ERISA BASICS

AUSTIN MEHR

MEHR, FAIRBANKS & PETERSON, PLLC

POSITION AVAILABLE- ERISA Lawyer:

Lawyer to work in a competitive, hostile environment. Must be willing to interact on a daily basis with other lawyers whose job it will be to make sure you fail. These interactions will discuss how you cannot win unless the other side has been arbitrary or capricious. Must be willing to work nights, weekends and holidays and you will never be able to present your case to a jury. Also, the best that you win for your client is to get the benefits they were entitled to and maybe a portion of the attorney's fees. There will be no extra contractual recovery available no matter how HORRIBLE the insurance company's conduct. During your briefing with Federal Courts, you will not get any discovery and your opponent will always get the benefit of the doubt by showing a bare minimum of evidence to overcome the standard of arbitrary and capricious. Your clients will be desperate and broke and put a lot of pressure on you. Your opponent will hire biased experts who you can never meet, or depose, or cross-examine. Their reports, even if clearly wrong, will be given deference. The insurer you file a claim against will not have to abide by any Unfair Claims Acts like other carriers.

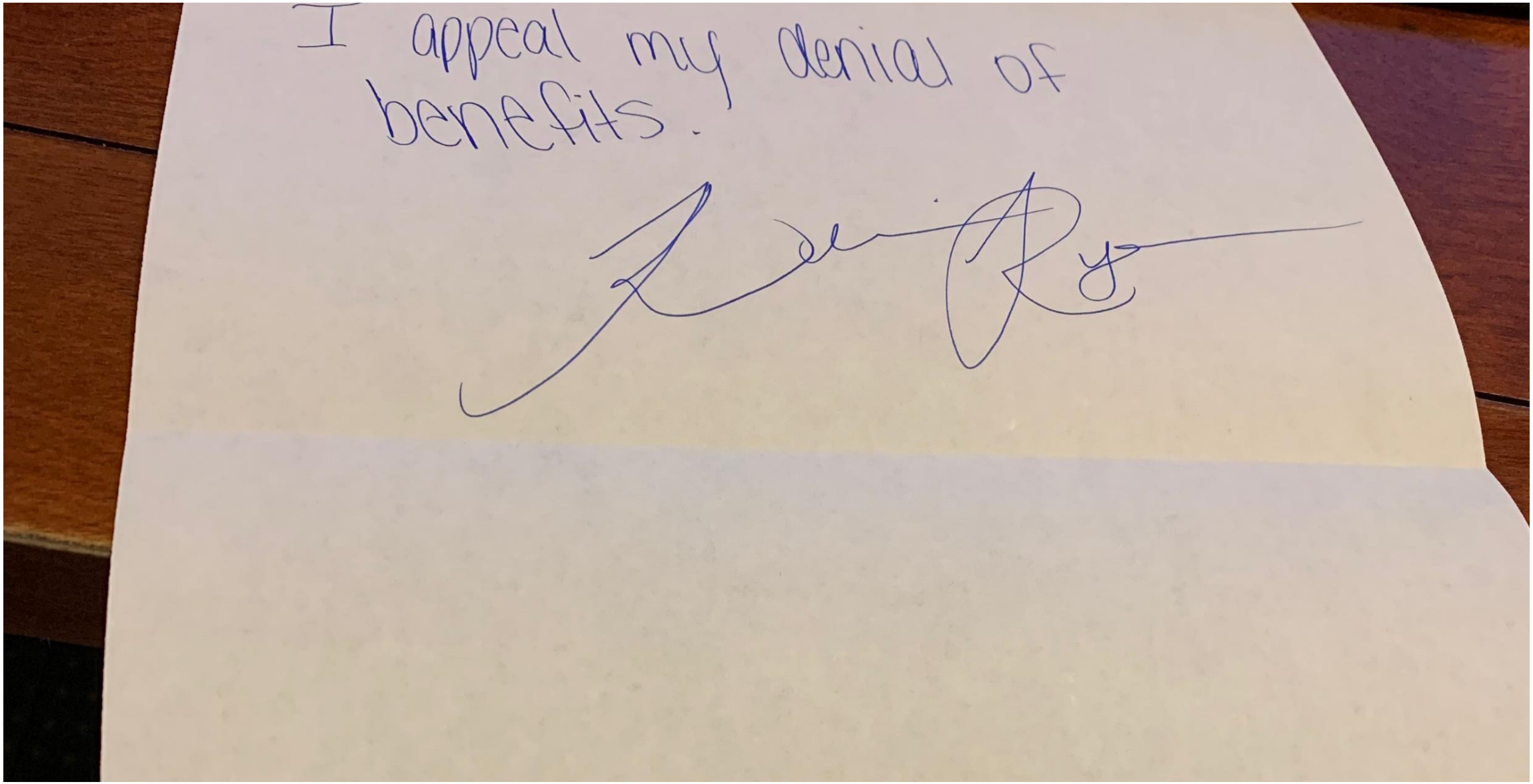
PRIVILEGED PROVIDENT INTERNAL MEMORANDUM

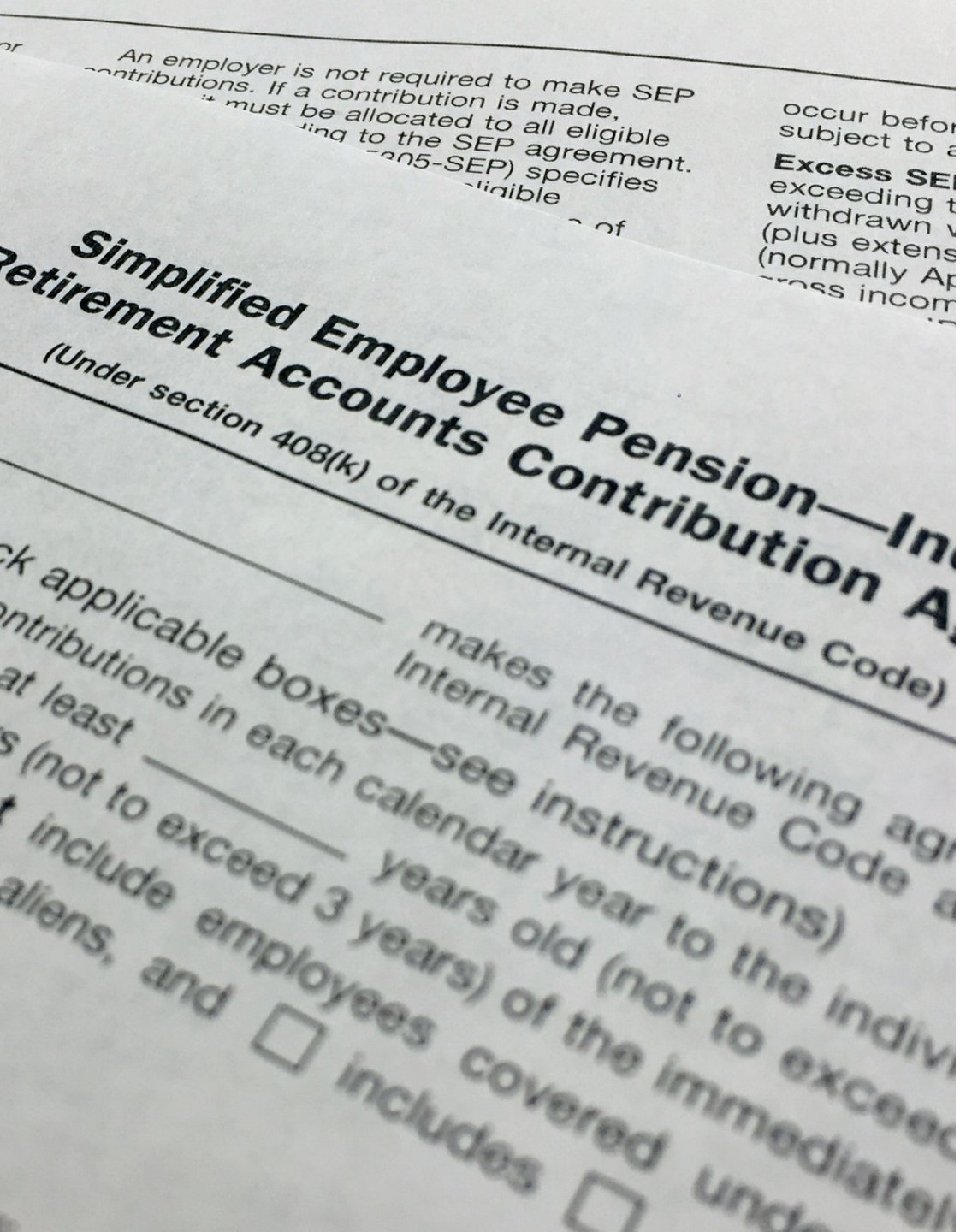
"The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of the benefits in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for 7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million."

-Individual Disability Group

LITIGATING AN ERISA CLAIM FOR DENIAL OF BENEFITS

"Section 1132(a)(1)(B) permits the beneficiary of an ERISA-governed plan to bring a civil action in federal court to recover benefits due to his under the terms of his plan, to enforce his rights under the terms of the plan, [and] to clarify his rights to future benefits under the terms of the plan."


I appeal my denial of
benefits.



ADMINISTRATIVE APPEALS PHASE

Prior to bringing a civil action under ERISA, a claimant must first exhaust his administrative remedies.

TWO CATEGORIES

Of state law that ERISA pre-empts.

IF THE LAW REFERENCES ERISA PLANS

Where a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . ., that reference will result in pre-emption.

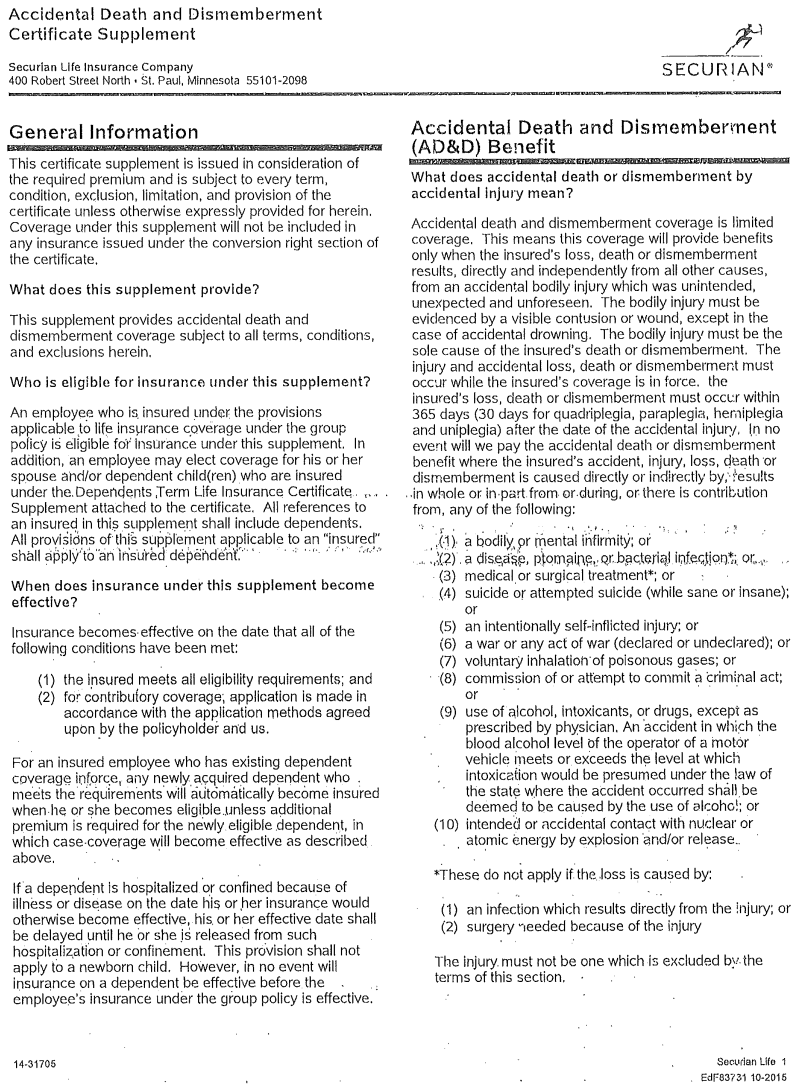
AN IMPERMISSIBLE CONNECTION

a state law that governs . . . a central matter of plan administration or interferes with nationally uniform plan administration.

"ERISA PRE-EMPTS 'ANY AND ALL [S]TATE LAWS INSOFAR AS THEY MAY NOW OR HEREAFTER RELATE TO ANY EMPLOYEE BENEFIT PLAN.'"

ACCIDENTAL DEATH AND DISMEMBERMENT

"This means this coverage will provide benefits only when the insured's loss, death or dismemberment results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of the insured's death or dismemberment."



Accidental Death and Dismemberment
Certificate Supplement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

General Information

This certificate supplement is issued in consideration of the required premium and is subject to every term, condition, exclusion, limitation, and provision of the certificate unless otherwise expressly provided for herein. Coverage under this supplement will not be included in any insurance issued under the conversion right section of the certificate.

What does this supplement provide?

This supplement provides accidental death and dismemberment coverage subject to all terms, conditions, and exclusions herein.

Who is eligible for insurance under this supplement?

An employee who is insured under the provisions applicable to life insurance coverage under the group policy is eligible for insurance under this supplement. In addition, an employee may elect coverage for his or her spouse and/or dependent child(ren) who are insured under the Dependents Term Life Insurance Certificate Supplement attached to the certificate. All references to an insured in this supplement shall include dependents. All provisions of this supplement applicable to an "insured" shall apply to an insured dependent.

When does insurance under this supplement become effective?

Insurance becomes effective on the date that all of the following conditions have been met:

(1) the insured meets all eligibility requirements; and
(2) for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us.

For an insured employee who has existing dependent coverage inforce, any newly acquired dependent who meets the requirements will automatically become insured when he or she becomes eligible unless additional premium is required for the newly eligible dependent, in which case coverage will become effective as described above.

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This provision shall not apply to a newborn child. However, in no event will insurance on a dependent be effective before the employee's insurance under the group policy is effective.

Accidental Death and Dismemberment (AD&D) Benefit

What does accidental death or dismemberment by accidental injury mean?

Accidental death and dismemberment coverage is limited coverage. This means this coverage will provide benefits only when the insured's loss, death or dismemberment results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of the insured's death or dismemberment. The injury and accidental loss, death or dismemberment must occur while the insured's coverage is in force. the insured's loss, death or dismemberment must occur within 365 days (30 days for quadriplegia, paraplegia, hemiplegia and uniplegia) after the date of the accidental injury. In no event will we pay the accidental death or dismemberment benefit where the insured's accident, injury, loss, death or dismemberment is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

(1) a bodily or mental infirmity; or
(2) a disease, ptomaine, or bacterial infection*; or
(3) medical or surgical treatment*; or
(4) suicide or attempted suicide (while sane or insane); or
(5) an intentionally self-inflicted injury; or
(6) a war or any act of war (declared or undeclared); or
(7) voluntary inhalation of poisonous gases; or
(8) commission of or attempt to commit a criminal act; or
(9) use of alcohol, intoxicants, or drugs, except as prescribed by physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol; or
(10) intended or accidental contact with nuclear or atomic energy by explosion and/or release.

*These do not apply if the loss is caused by:

(1) an infection which results directly from the injury; or
(2) surgery needed because of the injury

The injury must not be one which is excluded by the terms of this section.

14-31705

Securian Life 1
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AUTOEROTIC ASPHYXIATION…

- Critchlow v. First UNUM Life Ins. Co. of Am., 378 F.3d.246, *246; 2004 U.S. App. LEXIS 17106.

- A.A. is deemed *accidental*.

MORCUS V. MEDI-COPY SERVICES, INC.

No 5:17-cv-00229-DCR-EBA, 2017 U.S. Dist. LEXIS 195485, *18 (E.D. Ky. Nov. 28, 2017) (Reeves, J.)

01

ISSUE

The plaintiff sued Medi-Copy Services, Inc. (“Medi-Copy”) and Medi-Copy’s employee, Menika Bobo, who had filled out and signed the forms on behalf of Dr. Joshua Bailey at Lexington Clinic “without Dr. Bailey’s consent” and with significant errors.

02

ADMINISTRATIVE APPEALS

During the administrative appeals phase, Morcus submitted information from Lexington Clinic “stating that the information submitted by Medi-Copy . . . was not accurate . . . .” Guardian subsequently “reversed its decision to terminate benefits”

03

RULING

The Eastern District of Kentucky ruled that “the plaintiff’s claims [we]re not sufficiently related to ERISA to invoke the Act’s express preemption clause.”

04

COURT FINDS

Medi-Copy and Bobo argued that “Morcus’ claims [we]re completely preempted by [ERISA]” but the court explained that “ERISA does not preempt every state-law claim that touches the Act in some tangential way.” The court further explained that “it cannot be said that the damages sought are primarily plan-related.”

HALL V. MLS NATIONAL MEDICAL EVALUATIONS, INC.

No. 05-185-JBC, 2008 U.S. Dist. LEXIS 28756, *3 (April 8, 2008)

01

ISSUE

Plaintiff's claim stems from an independent medical evaluation by MLS which was incorrectly transcribed by the physician when transmitted to his plan administrator which lead to the termination of his benefits.

02

ADMINISTRATIVE APPEALS

After a successful administrative appeal, Hall's benefits were reinstated. Howerver, this process was not without cost to Hall, who hired an attorney using a contingency-fee agreement.

03

ADDITIONAL CLAIMS

Hall asserted a number of state law claims against MLS including

- Intentional interference with contractual relations, Fraudulent misrepresentation, Unfair or deceptive business practices, and Punitive Damages

04

COURT FINDS

The court overruled MLS' summary judgement motion in full and found that all claims could move forward.

CHOOSING THE CORRECT STANDARD OF REVIEW

DE NOVO

De novo review “is without deference to the decision or any presumption of correctness, based on the record before the administrator.”

ARBITRARY & CAPRICIOUS

“Under [the arbitrary and capricious] standard, [the Court] will uphold the administrator’s decision if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence.”

EVALUATING THE CLAIM DECISION AND PLAN LANGUAGE

The Sixth Circuit has considered both an initial administrative denial, and subsequent denials, in an ERISA claim to determine whether an arbitrary and capricious decision was made.

- Federal courts apply general rules of contract law as part of the federal common law.
- "General principles of contract law dictate that we interpret the provisions according to their plain meaning in an ordinary and popular sense."
- "Any ambiguity in the language of the contract is to be construed in favor of the employee insured in accordance with the principle of *contra proferentum*."
- Which provides that 'ambiguous contract provisions in ERISA-governed insurance contracts should be construed against the drafting party.
- ERISA plan terms are interpreted according to their "plain meaning, in an ordinary and popular sense."
- The court in Spangler v. Lockheed Martin Energy Systems, Inc., criticized the insurer for "cherry-picking" a file, hoping to find a report to support its benefits denial.
- The Supreme Court stated in Glenn II that ERISA requires "higher-than marketplace quality standards" of fiduciaries.
- Insurers must discharge their duties "solely in the interests of the participants and beneficiaries of the plan," and "provide a full and fair review of claim denials."

REMEDIES FOR AN ERISA CLAIMANT

29 U.S.C. § 1132(a)(1)(B) entitles an ERISA claimant to recover benefits under the terms of the Plan as a result of an improper denial of said benefits.

BENEFITS OWED

INTEREST & COSTS

ATTORNEY'S FEES

BRINGING A CLAIM UNDER ERISA
FOR PENALTIES

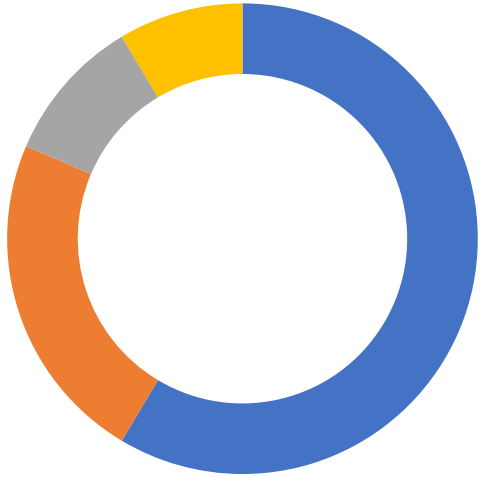
“The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.”

The administrator must provide the information within 30 days and a failure to comply could result in a penalty of up to $100 per day.

SUBROGATION BASICS

"[T]he so-called 'make whole' rule of federal common law . . . requires that an insured be made whole before an insurer can enforce its right to subrogation under ERISA, unless there is a clear contractual provision to the contrary."

The insurer must specify a particular fund, distinct from the claimant's general assets.



The insurer must specifically identify a particular share of that fund to which the insurer is entitled.

THANK YOU

AUSTIN MEHR & BARTLEY HAGERMAN

MEHR, FAIRBANKS & PETERSON, PLLC

201 W SHORT ST, LEXINGTON, KY 40507