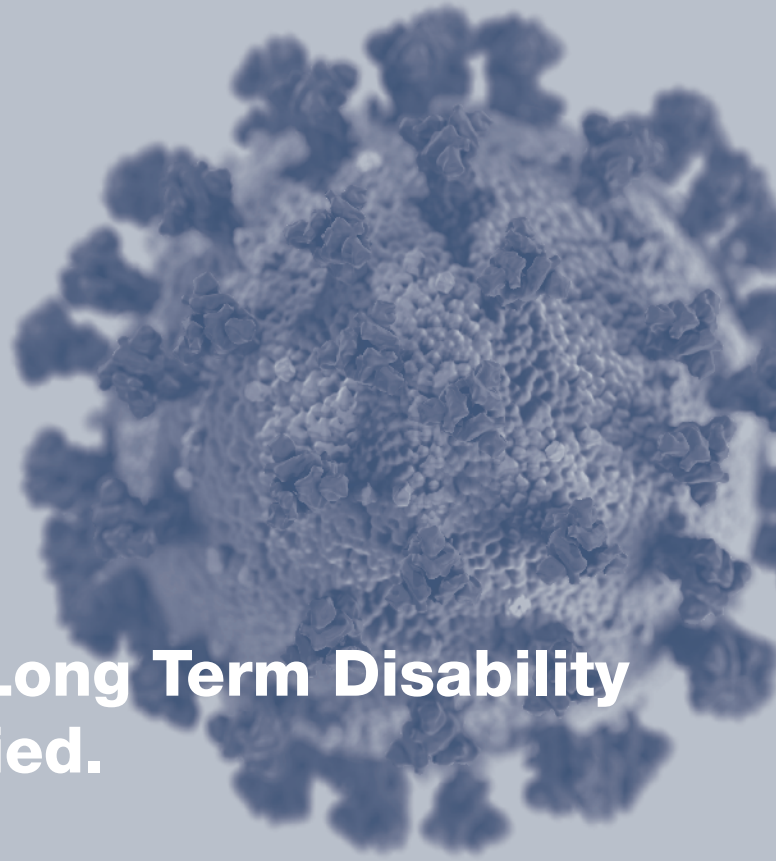


COVID-19 Insurance Denial Guidebook



What to do When Your Long Term Disability
Insurance Claim is Denied.

This information is provided to you by the attorneys at



Kantor & Kantor, LLP is one of the most experienced and highly respected law firms in the nation dealing with litigating insurance claims against insurance companies. Our firm also has extensive experience with the complex appeals procedure and federal court litigation of ERISA matters.

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WHY WE ARE PROVIDING THIS INFORMATION

I am immunosuppressed, and my doctor tells me it is physically unsafe for me to return to my workplace due to the risk of becoming infected with COVID? Is that a covered disability?

This is a question we have received from multiple insureds since COVID-19 rapidly changed our world. We anticipate this will be the first of several questions about COVID-19 and its implications in long-term disability insurance.

This question has no definitive answer. It will depend largely on the nature of their pre-existing physical condition, whether their employment can be modified, and the terms of their policies. Barring policy terms to the contrary, we would contend that if they need to go out into public to perform their occupation, and they have a condition which would greatly increase their risk of serious illness or death if they were to become infected by COVID-19, then they would be entitled to receive group or individual disability benefits.

Just having a diagnosis of a serious condition is not enough to demonstrate disability. There are many conditions which are sometimes disabling, and other times not. Good examples are lupus and multiple sclerosis. These conditions can cause symptoms which render someone unable to perform the material and substantial duties of their occupation with reasonable continuity. If an individual with one of these conditions has such symptoms, then an insurance company or claims administrator (which we will refer to as “administrator” in this guidebook) should find them disabled. However, there are many people with these conditions where the symptomology is mild, and they can work. An administrator would find that these people are not disabled.

For a medical condition to be considered disabling, it must result in symptoms which cause “restrictions” and “limitations.” Restrictions are things an insured cannot do as they will harm the insured. Limitations are things the insured is physically or mentally unable to do. For example, an individual with a serious cardiac condition might be physically able to perform a high stress job but doing so might greatly increase the likelihood of a heart attack or stroke. The cardiac condition is not a limitation, as they are physically able to perform the job, but they should not do so due to the risk of a heart attack. They are restricted from performing the occupation. In disability parlance, this is known as a “risk of relapse.”

COVID-19 can theoretically infect anyone, and arguably anyone has a risk of going out in public and catching the illness. However, the average person, even one with a fear of catching COVID-19, is unlikely to be considered disabled due to the fact of the possibility of becoming infected.

But consider people with lupus or multiple sclerosis. They are likely to be immunosuppressed, have a higher likelihood of becoming infected, and have a higher risk of serious side effects or even death if they become infected. If someone with lupus or multiple sclerosis also has a job which cannot be done from home, for example, an Emergency Room Physician, we would take the position that such a person is entitled to disability benefits.

Realizing that the answer to this question would likely lead to more questions, the lawyers at our firm put together an outline of what to expect when filing a long-term disability claim.

Please use the following as a guide to the disability insurance claims and disability process. We know that COVID-19 is complex enough; we hope we can simplify at least some parts of a person’s life. The more information you have and the more prepared you are, the stronger your fight for the benefits you deserve.



LONG-TERM HEALTH AND DISABILITY DUE TO CORONAVIRUS DISEASE 2019 (COVID-19)



To strengthen our effort to bring people as much information as we can, we asked Dr. Sarah Lowenthal to prepare a report to show us what the medical community has learned about the long-term health effects and potential disability associated with COVID. The research in this guide is current as of July 2020. Developments in this area are rapidly growing.

Dr. Lowenthal's report breaks down what she has found so far and what we may expect to come. She has separated the conditions into categories according to their severity:

1. Severe
2. Mild to Moderate
3. Asymptomatic
4. Persistent Positive (which holds the potential for long-term damage to individual and community well-being)

We will start this guidebook with the medical and health related information, to lay the groundwork for the legal information to follow.

Long-Term Conditions After Severe COVID-19 Disease

Severe COVID-19 causes severe dyspnea (shortness of breath), hypoxemia (low oxygen) and usually involves large areas of lung involvement (>50%). Severe COVID-19 mandates hospitalization, often in the intensive care unit (ICU). It can occur in otherwise healthy individuals but predominantly occurs in adults with advanced age and underlying medical comorbidities including Type 2 diabetes, serious heart conditions, obesity, COPD, cancer, immunocompromised states, sickle cell disease and chronic kidney disease. Other potential risk factors include smoking, HIV, asthma, and more.

Severe disease has the potential to cause enduring symptoms long after discharge from the hospital. The variety of long-term health problems are due not only to the underlying disease process but also to the consequences of prolonged hospitalization and intensive care. Some of these long-term outcomes include:

Pulmonary Conditions

Acute Respiratory Distress Syndrome (ARDS)

Acute Respiratory Distress Syndrome (ARDS), the type of respiratory failure seen in COVID-19 disease characterized by a rapid onset, widespread inflammatory condition usually requiring mechanical ventilation and extended treatment in the ICU. In the case of COVID-19, the ARDS can be particularly difficult to treat, requiring weeks of mechanical ventilation and many patients do not survive.

If patients do survive ARDS and go on to be discharged from the hospital, they often have long-term consequences including memory loss, cognitive problems, depression, pulmonary compromise, and impaired quality of life and global functioning. In one important study, these impairments lasted years and required a gradual transition to work, a modified work schedule, or job retraining in collaboration with third-party private insurers. Even young, previously healthy individuals with few coexisting illnesses who develop ARDS may not recover completely and may have ongoing functional limitations as mentioned above.

Long-Term Respiratory Compromise

While we do not yet have data regarding the long-term impairment from SARS CoV2 (COVID-19), studies from SARS CoV1 (SARS 2003) inform the likelihood of long-term lung damage and functional impairment lasting for years after initial infection. Specifically, pulmonary fibrosis seen on CT scan as well as respiratory compromise measured by pulmonary function testing were noted in some cases of SARS for up to 15 years after the initial infection.

Additionally, there is emerging data to suggest the potential for ongoing respiratory compromise after severe COVID-19. In a recent study of 179 patients hospitalized for COVID-19 87.4% reported persistence of at least one symptom, particularly fatigue and shortness of breath at 60 days after acute infection.



Post-Intensive Care Syndrome (PICS)

Post-intensive care syndrome (PICS) is defined as new or worsening cognitive, psychiatric, or physical function after a critical illness. PICS is frequently associated with the inability to return to work and decreased quality of life as well as an increased risk of death over the subsequent few years.

PICS can occur after intensive care for ARDS as well as other COVID-19 related conditions requiring ICU care. While the signs and symptoms of PICS improve modestly over the first 6 to 12 months following discharge from the intensive care unit (ICU), many patients continue to suffer deficits for years. Although cognitive function due to PICS may improve over the first 6 to 12 months, the vast majority of improvements are small, and the impairment persists for years.

Impaired cognition due to PICS is particularly associated with psychiatric impairment, the inability to return to work, and decreased quality of life. Psychiatric outcomes of critical illness may also improve but typically persists for years. While most studies report persistent anxiety and depressive symptoms at 12 months, some observational studies report symptoms of post-traumatic stress disorder (PTSD) lasting for up to eight years.

Compared to the other domains of PICS, physical dysfunction following critical illness (e.g. weakness, poor mobility, falls) is more likely to improve particularly over the first 12 months. However, some patients, especially those suffering from weakness in arms and/or legs may have more persistent impairment in activities of daily living (ADL's).

Neurologic Conditions

Neurologic complications occur in up to one half of hospitalized COVID-19 patients. Some of these include encephalopathy (brain disease causing brain damage or malfunction), stroke, Guillain-Barre syndrome, seizures, headaches, dizziness, smell and taste disorders and others. All of these complications have the potential to cause long-term neurologic disability, with encephalopathy and stroke being two of the most devastating.

Encephalopathy

Encephalopathy is common in critically ill patients and can be seen in up to two-thirds of patients who develop ARDS. In the short term, patients with COVID-19 encephalopathy often develop delirium, agitation, somnolence, and decreased consciousness. The cause of encephalopathy is thought to be “multifactorial” involving hypoxemia (low oxygenation), metabolic due to organ failure and medication related.

Encephalopathy due to other disease processes (e.g. hepatic/liver failure related) is known to cause persistent deficits in working memory, response inhibition and learning. While the long-term neurologic prognosis of patients with encephalopathy and COVID-19 remains to be elucidated, one series reports that one-third of such patients are impaired at the time of hospital discharge.

It is also important to note that MRI studies are beginning to document underlying brain changes seen

in COVID-19 encephalopathy that cannot be explained by an alternative diagnosis.

Stroke Occurring with COVID-19

Stroke appears to be relatively infrequent in the setting of COVID-19¹⁴ but can have devastating long-term consequences. The risk of stroke varies with severity of illness with the risk being as low as <1% in mild disease and up to 6% in severe disease. Limited data suggest that ischemic stroke associated with COVID-19 occurs primarily in older patients with vascular risk factors. However, there have been case reports of young patients, often without traditional risk factors, experiencing large vessel occlusive stroke.

There is significant heterogeneity in terms of the types of strokes seen related to COVID-19 which has led investigators to believe that COVID-19 associated stroke is due to non-specific effects of inflammation, blood clotting and vessel damage sometimes superimposed on pre-existing risk factors.

As with all strokes, there are variable long-term complications depending on the extent and location of the stroke. Some of these most significant include partial or full paralysis, speech difficulty and cognitive impairment. Also, of note, there is a known syndrome of “poststroke depression” which appears to have a prevalence of 16-21%, can last for years after the acute stroke, and is associated with poor functional outcomes.

Psychiatric Conditions

There is currently limited data regarding the long-term psychiatric conditions seen in patients who are critically ill with COVID-19. However, based on studies of previous coronavirus epidemics clinicians anticipate that patients who are hospitalized and recover will suffer persistent psychiatric symptoms and disorders.

As an example, one large systematic review (1963 studies, n>3000 patients) examined patients who were hospitalized with severe acute respiratory syndrome (SARS) or Middle East respiratory syndrome (MERS). At hospital discharge one-third of patients suffered from “dysexecutive syndrome”, disruption of executive function which is closely related to frontal lobe damage and encompasses cognitive, emotional, and behavioral symptoms. At 3 to 46 months after recovery, the most prevalent outcomes of other psychiatric conditions were the following:

- Posttraumatic Stress Disorder (PTSD) - 32%
- Depressive Disorders - 15%
- Anxiety Disorders - 15%

The same review also examined psychiatric symptoms at follow-up ranging from 2 months to 12 years after recovery. The most common symptom was frequent recall of traumatic memories, which occurred in 30 percent of patients. Other relatively common symptoms included anxiety, depressed mood, fatigue, irritability, and insomnia, as well as impairment of attention, concentration, and memory. In addition, social functioning and role functioning were each impaired among survivors, compared with the general population. Longer-term psychiatric outcomes also included stigma from health care

professionals, families and friends, and the general public.

While much of what is known about long-term psychiatric effects of coronaviruses comes from prior epidemics, it is reasonable to predict that the prevalence of persistent psychiatric symptoms may be similar if not worse with COVID-19 given the social disruption and economic crisis associated with this pandemic.

Cardiovascular Conditions

Some of the immediate cardiovascular complications of severe COVID-19 include arrhythmias, acute cardiac injury and shock. These cardiac complications can cause long-term health problems due to the effects of inadequate blood circulation including but not limited to stroke, limb compromise and organ damage. Additionally, it has been shown that up to one-third of patients with COVID-19 who are admitted to the ICU in the United States develop cardiomyopathy, a disease of the heart muscle which can permanently damage the structure and long-term function of the heart.

Vascular Conditions

“Post Thrombotic Syndrome” (PTS): COVID-19 is associated with increased blood clotting leading to deep vein thrombosis and other acute issues related to blood clotting and bleeding. One syndrome that can cause long term disability is Post Thrombotic Syndrome (PTS) following a deep vein thrombosis (DVT) causing long-term symptoms such as swelling, pain, discoloration, and in severe cases, scaling or ulcers in the affected part of the body.



PERSISTENT SYMPTOMS IN MILD TO MODERATE COVID-19 DISEASE

Mild COVID-19 disease is characterized by fever, generalized malaise, cough, upper respiratory symptoms and/or less common features of COVID-19, in the absence of shortness of breath. Most of these patients do not need hospitalization and can recover at home. Moderate COVID-19 is characterized by the same symptoms but with shortness of breath. Patients with moderate COVID-19 can sometimes have findings on chest x-ray and often warrant hospitalization but they are able to maintain oxygen levels at or above 94% and do not require supplemental oxygen or ventilation.

“ Long-Haulers ”

The term “long-hauler” first came to popular attention in Ed Young’s article in *The Atlantic* , “*COVID-19 Can Last for Several Months*”. It has been used to describe individuals who are initially diagnosed with “mild” disease but go on to struggle with “relentless and rolling waves of symptoms” that made it hard to perform simple tasks, some for months after their initial infection. Some of the symptoms described by long-haulers include chronic cough, debilitating fatigue, intermittent fevers, prolonged loss of taste or smell, “brain fog”, memory loss and chronic joint pain. Support groups on Slack and Facebook host tens of thousands of people who describe these symptoms. Young notes that one of the barriers to understanding these smoldering COVID-19 syndromes is that they have been excluded from the typical dashboards which only track new cases, hospitalizations and death rates but leave out this important cohort.

In order to address that deficiency, one group of long-haulers with symptoms >30 days is now conducting its own survey which reflects a “snapshot” of their experience. While not peer-reviewed, some of the survey’s findings show that 40% are between the ages of 30-49, 56% have never been hospitalized and 50% have never been tested either because they became ill when there was a shortage of tests or they were denied testing because they lacked the typical symptoms of cough, shortness of breath and fever. Some long-haulers tested negative but are still assumed to have the disease given the consistency of their symptoms with those who tested positive as well as the high false negative rate of some tests (up to 30% 45). In his interviews with long-haulers Young described some of the psychological consequences these individuals face including isolation due to fear and stigma from family and friends, as well as disbelief from medical providers and others. Moreover, some have been disallowed to return to work due to intermittent fevers.

A large study from the Netherlands supports the experience of long-haulers. That study which included 1622 COVID patients, 91% not hospitalized (mild disease) and with an average age of 53 showed that nearly 88% of patients reported persistent intense fatigue, while almost three out of four had continued shortness of breath. Other enduring symptoms included, among other things, chest pressure (45% of patients), headache and muscle ache (40% and 36%, respectively), elevated pulse (30%), and dizziness (29%). As Forbes Magazine author, Joshua Cohen, put it, “Perhaps the most startling finding was that 85% of the surveyed patients considered themselves healthy prior to getting COVID-19. One or more months after getting the disease, only 6% consider themselves healthy.”

At UCSF Medicine Grand Rounds on June 18, 2020 the chair of the department interviewed several physician faculty members who themselves had contracted COVID-19 and are now long-haulers. In that presentation, one physician described having persistent memory issues, having to re-learn how to use his computer and “feeling like he had a stroke”. Another female physician described persistent phantosmia (smelling first fires and stale cigarettes) as well as ageusia (loss of taste) and anosmia (loss of smell) that still persists months after her initial infection. She has also had persistently positive COVID-19 tests nasal PCR tests which have prevented her from engaging in direct clinical work.

Dr. Michael Pelusa of UCSF is currently conducting a study called “Long-Term Impact of Infection with Novel Coronavirus ” (LIINC). It is a large cross departmental study which enrolls people who are recovering (weeks to months) and have been referred by a clinician. So far they have collected very robust data with thousands of specimens banked looking at sequelae in multiple sub-specialties. So far they have discovered that while most people recover from COVID-19, there is definitely a cohort with persistent or recurrent symptoms. From their preliminary findings, at 1-3 months out from acute illness people report experiencing trouble with concentration and memory that is interfering with their jobs and quality of life. They have also found trends of dramatically prolonged gastrointestinal symptoms (months of nausea and diarrhea, significant weight loss), intermittent disruptive bone pain and further reports of a persistent fire smell. These protracted symptoms don’t seem to affect a specific cohort in terms of age, gender or sexual orientation. Dr. Pelusa reported that even previously healthy, young individuals were experiencing long-term symptoms, even “world class athletes.” The results of LIINC will shed important light on the long-term impact of COVID-19.

“ Post-COVID Syndrome ”

Many symptoms experienced by COVID-19 long-haulers are similar to the symptoms experienced by patients with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS). Following infection with SARS in 2003 some patients, many of whom were healthcare workers, went on to develop a ME/CFS, with some being unable to work for nearly a year. Post-mortem SARS research done at the time indicated that the virus crossed the blood-brain barrier and disturbed the lymphatic drainage system of the brain causing a build-up of inflammatory agents. This build-up in the central nervous system has been thought to lead to autonomic dysfunction which underlies many of the symptoms of ME/CFS. This same process has been proposed to be occurring in the brains of patients with COVID-19 causing them to develop a “Post COVID-19” syndrome closely resembling ME/CFS.

POTENTIAL LONG-TERM IMPLICATIONS OF ASYMPTOMATIC INFECTION

Asymptomatic infections have been well documented. At the writing of this review, the proportion of asymptomatic carriers has not been well studied. One literature review estimated that it is as high as 30 to 40 percent, based on data from three large cohorts that identified cases through population-based testing.

In terms of long-term impact, what is important to know about asymptomatic infection is that even patients who are asymptomatic can have objective findings of organ involvement. As an example of this, in a study of 24 patients with asymptomatic infection who underwent chest CT, 50% had the typical findings seen in COVID-19 (“ground-glass” opacities) and another 20% had other chest CT abnormalities. That there is evidence of organ involvement in asymptomatic infection leads to the question of whether these individuals will go on to develop long-term damage even without an initial symptomatic infection.

POTENTIAL LONG-TERM IMPLICATIONS OF PERSISTENT POSITIVITY

Patients diagnosed with COVID-19 can have positive nasal PCR tests for weeks after the onset of symptoms. Recurrently positive tests following several negative tests have also been well documented in some patients. Studies have suggested that repeat positive nucleic acid tests soon after convalescence from COVID-19 do not represent reinfection. However, currently the understanding of this phenomenon remains incomplete, and the possibility of early reinfection has not been ruled out.

There are significant social, financial, and psychological consequences of recurrent positive tests including exclusion from work and social events, stigmatization, and isolation. A better understanding of persistent positive tests is urgently needed to help mitigate the potential long-term damage to individuals, families, and communities due to this condition.

CONCLUSION

There is much left to be learned about the potential long-term effects of COVID-19. However, early scientific, and anecdotal information, as well as experience with other coronaviruses point to the breadth and depth of potential health problems and disability following infection with SARS CoV2.

Now that we have provided medical and healthcare intelligence and perspective, we will cover key elements that individuals, their families, and caregivers need to know when their long-term disability insurance benefits are denied.



What Is Long-Term Disability Insurance?

Long-term disability (LTD) insurance protects an employee from loss of income in the event that he or she is unable to work due to illness, injury, or accident for a long period of time.

Long-Term Disability Insurance Plan Coverage

The terms of LTD policies will vary depending on the employer (if one received the coverage through employment), the insurance company or funding source, and whether the policy is a group or individual policy.

Many LTD policies will have two definitions of Disability or Disabled, Partial Disability or Total Disability. In general, the definitions will be something along the lines of:

- (example) **PARTIAL DISABILITY** or **PARTIALLY DISABLED** means the Insured Person is not Totally Disabled and that while actually working in his or her Own Occupation, as a result of Sickness or Injury, the Insured Person is unable to earn 80% or more of his or her Basic Weekly Earnings.
- (example) **TOTAL DISABILITY** or **TOTALLY DISABLED** means that as a result of an Injury or Sickness the Insured Person is unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue his or her Own Occupation and is not working in his or her Own Occupation.

Many policies define disability or disabled as an inability to perform not just your “own occupation” but “any occupation.” In general, but not always, most policies say that for the first 12 or 24 months after making a claim, you only need to prove that you are disabled from performing your own job. However, beyond this time, you must prove that you are disabled from working at any reasonable job.

LTD policies often contain conditions for payout, including exclusions (i.e., disabilities which are

not covered) and limitations (i.e., disabilities payable for only a limited period). The most common limitations are for disabilities caused by mental or nervous conditions and drug or alcohol abuse. Some policies may limit or exclude disabilities based on musculoskeletal disorders or Chronic Fatigue Syndrome. This is important where the budding research shows that COVID-19 may lead to long term symptoms like Chronic Fatigue Syndrome.

LTD Offsets

Nearly all LTD policies have provisions for offsets—that is, the benefit is reduced by payments from other sources. The most common offsets are Workers' Compensation benefits, State Disability Insurance payments, and Social Security Disability Insurance payments.

Some LTD policies will provide a minimum benefit amount. In the event other benefits exceed the LTD benefit payable, the employee will still be entitled to the minimum payment. These payments vary but may be as low as \$50 per month to as high as 10-15% of the gross benefit payable.

Elimination Period

LTD policies will contain a waiting period, or what is referred to as an “elimination period.” This is how long an insured must be disabled under the terms of the policy before benefits become payable. This waiting period varies and can be anywhere from 60 days up to a year. We mostly see LTD policies with 180-day waiting periods.

Maximum LTD Benefit Date

LTD benefits are not payable forever even if the employee remains disabled for the rest of her life. Typically, LTD benefits will cease either upon the employee reaching age 65 or her Social Security retirement age. If an insured becomes disabled after age 60, many LTD policies will provide a set number of months that the insured can collect benefits.

Now that we know the basics of LTD insurance, we want to explain the laws and the legal rules that govern these insurance plans or policies.

Two Legal Frameworks: ERISA and Non-ERISA

There are two very different sets of legal rules that govern claims for LTD benefits. Some claims are governed by federal law, and some are governed by state law. It is important to know the difference because it affects the way your claim is handled by the administrator and the way courts look at your case if you have to file a lawsuit.

How do you know which law governs your insurance or disability plan? Generally, if you purchased your insurance independently from an agent or broker, your claim is governed by traditional state insurance laws. However, if, like most people, you have insurance coverage through your employer—even if you pay for some of the premiums through payroll deductions—your claim is likely governed

by a federal law called **ERISA**, which stands for the **Employee Retirement Income Security Act of 1974**.

What is ERISA?

ERISA was passed by Congress in 1974 in response to several highly publicized failures by employers to pay pensions they promised to their employees. ERISA is not limited just to pensions, however. ERISA applies to many benefits you might receive as part of your employment. This includes health insurance, disability insurance, life insurance, severance plans, or retirement plans. ERISA does not require employers to establish any of these plans, but it does impose rules on how those plans must be administered once they are created.

ERISA has a very broad “preemption clause,” which means that ERISA overrides any state or local law that relates to an employee benefit plan. The idea is that employers across the country can establish benefit plans for their employees and know that their plans will be subject to a uniform set of federal rules.

Exceptions to ERISA

Of course, as with any legal rule, there are exceptions to ERISA’s sweeping coverage. Here are some of the biggest examples of employee plans that are **not** governed by ERISA (although some of these plans can “opt in” to ERISA if they choose):

- Government plans. This includes any plan established by the federal government, a state government, or any subdivision such as a county or city, or any agency of any of these government entities.
- Church plans. Church plans include plans that not only cover employees of a religious organization, but also employees of a church-*affiliated* organization. This is a bigger exception than you might think, as it can cover schools, charities, and even hospitals that have a religious connection.
- Plans that fall under ERISA’s “safe harbor” provision. An employer can avoid ERISA by creating a plan in which it has limited involvement. To create such a plan, the employer must not make any contributions, employee participation must be voluntary, the employer must not endorse the arrangement or receive any consideration for the arrangement, and its participation must be limited to allowing the insurer to publicize the program and collect premiums through payroll deductions.
- Payroll practices. Payments to an employee *out of a company’s general assets* for periods of time when the employee is unable to perform his or her job or is absent for medical reasons are not governed by ERISA. A classic example of this is paid time off (PTO) for being sick or on vacation. Once a company sets up a separate fund or insurance policy to pay benefits, however, ERISA will likely apply.

- Business owners. ERISA was designed to protect employees. Thus, a benefit plan created by a sole proprietor of a business is not governed by ERISA. However, as soon as the proprietor hires an employee who is covered by the plan, the plan will become covered by ERISA.

State Laws Can Sometimes Apply Even in ERISA Cases

Even if ERISA applies, other laws may still apply. For example, ERISA provides that state insurance, banking, or securities laws, generally applicable criminal laws, and certain domestic relations orders are not preempted by ERISA.

The most important state laws that are not preempted are insurance laws. Many states have laws that are designed to protect consumers from unfair insurance practices, and these protections can still apply even in cases governed by ERISA.

However, for state insurance laws to apply in ERISA cases there must be an actual insurance policy funding the benefits at issue. If a company pays plan benefits itself without purchasing a group insurance policy, the plan is called “self-funded.” State insurance laws do not apply to self-funded plans. (This rule arises from ERISA’s “deemer clause,” which says that states cannot evade ERISA by “deeming” a self-funded plan to be in the business of insurance when there is no insurance policy in place.)

Even if ERISA allows for the application of a state law, if the law conflicts with any of ERISA’s provisions, ERISA will still override it. For example, if a state insurance law allows a beneficiary to sue for “bad faith” or punitive damages, this will not be permitted in a case governed by ERISA because ERISA has specific remedies that do not include these types of claims or damages.

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A federal judge once joked that ERISA stands for “Everything Ridiculous Imagined Since Adam.” Nevertheless, it is important to know if ERISA governs your benefit claim because there are serious legal implications if it does.

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How ERISA Affects Your Legal Rights

As you can see, ERISA can be quite complicated. A federal judge once joked that ERISA stands for “Everything Ridiculous Imagined Since Adam.” Nevertheless, it is important to know if ERISA governs

your benefit claim because there are serious legal implications if it does. Some of those implications are:

- Your case will be heard in federal court, not state court. This will make it more difficult for you to find an attorney, because many attorneys do not have experience in federal court and are reluctant to practice there.
- Your remedies are limited to those explicitly allowed by ERISA. As mentioned above, you cannot recover any emotional distress damages, punitive damages, or sue your insurer for bad faith like you might be able to if your case was governed by state insurance laws. Typically, the only damages you can get under ERISA are the benefits you should have been paid in the first place. As you might imagine, this does not create an incentive for an administrator to do the right thing at the outset because there is no punishment for doing the wrong thing. It also makes hiring an attorney more difficult, because while attorney's fees can be awarded under ERISA, they are not guaranteed, and there is no chance at a big windfall verdict.
- You do not have the right to have your case heard by a jury. Instead, your case will be heard solely by a federal judge who will make the ultimate decision as to whether you are entitled to benefits. If your case is assigned to a judge who is skeptical of insurance claimants, you will be facing an uphill battle from the very start of your case.
- The facts that the judge can consider at trial are limited. Usually the judge will only review what is called the "administrative record," which consists of the documents that the administrator had at the time it denied your claim. For this reason, judges are reluctant to allow plaintiffs in ERISA cases to conduct discovery to bolster their claims. Because of this rule, it is very important during the claim process to give the administrator all the records, documents, and other evidence you might have that support your claim. If you do not, you probably will not be allowed to use it in court later.
- In ERISA cases the insurer can get deferential review from the court. If the benefit plan gives the administrator "discretionary authority" to determine benefit eligibility or to interpret the plan, the judge will not overturn the decision unless it was unreasonable. There have been cases where the judge felt that the denial of benefits was wrong, but let it stand because of the deference granted by the plan language. Some states have fought back against this rule and passed laws prohibiting discretionary language in insurance policies. However, many states have not, and none of these laws apply to self-funded plans.

As you can see, these ERISA-specific rules can be problematic for beneficiaries. It is ironic that a law designed to protect benefit plan participants very often works to their detriment, but that is the system we have. Of course, administrators are aware of these rules, and it affects the way they handle claims. They are more likely to deny claims because they know the deck is stacked against claimants if they ever try to challenge the denial in court.

As we continue through the process, we will look at what goes into submitting a claim.

Submitting a Claim

The process for submitting a claim for LTD benefits can seem confusing, time-consuming, and sometimes daunting. Here are some helpful tips to guide you through the process for how to submit your claim.

Step One: Obtain Copies of Your Policy or Plan

- Your policy is where you will find all the rules and information to submit your claim. You should request your LTD policy **in writing** so that you have proof of making the request. Note: we recommend that you send your request with a form of tracking, including certified USPS letter, UPS, FedEx, email, or fax.
- If you have LTD disability benefits through your employer, you should be able to request a copy of your LTD policy from your human resources department, but the request should be addressed to the Plan Administrator.
- If you have disability benefits through a policy you purchased on your own, you should contact the insurance company to get a copy of your policy.

PRO TIP: GET AHEAD: If you can, or if someone can help you, now is a good time to start a written timeline and symptom journal so you can know where you are in your personal case at any time. Keeping this up to date will help you through what could be a very confusing process. Additionally, keeping track of your symptoms in a journal will help you when you see your doctor. For example, if you are disabled because of post-COVID gastrointestinal issues like diarrhea, when your doctor asks you about your symptoms, you can refer to your symptom journal and rely on exact information about how many times you had diarrhea.

Step Two: Read Your Policy

- One of the most important items to look for within your policy is anything that mentions a **Time Limit** related to filing a claim. **Time Limits are deadlines that you should not ignore.**

Step Three: Look To See If There Are Any Exclusions and Limitations

- Disability policies often exclude benefit coverage for “pre-existing conditions.” In general, a pre-existing condition is a condition for which you had any sort of treatment, including medication treatment, within a specified timeframe prior to becoming eligible for LTD coverage. Additionally, benefit coverage is often limited and/or excluded if you are disabled due to substance abuse or a mental health condition.

Step Four: Make Sure You Have Satisfied Any Waiting Periods

- Most policies have what is referred to as an Elimination Period. We talked about this above, but an elimination period means that there is a waiting period from the time you become disabled to the time when you start receiving benefit payments. You should file your claim as soon as possible upon becoming disabled, just be aware benefits will not be paid until you are disabled during the entire elimination period.

Step Five: Submit Your Claim With Supportive Documentation

- The claim application itself generally consists of several parts that will be supplied to you by your employer or administrator:
 1. Employee's Statement (claimant statement/personal statement)
 2. Employer's Statement (if your policy is governed by ERISA)
 3. Attending Physician's Statement (APS)
 4. Miscellaneous Questionnaires and Releases

You are responsible for completing the Employee Statement and questionnaires, your employer (generally your HR department) is responsible for completing the Employer's Statement, and your doctor needs to complete the APS.

- After you get the forms completed, **you are not yet ready to submit your claim.** Why? Because there are many other additional items that you should gather and submit with your claim so that your claim is as strong as possible. It is your job to prove you are disabled and you may submit any evidence that will support your claim—you are not limited to what the insurance company tells you that you may submit. We suggest the following:
 - Submit a journal of your symptoms and conditions.
 - Submit statements from your supervisor, co-worker(s) and/or subordinates, caretaker, family, and friends. It is helpful for their statement to include things such as: *how long have they known you and what is their relationship to you; their observations of your demeanor and activity level prior to getting sick/becoming disabled; their observations of your deteriorating condition(s) and any restrictions/limitations your condition(s) has placed on your activity level and ability to work; and your motivation to return to work.*
 - Submit an up-to-date and detailed job description.
 - Submit all medical records that support your diagnosis and your disabling symptoms and condition(s).
 - Submit copies of any benefit award letters that you received from other disability benefit sources.
 - Submit articles that explain your condition(s) and/or medications you are prescribed.
 - Submit as much information that explains your symptoms and conditions and how they disable you from working.

PRO TIP: KNOW WHAT'S IN YOUR MEDICAL RECORDS: Along the way, ask to see how your doctor is documenting your symptoms and conditions. If you see inaccuracies, ask your doctor to amend your record before you submit it to the insurance company

PRO TIP: GET THE RIGHT TREATMENT: We cannot stress enough how important it is to have your doctor on your side. You will see later in this guide that there are doctors who are paid by the insurance companies to review your claim. Your doctor should be qualified to be treating you for your condition. Also, if your doctor recommends certain testing or imaging (e.g., x-rays, MRIs) or refers you to a specialist, make sure to follow through on those recommendations.

PRO TIP: CONFIDE IN YOUR DOCTOR: Please tell your doctor the whole truth about every symptom you suffer—even if it feels embarrassing. Your doctor’s notes (your medical records) are going to be heavily relied upon when the insurance company reviews your claim. A few things to remember when you see your doctor: bring your symptom journal to their office; remember to mention any medication reactions you are having; do not miss your appointments (unless you call and explain why you missed); and follow your doctor’s advice.

Your Claim: Pitfalls to Avoid

Over the years we have seen situations where things have gone wrong with claims. Fortunately, many of the things that have gone wrong are correctable. Here are some common pitfalls to avoid:

“*Sometimes you cannot avoid speaking with an insurance company representative, and you should never ignore their calls.*”

Pitfall #1: Verbally Communicating with the Insurance Company

Sometimes you cannot avoid speaking with an insurance company representative, and you should never ignore their calls. However, the preferred method for communicating with them is always in writing. Therefore, if you do engage in any telephonic communication, confirm the conversation in writing afterwards. Your confirmation does not need to be elaborate—you can send a simple and brief note, it can even be hand-written, but make sure the note confirms:

- Date and time of call
- Name of person you spoke to
- Summary of the call

Also, within your letter, give the insurance company an opportunity to respond. You can write something along the lines of, “Please confirm, within 10 days from the date of this letter, that Insurance Company Name concurs with what I have summarized herein about my call with Insurance Company Representative Name.”

PRO TIP: TRACK YOUR MAILINGS: Remember to send all communications via a trackable method such as USPS Certified Mail, UPS, FedEx, or fax.

Pitfall #2: Overstating Your Restrictions and Limitations

Your claim is based largely on your perceived credibility, so remember to keep that in mind when you report your symptoms and conditions and the effect they have on your ability to work. By not exaggerating or overstating your symptoms, you will protect your credibility, in large part because you will not appear to be a fraud or malingerer. Here are a few additional things to think about when it comes to protecting your credibility:

- Never say never, always avoid saying always. For example: “I never go anywhere because of my pain. I am always at home because of my pain.” The words “never” and “always” can be problematic because most people eventually leave their house at some point to attend a doctor’s appointment. Do you ever go to the grocery store? Do you walk down your front steps to take your dog outside? Do you go to get your hair cut? Those are things that make “never” and “always” words to avoid. A better way to report your symptoms is something along the lines of:
“I am rarely able to go out of my house because of my pain. I do sometimes have a “good day” when my pain is less than 8 of 10, and on those days, I try to get things done, such as grocery shopping or attending doctor appointments. Even on a good day, I am still in pain and I would rather be home lying down than trying to move around the world in pain.”
- By avoiding the words “always” and “never,” you will protect your credibility.
- **Answer all questions honestly.** “Honesty is the best policy” is an adage for a reason and it certainly applies to your claim. This is an exception to the above bullet point because we advise: it is always best to always be honest!
- **Assume you will be surveilled.** It is not fun to think that someone is watching you and/or videotaping you, but you need to be aware that the insurance company may collect surveillance footage of you. It is within their right to do so. If the administrator conducts surveillance on your activities outside of the home, it will be even more important that what you represent as your activity level matches what may be seen on surveillance.



Pitfall #3: Social Media

You need to assume that the insurance company is looking at your social media, including its history, because they are! Here are some things to remember when it comes to social media:

- For the most part, we see people posting their best selves and happy moments on social media, right? Meaning: People tend to post about the one day when they were able to go on a short hike, but they do not tend to post about the other 29 days of agony and exhaustion they faced that month. If the insurance company only sees you “happy and active,” how will that impact your claim? The answer is, very likely in a negative way because it will not show the daily and multiple struggles you face. Not only will you appear that you are “fine” in the eyes of the insurance company, but they will twist your social media and use it to purport that you lied about the severity of your symptoms. BE CAREFUL when you post...or...DO NOT POST at all.
- When you post, whether on Facebook, Instagram, Twitter or other sites, your post and its material become public. No matter what privacy settings you use, the insurance company might still be able to view it. However, do not delete photos or posts from your social media to avoid its discovery. This could be construed as hiding or destroying evidence and hurt your credibility.

You Submitted Your Claim. Now What?

Once your claim is submitted, there are several steps you can take to maximize the chances of your claim being paid.

First, you will eventually receive a letter confirming receipt of your claim and requesting completion of outstanding forms. Fill those out promptly and completely, as failure to do so can delay processing of your claim. If you do not receive confirmation of your claim within a week, then follow up.

If you have not done so, take this opportunity to request your updated medical records. Review them to verify accuracy and completeness. If something is off, bring it up with your doctor immediately.

The administrator may elect to send you for an Independent Medical Examination (“IME”) where a medical professional examines you in-person as well as reviews your medical records. Compliance with such requests is usually a requirement within the policy, so it is difficult, if not impossible, to avoid attending a requested examination at the initial claim stage. (Even if you could avoid it, a judge or jury might find suspicious your refusal to avoid an in-person examination, even if your reasons for avoiding the examination are fully justified.)

Unfortunately, many of these physicians are not truly “independent,” and will do their best to justify a pro-administrator decision. If you are required to attend an examination, request that a legal nurse be allowed to observe and document the examination. This can become useful evidence down the road should you need to dispute the accuracy of the IME report.

If the administrator does provide you with a copy of the IME or other report, provide it to your supportive physicians as promptly as possible for rebuttal or comment, if necessary.

Sometimes, an insurance company will agree with your doctors’ opinions regarding your specific functionality but determine that you can still work under the terms of the policy. If this occurs, the insurer should have generated a “vocational report” confirming this conclusion. Request a copy of

this report, and if possible, enlist the assistance of a vocational expert to respond to that conclusion. Admittedly, this is a more nuanced and technical argument, and usually involves the assistance of counsel.

After you have submitted your rebuttals, you will receive a response from the insurer, usually in the form of a denial or approval. Regardless, make sure to read the response very carefully—both will provide critical information about next steps. Approval letters can also include critical limitations applied to the claim, and denial letters could provide you with a final chance to respond before initiating the formal appeal process.

Your Claim Was Denied – What Should You Do Next?

The Law of ERISA Appeals

If your claim is denied, the administrator will inform you of your right to appeal the decision. If ERISA applies to your claim, you may be required to submit a timely appeal to the administrator or else a court may dismiss your case. In other words, the appeal may be mandatory for you to continue to pursue your claim.

The current ERISA regulations require that the administrator give you at least 180 days to appeal. This deadline may be extended by regulation (i.e., U.S. Department of Labor COVID-19 Relief and Guidance for Employee Benefit Plans) or by agreement with the administrator. Note: If the administrator agrees to give you an extension of time to submit your appeal, document the extension in writing.

Know What Is In Your File

The ERISA regulations give you a right to obtain a copy of your entire claim file. The denial letter should also explain that you have a right to request documents. Time permitting, you should request your complete claim file in writing before you submit your appeal. This is so you can get a fuller picture of why your claim was denied and what information the administrator considered. Information that may be in your file includes:

- Reasons for the claim denial
- Internal notes
- Medical reviews
- Vocational reviews and
- Surveillance reports and videos

Preparing a written ERISA Appeal

What most claimants do not understand about ERISA is the importance of the claims and appeals process. In most circumstances, a reviewing court will be limited to reviewing only what is in the claim file up to the point the administrator issues a final denial letter. This means that what you submit in

connection with your appeal will need to demonstrate that you are entitled to disability benefits.

What Should I Submit With My Appeal?

Let us first start with what not to do. A written statement simply stating “I appeal” is not enough. Your appeal should include documentary and other evidence supporting your claim of disability.

While you do not need an attorney to submit an appeal, we recommend that you first consult with an experienced ERISA attorney before you attempt to appeal on your own. If legal representation is not possible, your appeal should contain all available helpful evidence.

Medical Records

Medical records covering the relevant period may include “objective” evidence to support your claim. These records may include some or all the following information:

- current symptom[s]
- other medical conditions that might affect or lengthen the recovery period
- existing abnormalities or deficiencies
- results from physical examinations
- observations made by the treatment provider during office visits/therapy sessions
- diagnostic tests and their results (for example, lab results, x-rays and MRIs)
- a treatment plan
- any prescribed medications and the response to those medications
- level of functionality (restrictions and limitations)
- clinical documentation that supports the rationale that the treatment provider used when determining the level of functionality
- description of the impact that the patient’s level of functionality has on her ability to perform her job or other similar job.

Other Evidence

Your appeal should not be limited to just medical records, especially where your doctor may not document all the above in her treatment notes. Other evidence you should consider submitting include:

- **Letters from Medical Providers.** Again, it is not enough for your doctor to just state you are “disabled.” Whether you are disabled is a legal and factual determination based on the definition of disability in your policy, your occupation, and your medical restrictions and limitations. Ideally, letters from your doctors will address the following:
 - » The length of treatment (e.g., “I have been treating Mr. Smith for over 10 years.”)
 - » The diagnoses treated
 - » The symptoms experienced because of the diagnoses and whether those symptoms are credible
 - » The treatment plan

- » Any complicating factors and medication side effects
- » Work restrictions and limitations resulting from the diagnoses and symptoms
- » Prognosis
- » If there was a medical review of your claim, whether the doctor agrees or disagrees with the review and
- » If there was surveillance, whether activities seen on surveillance are consistent with the doctor's opinion about assigned restrictions and limitations
- **Third-party Statements.** Courts are increasingly acknowledging the value of third-party statements when it comes to evaluating disability. If you have friends, family members, or (former) co-workers who can attest to your work ethic or observations of your struggles and limitations, a written and signed statement from them will help illustrate how you are disabled.
- **Independent Medical Examinations.** Sometimes administrators will have you evaluated by a doctor of their choosing. You can also choose to be evaluated by an outside doctor or service that is familiar with the issues that arise in disability claim disputes. For example, a Functional Capacity Evaluation (FCE) may show objectively how you can only sit for 30 minutes at a time for no more than 3 hours a day. If your sedentary job requires you to sit for over 4 hours, you cannot perform your job. Or, if you have cognitive issues due to pain or medication side effects, a neuropsychological evaluation may show objectively how you cannot meet the cognitive demands of your job.
- **Vocational Information.** If there is a dispute about the classification of your job or the physical or mental requirements of your occupation, you may need to provide vocational information. That may include your formal job description with the employer, your personnel file, or a report from a vocational expert.
- **Social Security File.** If the Social Security Administration ("SSA") found you disabled, the administrator must consider that decision. Though the administrator is not bound by the SSA's determination, it cannot disregard it entirely. The administrator may ask for your complete SSA file to decide if there is a valid basis for disagreement with the SSA's decision. You should obtain and review your SSA file before submitting it to the administrator. If you are not able to get your complete file but SSA approved your claim after a hearing before an Administrative Law Judge, you should have received a written explanation of decision that may provide helpful analysis for your disability claim.
- **Medical Literature.** There are ample credible medical sources that are freely available online. You can print these out and submit them with your appeal to help the administrator understand the nature of your condition and the symptoms you experience. Additionally, if your matter proceeds to a lawsuit, the medical explanations may be helpful to a reviewing judge who may not be well-versed in your condition.

After you Submit the Appeal

If the administrator denied your LTD claim based upon a finding that you are not medically disabled, it will obtain a medical review of your file with the appeal evidence. Request that the insurer do the following:

1. Provide you a chance to review and respond to any reports generated during the appeals

process before the insurer issues a decision. This includes medical peer review reports by medical professionals who assess your impairments from a medical perspective, as well as vocational reports which analyze your ability to work in light of the impairments provided by those experts.

2. Require any reviewing physician to only contact your doctors in writing so that their exchange will be captured in writing. This is to avoid a situation where the reviewing doctor inaccurately summarizes what your doctors told her in her final report. Additionally, request that any communications that are sent to your doctors are also sent to you so that you can follow up accordingly.

Next, reach out to your physicians and let them know that the administrator or its reviewing physician may reach out to them directly for comment. Ask that they not communicate via telephone, and instead request that questions be put in writing, to which they can respond in like form. Request that your doctor provide that response to you so that you can submit it and ensure the administrator received it. Many times, communications from doctors' offices are not received by the administrator. Be mindful of what you say in written communications to your doctor through a communication portal as those become part of your official medical record. An administrator could misconstrue communications you make to your doctor about your LTD claim.

For a claim governed by ERISA, an administrator must decide the appeal within 45 days of its receipt of your appeal. If there are "special circumstances" which make a decision impossible within 45 days, the administrator can take one 45-day extension (for a total of 90 days to decide). If there is information the administrator has requested of you that is essential to its ability to decide your appeal, it may be able to extend the deadline further. If the administrator has not made a timely decision, you will be deemed to have "exhausted" administrative remedies and can file a lawsuit.

In sum, the ERISA appeals process is a crucial stage of your disability claim and you must be careful to submit all the available information to strengthen your case. Even if you do not hire an attorney to help with your appeal, it is important to consult with one who has experience handling ERISA claims.

The Appeal Was Denied, Now What?

1. Find an experienced attorney
2. Request the claim file (again)
3. Determine what law applies
4. Find an experienced attorney
5. ***Find an experienced attorney!!!***

We will not sugarcoat it—if you do not already have an experienced attorney helping you with your disability claim, now is the time to find one. Following steps two and three will make the process more efficient and effective. Below are some pointers on how to determine what law applies—which will help you refine your search for an attorney—and having the most current file will help you and the attorney decide the best path forward. That path will likely include filing a lawsuit unless your disability plan requires a second level appeal.

What to look for in your attorney?

- Multiple court decisions ruling for their clients—including decisions from courts of appeals. If an attorney cannot demonstrate they go to the mat for their clients and win, they may settle or lose too many cases (potentially leaving money on the table for their clients).
- A list of the lawsuits they have filed. Lawsuits are public records and technology allows attorneys to quickly generate a list of all the cases they (or their firm) has filed. Look for an attorney with a well-established history of filing lawsuits like yours.
- Free case review. An attorney willing to devote the time to review your information at no cost shows she may be more interested in the long haul and maximizing your recovery, not short-term profit.
- Unbiased positive online reviews (Yelp, Google, Avvo, etc.). Some will scoff at this, but you can learn a lot about a law firm by seeing what their clients say about them. The reality is that not all clients will be satisfied with their representation (and any firm without a few negative reviews is suspect), but you want to see that the overwhelming majority had a positive experience and recommend the firm.

Can you afford an experienced attorney?

Yes. This is true even though most people on disability experience a disastrous drop in income. Do not let that dissuade you. While attorneys usually bill by the hour, look for an attorney that works on contingency. An attorney working on contingency will not charge you a fee unless your benefits are reinstated or there is a settlement. Many will also “front” your costs and recover them only if you get a recovery. A contingency arrangement is the best alternative for someone without an income and who cannot afford to pay an attorney on an hourly basis.

Conclusion:

From our colleagues across the country, we are learning that insurance carriers have taken a united position that fear of catching COVID is not a disabling condition, no matter the seriousness of the underlying immunosuppressing condition.

The Kantor & Kantor team is confident that insurance companies will be fighting very hard to deny the existence of disabling side effects from COVID. We anticipate a tsunami of cases, and we want to be as prepared as possible to ensure individuals receive the long-term disability benefits they deserve.

If you have questions about your long-term disability insurance benefits, please call **877-783-8686** to schedule a free consultation with a Kantor & Kantor attorney.