§4. A. CLAIMS PROVISIONS, ***New Item (5) Procedures for Review of Claim Determination, Page 40***
§6. OPTIONAL PROVISIONS, ***Item H. Procedures For review of a Denial of a Claim (Proposed Deletion, Pages 64-65***

Item (5) addresses all claim determinations. We are advised that the PSC prefers to include this since it was included in the IDI standards. However, the language was taken from IDI standards Item (11)(b) on pages 18-19 and only addresses facility of payment determinations, and only those where appeals or a resolution is needed – meaning that payment of any indemnity under the policy to an estate or a beneficiary deemed by the company to be equitably entitled to such payment may be challenged, and the company needs to describe how it would do so.

Additionally, there are no specific standards, so is it anticipated that companies may include whatever procedures they want? What standards will the IIPRC examiners use to determine if the language filed is acceptable?

We advise that no other IIPRC product standards address a claim determinations process for a good reason – while one could argue that there is "one process", the process for each claim is determined by the claim specifics such as type of disability involved, type of injury or sickness involved, timelines involved, information required, etc. Initial claim determinations would require a different process than the process required for determination of ongoing claims.

For the reasons stated above, we respectfully oppose the inclusion of this standard.

Sub-section H was reflecting the ERISA requirement which is only applicable to adverse claim determinations, and not all determinations, and the ERISA requirements. The language we proposed made no reference to ERISA and this was intentional**..** This sub-section was included so that employers subject to ERISA can elect to include this in the certificate, or any employer may also do so (raising the bar), which is why ERISA is not mentioned. The other option for employers is to include this in the ERISA required Summary Plan Description (SPD). Employers comply with the SPD requirements in various ways: they may incorporate the SPD requirements in the back of a certificate following the filed provisions, or they may issue a separate SPD to be issued with the certificate. Some employers have elected to include the ERISA claim denial information in the certificate for all employees, which is why the sub-section was located in the Optional Provisions section. By removing this sub-section, the PSC has eliminated the employer options.

As an alternative to including this as an OPTIONAL PROVISION, the PSC may consider including this as a "may" in the Claim provisions section.

While the PSC would like to have the ERISA requirements applied to all employers, the federal law does not require this. It should be noted that the ERISA requirements are quite specific as to what constitutes such determinations. Not all employers are subject to ERISA and they may not want the language included since it is not a requirement for them. This is why the language needs to be optional/variable.

We urge the PSC to reconsider reinstating the deletion and including it in a way that allows the employer and the insurance company to decide what is required/appropriate, as applicable.

§5. REHABILITATION PROVISIONS

Item (2)(a) at bottom of page 53

The PSC has added a leading sentence to (2) which presumes that rehabilitation benefits will be provided, so (2)(a) should just say:

"The certificate shall specify which rehabilitation services are offered by or through the insurance company."

This language is consistent with item (1).

Item (2) (b) and (d) on page 54

In the last sentence of (b) and the second sentence of (d), we are concerned about the reference to "any expenses". If a company has a rehabilitation plan that requires a Covered Person to complete an Excel training course, the company would typically pay for course tuition, but would not pay for mileage, meals, paper, pens, etc. If a company had a rehabilitation plan requiring a Covered Person to apply for a certain number of jobs per week, the company would pay for the job coach to help draft a resume, but would not pay the internet access costs, or printer ink and postage costs for submitting the resumes. We believe that these are "diminimus" expenses that should not justify classifying a rehabilitation plan as "voluntary".

We believe that some type of a "qualifier" is needed for "any expenses". We could add an out of pocket dollar maximum for the Covered Person as a delineator for "voluntary", but it would be difficult to set an amount that would be fair/appropriate for each Covered Person, and the maximum would apply for each plan component? Monthly? For the entire plan?

We respectfully request that the PSC consider this issue further.

Item (2) (d) on page 54, "treating physician"

We respectfully advise that companies cannot agree to be bound by the opinion of the Covered Person's treating physician. Companies want and need the ability to determine good cause like they determine any other medical issue relating to disability. While the treating physician's opinion would certainly be considered, it cannot be binding on the company. If a company reaches a contrary conclusion, it will explain why it disagrees with the treating physician and give the physician the opportunity to appeal.

§6. OPTIONAL PROVISIONS

C. AUTHORITY, Item (1), Page 56-57

While we understand what the PSC intended with "the initial", we respectfully point out that with regard to any disability, companies would be making initial ***and periodic ongoing*** determinations for the disability for the duration of the disability. As proposed, the language could and will be interpreted by others to mean that a policyholder does not have the right to delegate "periodic ongoing" determinations. Additionally, we believe that the process of making a determination may, and often does, require an interpretation of the terms of the policy and certificate.

We request consideration of the following substitute language:

"The policy and certificate…….the insurance company reserves the right to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the policy and certificate for the purpose of administering the terms of the policy and certificate."

J. SUBROGATION RIGHTS, Item (1), Pages 65-67

We have no issues with the addition of "applicable laws" since we agree that any subrogation would be subject to state laws for any right of recovery. That being the case, we presume that "deducting anticipated recovery" is also addressed by such state recovery laws, and our preference is that, if this sentence is needed, the language be changed to say:

"The insurance company may only deduct anticipated recovery from a third party from benefits paid to a Covered Person if applicable law in the state where the policy is issued for delivery permit such deduction."