IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

CAROL DaCOSTA,
WAYNE COOPER, M.D,
DANA DiCOCCO and
MELANIE GREEN, individually,
and on behalf of all others similarly situated,

Plaintiff(s),

vs.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
a for- profit corporation

Defendant(s).

CASE NO. CV 10- 0720

CLASS ACTION

SEYBERT, J.

LINDSAY, M.J.

ORIGINAL

CLASS ACTION COMPLAINT

PLAINTIFFS, CAROL DaCOSTA (hereinafter "DaCOSTA"), WAYNE COOPER, M.D. (hereinafter "COOPER"), DANA DICOCCO (hereinafter "DICOCCO") and MELANIE GREEN (hereinafter "GREEN") by and through their attorneys of record, file this Complaint on behalf of themselves and all persons similarly situated within the United States. This Complaint is based upon the current information and belief of the PLAINTIFFS, who hereby allege as follows:

NATURE OF THIS ACTION

1. This is an action brought against Prudential Insurance Company of America, (hereinafter "PRUDENTIAL") a prominent insurance company and leading provider of group long-term disability insurance in the United States. The Defendant, PRUDENTIAL, breached their fiduciary duty to PLAINTIFFS by flagrantly violating multiple mandatory procedures set forth in The Employment Retirement Income Security Act of 1974 ("ERISA"). PRUDENTIAL failed to provide

its beneficiaries a "full and fair review" of long-term disability claims and adverse benefit determinations during voluntary appeals, as required by ERISA and The United States Department of Labor. PRUDENTIAL implemented a secretive company-wide policy amending their voluntary review process in violation of ERISA solely for the purposes of cutting costs and increasing profitability. Although Defendant is an insurance carrier, whose business involves elements of public trust, and has a duty to act in good faith to all of their plan participants, PRUDENTIAL acted solely in their own interest, perverting their claims process for long-term disability benefits. As a result, upon information and belief, thousands of disability claimants were wrongfully deprived and continue to be deprived of an appeals process that provides them with a full and fair review and which complies with ERISA. This action is necessary to prevent PRUDENTIAL'S illegal practices and to ensure that all participants of any group long-term disability plan receive a "full and fair review" of their claims.

2. The Employment Retirement Income Security Act of 1974 ("ERISA") was enacted to protect the rights and interests of employees in the administration of their employer's welfare benefit plans. In addition to conferring numerous rights upon plan participants, ERISA imposes duties upon the individuals and companies who are responsible for the operation and administration of such plans. Under this law, plan fiduciaries are required to discharge their duties prudently, diligently, and solely in the interest of the plan's beneficiaries, for the exclusive purpose of providing promised benefits.

3. Thousands of employers across the United States sponsor employee welfare benefit plans and millions of employees participate in those plans. Long-term disability insurance provides an employee with income security when he or she becomes disabled due to injury or illness.

4. Employers purchase these plans and routinely delegate their fiduciary duties to the long-term disability insurer that has issued the group policy. In this action PRUDENTIAL is and was the fiduciary for potentially thousands of beneficiaries.

NAMED PLAINTIFFS

CAROL DaCOSTA

5. PLAINTIFF DaCOSTA is and has been at all times material to the allegations in this Complaint a resident of Cambria Heights, New York. DaCOSTA was a human resources manager at Dentsu Holdings, Inc. at which time she became insured under a group long-term disability policy issued by PRUDENTIAL.

6. On or about August 2006 DaCOSTA became disabled due to temporal arteritis causing severe and frequent headaches, dizziness, tightness in her temple and neck and numbness in her head. DaCCOSTA was therefore not able to perform the material and substantial duties of her occupation.

7. On April 1, 2008 DaCOSTA's disability benefits were terminated as PRUDENTIAL determined that she was no longer disabled.

8. On September 9, 2008 DaCOSTA appealed the initial adverse long-term disability benefit determination.

9. On October 23, 2008, **Kim Boivin**, a Senior Appeals Analyst, upheld PRUDENTIAL's decision to terminate DaCOSTA's disability benefits.

10. DaCOSTA filed a second, voluntary appeal on April 9, 2009.

11. DaCOSTA requested in writing, pursuant to ERISA and PRUDENTIAL's policies, copies of "all documents, records and other information relevant to her claim, and a complete copy of her claim file."

12. PRUDENTIAL failed to provide the above requested information as required by ERISA. PRUDENTIAL failed to inform DaCOSTA that the same individual, **Kim Boivin**, who reviewed and denied her first appeal was also going to review and decide the fate of her second, voluntary appeal. PRUDENTIAL also failed to advise her that the same physicians who provided medical opinions during her first appeal were going to review and provide opinions in her voluntary appeal in violation of ERISA. In effect, PRUDENTIAL did not afford an "appeal" at all.

13. On May 26, 2009, **Kim Boivin** informed DaCOSTA that her second appeal was denied and her disability benefits would not be reinstated.

WAYNE COOPER, M.D.

14. PLAINTIF COOPER, M.D. is and has been at all times material to the allegations in this Complaint a resident of Mclain, Virginia.

15. COOPER is 62 years old and worked as an OB/GYN for more than 30 years. He was employed by Geisinger Medical Center as an obstetrician-gynecologist for 16 years at which time he became insured under a group long-term disability policy issued by PRUDENTIAL. COOPER became disabled due to lumbar radiculopathy and extensive coronary artery disease necessitating cardiac surgery rendering him permanently disabled.

16. COOPER was no longer able to perform the material and substantial duties of his occupation and therefore was forced to leave his position at Geisinger Medical Center on August 17, 2006.

17. COOPER applied for disability benefits which were denied by PRUDENTIAL on January 16, 2008. On July 11, 2008 COOPER filed his first appeal of the denial of long-term disability benefits. COOPER's claim was referred to two external physicians hired by PRUDENTIAL, Dr. David Bauer (an orthopedic surgeon) and Dr. Mark Eaton (an internist) who both rendered the opinion that COOPER was not disabled. The first appeal was overseen by **Kim Boivin**, a Senior Appeals Analyst for PRUDENTIAL. **Ms. Boivin** determined that PRUDENTIAL's initial determination to deny benefits to COOPER was proper and that COOPER was not disabled. **Ms. Boivin** advised COOPER that he:

> "may again appeal this decision to Prudential's Appeals Unit for a final decision....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 your claim...You are entitled to receive upon request, sufficient information to make a decision about filing this appeal."

18. On September 10, 2008, COOPER requested in writing, pursuant to ERISA and PRUDENTIAL's policies, copies of "all documents, records and other information relevant to his claim, and a complete copy of his claim file. He also specifically requested "sufficient information to make a decision about filing this appeal" as provided for in PRUDENTIAL's denial letters and Summary Plan Description.

19. PRUDENTIAL did not provide information, regarding the second appeal procedures, much less any information allowing him to make an "informed" decision.

20. On February 13, 2009 COOPER filed a voluntary appeal with PRUDENTIAL.

21. On March 12, 2009, **Kim Boivin**, the same Senior Appeals Analyst who denied COOPER'S first appeal, advised him that she also denied his second, voluntary appeal.

DANA DiCOCCO

22. PLAINTIFF DiCOCCO is and has been at all times material to the allegations in this Complaint a resident of Springfield, Massachusetts. DiCOCCO is 55 years old. She became disabled after being employed for fifteen years as a Senior Property Manager for Winn Residential at which time she became insured under a group long-term disability policy issued by PRUDENTIAL.

23. On or about December of 2007 DiCOCCO received chemotherapy for the diagnosis of breast cancer.

24. Soon after receiving chemotherapy, DiCOCCO was diagnosed with a severe Cognitive Disorder and Depression due to the chemotherapy that she received to attempt to cure her cancer. Due to her disability, DiCOCCO became unable to perform the material and substantial duties of her occupation.

25. DiCOCCO began receiving disability benefits from PRUDENTIAL on January 31, 2007.

26. On November 1, 2007 DiCOCCO's disability benefits were terminated as PRUDENTIAL claimed she was no longer disabled.

27. On August 8, 2008 DiCOCCO appealed PRUDENTIAL'S decision to terminate her long-term disability benefits.

28. On September 25, 2008 DiCOCCO's first appeal was denied by PRUDENTIAL Senior Appeals Analyst, **Susan Gatti**, stating that she was not disabled and therefore able to perform the substantial duties of her occupation.

29. DiCOCCO requested in writing, pursuant to ERISA and PRUDENTIAL's policies, copies of "all documents, records and other information relevant to her claim, and a complete copy of her claim file. She also specifically requested "sufficient information to make a decision about filing this second appeal" as provided for in PRUDENTIAL's denial letters and Summary Plan Description.

30. PRUDENTIAL failed to provide the above requested information as required by ERISA. PRUDENTIAL failed to inform DiCOCCO that the same individual, **Susan Gatti**, who reviewed and denied her first appeal was also going to review and make a final determination on her second appeal. PRUDENTIAL also failed to advise her that the same physicians who provided medical opinions during her first appeal were going to review and provide opinions to be relied upon in her second appeal in violation of ERISA.

31. On March 19, 2009 DiCOCCO filed a second, voluntary appeal with PRUDENTIAL.

32. On October 1, 2009, **Susan Gatti** informed DiCOCCO that her second appeal was denied and her disability benefits would not be reinstated.

MELANIE GREEN

33. PLAINTIFF GREEN is and has been at all times material to the allegations in this complaint a resident of Delray Beach, Florida. GREEN is fifty years old and worked as a Financial Analyst. During her employment, she became insured under a group long-term disability policy issued by PRUDENTIAL.

34. In January of 2007, GREEN was diagnosed with severe depression and anxiety and was unable to perform the material and substantial duties of her occupation as a Financial Analyst.

35. On July 19, 2007, PRUDENTIAL terminated GREEN'S disability benefits.

36. GREEN appealed this decision on December 18, 2007.

37. On March 5, 2008, **Nancy Pichette**, a Senior Appeals Analyst for PRUDENTIAL upheld the decision to terminate GREEN'S disability benefits.

38. GREEN requested in writing, pursuant to ERISA and PRUDENTIAL's policies, copies of all documents, records and other information relevant to her claim, and a complete copy of her claim file. GREEN also specifically requested sufficient information to make a decision about filing this second appeal including the entire claims handling practices, policies and procedures.

39. GREEN filed a second, voluntary appeal with PRUDENTIAL.

40. PRUDENTIAL failed to provide the above requested information as required by ERISA. PRUDENTIAL failed to inform GREEN that the same individual, **Nancy Pichette**, who reviewed and denied her first appeal was also going to review and make a final determination on her second appeal. PRUDENTIAL also failed to advise her that the same physicians who provided medical opinions during her first appeal were going to review and provide opinions to be relied upon in her second appeal in violation of ERISA.

41. On September 3, 2008, **Nancy Pichette** upheld her initial decision to terminate GREEN'S disability benefits as she did on March 5, 2008.

42. DaCOSTA, COOPER, DICOCCO and GREEN were all misled by PRUDENTIAL into believing they would receive a "full and fair review" of their claim denial if they filed a second, voluntary appeal. Rather, PRUDENTIAL disregarded ERISA's requirements and utilized the second appeal to bolster their administrative record in support of denial by rubber stamping their previous appeal with the same decision makers and medical professionals. PRUDENTIAL failed to disclose

claim appeal procedures and failed to adopt and implement reasonable procedures in accordance with ERISA, conducting appeals in an effort to cut costs and increase profits.

DEFENDANTS

43. PRUDENTIAL is a corporation with its principal place of business in the state of New Jersey. Prudential has agents in the state of New York and conducts a substantial amount of its business in the state of New York.

44. PRUDENTIAL is an insurance company and one of the largest sellers of group long-term disability insurance coverage in the world. PRUDENTIAL insures over 5,100 long-term disability clients covering more than 2.3 million individuals[1], including PLAINTIFFS, DaCOSTA, COOPER, DiCOCCO, GREEN and those individuals similarly situated. In 2008 PRUDENTIAL collected over $4.3 billion in group insurance reported premiums, policy charges and fee income[2].

45. At all relevant times, PRUDENTIAL sold group long-term disability insurance plans (hereinafter referred to as "The Plans" or "The Plan") to thousands of employers, including the employers of the PLAINTIFFS and Class Members.

46. At all relevant times, PRUDENTIAL was the entity responsible for paying monthly benefits to all participants and/or beneficiaries of The Plans.

47. At all relevant times, PRUDENTIAL was the "Administrator" as the term is defined under ERISA, 29 U.S.C. § 1002(16)(A) of The Plans and made all decisions regarding eligibility for benefits under The Plans.

48. At all relevant times, PRUDENTIAL was also the "Fiduciary" as the term is defined under ERISA, 29 U.S.C. § 1002(21)(A), in that PRUDENTIAL acted as a claims

1 LIMRA, 2008 Annual U.S. Group Disability Sales and Inforce Surevy.
2 Http://prudential.com/view/page/public/11430.

fiduciary for The Plans and executed authority and control over the payment of long term disability benefits, which are assets of The Plans and were charged with making benefit determinations under The Plans, including the determinations made on PLAINTIFFS claims at issue in this action.

49. At all relevant times, The Plans were an "employee welfare benefit plan(s)" as the term is defined under ERISA, 29 U.S.C. §1002(1).

50. At all relevant times, pursuant to The Plans, PRUDENTIAL provided long-term disability coverage to "participant(s)" of The Plans, as defined under 29 U.S.C. § 1002(7).

JURISDICTION AND VENUE

51. Pursuant to 28 U.S.C. §1331 and 29 U.S.C. §1332(e) this Court has jurisdiction over the claims brought by the PLAINTIFFS since the claims brought in this Complaint arise under Federal Law, specifically the Employment Retirement Income Security Act of 1974 and the regulations promulgated thereunder.

52. Venue is proper in the Eastern District of New York pursuant to 28 U.S.C.§ 1391, as PLAINTIFF DaCOSTA is a resident of and citizen of Cambria Heights, New York.

53. Venue is also proper in this district pursuant to 28 U.S.C.§1391 as PRUDENTIAL is registered to do business in the state of New York and in fact is doing a substantial amount of business in the state of New York. This purposeful availment renders the exercise of jurisdiction by New York courts over it and its affiliated and related entities permissible under judicially accepted notions of fair play and substantial justice. Moreover, PRUDENTIAL is subject to the general jurisdiction of this Court because it has extensive facilities and operations within the state of New York.

FACTUAL ALLEGATIONS

54. Before filing the present action, DaCOSTA, COOPER, DiCOCCO, GREEN and all unnamed PLAINTIFFS fulfilled all conditions precedent to the filing of this action, including the exhaustion of all administrative remedies under The Plan(s).

55. PRUDENTIAL has designed a scheme to maximize corporate profits to the detriment of PLAINTIFFS and The Class. PRUDENTIAL failed to properly, fully and fairly review the second/voluntary appeals presented for long-term disability benefits. Instead, PRUDENTIAL made claim determinations with the intent of positively affecting their financial position, in derogation of its fiduciary obligations under ERISA.

56. Prior to January 1, 2005, PRUDENTIAL had a three-step appeals procedure in the event a long-term disability claim had been terminated or denied in which the claimant had two mandatory level appeals required prior to the filing of a lawsuit and then one voluntary appeal. Each of the three appeals were afforded "full and fair review" as required under ERISA. Specifically, PRUDENTIAL complied with ERISA's requirements that all three levels of appeal review were to be reviewed by individuals that **were not involved in a claim decision at any prior level.** (Attached as Exhibit "A")

57. On December 27, 2004, PRUDENTIAL documented its new disability claim procedures in a Memorandum titled "Appeals Procedures Division Memorandum" and authored by Drew De Christopher, Manager of Disability Claims. (Attached as "Exhibit B") According to pages 8-10 of the December 27, 2004 Appeals Memo, as of January 1, 2005 Prudential would no longer have a three-step appeals process. There would now only be two appeals available to the

participants. The first appeal will be mandatory and the second will be voluntary. Prudential specifically laid out the procedures for the new appeal process which provided in pertinent part:

> Upon receipt of a first appeal, Prudential's Appeals Review Unit will conduct a **full and independent review of the information in the claim file and any new information submitted to support the appeal utilizing individuals not involved in the initial decision. No deference will be given to the initial decision.**
>
> **The decision on appeal will be authorized by a member of Prudential's Management Team not involved in the initial adverse decision on the claim**. If the first appeal is denied the claimant will be advised of their right to file a **voluntary second appeal and of their right to receive additional information about the voluntary level of appeal.**
>
> **UPON RECEIPT OF THE SECOND, VOLUNTARY APPEAL, THE APPEALS REVIEW UNIT WILL AGAIN CONDUCT A FULL AND INDEPENDENT REVIEW OF THE CLAIM FILE. NO DEFERENCE CAN BE GIVEN TO EITHER THE INITIAL DENIAL OR THE DENIAL ON APPEAL.**
>
> **THE DECISION ON SECOND APPEAL WILL BE AUTHORIZED BY A MEMBER OF PRUDENTIAL'S MANAGEMENT TEAM THAT WAS NOT PREVIOUSLY INVOLVED IN AN ADVERSE DECISION ON THE CLAIM.**

58. The claim procedures established in Prudential's Appeal Memorandum dated December 27, 2004 were compliant with ERISA and 29 C.F.R. §2560.503-1. These procedures were to be applied to all long-term disability claims from January 1, 2005 forward.

59. However, on November 18, 2005 at 12:10 a.m., Drew De Christopher circulated an internal email (Attached as "Exhibit C") to Prudential employees setting out the details of their new scheme to undermine and violate ERISA:

> Our operation is **shifting its approach to the handling of volunteer appeal levels,** this refers to the second or third appeal, whichever is deemed voluntary…**For the voluntary appeal**, the appeal can be handled by the **same individual** who handled the prior mandatory appeals. There are **no requirements** that Prudential consult with a different medical consultant if the claim was previously based on the medical. **A de novo standard does not apply.**

> Beginning with any voluntary appeals received 11/14/05 or later, I would ask you to begin to **manage your own 2nd appeals**...**There are no hard and fast rules for what steps to take on such an appeal.** You are expected to exercise good judgment based on the circumstances of the claim. If the claim review can be perfected further by taking action, you should take such appropriate action. **If no action is warranted, that is ok too....**
>
> **Hopefully this change will reduce case load burden a bit since there will be files you will receive/self assign as new pendings that you will not need to learn from scratch**. Desired behavior is to ensure that the 1st review is the strongest review possible... as it could be the last review Prudential is afforded. If that behavior occurs, **the burden of 2nd appeal reviews should be further lessened.**

60. It is impossible for PLAINTIFFS to receive a "full and fair review" of their claims on appeal if the same PRUDENTIAL employee and/or manager that reviewed and decided to deny their first appeal is the same exact person that will review and make a decision on their second, voluntary appeal.

61. PRUDENTIAL never advised either the PLAINTIFF or their employers of their sub rosa decision to change the appeal claims procedures for long-term disability denials.

62. PRUDENTIAL unilaterally and without notice to any of its participants, determined that they no longer had to comply with ERISA standards when handling voluntary appeals on or after November 14, 2005. PRUDENTIAL decided that it would bypass ERISA regulations and utilize the same individual to review first and second appeals as well as the same physicians to give opinions on first and second appeals in order to save time and money, to the detriment of disabled participants. PRUDENTIAL failed to provide any notice that would remotely suggest that the same person that denied the claimants first appeal was going to be assigned to review and determine the fate of the second appeal. No documents were **ever** provided to participants establishing PRUDENTIAL'S new claims handling procedures, as required by federal law. These new procedures, created in an email,

were never added to PRUDENTIAL'S Summary Plan Description nor were they disclosed in Prudential's Summary of Material Modifications of Claims Procedures (SMM) drafted in 2005 and again in 2006. (Attached as "Composite Exhibit D").

63. PRUDENTIAL'S November 14, 2005 change in appeal claims procedures were never provided to participants or their employers, even when specifically requested. These secret voluntary appeal policies have been in effect since November of 2005, yet were never put into PRUDENTIAL'S policies and procedures, ERISA Statement, SPD, or SMM, as they are in complete violation of ERISA.

64. PRUDENTIAL has a fiduciary duty to thousands of beneficiaries. It is difficult to comprehend that PRUDENTIAL can declare an appeal to be "voluntary" in a denial letter and expect that the claimant would understand that their fiduciary is going to conduct a review with **"no hard and fast rules,"** that will be conducted by the same biased individual who denied their first appeal, by the same biased physicians hired by PRUDENTIAL, who denied disability during the first appeal, and that the same Manager or Director will oversee and decide both levels of their appeals.

65. At all relevant times, PRUDENTIAL failed to conduct voluntary appeals in compliance with 29 C.F.R. §2560.503-1(c)(3)(iv), 29 C.F.R. §2560.503-1(j)(4) and (5)(i), as they failed to provide the PLAINTIFFS with sufficient information relating to the voluntary level of appeal; PLAINTIFFS were deprived of a meaningful opportunity to make an informed decision about whether to submit a benefit dispute to the voluntary level of appeal. Specifically 29 C.F.R.§2560.503-1(c)(3)(iv) states in pertinent part:

> To the extent that a plan offers voluntary levels of appeal…the claims procedures provide that: The plan provides to any claimant, upon request, **sufficient in formation relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the**

> **voluntary level of appeal...the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as financial or personal interests in the result or any past or present relationship with any party to the review process.**

a. PRUDENTIAL failed to advise PLAINTIFFS of the "process for selecting the decision maker";

b. PRUDENTIAL failed to advise PLAINTIFFS of the circumstances "that may affect the impartiality of the decision maker, such as a financial or personal interest in the result or any past or present relationship" with any party to the review process;

c. PRUDENTIAL failed to inform the PLAINTIFFS that their voluntary appeal would be reviewed and/or decided by the same decision maker that denied their first appeal; and,

d. PRUDENTIAL failed to inform PLAINTIFFS that the same physicians that reviewed their first appeal, and declared them not disabled, would also be responsible for rendering the medical opinion in their voluntary appeal.

66. PRUDENTIAL's procedures for voluntary appeals are in violation of "full and fair review" standards required by 29 U.S.C. §1133(2), 29 C.F.R.§ 2560.503-1(b)(1) and are contrary to the entire intent behind ERISA.

67. According to ERISA regulations:

> Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations and appeal of adverse benefit determinations. 29 C.F.R. §503-1(b)(1)
>
> The plan administrators shall provide a claimant with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant...A description of the plans review procedures following an adverse benefit determination on review. 29 C.F.R. §503-1(g)(iv).

deference to the decision at the first level of review, and the reviewer must not be the same person who made the first level review decision on the claim or a subordinate of that person. See §§2560.503-1(c)(2) and 2560.503-1(h)(3)(ii).

E-1 While regulation limits a plan's claim procedure to a maximum of two mandatory appeal levels, the regulation does permit plans to offer voluntary additional levels of appeal…providing certain conditions are met. The conditions of the regulation focus on ensuring that the claimant elects the additional appeal voluntarily. **Specifically, the regulation provides that, in the case of such voluntary levels of appeal, the plan's claim procedure must provide…the claimant with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including the specific information delineated in the regulation.**

70. PRUDENTIAL has committed multiple flagrant violations of ERISA, 29 C.F.R.§2560.503-1 throughout the administration and handling of long-term disability appeals from November 14, 2005 to the present, including, but not limited to the following:

a. Failing to establish and maintain reasonable claim procedures in accordance with ERISA regulations and 29 C.F.R.§ 2560.503-1(h);

b. Failing to provide plan members with a description of The Plan's internal appeals procedures following the denial of the initial claim and subsequent denial of the first appeal, in violation of 29 C.F.R.§ 2560.503-1(g)(iv);

c. Utilizing the same healthcare professional to evaluate claims during the first, mandatory, and second, voluntary appeal in violation of 29 C.F.R.§ 2560.503-1(h)(3)(v);

d. Utilizing the same individual who reviewed and denied the first appeal to review, determine and sign off on the second, voluntary appeal in violation of 29 C.F.R.§ 2560.503-1(h)(3)(ii);

e. Utilizing the same Manager and/or Director in the first and second appeal to make the final decision to approve and/or deny claims in violation of 29 C.F.R.§ 2560.503-1(h)(3)(ii); and

f. Failing to disclose and provide the internal rules, guidelines and protocols that PRUDENTIAL relied upon to review and deny PLAINTIFFS second appeal in violation of 29 C.F.R.§ 2560.503-1(g)(v)(A).

71. The allegations above represent unfair, deceptive, and fraudulent practices in violation of ERISA, 29 CFR §2560.503-1. PLAINTIFFS, DaCOSTA, COOPER, DiCOCCO, GREEN and those similarly situated have incurred similar damages due to PRUDENTIAL'S violations of ERISA.

CLASS ACTION ALLEGATIONS

72. Pursuant to Fed.R.Civ.P. 23 (a) and (b), the Class PLAINTIFFS bring this action both individually and on behalf of all persons similarly situated.

73. The Class is defined as follows: All individuals insured under an ERISA governed long-term disability plan who filed a second or voluntary appeal which was denied by PRUDENTIAL on or after November 14, 2005 by the same person and/or manager that denied the individual's first appeal. Excluded from the class are all employees of the Defendant.

74. PRUDENTIAL has refused to act on grounds generally acceptable to The Class, thereby making appropriate final injunctive relief with respect to The Class as a whole.

75. PRUDENTIAL has engaged in a common course of conduct by adopting corporate-wide claim procedures that apply to all long-term disability Plans regardless of the type of Plan each participant may have.

76. The Class has been denied, and will continue to be denied the procedural safeguards to which it is entitled according to ERISA.

NUMEROSITY

77. The Class of persons or entities described above is so numerous that joinder of all members by name in one action is impracticable. There are believed to be thousands of Class members. Their exact number, identities and addresses are known to PRUDENTIAL and can readily be determined from PRUDENTIAL'S records.

COMMONALITY

78. Questions of law and fact exist which are common to the entire Class and predominate over any questions that may affect individual Class Members in that PRUDENTIAL has acted on grounds generally applicable to the entire Class. Specifically, the common questions of law which apply to each class member are:

a. Whether PRUDENTIAL implemented a company-wide policy which does not comply with ERISA regulations.

b. Whether PRUDENTIAL failed to adhere to ERISA regulations which require a "full and fair review" during the voluntary appeals process.

c. Whether PRUDENTIAL provided appropriate notice to PLAINITFFS and Class Members concerning second or voluntary appeals procedures.

d. Whether PRUDENTIAL utilized the same appeal personnel to evaluate first and second appeals.

TYPICALITY

79. The claims of the Class representatives, PLAINTIFFS, DaCOSTA, COOPER, DiCOCCO, and GREEN are typical of the claims of The Class in that PLAINTIFFS and The Class were not afforded the informational and procedural safeguards mandated by ERISA during the voluntary review process as a result of PRUDENTIAL's uniform and company-wide business practices in violation of ERISA. PLAINTIFFS' claims are typical of the claims of The Class since they arise from corporate-wide claims directives and procedures which constitute a prohibited course of conduct and a common element of fact and law. Particularly the failure to provide required information concerning the appeals process and utilizing the same examiners and medical personnel utilized in the initial appeal.

ADEQUACY

80. PLAINTIFFS, DaCOSTA, COOPER, DiCOCCO and GREEN will fairly and adequately represent and protect the interests of the entire Class because of the common interests of themselves and the Class Members in ensuring that PRUDENTIAL employs the proper standards set forth in ERISA for reviewing their claims.

81. PLAINTIFFS have retained counsel that is competent and experienced in the prosecution of ERISA disability litigation.

82. PLAINTIFFS have no interest that is contrary to or in conflict with those of The Class they seek to represent.

FRCP RULE 23(b)(1)

83. Prosecuting separate actions by or against individual Class members would create a risk of inconsistent and varying adjudications, with the concomitant risk of the establishment of incompatible and conflicting standards of conduct for PRUDENTIAL.

84. Adjudication with respect to individual members of The Class could, as a practical matter, be dispositive of the interests of others not parties to the adjudication or substantially impair or impede their ability to protect their interests.

FRCP RULE 23(b)(2)

85. PRUDENTIAL has refused to act on grounds generally acceptable to The Class, thereby making appropriate final injunctive relief with respect to The Class as a whole.

FRCP RULE 23(b)(3)

86. A class action is superior to all other available methods for fair and efficient adjudication of this controversy. A class action will permit a large number of similarly situated persons to prosecute their common claims, in a single forum, simultaneously, efficiently, and without the necessary duplication of evidence, effort and expense that numerous individual actions would require. There is no difficulty to be encountered in the management of this action that would preclude its maintenance as a class action.

COUNT I
BREACH OF FIDUCIARY DUTY PURSUANT TO 29 U.S.C. §§1104 and 1132(a)(3)

87. PLAINTIFFS' incorporate by reference the allegations in Paragraphs 1-86 above as if set forth verbatim herein.

88. PRUDENTIAL has breached their fiduciary obligations to PLAINTFFS and The Class under ERISA 29 U.S.C. §1104(a) by failing to discharge their duties "solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries…with the care, skill, prudence, and diligence…of a prudent man…and in accordance with the documents and instruments governing the plan."

89. PRUDENTIAL, by acting in the manner described above, has failed to exercise the care of an ordinary prudent person engaged in a similar activity under prevailing circumstances, all in violation of ERISA.

90. As a result of the breach of fiduciary duty described above, PLAINTIFFS and The Class have been harmed, continue to be harmed and will be harmed in the future, due to the acts and/or omissions detailed above.

91. PLAINTIFFS and The Class are entitled to appropriate declaratory and equitable relief under ERISA 29 U.S.C. §1132(a)(3) to obtain appropriate injunctive relief stopping the offending and egregious practices that are causing ongoing harm to PLAINTIFFS and The Class.

92. Pursuant to ERISA, 29 U.S.C.§1132(g)(1), PLAINTIFFS are entitled to reasonable attorney's fees and costs.

COUNT II
ACTION PURSUANT TO 29 U.S.C. §1132(a)(1)(B)

93. PLAINTIFFS' incorporate by reference the allegations in Paragraphs 1-92 above as if set forth verbatim herein.

94. PLAINTIFFS bring this claim for benefits pursuant to 29 U.S.C. §1132(a)(1)(B) to enforce their rights under The Plan and ERISA.

95. PRUDENTIAL has committed multiple violations of ERISA, 29 C.F.R.§ 2560.503-1 throughout the administration and handling of long-term disability appeals from November 14, 2005 to the present, including, but not limited to the following:

a. Failing to establish and maintain required appeal procedures in accordance with ERISA regulations and 29 C.F.R.§ 2560.503-1(h);

b. Failing to provide plan members with a description of The Plan's appeals procedures following the denial of the initial claim and denial of the first appeal in violation of 29 C.F.R.§ 2560.503-1(g)(iv);

c. Utilizing the same healthcare professional to evaluate claims during the first, mandatory, and second, voluntary appeal denial in violation of 29 C.F.R.§ 2560.503-1(h)(3)(v);

d. Utilizing the same individual and/or managers who reviewed and denied the first appeal to review, determine and/or approve the second, voluntary appeal in violation of 29 C.F.R.§ 2560.503-1(h)(3)(ii); and

e. Failing to disclose and provide the internal rules, guidelines and protocols that PRUDENTIAL relied upon to review and deny PLAINTIFFS second, voluntary appeal in violation of 29 C.F.R.§ 2560.503-1(g)(v)(A).

96. At all relevant times, PRUDENTIAL failed to conduct a voluntary appeal in compliance with 29 C.F.R. §2560.503-1(c)(3)(iv), 29 C.F.R. §2560.503-1(j)(4) and (5)(i), as they failed to provide the PLAINTIFFS with sufficient information relating to the voluntary level of appeal to enable them to make an informed decision about whether to submit a benefit dispute to the voluntary level of appeal. Specifically 29 C.F.R.§2560.503-1(c)(3)(iv) states in pertinent part:

> To the extent that a plan offers voluntary levels of appeal…the claims procedures provide that: The plan provides to any claimant, upon request, **sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal…the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as financial or personal interests in the result or any past or present relationship with any party to the review process.**

97. PRUDENTIAL's procedures for voluntary appeals are in violation of "full and fair review" standards required by 29 U.S.C. §1133(2), 29 C.F.R.§ 2560.503-1(b)(1) and are contrary to the spirit and letter of ERISA.

98. Pursuant to ERISA, 29 U.S.C. §1132(g)(1), PLAINTIFFS are entitled to reasonable attorney's fees and costs.

WHEREFORE, PLAINTIFFS, on behalf of The Class, pray for judgment as follows:

(1) For certification of this matter as a Class action lawsuit under FRCP Rule 23(b)(1), (b)(2) and/or (b)(3) to proceed on behalf of The Class of all Currently Unnamed PLAINTIFFS as described herein after suitable discovery has been completed;

(2) Awarding PLAINTIFFS and The Class injunctive relief whereby PRUDENTIAL is ordered to cease engaging in the offending practices delineated herein;

(3) Awarding PLAINTIFFS and The Class equitable relief whereby Defendant PRUDENTIAL is ordered to modify its existing policies and procedures involving voluntary appeals to comply with ERISA standards;

(4) Awarding PLAINTIFFS and The Class equitable relief whereby PRUDENTIAL is ordered to re-evaluate all of the denied, terminated or suspended claims of

PLAINTIFFS and The Class in full compliance with ERISA providing a full and fair review of each claim and rendering disability payments to all such individuals whose adverse claim decisions are reversed upon re-evaluation.

(5) Alternatively, an independent third-party administrator should be retained by PRUDENTIAL to re-evaluate all of the denied, terminated or suspended claims of PLAINTIFFS and The Class in full compliance with ERISA providing full and fair review of each claim;

(6) For an award of such damages as are authorized by law;

(7) For an award of all reasonable costs and attorneys' fees incurred by PLAINTIFFS; and

(8) For such other and further relief as the Court may deem just and equitable.

Dated: February 18, 2010

Respectfully Submitted,

ATTORNEYS DELL AND SCHAFFER,
Attorneys for PLAINTIFFS
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New York, NY 10016
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GREGORY MICHAEL DELL, ESQUIRE
New York Bar #4513115

EXHIBIT "A"

ERISA STATEMENT

Plan Benefits Provided by

The Prudential Insurance Company of America
Prudential Plaza
Newark, New Jersey 07102

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer's ERISA plan(s). The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious.

Claim Procedures

1. **Determination of Benefits**

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a description of the Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and

(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

2. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Prudential Appeals Review Unit. The claim decision will be made by a member of the Prudential Claims Management Team. The Prudential Appeals Review Unit and Claims Management Team members are made up of individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

The Prudential Appeals Review Unit shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Prudential Appeals Review Unit expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

(a) the specific reason(s) for the adverse determination,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Upon receipt of a second appeal, the Prudential Appeals Review Unit will again conduct a full review of the claim file and any additional information submitted. The claim decision will be made by a member of the Prudential Senior Claims Management Team. The Appeals Unit and Senior Claims Management Team member would not have been involved in the initial benefit determination or in the first appeal.

The Prudential Appeals Review Unit shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Appeals Review Unit expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter as well as your right to appeal the decision to Prudential's Appeal Committee. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied upon appeal.

If the second appeal of your benefit claim is denied or if you do not receive a response to your second appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your authorized representative may make a third appeal of your denial in writing to the Prudential Appeals Committee within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your third appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Upon receipt of a third appeal, the claim will be directed to Prudential's Appeals Committee by a member of the Prudential Senior Claims Management Team. This Committee will be composed of three members of the Senior Claims Management Team who have not been involved in any previous appeals.

The Prudential Appeals Committee shall make a determination on your third claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to 90 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Appeals Review Unit expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to the third level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a third level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the third level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a third time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Rights and Protections

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EXHIBIT "B"

Appeals Procedures Division Memorandum

MEMORANDUM

Title : Appeals Procedures

Date: **December 27, 2004**

Prepared by: Drew DeChristopher
Manager, Disability Claims

Contents :

This memo serves as an addendum to Memorandums 2001-004 and 2002 -02 as well as to SOP 99-003 to reflect changes to appeals procedures effective January 1, 2005 and contains the following information :

- Outline of each step in the appeals process that applies to denied and terminated Short Term Disability and Long Term Disability claims effective January 1, 2005.
- Two attachments

Steps :

Specific steps for the **Short Term Disability** claims appeals process are included as **Attachment A** ; the specific steps for the **Long Term Disability** claims appeals process are included as **Attachment B**.

Exceptions :

- Claims subject to state mandated appeals procedures. For example, certain statutory STD plans - such as New Jersey TDB, New York DBL, and California SDI - mandate specific appeals procedures that must be followed on claim denials. We will continue to follow established procedures on claims under those plans.
- For ASO plans where Prudential is not designated as the appropriate named claim fiduciary for the review of appeals, appeals should be directed to the person/entity named in the ASO Plan to review appeals.
- ***Claims whereby an initial determination to terminate/deny benefits was made prior to January 1, 2005 and a 3 level appeal process was communicated in the most recent decision prior to January 1, 2005. In such a case where a 3 level appeal process was outlined in the most recent termination/denial prior to January 1, 2005, appeals procedures from GDM 99-003 dated January 8, 2004 will be applied.***

Appeals Procedures Division Memorandum

Attachments :

The following items are attached to supplement the above :

- **Attachment A** – describes the Short Term Disability claims appeals process effective January 1, 2005 for claims initially terminated/denied on or after January 1, 2005 (unless an exception applies).

- **Attachment B** – describes the Long Term Disability claims appeals process effective January 1, 2005 for claims initially terminated/denied on or after January 1, 2005 (unless an exception applies).

Attachment A : Short Term Disability claims appeal process for claims where an initial decision to terminate/deny benefits is made on or after January 1, 2005.

Initial Decision: In the event that a claim for Short Term Disability has been terminated or denied, the claimant is notified, in writing, of the decision, the specific reason for the decision and the information on which that decision was based. The letter will also advise the claimant of his/her right to appeal that decision and will include a description of the appeal process. This description will include the appropriate person to whom the appeal should be submitted, applicable time limits and a statement that the claimant has a right to bring a civil suit under section 502(a) of ERISA. The appeal must be filed in writing. In that appeal, the claimant may raise any issues or comments he/she wishes to be considered in the appeal, as well as providing any evidence or other documents to be considered.

First appeal: The first appeal of a denied or terminated claim is directed to Prudential's Short Term Disability Appeals Review Unit. Upon receipt of an appeal, the Short Term Disability Appeals Review Unit will conduct a full and independent review of the information in the claim file and any new information submitted to support the appeal utilizing individuals not involved in the initial decision. No deference can be given to the initial denial. Any additional information needed to reach a decision will be obtained. The Short Term Disability Appeals Review Unit will make a determination on the appeal within 45 days of receipt of the appeal. That period may be extended by another 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date the Short Term Disability Appeals Review Unit expects to render a decision will be provided to the claimant within the initial 45 day period.

The decision on the appeal will be authorized by a member of Prudential's Management Team not involved in the initial adverse decision on the claim. The claimant will be notified of the decision in writing. If the claim is again denied, the claimant will be advised in writing of the specific reason for the denial and the information on which that

denial was based. The letter will also advise the claimant of his/her right to file a voluntary second appeal, to whom the voluntary appeal should be submitted, applicable time limits, a statement that the claimant has a right to bring a civil suit under section 502(a) of ERISA and a statement that the claimant has a right to receive upon request information about the voluntary level of appeal. The letter will also inform the claimant that he/she is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits. That second appeal must also be made in writing, and must be filed within 180 days of receipt of the first appeal denial notice.

Second Appeal: Upon receipt of a second appeal, the Short Term Disability Appeals Review Unit will again conduct a full and independent review of the claim file and any additional information submitted. No deference can be given to either the initial denial or any denial on appeal. If it is determined that additional information is needed in order to reach a decision, that information will be obtained. The Short Term Disability Appeals Review Unit will make a determination on the second appeal within 45 days of receipt of the appeal. That period may be extended by another 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date the Short Term Disability Appeals Review Unit expects to render a decision will be provided to the claimant within the initial 45 day period.

The decision on the second appeal will be authorized by a member of Prudential's Management Team not previously involved in an adverse decision on the claim. The claimant will be notified of the decision in writing. If the claim is again denied, the claimant will be advised in writing of the specific reason for the decision and the information on which that decision was based. The letter will also include a statement that the claimant has a right to bring a civil suit under section 502(a) of ERISA. The second appeal decision will be final and cannot be further appealed.

After completion of the first level of appeal, the claimant may file a lawsuit under the Employee Retirement Income Security Act (ERISA). ERISA allows the claimant to file suit for policy benefits and reasonable attorney's fees. The claimant's decision on whether to file a second appeal will not affect his/her rights under ERISA.

Attachment B : Long Term Disability claims appeal process for claims where an initial adverse decision has been rendered on or after January 1, 2005 (other than where an exception applies).

Initial Decision: In the event that a claim for Long Term Disability has been terminated or denied, the claimant is notified, in writing, of the decision, the specific reason for the decision and the information on which that decision was based. The letter will also

advise the claimant of his/her right to appeal that decision and will include a description of the appeal process. The description will include the appropriate person to whom the appeal should be submitted, applicable time limits and a statement that the claimant has a right to bring a civil suit under section 502(a) of ERISA. The appeal must be filed in writing. In that appeal, the claimant may raise any issues or comments he/she wishes to be considered in the appeal, as well as providing any evidence or other documents to be considered.

First appeal: The first appeal of a denied or terminated claim is directed to Prudential's Appeals Review Unit. Upon receipt of an appeal, the Appeals Review Unit will conduct a full and independent review of the information in the claim file and any new information submitted to support the appeal utilizing individuals not involved in the initial decision. No deference will be given to the initial decision. Any additional information needed to reach a decision will be obtained. The Appeals Review Unit will make a determination on the appeal within 45 days of receipt of the appeal. That period may be extended by another 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date the Appeals Review Unit expects to render a decision will be provided to the claimant within the initial 45 day period.

The decision on the appeal will be authorized by a member of Prudential's Management Team not involved in the initial adverse decision on the claim. The claimant will be notified of the decision in writing. If the claim is again denied, the claimant will be advised of the right to file a voluntary second appeal, to whom the appeal should be submitted, applicable time limits a statement that the claimant has a right to bring a civil suit under section 502(a) of ERISA and a statement that the claimant has a right to receive additional information about the voluntary level of appeal. The letter will also inform the claimant that he/she is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits. That second appeal must also be made in writing, and must be filed within 180 days of receipt of the initial appeal denial notice.

Second Appeal: Upon receipt of a second appeal, the Appeals Review Unit will again conduct a full and independent review of the claim file and any additional information submitted. No deference can be given to either the initial denial or the denial on appeal. If it is determined that additional information is needed in order to reach a decision, that information will be obtained. The Appeals Review Unit will make a determination on the second appeal within 45 days of receipt of the appeal. That period may be extended by another 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date the Appeals Review Unit expects to render a decision will be provided to the claimant within the initial 45 day period.

The decision on the second appeal will be authorized by a member of Prudential's Management Team that was not previously involved in an adverse decision on the claim . The claimant will be notified of the decision in writing. If the claim is again denied, the

claimant will be advised in writing of the specific reason for the decision and the information on which the decision was based. The letter will also include a statement that the claimant has a right to bring a civil suit under section 502(a) of ERISA. The second appeal decision of is final and cannot be further appealed.

After completion of the first level of appeal, the claimant may file a lawsuit under the Employee Retirement Income Security Act (ERISA). ERISA allows the claimant to file suit for policy benefits and reasonable attorney's fees. The claimant's decision on whether to file a second appeal will not affect his/her rights under ERISA.

EXHIBIT "C"

Drew De Christopher/GLDI/INST/Prudential
Disability Management Services
Phone Number: (973) 548-5739
Fax Number: (866) 285-8569

To See Below
cc
bcc
Subject Updated guidelines for 2nd appeal handling

Fri 11/18/2005 12:10 AM

History: This message has been replied to and forwarded.

As discussed recently in full ARU staff meetings, our operation is shifting in its approach to the handling of volunteer appeal levels. This refers to either the 2nd or 3rd appeal, whichever is deemed to be the voluntary final appeal level.

For the voluntary appeal, the appeal can be handled by the same individual who handled the prior mandatory appeals. There are no requirements that Prudential consult with a different medical consultant if the claim was previously denied based upon the medical. A de novo standard of review does not apply.

Beginning with any voluntary 2nd appeals received 11/14/05 or later that have yet to be assigned, I would ask that each of you begin to manage your own 2nd appeals. You should make them pending and begin the review.

There are no hard and fast rules for what steps to take on such an appeal. You are expected to exercise good judgment based on the circumstances of the claim. If the claim review can be perfected further by taking an action, you should take such an appropriate action. If no action is warranted, that is ok too.

Due to needed changes to our Procedures Memos still pending final approval, there is one thing we will need to do at least on at least an interim basis. Whoever signed off on/authorized the 1st appeal can authorize/sign off on the 2nd. That does not mean the analyst cannot handle the claim steps and make a recommendation ... it just needs sign off. I'll keep you posted of any progress with the procedures memo.

A few things to remember:
- If the 1st appeal decision was such that it reverted back to 1st appeal wording (i.e. a closed period recon 1 decision), the new 1st appeal must be handled by someone different.
- If a claim is operating under a 3 step appeal process, the 2nd level is considered a "mandatory" level and therefore the 2nd appeal should not be handled by the same analyst.

Hopefully, this change will reduce caseload burden a bit since there will be files you will receive/self assign as new pendings that you will not need to learn from scratch. Desired behavior is to ensure that the 1st appeal review is the strongest review possible...as it could be the last review Prudential is afforded. If that behavior occurs, the burden of 2nd appeal reviews should be further lessened.

Please let me, Adam or Andrea know if you have any questions.

Thanks,
Drew DeChristopher
Manager, Appeals Review Unit
973-548-5739
866-285-8569 - (FAX)

To:
Andrea Degroot/GLDI/INST/Prudential
Tamika Artis/GLDI/INST/Prudential
Celeste Kolodin/GLDI/INST/Prudential
Renita Powell/GLDI/INST/Prudential
James Furman/GLDI/INST/Prudential
Nur Adiguzell/GLDI/INST/Prudential
Joseph Wallea/GLDI/INST/Prudential
Philip Miraldo/GLDI/INST/Prudential
Tara Johnson/GLDI/INST/Prudential
Nancy Pichette/GLDI/INST/Prudential
Adam Garcia/GLDI/INST/Prudential
Francesca Ledoux/GLDI/INST/Prudential
Tanya Anderson/GLDI/INST/Prudential
KRISTIE Charette/GLDI/INST/Prudential

EXHIBIT "D"

Summary of Material Modifications
of Claim Procedures

Effective Date: August 1, 2006

The following describes the current claims procedures followed by Prudential when processing Group Short Term Disability and Long Term Disability claims. It clarifies when a claim is considered to have been filed, and restates our current process for determining benefits and for the processing of appeals of adverse claim determinations. It is a Summary of Material Modifications (SMM), which is required to be disclosed to participants by federal law, and which explains the changes to the Summary Plan Description (SPD) of the Plan.

Claims Procedures

1. Filing of Disability Claims

Your disability claim will be considered filed when :

- If you have Short Term Disability (STD) coverage with Prudential, your claim for STD benefits will be considered filed the later of (1) when we receive your employee's statement, your employer's statement and your attending physician's statement, and (2) the start of your STD Elimination Period. (We interpret "statement" to mean, depending on the claim submission process in place with your employer, paper forms, electronic file feeds, web submissions, or information received via the telephone.)

- If you have Long Term Disability (LTD) coverage with Prudential, your claim for LTD benefits will be considered filed the later of (1) when we receive your employee's statement, your employer's statement and your attending physician's statement, and (2) the date that is 45 days before the end of your LTD Elimination Period. (We interpret "statement" to mean, depending on the claim submission process in place with your employer, paper forms, electronic file feeds, web submissions, or information received via the telephone.)

- If you have both STD and LTD coverages with Prudential and you have filed a claim for STD, there is no need to re-submit the statements noted above for the LTD portion of your claim. However, in this case your claim for LTD benefits will be considered filed the later of (1) when we receive the statements indicated above, and (2) the date that is 45 days before the end of your LTD Elimination period, provided you are receiving STD benefits on that date. If you are approved for STD benefits at a later date, your LTD claim will be considered filed on the date of the STD approval.

2. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the date your claim is considered filed. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45 day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on

which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information and the deadline, if any, stated in the information request.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,
(b) references to the specific plan provisions on which the benefit determination was based,
(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
(d) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and
(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

3. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information and the deadline, if any, stated in the information request.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the adverse determination,
(b) references to the specific plan provisions on which the determination was based,
(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all records, documents and other information relevant to your benefit claim upon request,
(d) a description of Prudential's review procedures and applicable time limits,
(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
(f) a statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information and the deadline, if any, stated in the information request.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no affect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by you and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied upon appeal.

Summary of Material Modifications
of Claim Procedures

The following describes some of the changes that will be made to the Plan's claims procedures, effective for claims where an initial adverse determination is made on or after January 1, 2005 . It is a Summary of Material Modifications (SMM), which is required to be disclosed to participants by federal law, and which explains the changes to the Summary Plan Description (SPD) of the Plan.

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45 day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,
(b) references to the specific plan provisions on which the benefit determination was based,
(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
(d) a description of the Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and
(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

2. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day

period . However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

(a) the specific reason(s) for the adverse determination,
(b) references to the specific plan provisions on which the determination was based,
(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
(d) a description of Prudential's review procedures and applicable time limits,
(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
(f) a statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no affect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied upon appeal.