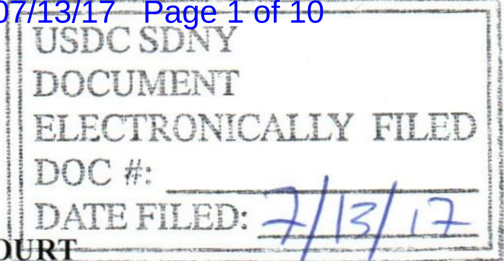
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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

R. ALEXANDER ACOSTA, Secretary, United States Department of Labor Plaintiff, v. MAGNACARE ADMINISTRATIVE SERVICES, LLC and MAGNACARE, LLC, Defendants.	Civil Action No. :16-cv-07695-DAB

CONSENT ORDER

Thomas E. Perez, former Secretary, United States Department of Labor, filed a complaint in the above-captioned action ("Complaint") against MagnaCare Administrative Services, LLC and MagnaCare, LLC (collectively, "MagnaCare") under Title I of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seq., as amended. On April 28, 2017, R. Alexander Acosta became the Secretary of Labor (the "Secretary"). Per Rule 25(d) of the Federal Rules of Civil Procedure, the Secretary is automatically substituted as plaintiff. Based on extensive discussions and negotiations, the parties have negotiated an agreement to settle all claims and issues between them in this action, and each of the parties consents to the entry of this Consent Order ("Order") by this Court as the sole and complete memorialization of the terms of such agreement.

1. This action was filed pursuant to ERISA section 502(a)(2) and (5), 29 U.S.C. § 1132(a)(2) and (5).

2. The Complaint alleges that MagnaCare breached its fiduciary duties and committed prohibited transactions in violation of ERISA in connection with the network

management fees that it charged to ERISA-covered healthcare benefit plan clients ("Plan Clients")[1] and its handling of emergency room claims and claims for which third parties may have been liable.

3. Specifically, the Complaint alleges, among other things, that MagnaCare failed to disclose the amount of its network management fee, thereby setting its own compensation for certain ancillary services provided in its proprietary provider network ("Network"); that MagnaCare processed certain emergency services claims in accordance with certain clients' benefit grids but not consistent with the "prudent layperson standard" and the Department's claims regulation; and that it failed to implement comprehensive procedures to address the processing of claims for which there could be potential third party liability.

4. The U.S. Department of Labor and MagnaCare engaged in constructive and collaborative discussions which resulted in the establishment of updated and binding policies and procedures relating to MagnaCare's fee structure for access to its Network and to certain of its claims processing procedures. MagnaCare met with the U.S. Department of Labor several times to resolve the Secretary's claims for the benefit of MagnaCare's ERISA Plan Clients. The U.S. Department of Labor and MagnaCare have negotiated this settlement through their respective attorneys in a mediation process.

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[1] For purposes of this Order, "Plan Clients" refers only to ERISA-covered plans that have purchased access to MagnaCare's Network, including the ancillary services portion of the Network, whether or not MagnaCare also provided third party plan administration services to those plan clients. "Plan Clients" does not include third party administrators that purchase access to MagnaCare's Network and resell such access to other plans; nor does it include any ERISA-covered plans obtaining access to MagnaCare's Network through such third party administrators; nor does it include any insurance company, third party administrator or other non-plan entity; nor does it include any plan not covered by ERISA.

5. MagnaCare neither admits nor denies the allegations in the Complaint and neither admits nor denies the existence of any facts upon which liability could be based. MagnaCare admits only the Court has jurisdiction over the parties and the subject matter of this action and that venue is proper and expressly waives service of the Complaint.

6. The parties expressly waive findings of fact and conclusions of law and consent to the entry of this Order as a full and complete resolution of the claims raised in the Secretary's Complaint, without trial or adjudication of any issue of fact or law raised in the Complaint. The parties agree that neither will appeal this Order as written and entered.

ACCORDINGLY, it is hereby ORDERED, ADJUDGED AND DECREED that:

I. JURISDICTION

The Court has jurisdiction over the parties to this Order and subject matter of this action and is empowered to provide the relief herein.

II. MONETARY RELIEF

II.A. MagnaCare shall pay or cause to be paid the total sum of $16,000,000.00, and possible future payments as described in paragraph II.B below, to settle the Secretary's allegations and claims for monetary relief as described in the Complaint and inclusive of civil penalties pursuant to ERISA § 502(l), 29 U.S.C § 1132(l). This amount includes a lump sum payment of $14,050,000.00 and payments of $650,000.00 per year for three years beginning in 2017 and ending in 2019. These payments shall be made as described below:

1. Payment of $12,772,727.27 shall be made to the MagnaCare Plan Clients listed on Exhibit A (previously filed with the Court under seal) within forty-five (45) days from the date of this Court's entry of this Order, with each Plan Client receiving a pro rata share as set forth in Exhibit A.

2. Payment of $1,277,272.73 shall be made to the Department of Labor as a civil penalty pursuant to ERISA § 502(l), 29 U.S.C § 1132(l), as described in paragraph II.C below.

3. Beginning on August 30, 2017 or forty-five (45) days after entry of this Order, whichever is later, and on August 30 of the next two years thereafter, MagnaCare shall pay $590,909.09 to the Plan Clients listed on Exhibit A, with each Plan Client receiving a pro rata share as set forth in Exhibit A, and $59,090.91 to the Department of Labor as a civil penalty pursuant to ERISA § 502(l), 29 U.S.C § 1132(l), as described in paragraph II.C below.

II.B. In addition, to the extent that MagnaCare's actual revenue in the "Access" and "Plan Management" categories exceeds its projected revenue as set forth in previously-filed Exhibit B, MagnaCare shall make additional payments equal to 10% of the excess, up to an aggregate maximum of $5,000,000.00, inclusive of civil penalties pursuant to ERISA § 502(l), 29 U.S.C § 1132(l), as described below.

1. MagnaCare's projected revenue in the "Access" and "Plan Management" categories for the years 2016 through 2018 is set forth in Exhibit B, previously filed with the Court under seal.

2. MagnaCare will provide to the Secretary a copy of its audited financial statements for the years ending 2016, 2017, and 2018 within thirty (30) days of either their issuance or entry of this Order, whichever is later.

3. Whether MagnaCare has exceeded its revenue projections in Exhibit B will be determined based on the audited financial statements.

4. If a payment is due, MagnaCare will pay or cause to be paid 90.9% of the payment to the Exhibit A Plan Clients on a pro rata basis as set forth in previously-filed Exhibit A and 9.1% of the payment to the Department of Labor as a civil penalty pursuant to ERISA § 502(l), as described in paragraph II.C below.

5. If a payment is due, it will be paid by August 30 of the following year. For example, if MagnaCare exceeds its projected revenue in 2016 by $1,000,000.00, as reflected in the audited financial statements issued for 2016, then $100,000.00 will be paid by August 30, 2017, with $90,909.09 paid to the Plan Clients on Exhibit A and $9,090.91 paid to the Department of Labor, as described in paragraph II.C.

II.C. For each payment made to Plan Clients as required by paragraphs II.A and B, the Secretary hereby assesses a penalty under ERISA § 502(l), 29 U.S.C. § 1132(l), of 20% of each "applicable recovery amount" as defined in ERISA § 502(l)(2). However, under the circumstances of this case, the Secretary hereby does and will accept, as full satisfaction of the assessed penalty, payment of 10% of the applicable recovery amounts paid pursuant to this Order. MagnaCare agrees to waive the notice of assessment and service requirement of 29 C.F.R. § 2570.83, and to waive all legal rights to appeal, contest, or seek a further reduction of this assessment. Within five (5) business days of making each payment to Plan Clients as required by paragraphs II.A and B above, the ERISA § 502(l) payment shall be paid by check made payable to the United States Department of Labor and shall reference EBSA Case No. 30-104763(48). The check shall be sent via U.S. mail to the following address:

U.S. Department of Labor
P.O. Box 71360
Philadelphia, PA 19176-1360

If MagnaCare wishes to remit a check by commercial express courier, MagnaCare shall contact Soroosh Nikouei (nikouei.soroosh@dol.gov or 202-693-8468), Shaqwaun Johnson (johnson.shaqwaun@dol.gov or 202-693-8494), or their successor at the United States Department of Labor's Employee Benefits Security Administration, and follow Department instructions.

II.D. Within sixty (60) days of each payment to Plan Clients as described in paragraphs II.B and C above, MagnaCare shall provide proof of payment to the Secretary. Such proof shall include statements verifying the allocation of amounts paid to Plan Clients as required by this Order, copies of cancelled checks, wire transfer confirmations of the payments, or such other proof as may be reasonably requested by the Secretary. Any proof provided under this paragraph shall be sent to the Secretary's representative at the following address:

Jonathan Kay, Regional Director
New York Regional Office
Employee Benefits Security Administration
U.S. Department of Labor
33 Whitehall St, Ste. 1200
New York, NY 10004

III. PROSPECTIVE RELIEF RELATING TO NETWORK MANAGEMENT FEES

III.A. Beginning forty-five (45) days after entry of this Order, prior to entering into any contracts with Plan Clients, MagnaCare shall provide a transparent fee disclosure to the prospective Plan Client that identifies each category of fees that MagnaCare charges. Such fee disclosure shall provide Plan Clients with sufficient detail so that a Plan Client can identify the potential amounts and components of each type of MagnaCare fee that may be charged, and estimate the total MagnaCare fees that may be charged during the contract period.

III.B. MagnaCare may continue to offer a fee arrangement that includes a Network Management Fee, provided that it complies with the requirements set forth herein.

III.C. Beginning with fees proposed on or after forty-five (45) days after entry of this Order, MagnaCare shall offer all of its Plan Clients, both existing and prospective, the option of a fixed fee arrangement, with no Network Management Fee or other embedded fee (the latter category constituting, regardless of MagnaCare's terminology, a "Network Management Fee").

III.D. Effective forty-five (45) days after entry of this Order, in quoting pricing arrangements to prospective Plan Clients that include a Network Management Fee, MagnaCare shall provide any prospective Plan Client, and any of such Plan's agents involved in determining whether to retain MagnaCare ("Procurement Agent"), that has not selected a fixed fee arrangement with access to the website, described in paragraph III.I below, after such prospective client and any of its Procurement Agents signs a confidentiality agreement. In addition, MagnaCare shall offer to reprice the prospective Plan Client's actual claims covering a reasonable prior period of time, not to exceed one year, and/or an up-front estimate of the Network Management Fees that the prospective Plan Client could incur in a calendar year, based on the experiences of other similarly situated Plan Clients. For the period of forty-five (45) days from the entry of this Order, MagnaCare shall provide any prospective Plan Client that has not selected a fixed fee arrangement (and such Plan's Procurement Agents(s)) with access to currently existing schedules containing, for each CPT code, the total amount MagnaCare charges a client for each CPT code procedure and the separate amount (generally lower for ancillary service providers) that MagnaCare has negotiated with each provider after such prospective client signs a confidentiality agreement.

III.E. Effective forty-five (45) days after entry of this Order, each contract proposed with a Plan Client or a third party administrator that chooses an arrangement with a Network Management Fee shall contain disclosures in language substantially identical to the following:

> In addition to fixed administrative fees for its services, MagnaCare generally charges Client a "Network Management Fee" for ancillary services (i.e., laboratory, radiology, durable medical equipment, ambulance/ambulatory, home care, and any other ancillary services). MagnaCare negotiates lower rates for services with certain ancillary service providers than it charges you as Client. MagnaCare retains, as MagnaCare's Network Management Fee, the difference between the rate paid to the ancillary provider and the rate charged to you as Client.

III.F. MagnaCare shall give all Plan Clients that choose an arrangement with a Network Management Fee the right to negotiate a switch to a fixed fee arrangement with no Network Management Fee at any time upon ninety (90) days' written notice.

III.G. MagnaCare shall not increase any Network Management Fee without giving Plan Clients ninety (90) days' advance written notice and the opportunity to terminate MagnaCare's services without penalty before the fees are effective by providing thirty (30) days' advance written notice to MagnaCare. This provision will not apply to regulatory changes made to CPT codes.

III.H. Effective forty-five (45) days after entry of this Order, each contract proposed with a Plan Client or a third party administrator that chooses an arrangement with a Network Management Fee shall contain disclosures in language substantially identical to the following:

> MagnaCare will provide each Client with ninety (90) days advanced written notice of any increase in the Network Management Fee. Upon such notice, Client shall have the right to terminate the agreement without penalty before the fees are effective by providing thirty (30) days advance written notice to MagnaCare.
>
> This provision will not apply to regulatory changes made to CPT codes.
>
> At any time, upon ninety (90) days' written notice, Client will have the right to negotiate a switch to a fixed fee arrangement with no Network Management Fee.

III.I. By forty-five (45) days after entry of this Order, MagnaCare shall provide a website to enable Plan Clients to look up CPT codes as to which MagnaCare charges a Network Management Fee and shall make this website available to Plan Clients and shall provide information to access the website in its contracts and explain what information the website contains. For each such CPT code, this website shall separately state the exact amount the Plan Client shall pay to the provider and the exact amount the Plan Client shall pay to MagnaCare for Network Management Fees; provided, however that, where appropriate, ranges or averages may be stated where different providers are paid different amounts. MagnaCare shall make the website available to all Plan Clients on a Network Management Fee arrangement as long as it continues to assess Network Management Fees. In the event that MagnaCare ceases charging Network Management Fees, it shall maintain all relevant records on Network Management Fees for six years after such discontinuance, as required under ERISA § 107, 29 U.S.C. § 1027.

III.J. By forty-five (45) days after entry of this Order, every batch bill sent to a Plan Client that chooses an arrangement with a Network Management Fee shall include, as separate items, (1) the dollar amounts of the Network Management Fees that MagnaCare has charged on each claim from that bill; and (2) the aggregate of Network Management Fee revenue charged by MagnaCare with respect to that batch bill.

III.K. Any Plan Client shall be permitted to terminate its contract with MagnaCare upon ninety (90) days' written notice following receipt of any disclosure of fees.

III.L. Starting forty-five (45) days after entry of this Order, each batch bill with any Plan Client that chooses an arrangement with a Network Management Fee shall contain disclosures in language substantially identical to the following:

> For ancillary services (i.e., laboratory, radiology, and durable medical equipment, ambulance/ambulatory, home care and any

other ancillary services), MagnaCare negotiates lower rates with certain providers than it charges Clients. MagnaCare retains the difference between these two. The difference is MagnaCare's Network Management Fee. This batch bill discloses totals for all such claims included in this batch bill.

III.M. Starting forty-five (45) days after entry of this Order, for Plan Clients who receive electronic claims in lieu of batch bills, and who choose an arrangement with a Network Management Fee, MagnaCare will provide reports, at least quarterly, that provide the information reflected in paragraph III.L above, including the cumulative Network Management Fees charged by MagnaCare for that quarter, as well as clear instructions for the Plan Client to be able to look up the Network Management Fee for each code reported on the electronic claims. Upon request, MagnaCare shall generate reports for electronic claims for Plan Clients showing the Network Management Fees for the codes billed to that client in that quarter.

III.N. MagnaCare shall disclose totals of the Network Management Fees charged to Plan Clients no less frequently than quarterly.

III.O. Starting forty-five (45) days after entry of this Order, MagnaCare shall communicate to Plan Clients all cumulative Network Management Fees, if any, on an annual basis, for Form 5500 reporting purposes. All such communications with Plan Clients shall refer to the fixed fees as "fixed fees" and the Network Management Fees as "network management fees."

III.P. Effective forty-five (45) days after entry of this Order, MagnaCare shall propose revisions to each of its contracts with Plan Clients as specified in paragraphs III.C, E, F, G, H, and K above; and revisions to each of its contracts with third party administrators as specified in paragraphs III.E and H above. MagnaCare may propose revisions to each contract by providing an addendum to the unexpired contract or by providing a new contract.

III.Q. By forty-five (45) days after entry of this Order, MagnaCare shall provide each Plan Clients that has not already received such a report, a report covering the past three years which shall separately state for each year the amounts of fixed fees and any Network Management Fees received by MagnaCare for that Plan Client for that time period.

III.R. MagnaCare shall permit each Plan Client access, during normal business hours, to inspect records to determine compliance with these terms. MagnaCare also shall cooperate with Plan Clients to enable Plan Clients to verify the accuracy of the amounts of fees, charges and the like paid by Plan Clients, including providing access to MagnaCare's Plan Client records and an explanation of such records.

IV. RELIEF RELATING TO EMERGENCY SERVICES CLAIMS

IV.A. The following procedures are intended to implement the "prudent layperson" standard regarding the processing of claims for services in an emergency department of a hospital ("ER Claims") embodied in Section 2719A of the Public Health Service Act and ERISA Section 715(a)(1). The provisions of this Section IV shall be effective forty-five (45) days after entry of this Order.

IV.B. In processing ER Claims for Plan Management Plan Clients ("PM Plan Clients"), MagnaCare shall ensure that its policies comply with the Department of Labor's claims procedures regulation, the internal claims and appeals and external review provisions and the prudent layperson standard of the Affordable Care Act, 42 U.S.C. §§ 18001 et seq., where applicable, as well as PM Plan Clients' plan requirements, plan documents, including the plan SPD. If MagnaCare is unable to give effect to any provision of a PM Plan Client's plan documents because that provision conflicts with applicable law or for any other reason, MagnaCare shall so inform the PM Plan Client.

IV.C. If, during the onboarding of a new PM Plan Client, MagnaCare identifies plan document provisions or other PM Plan Client directives that MagnaCare believes may not provide MagnaCare with appropriate direction or that may conflict with MagnaCare's obligations to process ER Claims consistent with applicable laws and regulations, MagnaCare shall work with the PM Plan Client, as well as its counsel and consultant(s), to set up the PM Plan Client's benefit grid to allow the processing of ER Claims consistent with MagnaCare's policies and procedures.

IV.D. If MagnaCare receives a PM Plan Client's plan documents and believes that the plan documents may be inconsistent with applicable requirements of the Affordable Care Act or the Department of Labor claims procedures regulation, MagnaCare shall recommend that the PM Plan Client obtain advice of plan counsel on amendments or changes to its plan documents.

IV.E. In processing ER Claims for PM Plan Clients, when (1) a claim is submitted to MagnaCare electronically (via the UB-04 Form CMS-1450, the Health Insurance Claim Form CMS-1500, or any other standard form which may be developed), (2) the claim does not include any diagnosis code matching any of the TRUE ER diagnosis codes in MagnaCare's automated claims system, and (3) MagnaCare does not have adequate information or documentation to adjudicate the claim under the prudent layperson standard, MagnaCare shall send an Explanation of Benefits (EOB) to the participant or beneficiary and Remittance Advice (RA) to the provider(s) containing the following statement:

> WE HAVE NOT YET DETERMINED WHETHER THIS CLAIM IS COVERED BY THE PLAN. WE NEED ADDITIONAL INFORMATION IN ORDER TO DECIDE THE CLAIM. YOU HAVE 45 DAYS FROM RECEIPT OF THIS NOTICE TO SUBMIT ADDITIONAL INFORMATION TO US. IF WE DO NOT RECEIVE ANY ADDITIONAL INFORMATION WITHIN 45 DAYS, THE CLAIM WILL BE DENIED.

THE DOCUMENTATION/MEDICAL RECORDS THAT WOULD ASSIST US IN REVIEWING THIS CLAIM SHOULD PROVIDE A DESCRIPTION OF ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) SUCH THAT A PRUDENT LAYPERSON, WITH AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, COULD REASONABLY EXPECT THAT ABSENCE OF IMMEDIATE MEDICAL ATTENTION WOULD PLACE THE INDIVIDUAL'S HEALTH (OR IN THE CASE OF PREGNANT WOMAN, HEALTH OF UNBORN CHILD), IN SERIOUS JEOPARDY, OR SERIOUSLY IMPAIR BODILY FUNCTIONS, ORGANS OR PARTS.

IF YOU HAVE ADDITIONAL RECORDS, MATERIALS, OR OTHER INFORMATION THAT YOU WOULD LIKE TO BE CONSIDERED, PLEASE TRANSMIT THEM TO [ADDRESS].

IV.F. Following the issuance of such an EOB and RA, if a participant, beneficiary and/or provider submits additional information before all applicable extensions expire, MagnaCare shall review that information and adjudicate the claim under the prudent layperson standard.

IV.G. Concurrent with, or before, MagnaCare's renewal of its contract with each current PM Plan Client, but in no event later than ninety (90) days after entry of this Order, MagnaCare shall transmit the Model Plan Amendment attached as Exhibit D to the PM Plan Client. On or before October 1, 2017 or five (5) months after entry of this Order, whichever is later, MagnaCare shall make a summary report to the New York Regional Office of the United States Department of Labor's Employee Benefits Security Administration ("EBSA New York") confirming that it did so.

IV.H. For the 4,520 ER Claims (1) which were adjudicated by MagnaCare and current PM Plan Clients with dates of service from January 1, 2011 through December 31, 2015, and (2) which were denied, in full or in part (and not later adjusted) because the claims forms did not

contain a diagnosis code that matched any of the emergency/TRUE ER codes in MagnaCare's automated claims system ("Past Claims"), MagnaCare shall proceed as set forth below:

1. MagnaCare shall write to each of the affected Clients and: (a) advise them that the Department of Labor is requiring that MagnaCare notify them that the Department of Labor requests them to re-open their appeal period to allow participants and beneficiaries to appeal the Past Claim denials despite the plans' time-bar for appeals; (b) request addresses for the participants and beneficiaries whose Past Claims were initially denied, for all Past Claims for which the clients agree to reprocessing; and (c) offer to process the new appeals of Past Claims without an additional fee and to process the payments of any Past Claims which the clients decide to fund after re-processing.

2. For all Claims for which the affected Clients agree to the terms of paragraph IV.H.1 above, MagnaCare shall send a letter to each participant or beneficiary with respect to such Claims and, if the participant or beneficiary agrees, also to each provider with respect to such Claims. The letters to participants, beneficiaries and providers shall include the following language:

A CLAIM YOU PREVIOUSLY SUBMITTED FOR PAYMENT FOR EMERGENCY SERVICES MAY HAVE BEEN DENIED IN WHOLE OR IN PART BASED ON LACK OF SUFFICIENT INFORMATION TO SUPPORT THE CLAIM.

IT IS RECOMMENDED THAT YOU AND/OR THE PROVIDER PROVIDE ADDITIONAL INFORMATION AS SOON AS POSSIBLE IN ACCORDANCE WITH THE INSTRUCTIONS BELOW.

THE DOCUMENTATION/MEDICAL RECORDS THAT WOULD ASSIST IN REVIEWING AN EMERGENCY SERVICES CLAIM SHOULD PROVIDE A DESCRIPTION OF ACUTE SYMPTOMS, IF ANY, OF SUFFICIENT SEVERITY

(INCLUDING SEVERE PAIN) SUCH THAT A PRUDENT LAYPERSON, WITH AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, COULD REASONABLY EXPECT THAT ABSENCE OF IMMEDIATE MEDICAL ATTENTION WOULD PLACE THE INDIVIDUAL'S HEALTH (OR IN THE CASE OF PREGNANT WOMAN, HEALTH OF UNBORN CHILD), IN SERIOUS JEOPARDY, OR SERIOUSLY IMPAIR BODILY FUNCTIONS, ORGANS OR PARTS.

IF YOU HAVE ADDITIONAL RECORDS, MATERIALS, OR OTHER INFORMATION THAT YOU WOULD LIKE TO BE CONSIDERED, PLEASE TRANSMIT THEM TO [ADDRESS] WITHIN 180 DAYS.

YOU MAY REQUEST COPIES OF THE CURRENT RECORD AND INFORMATION RELEVANT TO YOUR CLAIM BY CONTACTING US AT [CONTACT INFORMATION].

3. Letters to participants and beneficiaries shall also include the following paragraph:

If you (or anyone else) paid bills related to this claim, please tell us so, and send records of those payments if possible to [contact information]. If you suffered any adverse debt collection action (such as a negative notation on your credit report, a lawsuit, a lien, or a foreclosure) as a result of this claim remaining unpaid, please provide details to [contact information].

4. Letters to providers shall also include the following paragraph:

Please tell us if you have undertaken any debt collection activities with respect to this claim, including but not limited to adverse reporting to credit reporting bureaus, forwarding this debt to a collection agency, filing a lawsuit, or placing a lien. The Department of Labor requests that you suspend all debt collection activities relating to this claim until it has been readjudicated or until January 1, 2018, whichever is later. The Department of Labor further requests that you promptly reverse and correct any negative credit reporting related to this claim if this claim is subsequently paid after readjudication, by indicating that the debtor was not at fault. Furthermore, please tell us if your charges for this claim were actually paid, and if so, by whom.

5. MagnaCare shall send such communication regardless of whether MagnaCare believes that the provider has written off the bill and the participant or beneficiary faces no personal financial responsibility for the ER Claim.

6. MagnaCare shall not recommend the denial of a readjudicated claim as untimely due to the time required to submit documentation in response to the letter described above, so long as documentation is submitted by January 1, 2018.

IV.I. MagnaCare shall send a letter to the 25 former PM Plan Clients ("Former Clients") who terminated their relationships with MagnaCare after January 1, 2011 and for whom it has identified ER Claims adjudicated as set out in paragraph IV.H above. This letter will (a) inform the Former Client of the readjudication service that MagnaCare is providing to its PM Plan Clients under paragraph IV.H above (b) identify the 586 Past Claims (or any other number that MagnaCare subsequently agrees with the Secretary is correct) which MagnaCare reasonably believes, based upon the records in its possession, would be subject to such readjudication, and (c) offer the Former Client the opportunity to elect readjudication pursuant to paragraph IV.H above.

IV.J. MagnaCare shall, within thirty (30) days after receipt of such information, notify the EBSA New York if any provider or participant reports to MagnaCare debt collection action with regard to the Past Claims about which MagnaCare communicated to the participants, beneficiaries and/or providers.

IV.K. With regard to the ER Claims reprocessing effort, if a participant, beneficiary or provider appeals the original Past Claim denial and submits supplemental information within the one hundred eighty (180) days provided:

1. MagnaCare shall process the appeal and advise the affected PM Plan Clients of any Past Claims that it believes should be paid and process any payments approved and funded by the PM Plan Clients.

2. MagnaCare shall issue new EOB and RA forms for any re-processed Past Claims.

3. To the extent that MagnaCare determines that a previously denied Past Claim should be paid but the participant or provider reports that the Past Claim already had been paid by the participant, beneficiary, or other person to the provider, then MagnaCare shall advise the PM Plan Client of those facts and further advise the PM Plan Client that the Department of Labor believes that the PM Plan Client should make a payment to the participant, beneficiary, or other person (if allowable under the law), regardless of whether the person is still a plan participant or beneficiary.

4. Until June 30, 2018, MagnaCare shall provide to the Secretary, within thirty (30) days after the Secretary's demand, a list of Past Claims which MagnaCare has reprocessed and recommended to be denied because they did not meet the prudent layperson standard set forth in Section 2719A of the Public Health Service Act, along with all pertinent information MagnaCare received on the Past Claim and the basis for its decision.

IV.L. At the end of the re-processing program, on or about January 1, 2018, MagnaCare shall provide a report to the Secretary, through EBSA New York, including the following: (1) the number and type of communications made to plans, participants, and providers, (2) the identities of any participants or providers who reported debt collection action, (3) the number of claims reprocessed, (4) the number of claims payments processed, (5) the aggregate amount of claims

payments processed, and (6) a specification of which claims, if any, were denied in part or in full.

IV.M. Through June 30, 2018, MagnaCare shall fully cooperate with affected PM Plan Clients, participants, beneficiaries, and providers, by providing copies of previously provided documents and/or creating claims explanation documents to participants and beneficiaries on request, in connection with their efforts to ensure that the prior denial of Past Claims that are subsequently deemed payable, in whole or part, does not adversely impact such participants' credit history.

V. PROSPECTIVE RELIEF RELATING TO CLAIMS THAT IMPLICATE THIRD-PARTY LIABILITY

V.A. As a guiding principle, MagnaCare shall ensure that its Subrogation and Third Party Recovery Policies for current PM Plan Clients comply with the Department of Labor's claims procedures regulation and the PM Plan Clients' plan documents and requirements, including the plan SPD, provided by the PM Plan Clients to MagnaCare. The provisions of this Section VI shall be effective forty-five (45) days after entry of this Order.

V.B. MagnaCare shall implement a Subrogation and Third Party Recovery Policy, which shall provide that:

1. Each PM Plan Client's claims shall be processed in accordance with that client's plan provisions regarding subrogation and third party liability as shared with MagnaCare.

2. If, during the onboarding of a new Client, MagnaCare identifies in the PM Plan Client's plan document provisions or is provided other PM Plan Client directives that MagnaCare believes fail to provide MagnaCare with appropriate direction for identifying such potential subrogation claims, MagnaCare shall work with the PM Plan

Client, as well as the client's counsel and consultant(s), to set up the PM Plan Client's benefit grid to address whether or not the PM Plan Client seeks to have MagnaCare "turn on" subrogation and third party recovery service processes.

a. "Turn on" subrogation and third party recovery services means that MagnaCare will identify claims for which, based on the reported diagnosis codes, a possibility exists that the claim resulted from a third party accident or injury, triggering the "Subro" process described below.

b. If the PM Plan Client opts entirely to "turn off" the Subrogation and Third Party Recovery Services process, this policy will not apply and MagnaCare will process its claims under its default claims processing policies, ignoring the potential third party claim liability issues.

c. If the PM Plan Client chooses to "turn on" the Subrogation and Third Party Recovery Services process, this policy and the procedures set out herein will apply.

d. Notwithstanding the foregoing, if a PM Plan Client expressly asks MagnaCare to craft a customized policy and procedure for handling its claims that differs from this policy, MagnaCare may work with the PM Plan Client on such a customized policy, so long as MagnaCare believes such a policy would not conflict with MagnaCare's obligations under applicable laws and regulations.

3. The following procedures shall relate to claims submitted only through Health Insurance Claim Form HCFA (CMS 1500) forms:

a. Claims that are affirmatively identified by the medical provider as being covered by other insurance (such as workers compensation insurance or

automobile accident insurance) shall be automatically denied unless the PM Plan Client instructs otherwise.

(1). For example, a claim for which any field in Box 10 of the current HCFA form is checked Yes will be deemed to be subject to subrogation and denied unless the client instructs otherwise.

b. Claims that are not affirmatively identified by the provider on a HCFA form as being covered by other insurance will not be automatically denied. In its initial automated claims process, MagnaCare shall not assume that any accident or injury for which medical services or procedures were rendered to the patient will be covered by other insurance unless the HCFA form for that claim so indicates. Instead, where there is no Yes checked in Box 10 or equivalent affirmative identification on the HCFA form, MagnaCare shall follow the same procedure set out below for UB claim forms.

4. Procedures related to claims submitted only through UB-04 Form CMS-1450 forms:

a. If a submitted claim includes a diagnosis code matching any of the SUBRO diagnosis codes in MagnaCare's automated claims system, then the claim shall be placed in a "pend" status and a Subrogation Letter and Questionnaire ("Letter") shall be submitted to the participant and provider for further information.

b. If, in accordance with its established procedures, MagnaCare contacts participants and/or providers in order to obtain more information about other potential insurance coverage or third party liability before adjudicating the

claim, MagnaCare shall ensure that the claim is processed within applicable time limits.

(1). The participant and the provider will be given twenty-one (21) days from the date of the Letter to submit a response.

(2). If a response is received from the participant or provider within twenty-one (21) days expressly stating that the claim is not subject to subrogation or related to a workplace injury or accident, then the claim will be processed pursuant to MagnaCare's default claims processing procedures.

(3). If a response is received from the participant or provider within twenty-one (21) days expressly stating that the claim is subject to subrogation or related to a workplace injury or accident, then the claim will be denied and a copy of the completed response submitted to the client for follow up action per the client's plan design.

(4). If no response is received within twenty-one (21) days, then the claim will be initially denied, and the participant is free to appeal the claim under the client plan's ERISA claims procedures.

V.C. For all current PM Plan Clients with participant claims that were incurred, processed and denied (and not later adjusted) on the basis of third-party liability or subrogation between August 8, 2008 and December 31, 2015, MagnaCare shall contact each relevant client and ask it to determine, within one hundred eighty (180) days, whether it has any record or information of any participant or any other person identifying to it that no other insurer or other party was responsible for or paid the Claim and that the participant paid for the Claim himself or

herself and was not reimbursed for his or her out of pocket payment, or suffered an impairment to his or her credit history. For each such participant identified by the Client, MagnaCare shall offer to re-process the claim if the Client agrees to re-open its appeal period and pay otherwise eligible Claims so re-processed.

VI. RELEASES

VI.A. The present Order represents a full, final and complete resolution of all of the claims alleged in the Secretary's Complaint against MagnaCare and the investigation incident thereto, and the related civil penalty claims under ERISA § 502(l), 29 U.S.C. § 1132(l) based on payments by MagnaCare under this Order. Except as set forth herein, the Secretary hereby releases all actions, claims, and demands that he has or may have against MagnaCare, and each of its past and present agents, attorneys, trustees, consultants, representatives, servants, partners, principals, officers, directors, shareholders, members, employees, employers, subsidiaries, parents, affiliates, subsidiaries, joint venturers, insurers, participants, beneficiaries, predecessors, successors, spouses, in-laws, dependents, children, grandchildren, heirs yet unborn, executors, administrators, heirs, and assigns that are based upon or arise out of the allegations in the Secretary's Complaint, the maintenance of this action and any investigation incident thereto.

VI.B. MagnaCare does hereby release the Secretary and her officers, agents, attorneys, employees, and representatives, both in their individual and governmental capacities, from all actions, claims and demands of whatsoever nature, including those arising under the Equal Access to Justice Act or any statute, rule or regulation, that are based upon or arise out of the filing, prosecution, and maintenance of this action and any investigation incident thereto.

VI.C. The Secretary and MagnaCare shall each bear his or its own costs, expenses, and fees (including expert fees and attorney fees) in connection with this action and any investigation

incident thereto.

VII. OTHER TERMS

VII.A. In the event that, for any reason whatsoever, the Court declines to approve this Order, the parties may proceed with litigation of the action as if they had never executed this document.

VII.B. Nothing in this Order shall prevent MagnaCare from updating its policies and procedures to the extent the United States Congress, the Department of Labor or another federal governmental agency of competent jurisdiction issues statutes, regulations, rules or guidance updating the standards reflected herein with regard to fee disclosures, Form 5500 reporting, emergency room claims processing, or third party liability claims.

VII.C. MagnaCare has provided its balance sheet as of June 30, 2016, set forth in Exhibit C (previously filed with the Court under seal), and its revenue projections for the plan management and access clients for 2016 through 2018, set forth in Exhibit B. MagnaCare acknowledges that the Secretary is relying upon the information provided by MagnaCare in previously-filed Exhibits B and C in entering into this Consent Order. MagnaCare represents that the interim financial data set forth in Exhibit C, was true, accurate, and complete to the best of its knowledge and belief. MagnaCare further represents that the revenue projections contained in Exhibit B were prepared in the ordinary course of business and represent a good faith effort to project revenue at the time they were prepared. If, upon receipt of the year-end audited financial statements, the Secretary has a reasonable and good faith belief that MagnaCare's projections, set forth in Exhibit B, were not prepared in good faith or in the ordinary course of business, or that its balance sheet as of June 30, 2016, set forth in Exhibit C, contains material misrepresentations or omissions, the Secretary shall be permitted to conduct discovery and, upon

motion and with reasonable prior notice, to establish at an evidentiary hearing that MagnaCare has made a material misrepresentation or omission and seek relief from the Court.

VII.D. If the Secretary reasonably believes that MagnaCare has materially violated a material term of this Order, other than a default of MagnaCare's obligations in Section II above, the Secretary shall provide written notice ("Notice") to MagnaCare, via either overnight courier or electronic mail and first class mail, and to its counsel at the address set forth below for MagnaCare's undersigned counsel, or at such other address that MagnaCare specifies in writing, with a description of the alleged violation. The parties agree to meet, in person or by such means as are mutually agreeable, to confer in good faith to attempt to resolve the alleged violation no later than ninety (90) days following the mailing of such Notice. The Secretary may take such actions as the Secretary deems appropriate if the parties are unable to resolve their dispute within ninety (90) days following the mailing of the Notice. Nothing in this Order shall limit the Secretary's right to take immediate action upon MagnaCare's failure to comply with its obligations under Section II above.

VII.E. By entering into this Order, the parties hereto represent that they have been informed by counsel of the effect and purpose of this Order and agree to be bound by its terms. Each of the undersigned attorneys expressly acknowledges and represents that he or she is authorized and empowered to execute this Order on behalf of the party represented.

VII.F. This Order is not binding on any governmental agency other than the United States Department of Labor. This Order is binding on MagnaCare and its successors and assigns.

VII.G. Except for the releases set forth herein, nothing in this Order shall be construed to:

1. limit the powers and authority of any officer or employee of the United States under ERISA or any other law;

2. relieve MagnaCare or any of its officers, directors, attorneys, employees, advisers, providers of goods or services, consultants, representatives, or agents of any duty or responsibility under ERISA or any other law; or

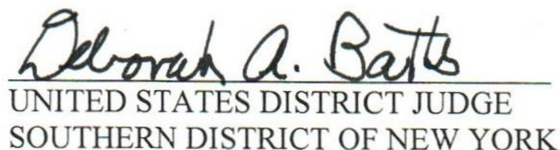
3. render the Secretary or any representative, attorney, or agent of the Secretary as a fiduciary or other responsible party under ERISA.

VII.H. The parties understand that the Court will close this case on its docket. MagnaCare agrees that it will continue to implement the policies and procedures set forth in Sections III through V of this Order. Assuming that MagnaCare has made the payments required under Section II of this Order, MagnaCare's payment obligations will cease as of September 1, 2019.

VII.I. This Order may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same instrument.

The Court finds that there is no just reason to delay the entry of this Consent Order and, pursuant to Rule 54(b) of the Federal Rules of Civil Procedure, expressly directs the entry thereof as a final Consent Order.

SO ORDERED this 13th day of July 2017.



UNITED STATES DISTRICT JUDGE
SOUTHERN DISTRICT OF NEW YORK

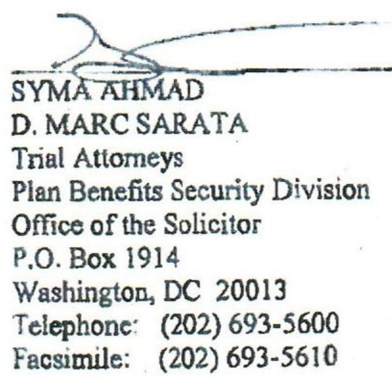
The parties, by themselves or their undersigned counsel, hereby consent to the entry of this Consent Order:

For the Secretary:

NICHOLAS C. GEALE
Acting Solicitor of Labor

G. WILLIAM SCOTT
Associate Solicitor
Plan Benefits Security Division

RISA D. SANDLER
Counsel for Fiduciary Litigation


____________________ Dated: 5/24/17

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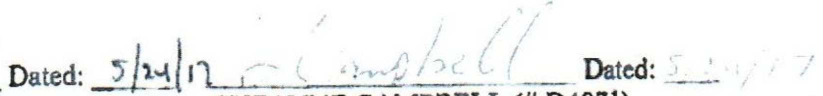
____________________ Dated: [illegible]

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For MagnaCare Administrative Services, LLC

ADAM YOUNG
Chief Legal Officer

____________________ Dated: 5/23/17

For MagnaCare, LLC

ADAM YOUNG
Chief Legal Officer

____________________ Dated: 5/23/17

MagnaCare Administrative Services, LLC and MagnaCare, LLC, having been represented by counsel:

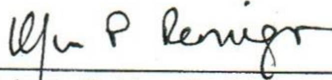

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EXHIBIT A

(Previously Filed Under Seal)

EXHIBIT B

(Previously Filed Under Seal)

EXHIBIT C

(Previously Filed Under Seal)

EXHIBIT D

The U.S. Department of Labor recommends that you adopt the Model Plan Amendment below to facilitate the Third Party Administrator's ("TPA") processing of claims for services in an emergency department of a hospital under your Plan.

As you know, TPAs process most emergency services claims on an expedited basis by comparing the diagnosis codes submitted by healthcare providers to a "TrueER list" of common emergency conditions. Some claims, however, cannot be decided in this expedited manner. For those claims, TPAs review additional medical documentation to determine whether the claim meets the "prudent layperson" standard. The purpose of this amendment is to give medical providers and plan participants and beneficiaries additional time to submit documentation so that TPAs can review the emergency services claim. This amendment conforms to the claims regulation, 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).

The ________________ Plan is hereby amended to incorporate the following additional claims processing provisions:

When a claim for services in an emergency department of a hospital ("emergency services claim") is submitted to the Third Party Administrator for payment, the Third Party Administrator shall adjudicate the emergency services claim under the prudent layperson standard contained in section 2719A of the Public Health Service Act, 42 U.S.C. § 300gg-19a, as incorporated into ERISA pursuant to section 715(a)(1), 29 U.S.C. § 1185d(a)(1).

If the Third Party Administrator determines that it does not have sufficient information necessary to decide the emergency services claim, the Third Party Administrator shall so notify the participant or beneficiary and the healthcare provider(s) through its Explanation of Benefits and Remittance Advice notices. This notice shall specifically describe the required information and the prudent layperson standard. The Plan directs the Third Party Administrator to give the participant or beneficiary and the healthcare provider 45 days from receipt of the notice within which to provide the specified information, pursuant to 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).