a concurrent care claim that is an urgent care claim), an expedited appeals process is available upon your oral or written request.*

For an Other Claim:

- *Within 60 days following your receipt of the claim's denial notice (or within 60 days of the date the claim is assumed to be denied).*

For a Rescission of Coverage under the Kodak Medical Assistance Plan:

- *Within 180 days following your receipt of the notice of rescission of coverage.*

No form of communication other than a letter (for example, telephone or e-mail) will constitute an appeal, unless the denial notice pertains to an urgent care claim (including a concurrent care claim involving an urgent care claim). When an urgent care claim is involved, an expedited appeals process is available upon your oral or written request, and an oral or written statement will constitute an appeal. Additionally, in connection with urgent care claims, all necessary information, including the decision on appeal, will be transmitted between you and the administrator reviewing the appeal by telephone, facsimile or another method which is similarly quick.

If you do not file your appeal by the deadline in an appropriate format, your claim will expire and the claim denial or assumed denial will be **FINAL**. You will not be able to pursue an appeal or a lawsuit in connection with that claim.

IMPORTANT!

A "claim" includes the issues and arguments you raised in your initial claim and all related issues and arguments, including any claim that the claims reviewer or any other plan representative is operating under a conflict of interest. You are free to make new arguments and provide additional evidence in support of your claim when you appeal, but if you do not appeal properly and on time, your claim cannot be raised in subsequent litigation. You cannot avoid this rule by filing a new initial claim on the same subject with different arguments.

Your appeal letter must be in the form directed by the claims reviewer, and must include all information required by the claims reviewer as well as the reasons why you believe the claim was improperly denied, and any other data, questions or comments you deem appropriate. Contact the claims reviewer with any questions you may have about how to file an appeal and what information to include. *Remember, it is very important for you to make all arguments you believe you have in support of your claim on appeal, and to provide any supporting documentation or other data.* The claims reviewer will conduct a full and fair review and will try to make a fair decision, but he or she cannot review arguments or evidence not filed, so it is in your interest to present your best possible case. *Also, any arguments not made and evidence not filed on appeal CANNOT BE RAISED in subsequent litigation.*

Please keep in mind that while the claims reviewer can assist you with questions about these procedures, the claims reviewer cannot provide you with legal advice. *You are solely responsible for preparing your own appeal and for making sure that it includes all necessary information. You may want to consult with your attorney about your appeal.*

When you appeal a denied claim, you have the right to file written comments, documents, records and other information relating to the denied claim. You also can access or obtain copies of any documents, records and other information relevant to the denied claim upon request and without charge (subject to applicable privilege rules). For appeals under the Kodak Medical Assistance Plan, if the claims reviewer considers, relies upon or generates new or additional evidence in connection with your claim, or if the claims reviewer intends to deny your appeal based on a new or additional rationale, the claims reviewer

will provide you with such new evidence or rationale as soon as possible and sufficiently in advance of the date on which a final determination must be made on your appeal to give you a reasonable opportunity to respond to the new evidence or rationale.

Finally, if you believe that the claims reviewer who reviewed your initial claim, and/or the claims reviewer to whom your claim has been assigned on appeal, is acting under a conflict of interest, your appeal letter must say so. If you do not object to any perceived conflicts on appeal, you will be considered to have agreed that the claims reviewer does not have a conflict of interest, and you cannot raise this issue in a lawsuit.

Claims Reviewer: The claims reviewer for appeals will be determined as follows:

If a denied Routine Claim for Payment of Benefits being appealed pertains to the following self-insured medical coverage, the plan's third-party claims administrator is the claims reviewer authorized to review the appeal:

- PPO coverage;
- CDHP coverage; and
- KRx coverage.

The claims administrator for a particular coverage is identified in the booklet describing the coverage or in the benefit summary in this handbook describing the applicable plan.

If a denied Routine Claim for Payment of Benefits applies to insured coverage under the following plans, the carrier is the claims reviewer authorized to review the appeals:

- LTD Plan;
- ADI;
- Dependent ADI;
- Dependent Life Insurance Plans; and
- Employee Life Insurance Plans.

If a denied Routine Claim for Payment of Benefits being appealed pertains to the following plan benefits, an individual (currently the Director, Global Benefits and Employee Services) has been authorized to review appeals of claims denials:

- KRIP; and
- SIP.

All other denied Routine Claims for Payment of Benefits, all denied Other Claims for any plan and all rescissions of coverage under the Kodak Medical Assistance Plan, must be appealed to the plan administrator.

Appeals Involving Routine Claims: Appeals involving routine claims for payment of benefits will be processed as follows:

Separate Procedures for Medical Benefits: If your denied claim is for medical benefits (excluding prescription drug benefits), the claim will be processed according to the procedures described in the most recent benefits booklet available for that option or, if no benefits booklet for your medical plan is in effect when the appeal is filed, according to the procedures described later.¹

If your denied claim is for any other benefits, the procedures described below will govern how the claim is processed.

Appeals of Rescissions of Coverage under the Kodak Medical Assistance Plan and Denied Claims Other Than Medical, Dental, HCRA, EAP or Disability:

The claims reviewer authorized to review your appeal has to make a decision whether to approve or deny the appeal within a reasonable period of time, not to exceed 60 days following the date on which the reviewer receives the written appeal. In special circumstances, however, an extension for an additional 60 days may be required for processing an appeal. In such a case, written notice of the extension will be furnished to you within the original 60-day period, explaining the reason for the delay and the date by which you can expect a decision.

In making a decision, the claims reviewer will take into account all information filed by you that relates to your denied claim without regard to whether the information was filed or considered when the initial claim determination was made. You will receive written or electronic notice of the claims reviewer's decision regarding the appeal. If the decision upholds the initial claim denial (that is, if your claim is denied on appeal), the notice will include:

- the specific reason(s) for the adverse determination;
- specific references to the pertinent plan provisions on which the decision is based;
- a statement that you are entitled to receive, upon request and without charge, reasonable access

¹ State laws generally have special rules governing the review of denied claims for insured health care benefits. These laws usually include appeal processes similar to the appeal procedures described in this summary. However, if a rule described in this summary is more favorable to a claimant than the rule under state law, this summary's rule may supersede the rule required by state law. As a result, the rules used to appeal a denied insured health care claim should be determined at the time that the appeal is filed.

to and copies of all documents, records and other information relevant to the denied claim;

- a statement describing any voluntary appeal procedures offered by the plan and how to obtain information about those procedures; and
- a statement about your right to start a civil lawsuit under ERISA.

If you do not receive notice of the decision regarding your appeal within the applicable 60-day review period (or 120-day review period if an extension applies), you must assume that the appeal has been denied.

Appeals of Denied Medical, Dental, HCRA or EAP

Claims: The claims reviewer authorized to review your appeal of a denied health care claim (i.e., a claim under the Kodak Medical Assistance Plan, KRx, Dental, HCRA or EAP) will be someone other than the decision maker of the initial claim determination. In

making a decision, the claims reviewer will not defer to the findings and conclusions made with respect to the initial claims determination. If the denied health care claim being appealed is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the claims reviewer must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved with the initial claims determination. The carrier or claims administrator making the initial claim determination must identify the medical and vocational experts whose advice was obtained on behalf of the plan in connection with that determination, regardless of whether the advice was relied upon in making the determination.

The claims reviewer must decide upon the appeal within the applicable timeframes described below:

Type of Claim	Timeframe for Making an Appeal Determination
Urgent Care Claims	As soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of your appeal.
Concurrent Care Claims	If the appeal involves extension of care, use the time period applicable to urgent, pre-service or post-service care claims, as applicable. If the appeal involves reduction or termination of care, before care is reduced or terminated.
Pre-Service Care Claims	Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your appeal in the case of a plan that offers one appeal of the claim denial or, in the case of a plan that offers two appeals, 15 days after the receipt of your first request for review with respect to the first appeal and 15 days after receipt of your second request for review with respect to the second appeal. ¹
Post-Service Care Claims	Within a reasonable period of time, but not later than 60 days after receipt of your appeal in the case of a health plan that offers one appeal of the claim denial or, in the case of a health plan that offers two appeals, 30 days after the receipt of your first request for review with respect to the first appeal and 30 days after receipt of your second request for review with respect to the second appeal. ¹

When a decision regarding an appeal is made, you will receive written or electronic notice from the claims reviewer. If the decision upholds the initial claim denial (that is, if your claim is denied on appeal), the notice will include:

- the specific reason(s) for the adverse determination (including an explanation of the scientific or clinical basis used to support a finding that the proposed care is not medically necessary or experimental);
- specific reference to applicable plan provisions on which the decision was based (including disclosure of any internal rule, guideline or protocol relied on in making the determination);

¹ Certain Health Plans under the Kodak Medical Assistance Plan offer two appeals. You should review your benefits booklet to determine if your Health Plan does and, if so, what the deadline is for filing the second appeal. In all other cases, only one appeal of a denied claim is permitted by the plan.

- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim;
- a statement regarding any voluntary appeal procedures offered by the plan and how to obtain information about those procedures;
- in the case of a denied health care claim under the Kodak Medical Assistance Plan, the notice will also identify the claim, include statements about your ability to request the applicable diagnosis and treatment codes and their corresponding meanings and regarding the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman, and describe available external review processes and information on how to initiate an external review;
- a statement about your right to bring a civil lawsuit under ERISA; and,
- if applicable, a statement about other voluntary alternative dispute resolution options available.

If you do not receive notice of the decision regarding an appeal within the applicable review period, you must assume that the appeal has been denied.

Appeals of Denied Disability Claims: The claims reviewer authorized to review your appeal will be someone other than the decision maker of the initial claim determination. The claims reviewer has to make a decision about the appeal within a reasonable period of time, not to exceed 45 days following the date on which the reviewer receives the written appeal. An extension of an additional 45 days may be taken if the reviewer determines that special circumstances apply and written notice of the extension is given to you before the initial 45-day period expires. The extension notice will explain the reason(s) for the delay and the date by which a determination on review can be expected.

In making a decision, the claims reviewer will not defer to the findings and conclusions made with respect to the initial claims determination. You will receive written or electronic notice of the reviewer's decision regarding the appeal. If the decision upholds the initial claim denial (that is, if your claim is denied on appeal), the notice will include:

- the specific reason(s) for the adverse determination;
- specific reference to applicable plan provisions on which the decision was based (including disclosure

of any internal rule, guideline or protocol relied on in making the determination);

- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim;
- a statement regarding any voluntary appeal procedures offered by the plan and how to obtain information about those procedures; and
- a statement about your right to bring a civil lawsuit under ERISA.

If you do not receive notice of the decision regarding your appeal within the applicable 45-day review period (or 90-day review period if an extension applies), you must assume that the appeal has been denied.

Appeals Involving Other Claims: The claims reviewer has to make a decision whether to approve or deny the appeal within 60 days of the date on which the reviewer receives the appeal. In special circumstances, however, an extension for an additional 60 days may be required for processing an appeal. In such a case, written notice of the extension will be furnished to you within the original 60-day period, explaining the reasons for the delay and the date by which a decision can be expected.

In making a decision, the claims reviewer will take into account all information filed by you that relates to your denied claim without regard to whether the information was filed or considered when the initial claim determination was made. You will receive written or electronic notice of the claims reviewer's decision regarding the appeal. If the decision upholds the initial claim denial (that is, if your claim is denied on appeal), the notice will include:

- the specific reason(s) for the adverse determination;
- specific references to the pertinent plan provisions on which the decision is based;
- a statement describing any voluntary appeal procedures offered by the plan and how to obtain information about those procedures; and
- a statement about your right to start a civil lawsuit under ERISA.

If you do not receive notice of the decision regarding your appeal within the applicable 60-day review period (or 120-day review period if an extension applies), you must assume that the appeal has been denied.

External Review for KMAP and KRx Claims: If your appeal relating to benefits under KMAP or KRx is denied after the final level of appeal, you have the right to request an external review for some claims. Only denials of appeals of rescissions of coverage and Routine Claims involving medical judgment are eligible for external review. Your request for external review must be filed in accordance with the instructions contained in your appeal denial notice and must be received not later than 130 days after the date you receive the appeal denial notice or the date the appeal is assumed denied. If you do not properly request an external review in a timely manner, your claim cannot be raised in litigation, unless you filed suit within 90 days after the date that your claim was denied on appeal.

Within 5 business days after receiving your external review request, the claims reviewer will complete a preliminary review to determine whether your request is complete and eligible for external review. That preliminary review will determine: whether you were covered under the plan at the time the item or service was requested or provided; whether the final denial of your appeal related to your failure to meet the plan's eligibility requirements; whether you exhausted the plan's internal appeal process (or are not required to exhaust the process); and whether you have provided all the information and forms required to process an external review. Within one business day after the claims reviewer completes its preliminary review, it will issue you a written notification. If your request is complete, but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review within the original 130-day filing period or, if later, the 48-hour period following your receipt of the notification.

If your request for external review is complete and eligible, the claims reviewer will assign a qualified Independent Review Organization (IRO) to conduct the external review and within 5 business days after making the assignment will provide the IRO with the documents and information the claims reviewer considered in making its final appeal denial.

The IRO will review all of the information and documents received and will not be bound by any decisions or conclusions reached by the claims reviewer during the plan's internal claim and appeal

process. The IRO may also consider the following in reaching its decision: your medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the claims reviewer, you or your treating provider; the terms of the plan, to ensure that the IRO's decision is not contrary to the terms of the plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the plan; and the opinion of the IRO's clinical reviewer(s).

The IRO will provide written notice to you and the claims reviewer of the final external review decision within 45 days after the IRO receives the request for external review. The IRO's notice will contain: a general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial; the date the IRO received the assignment and the date of the IRO's decision; references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards; a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the plan or you; a statement that judicial review may be available to you; and, if applicable, current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Under the following circumstances, you may be eligible to file for an expedited external review:

- if you receive a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the claims reviewer would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- if you receive a final claim denial from the claims reviewer and:
 - you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or

- if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited external review, the claims reviewer will complete a preliminary review of your request in order to determine your eligibility for an external review. Immediately after completion of the preliminary review, the claims reviewer will issue you a written notification of your eligibility for an external review. If your request is complete but not eligible for external review, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to make the request complete and you will have an opportunity to complete the request.

Upon a determination that a request is eligible for an expedited external review, the claims reviewer will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice to you and the claims reviewer of the final external review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited external review. The notice will contain the information described above.

Limits on Legal Actions

If your claim is denied on appeal and you are not satisfied with the claims reviewer's decision, you may contact the claims reviewer and attempt to resolve your concerns informally. However, if you do not wish to do so, or if the claims reviewer cannot resolve your concerns to your satisfaction, you generally may file a lawsuit under ERISA, provided you comply with the deadlines for filing a lawsuit described in this section. As an alternative to litigation in court, the plan administrator for the plan in question retains the right to compel binding or non-binding arbitration or mediation. Also, in some cases, a plan may require or permit a second level of appeal (see your benefit summary for the particular plan). If the second level of appeal is mandatory, you must complete the second appeal process before you will be entitled to file suit. If the second level is voluntary, it is up to you whether or not you want to pursue a second appeal. If you decide to pursue a voluntary appeal, make sure that you have a written agreement from the plan

administrator that the deadline for filing suit will be extended, or that the second level of appeal will be finished in time for you to file suit if your claim is denied and you wish to do so.

If you want to file suit, you must do so by the earlier of:

1. The date that is 90 days after the date that your claim is denied on appeal (or, if later, 90 days after the date of a final external review decision); or
2. The date that is 90 days from the date a cause of action accrued (except that in the case of claims under KRIP this deadline is instead the date that is one year from the date a cause of action accrued). A cause of action "accrues" when you know or should know that a representative of the plan or Kodak as plan sponsor (whichever is applicable) has clearly denied or otherwise repudiated your claim. However, if you file a timely initial claim with the plan administrator or other appropriate plan authority, and complete the claims and appeals process, the deadline for filing a lawsuit will always be 90 days from the date that your claim was denied on appeal or external review (as described in (1) above), and you will not need to worry about this special rule for when a cause of action accrues. (Of course, if you do not file a timely initial claim and complete the claims and appeals process, you generally cannot file a lawsuit in any event.)

Example: *Kodak amends its health plan to increase cost and/or reduce coverage – Kodak has clearly repudiated or denied your right to continued coverage under the plan's prior terms, and the 90-day time period for filing a lawsuit will begin to run when the amendment is first communicated to plan participants.*

However, if you file a claim with the plan administrator within 60 days of the date the amendment is communicated to plan participants, and you follow the appeal procedure if your claim is denied by the plan administrator, then the deadline for you to file a lawsuit about the amendment will be 90 days from the date the plan administrator denies your claim on appeal. If you do not file a claim within 60 days of the date the amendment is communicated, the deadline for filing a lawsuit will expire on the 90th day after the amendment is communicated, and the plan administrator will ask the court to dismiss your lawsuit due to your failure to follow the claims and appeals procedure even if you file your lawsuit by the deadline.

If the applicable 90-day deadline for filing a lawsuit described above is, for any reason, not applied by a court, then the deadline for filing the suit will be no longer than one year from the earlier of the date

the claim was denied on appeal or the date the cause of action accrued.¹ As explained above, the date the cause of action accrues is the date your claim is denied or repudiated by Kodak or a plan representative. For example, a cause of action relating to a plan amendment accrues when the amendment is communicated to plan participants.

IF YOU DO NOT FILE SUIT BY THE APPLICABLE DEADLINE, YOUR CLAIM WILL EXPIRE AND YOU WILL NEVER BE ABLE TO PROCEED WITH A LAWSUIT IN CONNECTION WITH THAT CLAIM OR A RELATED CLAIM.

As described above, you are required to follow the procedures described in this section for plan claims and appeals. However, the deadlines for filing a lawsuit apply regardless of whether you follow the procedures. For example, the 90-day period for filing a lawsuit involving a plan change or amendment starts to run as of the date the change or amendment is first communicated to plan participants even if you do not file a claim.

All lawsuits against or involving one or more of Kodak's plans **must** be filed in the Federal Court for the Western District of New York located in Rochester, New York, unless the plan administrator agrees to a different forum.

Attorney's Fees: If you file a lawsuit and the court or arbitrator rules against your claim, you will be responsible for the attorney's fees and other expenses incurred by the plan, its fiduciaries, Kodak and other related parties in defending against your action, unless otherwise agreed to by the plan administrator or otherwise ordered by the court or arbitrator. If you file a lawsuit and the court rules in your favor, the plan, its fiduciaries, Kodak and other related parties will not be responsible for your attorney's fees and other expenses unless otherwise ordered by the court or arbitrator. The applicable plan, its fiduciaries, Kodak and other related parties will not be liable to pay attorney's fees based on the amount of recovery you and/or plan participants in general receive in a lawsuit (these kinds of fees are commonly referred to as "contingency fees").

If your lawsuit is successful, the applicable plan, its representatives and fiduciaries, Kodak, and related parties will not be liable for extracontractual or punitive damages, and will only be liable for pre-judgment interest if ordered by a court or arbitrator. You will not be entitled to benefits in excess of those promised by the terms of the written plan document, regardless of what oral or written statements may have been made to you.

¹ This is the deadline determined under Del. Code Ann. tit. 10 Section 8111.