Employee Benefits Law
Chapter 13 Benefit Claims
2018 Midwinter Report

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13
Benefit Claims

I. Introduction

II. Claims Procedures

A. Overview

Third Circuit

U.S. Renal Care, Inc. v. Wellspan Health, 2017 WL 1062374 (M.D. Pa. March 21, 2017). In deciding a claim for additional benefits by Plaintiff, an out-of-network dialysis provider suing as assignee of plan beneficiary, the Court found Plaintiff failed to satisfy exhaustion requirements and denied its motion for summary judgment. The Court also denied Plaintiff's claim for a disclosure violation and for enhanced discovery beyond the administrative record. The Court also found the Plan was within its rights to recoup overpayments to the provider-assignee by withholding future payments due on account of the same patient.

Eleventh Circuit

Griffin v. General Electric Company, No. 15–4439 (AT), 2017 WL 3449607 (N.D. Ga. Jan, 6, 2017). Plaintiff, an out-of-network dermatologist proceeding pro se, asserted that Defendant-Plan secretly discriminates against female and minority medical provider-assignees by selectively enforcing the plan's anti-assignment provision based on the demographics of the provider seeking to enforce the patient's ERISA rights. "As the basis for her Section 1557 claim for discrimination, Plaintiff asserts the following: (1) she was treated differently than her similarly situated colleagues who are mostly white males; (2) she was subjected to more restrictive assignment of benefits policy language in the health plan documents as compared to similarly situated colleagues who are mostly white males; (3) Defendant discriminated against her by denying her derivative standing under ERISA because of her gender and race; and (4) as a result, she is denied an equal opportunity to stand in the shoes of her patients because of her gender and race." On a motion to dismiss, Defendant-plan argued that Plaintiff had not sufficiently pled that Defendant received "Federal financial assistance," the triggering prerequisite for Section 1557 applicability. The Court granted the motion without prejudice; Plaintiff may amend her complaint to plead sufficient facts.

B. Reasonable Internal Claims Procedures

1. Claims and Review Procedures for Other Than Affordable Care Act Claims

Second Circuit

Professional Orthopaedic Associates, PA v. 1199SEIU National Benefit Fund, 697 Fed.Appx. 39 (2d Cir. Sept. 6, 2017) (unpublished). Citing *Halo v. Yale Health Plan et. al.*, 819 F.3d 42, 58 (2d Cir. 2016), the Court held that failure to provide information required under ERISA § 503 and 29 C.F.R. § 2560.503-1 did not give rise to civil penalties under ERISA, and that a request for the data and policies used to establish the reimbursement rate does not constitute a request for documents under Section 104(b)(4), but rather a request for an explanation of the Fund's determination of benefits.

Third Circuit

Roche v. Aetna, Inc., 681 Fed.Appx. 117 (3d Cir. Mar. 9, 2017). After Plaintiff, an accident victim, reached a settlement with the tortfeasor entitling her to compensation for her accident-related injuries, Aetna requested from Plaintiff reimbursement of the approximately $88,000 it paid to cover her accident-related medical expenses. Plaintiff reimbursed Aetna but brought suit against Aetna contesting its demand. Plaintiff argued that her claim was outside the scope of ERISA claims procedures because Aetna's demand occurred after the benefits had been granted and paid. The Court disagreed, finding that the Aetna's request for reimbursement was unquestionably an adverse claim determination, triggering the exhaustion requirement under the plan, because it was a claim decision that resulted in a reduction of a benefit payment to a participant. Therefore, Plaintiff had to exhaust her administrative remedies before returning to court.

Shah v. Aetna, No. 17-195, 2017 WL 2918943 (D.N.J. July 6. 2017). A provider-assignee alleged the payor failed to establish and maintain reasonable claims procedures under the DOL Claims regulations. The Court found that § 1133 and 29 CFR 2560.503-1 do not create a private right to action and are not enforceable through ERISA's civil enforcement provision, no matter how the remedy is styled; therefore the Court dismissed the count.

Bloomfield Surgical Center v. CIGNA Health and Life Ins., No. 16-8645 (SDW)(LDW), 2017 WL 2304642 (D.N.J. May 25, 2017). The Court found that § 29 CFR 2560.503-1 does not create a private right to action and is not enforceable through ERISA's civil penalties provision, and accordingly, dismissed the provider-assignee's claim for failure to establish and maintain reasonable claims procedures.

Masri, M.D. v. Horizon Healthcare Services, Inc., No. 16-6961 (JBC), 2017 WL 4122434 (D.N.J. Sept. 18, 2017). The Court found that § 1133 and 29 CFR 2560.503-1 do not create a private right to action and violations are not in and of themselves actionable, but

nevertheless declined to dismiss the related count because violations may be probative of whether a benefit decision was arbitrary and capricious.

Fourth Circuit

No update.

Fifth Circuit

Hendrix v. Prudential Insurance Company of America, 697 Fed.Appx. 806 (5th Cir. June 21, 2017)(unpublished). The Court dismissed Plaintiff's claim that Prudential violated 29 C.F.R. § 2560.503-1(h)(2)(iii), in its handling of her claim for life insurance benefits, because Prudential was not under a duty to provide the employment records she sought.

Ninth Circuit

DB Healthcare, LLC v. Blue Cross Blue Shield of Arizona, Inc., 63 EBC 1432, 852 F.3d 868 (9th Cir. 2017). In a decision merging two cases (also *Advanced Women's Health Center v. Anthem*), both sets of providers generally sought a declaratory judgment finding and enjoining the claims administrators violating ERISA Claim procedures (29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1) when they unilaterally and retroactively determined that payments made for certain blood tests were not covered, and employed various strategies to recover the overpayments, like offsetting other reimbursable claims. The Court dismissed the complaint for lack of statutory standing.

2. Claims and Review Procedures for Non-Grandfathered Health Plans under the Affordable Care Act

Second Circuit

Hartford Healthcare Corp. v. Anthem Health Plans, Inc., No. 2017 WL 4955505 (D. Conn. Nov. 1, 2017). The Plaintiff, a healthcare provider, alleged that Defendant-plan violated the ACA by refusing to pay Plaintiff directly for emergency services provider to its participants, and instead paying reimbursements to the participants directly. Plaintiffs argued the ACA and the accompanying regulations (26 C.F.R. § 54.9815-2719A(b) and 29 C.F.R. § 2590.715-2719A(b)) create "a legal obligation to pay Hartford healthcare directly for medically necessary emergency services ... so as to avoid the imposition of an administrative requirement on an out-of-network provider and its patients that is more restrictive, limiting, and burdensome than that imposed on network providers." The Court noted that the relevant inquiry is whether the Defendant-Plan's claims reimbursement procedure for out-of-network providers constitutes an improper "limitation on coverage" under the ACA provisions. Contrary to Plaintiff's position, the Court agreed with the Defendant "that the plain meaning of the term 'coverage' refers to the type or

amount of benefits or services covered under a plan and does not include how the insurer pays for what it covers," so the Plan's practice was not unreasonable.

3. Claims and Review Procedures for Disability Benefits

First Circuit

Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc., 852 F.3d 105 (1st Cir. 2017). On appeal, Plaintiff, seeking to overturn a denial of payment for her son's three month stay at a wilderness therapy program in Utah specializing in neurodevelopmental disorders, contended that BCBS did not properly notify her of its determination that the program was offered in an educational setting, another relevant plan exclusion supporting the denial. of coverage for programs in an educational setting constituted a reason for its denial of benefits. She concedes that BCBS communicated the reason to her son's father in a phone call during the claim process, and that she was made aware prior to litigation; nonetheless she argued that the Plan's educational setting rationale should be disregarded because it was never communicated in writing, and point to 29 U.S.C. § 1133(1) (requiring plan administrators to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant") and 29 C.F.R. § 2560.503-1(g)(1) ("[T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination."). Because Plaintiff did not raise the argument in district court, the Court refused to consider it.

Second Circuit

Arkun v. Unum Group, Unumprovident Corporation, et. al., No. 15 CIV. 8425, 2017 WL 4084050 (S.D.N.Y. Sept. 14, 2017). Plaintiff's lawsuit for long-term disability benefits was determined to be time-barred, where benefits were terminated on July 14, 2004, the plaintiff timely appealed but her claim was closed pending additional medical documentation. The plaintiff submitted the documentation more than four years later on October 6, 2008. The defendant denied the appeal on March 20, 2009. The plaintiff filed her lawsuit on October 22, 2015. Based on the plan's contractual limitations period, the plaintiff had to bring suit within three years of the date proof of loss was due. The court determined that the three years ran from October 6, 2008, the date she submitted proof of loss.

Fifth Circuit

Whitley v. Dr. Pepper Snapple Group, Inc., et. al., No. 4:17-CV-0047, 2017 WL 4155257 (E.D. Tex. Sept. 19, 2017). The court found that the three-year limitations period in the 2016 Summary Plan Description governs L.K.W.'s first claim for benefits since it was incurred in January 2016. Because the 2016 SPD applied, the plaintiff's claim was not time-barred under the 2013 SPD containing a ninety-day limitations period.

Seventh Circuit

Druhot v. Reliance Standard Life Insurance Company, No. 16-CV-2053, 2017 WL 4310653 (N.D. Ill. Sept. 28, 2017). The court, on *de novo* review, determined the plaintiff, a former attorney, was entitled to long term disability benefits despite her alleged ability to walk a small dog around the block. The plaintiff claimed disability as a result of common variable immunodeficiency, osteoarthritis, possible rheumatoid arthritis, severe fibromyalgia, severe diverticulosis, and a number of other conditions. Reliance Standard and its doctors relied heavily on Druhot's ability to walk her dog but the court noted that lawyers are not dog walkers, at least for disability plan purposes. Instead, the court found that the evidence and supporting medical records demonstrate that her conditions make her unable to effectively meet with clients, conduct research, and draft legal documents in any reasonable practice setting. The court further found the Social Security Disability Insurance award of benefits to the plaintiff weighed in favor of a finding of disability. The court awarded plaintiff benefits, attorneys' fees, and pre-judgment interest.

Ninth Circuit

Flaaen v. Principal Life Insurance Company, No. C15-5899 BHS, 2017 WL 4286358 (W.D. Wash. Sept. 27, 2017). The court addressed vocational considerations that often arise in long term disability claims, determining the reasonable interpretation of the term "gainful occupation" requires an evaluation of the insured's actual employment prospects and wages based on his current experience and qualifications. The court rejected Principal's argument that the term "could reasonably be expected to earn" should be interpreted to mean that a median wage could be earned at any time in the future. Instead, the court adopted Flaaen's proposed reasonable interpretation that the term "could reasonably be expected to earn" means "what is reasonably likely now, as of the date of denial of his benefits."

C. Adequate Notification of Benefit Determination

1. Adverse Benefit Determinations

First Circuit

Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc., 852 F.3d 105 (1st Cir. 2017). On appeal, Plaintiff, seeking to overturn a denial of payment for her son's three month stay at a wilderness therapy program in Utah specializing in neurodevelopmental disorders, contended that BCBS did not properly notify her of its determination that the program was offered in an educational setting, another relevant plan exclusion supporting the denial. of coverage for programs in an educational setting constituted a reason for its denial of benefits. She concedes that BCBS communicated the reason to her son's father in a phone call during the claim process, and that she was made aware prior to litigation; nonetheless she argued that the

Plan's educational setting rationale should be disregarded because it was never communicated in writing, and point to 29 U.S.C. § 1133(1) (requiring plan administrators to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant") and 29 C.F.R. § 2560.503-1(g)(1) ("[T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination."). Because Plaintiff did not raise the argument in district court, the Court refused to consider it.

Third Circuit

Fiorentino v. Bricklayers & Allied Craftworkers Local 4 Pension Plan, 696 Fed.Appx. 594 (3d Cir. June 6, 2017)(unpublished). Although Plaintiff was never a member of the Union, following her retirement in 2014, she filed for a pension benefit from the Union plan, was denied, and filed suit. The Court agreed with the Defendant-plan that Plaintiff's claim was time-barred under the applicable statute of limitations, because as Plaintiff concedes, she was informed by a fiduciary that she was not a participant sometime between 2006 and 2007. Because that representation was adverse and repudiated Plaintiff's rights under the Plan, the Court concluded that there was a clear repudiation made known to the beneficiary, it constituted an adverse benefit determination, and she lost her right to bring a claim six years later.

Patient C.E. v. Excellus Blue Cross, Blue Shield, 2017 WL 593492 (D. N.J. Feb. 14, 2017). The Court granted summary judgment against defendant insurance plans, finding inadequate information in notice of denial of claims for additional reimbursement by out-of-network surgeon. The Court held the notices needed to at least specify the UCR schedule employed by the Plan so that Plaintiff could make a meaningful challenge. Accordingly, the plan was found to have violated its disclosure requirements of 29 C.F.R. 2560.503-1(g) and the Court remanded the case to the Plan for full development of administrative record.

Ninth Circuit

Taylor v. Eskaton Properties, Inc., et al., No. 2:16-CV-00102-KJM-DB, 2017 WL 4883364 (E.D. Cal. Oct. 27, 2017). The court granted summary judgment in favor of Defendants, finding that it was not an abuse of discretion to deny coverage based on Plaintiff's refusal to sign a subrogation agreement.

Tenth Circuit

William G. v. United Healthcare, No. 16-00144 (DN), 63 EBC 1475, 2017 WL 2414607 (D. Utah, June 2, 2017). Courts holds that plan's limitations period was not enforceable against Plaintiff with mental health claims because it was not adequately disclosed in plan's communications to him. Court reads 29 C.F.R. Sects. 2560.503-1(g)(1) and 1(j)(4)(i) to require

disclosure of limitations periods for both appeals procedures and court actions in both interim and final denial letters. The new regulations applicable to disability claims did not apply here.

2. Timing of Notification of Benefit Determinations

a. Notification of Adverse Benefit Determinations Generally

Second Circuit

McFarlane v. First Unum Life Insurance Company, No. 16-7806 (RA), 2017 WL 3495394 (SDNY Aug. 15, 2017). The Court determined the Plan's letter requesting an extension of time for review was insufficient, because it failed to indicate the expected date for review.

Fourth Circuit

Shepherd v. Community First Bank, No. 15-04337 (MGL), 2017 WL 735582 (D.S.C. Feb. 24, 2017). The Plan notified the plan participant of its receipt of his claim for reinstatement of annuity benefits, but then failed to send notice of its claim determination or of an extension of time within 90 days, pursuant to the plan. Accordingly, the Court remanded the claim to the plan for exhaustion of the appeal process, and dismissed Plaintiff's claims without prejudice.

b. Notification of Health Plan Benefit Plan Determinations
No update.

c. Notification of Disability Plan Determinations

Sixth Circuit

Carlson v. Reliance Standard Life Ins., No. 15-0200, 2017 WL 476770 (M.D. Tenn. October 20, 2017). The Court found that Plaintiff, the beneficiary of a life insurance policy, did not receive a full and fair review under 29 CFR 2560.503-1(h)(2), because the Defendant-plan failed to await the amended medical examiner's report and arbitrarily applied deadline and tolling rules, and remanded the case back to the Plan Administrator.

3. Manner and Content of Notification of Benefit Determinations

a. Notification of Adverse Benefit Determinations Generally

Fourth Circuit

Turner v. Volkswagen Group of America, No. 2:16-cv-06570, 2017 WL 3037803 (S.D.W. Va. July 18, 2017). The Court found that the health plan's denial letter was not reasonable where it failed to explicitly state the applicable time limit to appeal, despite the fact

the letter referred to the SPD and attached the relevant portion of the SPD; therefore, plaintiff was deemed to have exhausted her appeal rights.

Ninth Circuit

Dresel v. Pension Plan of Pacific Northwest Laboratories, Battelle Memorial Institute, 2017 WL 6420974 (9th Cir. Dec. 18, 2017). The Court held the Plan was precluded from asserting a reason for denial of pension benefits that it had not asserted in its denial notice to the purported beneficiary—that "Retirement" meant the termination of employment. Specifically, the Court noted that 29 C.F.R. § 2560.503-1(g)(ii) required the plan administrator to provide the claimant with "[r]eference to the specific plan provisions on which the determination is based," but that the Plan neither explicitly cited its interpretation of "Retirement" nor referenced the relevant plan section, thus the Plan waived the argument.

b. Notification of Health Plan Adverse Benefit Determinations

No update.

c. Notification of Health Plan Adverse Benefit Determinations in Non-Grandfathered Plans

No update.

d. Notification of Disability Plan Adverse Benefit Determinations

Third Circuit

Erwood v. Life Ins. Co. of North America, No. 14-1284, 2017 WL 1383922, 63 EB Case 1492 (W.D. Pa. April 13, 2017). Life Insurance Company, fiduciary, breached its duty by failing to provide adequate notice of right to convert and timing of when and how to convert policy.

Fourth Circuit

Prince v. Sears Holdings Corporation, et al., No. 1:17CV142, 2017 WL 6540493 (N.D.W. Va. Dec. 21, 2017). In this life insurance dispute alleging breach of fiduciary duty for the failure to provide accurate information concerning life insurance coverage, the court determined the plaintiff had actual knowledge of the alleged breach on September 26, 2013, when Sears sent him a notice informing him that his wife's coverage had been reduced, but he did not file suit before the end of the three-year statute of limitations. The court declined to find that the statute of limitations was tolled pending his exhaustion of administrative remedies, nor by the removal of his initial lawsuit to the Northern District. The court held that his complaint is time barred by ERISA's statute of limitations for breach of fiduciary duty claims.

Ninth Circuit

Nelson v. Standard Insurance Company, et al., No. 16-55227, __F.App'x__, 2017 WL 6420993 (9th Cir. Dec. 18, 2017)/ The court affirmed the district court's decision that Standard did not abuse its discretion by determining the plaintiff was not entitled to disability benefits payments under the plan limitation for a non-limited condition after December 31, 2009. "The record on which the administrator relied included the results of extensive examinations by Nelson's physicians, medical records from treating physicians, and the opinions of other physicians establishing that mental disability was the substantial component of Nelson's illness. Standard was not required to assess the cause of Nelson's depression because Standard's plan explicitly addressed combined or concurrent causation. Thus, the state law doctrine of proximate cause was inapplicable.

Curran v. United of Omaha Life Insurance Company, 697 Fed.Appx. 558 (9th Cir. Sept. 22, 2017)(unpublished). The Court found United gave Plaintiff meaningful notification of its adverse LTD benefit determination, including the "specific reason or reasons for the adverse determination" and a "[r]eference to the specific plan provisions on which the determination is based," as required by 29 C.F.R. § 2560.503-1(g). United's denial letter provided a detailed summary of the medical file, repeatedly noted the absence of specific objective evidence supporting her claim, and identified the evidence required to provide an objective basis for Plaintiff's diagnoses. Its letter, which also explained the relevant limitation was one of the two policy provisions on which the claim was based and provided the full text of that provision, and adequately described the "additional material or information necessary ... to perfect [her] claim" complied with the regulatory requirements.

D. Full and Fair Review of Adverse Benefit Determination

1. Procedures for Appeals of Adverse Benefit Determinations

a. Appeal Procedures for All Employee Benefit Plans

No update.

b. Additional Appeal Procedures for Health Care Benefit Plans

Ninth Circuit

Cohorst v. Anthem Health Plans of Kentucky, Inc., No. CV 16-7925-JFW (SKX), 2017 WL 6343592 (C.D. Cal. Dec. 12, 2017). The court concluded that Anthem improperly denied plaintiff's claim for benefits for the artificial disc replacement ("ADR") surgery using the Mobi-C device and entered judgment in favor of Plaintiff, holding: (1) Anthem's "Medical Policy" is part of the Plan; (2) the use of the Mobi-C in ADR surgery does not fall within the scope of the exclusion because the uncontroverted evidence presented clearly demonstrates that the Mobi-C

could be legally marketed in the United States at the time of plaintiff's surgery and that the FDA had approved sales of the device; (3) an ADR surgery in a patient with a prior fusion falls within the scope of the Investigative/Experimental exclusion; (4) Anthem waived its right to deny plaintiff's claim under this exclusion because it initially approved her ADR surgery, albeit with a Pro Disc-C device.

c. Additional Appeal Procedures for Non-Grandfathered Health Care Benefit Plans

No update.

d. Additional Appeal Procedures for Disability Benefit Plans

First Circuit

Doe v. Harvard Pilgrim Health Care, Inc., No. CV 15-10672, 2017 WL 4540961 (D. Mass. Oct. 11, 2017). De novo review applied where the plan stated the administrator would "use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care" and the plan's definition of medical necessity pointed to "generally accepted principles of professional medical practice," and not administrator discretion, as the basis for a determination. Discretionary authority "must be expressly provided for," and only when the delegation of such authority is "sufficiently clear and notice of it has been appropriately provided" does the standard of judicial review change from de novo review to abuse of discretion.

Tenth Circuit

Dardick v. Unum Life Insurance Company of America, et al., No. 16-CV-02838-LTB-KLM, 2017 WL 4697495 (D. Colo. Oct. 19, 2017). The court granted judgment to Unum after finding that its denial of Plaintiff's claim for ongoing disability benefits was not arbitrary and capricious. Even if it was a procedural irregularity to have the same registered nurse twice review Plaintiff's file, assuming that Plaintiff was entitled to a second appeal, the fact that Unum also had another doctor review Plaintiff's file in connection with the second appeal cures any irregularity resulting from the nurse's second review.

Owings v. United of Omaha Life Ins. Co., No. 16-3128, __F.3d__, 2017 WL 4637928 (10th Cir. Oct. 17, 2017). The court reversed the judgment of the district court and remanded the matter with directions to enter summary judgment in favor of plaintiff, rejecting United of Omaha's interpretation of the policy that precluded recovery of long-term disability benefits solely because plaintiff was able to perform at least one job duty on the day that he sustained a disabling injury on the job. The court found that plaintiff's disability occurred immediately after he sustained the injury and United of Omaha acted arbitrarily and capriciously when it determined that he was not disabled until the day after he sustained injury.

2. Access to Relevant Documents

Seventh Circuit

Tuhey v. Ill. Tool Works, Inc., Case No. 17 C 3313, 2017 U.S. Dist. LEXIS 121802 (N.D. Ill Aug. 2, 2017). Plaintiff alleged that Defendant breached its fiduciary duties by failing to disclose participants' rights to convert vested benefits under a long-term disability policy. The court explained that there is no general fiduciary obligation to "provide specific information about conversion rights." *Id*. at *22. The court held that Plaintiff had failed to demonstrate that Defendant "failed to disclose material information which they knew the beneficiary did not have or affirmatively misinformed the plan participant . . . concerning plan benefits." *Id* at *23-24. Therefore, Plaintiff's allegations were insufficient to survive Defendant's motion to dismiss.

St. Alexius Med. Ctr. v. Roofers' Unions Welfare Tr. Fund, No. 14 C 8890, 2017 U.S. Dist. LEXIS 15588 (N.D. Ill. Jan. 31, 2017). The parties disputed whether the SPD or a 1996 Plan document constituted the Plan document from 2011 forward. *Id*. at *2. Plaintiff relied upon a 2011 notice to participants, which stated that the "Summary Plan Description . . . and subsequently issued Summaries of Material Modifications . . . serve as the Welfare Plan's Plan document" as support for its contention that the SPD's terms governed. *Id*. at *3 (citation omitted). The primary material difference between the two documents was that the SPD did "not contain any limitations period for filing suit to challenge an adverse benefits determination." *Id*. at *6. The court determined, "[a]fter careful review of the record," that the SPD was the operative Plan document, in part based upon the language of the 2011 notice, and therefore the SPD's limitations terms, or lack thereof, governed. *Id*. at *19.

Ninth Circuit

Lee v. ING Groep, N.V., 829 F.3d 1158, 1160-61, 62 EB Cas. 1712 (9th Cir. 2016). The Ninth Circuit joined several other circuits in holding that a plan's failure to comply with this requirement cannot give rise to a statutory penalty under 29 U.S.C §1132(c)(1) because the requirement is imposed on plans, rather than plan administrators.

Romanchuk v. Bd. of Trs. of the S. Cal. United Food & Commercial Workers Joint Pension Trust Fund, No. CV 15-08180-AB (KS), 2017 U.S. Dist. LEXIS 209636 (C.D. Cal. June 29, 2017). Plaintiff brought a claim for breach of fiduciary duty, alleging that Defendant failed to disclose participant rights under a "Grandfather Clause" in the SPD. The court denied Defendant's motion for summary judgment, holding that Plaintiff established a triable issue of fact as to whether this failure to disclose constituted a breach of fiduciary duties owed to plan participants. *Id*. at *55-58.

Eleventh Circuit

Laird v. Aetna Life Ins. Co., 263 F. Supp. 3d 1231 (M.D. Ala. 2017). Plaintiff argued that her husband's employer, life insurance benefit provider, and life insurance plan

administrator, all breached their fiduciary duties by failing to furnish accurate plan information (and making material misrepresentations about plan benefits) that would have guided her husband's benefit elections. Plaintiff alleged that the defendants failed to disclose (and intentionally misled the Plaintiff and her husband to believe otherwise) the fact that her husband's life insurance benefit would reduce from a 100% payout to a 65% payout once he turned 70. Plaintiff claimed that neither she nor her husband ever received a SPD from the employer or plan administrator. The court concluded that under *Amara* precedent, the Plaintiff had a viable breach of fiduciary duty claim under ERISA § 502(a)(3) for a failure to disclose required plan information since Plaintiff and her husband would have elected additional coverage had they been properly informed of the plan's terms concerning the reduced payout.

E. Adequate Notice of Adverse Benefit Determinations After Appeal

1. Timing of Notification of Benefit Determinations After Appeal

a. In General

b. Timing of Health Plan Benefit Determinations After Appeal

No update.

c. Timing of Disability Plan Benefit Determinations After Appeal

Second Circuit

Hafford v. Aetna Life Insurance Company, No. 16-CV-4425, 2017 WL 4083580 (S.D.N.Y. Sept. 13, 2017). The court disagreed with the Magistrate Judge's R&R finding de novo review applies and the plaintiff prevails. The court found Aetna's letter to the plaintiff explaining the circumstances necessitating a 45-day extension of the appeal process was adequate under the applicable Department of Labor regulation, 29 C.F.R. §§ 2560.503-1(i)(1)(i), (i)(3)(i) (if the plan administrator determines special circumstances warrant an extension it must "indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination" in writing). Under the arbitrary and capricious standard, the court found that Aetna's denial of long-term disability benefits was supported by substantial evidence.

Sixth Circuit

Wagner v. American United Life Insurance Company, No. 2:16-CV-084, 2017 WL 4099216 (S.D. Ohio Sept. 15, 2017). De novo review applied where the plan grants discretion to American United Life, not to DRMS, the entity that held itself out to to the plaintiff as the administrator for the plan. The court found the plaintiff failed to meet his burden to establish disability from his own sedentary occupation. The plaintiff was rendered paraplegic in a

motorcycle accident as a teenager and went to school and worked for much of his adult life. He stopped working and received long term disability benefits after that time but Defendant terminated his claim in reliance on surveillance video showing Plaintiff active and not in pain as well as medical reviewers' opinions of non-disability. Plaintiff claimed moderate narcotics-induced cognitive impairment that makes him groggy and tired, but the court found that the surveillance video showed a different reality. The court also rejected the plaintiff's argument that the defendant must prove that he can do the thinking required for his job.

Seventh Circuit

Hennen v. Metropolitan Life Insurance Company, No. 15 C 9452, 2017 WL 4164027 (N.D. Ill. Sept. 20, 2017). In a section titled "Limitation For Disabilities Due to Particular Conditions," the disability plan explains that "Monthly Benefits are limited to 24 months during your lifetime if you are Disabled due to a...Neuromusculoskeletal and soft tissue disorder . . . unless the Disability has objective evidence of...radiculopathies." The court held that MetLife reasonably construed the plan to require proof of active, current, or ongoing radiculopathy at the end of the 24-month period to support continuing benefits. MetLife also reasonably determined the plaintiff did not have active radiculopathy. The court granted summary judgment to MetLife but denied its motion for attorneys' fees.

Eighth Circuit

Thiry v. United of Omaha Life Insurance Company, et al., No. CV 15-3544, 2017 WL 4156998 (D. Minn. Sept. 19, 2017). The court overruled plaintiff's objections to the Magistrate Judge's R&R granting judgment in favor of United of Omaha on plaintiff's long-term disability claim. The court explained a plan administrator's denial of long-term disability benefits is based on substantial evidence where the claimant has diagnosed fibromyalgia, but fails to set forth objective medical evidence to support the limitations caused by the disease.

Ninth Circuit

Pagendarm v. Life Ins. Co. of N. Am., No. 5:17-CV-04131, 2017 WL 6405617 (N.D. Cal. Dec. 15, 2017). The court granted defendant's motion to dismiss for lack of subject matter jurisdiction on the basis that the plaintiff had not met the "injury in fact" requirement for standing. The Plaintiff was awarded long-term disability benefits upon the finding that he was disabled due to a condition subject to a 24-month mental illness limitation. This determination came after the plaintiff appealed an initial denial of long-term disability benefits on the grounds that he did not meet the definition of disability. In the award letter, the plaintiff was advised that "payment of future benefits will depend on confirmation of continuing disability status…" Within two weeks of receiving the award letter, the plaintiff filed a lawsuit seeking clarification that his disability was "physical" and not subject to the plan's mental illness limitation. Although the award letter stated that "benefits will cease" at the end of the 24-month mental illness limitation period, since it did not mention or address plaintiff's claim for benefits based

upon a physical impairment, it was not reasonable for plaintiff to interpret the letter as a denial of benefits for his claimed physical impairment. The court determined that the possibility that defendant might terminate benefits in the future is "too conjectural to establish an 'injury in fact' at present."

Tenth Circuit

Johnson v. Life Insurance Company of North America, No. 16-CV-0159, 2017 WL 4180328 (D. Colo. Sept. 21, 2017). The court determined that LINA's termination of Plaintiff's long-term disability benefits was arbitrary and capricious because when the "evidence is actually examined, the amount of reliable, probative evidence detracting from Johnson's credibility is essentially zero." The court awarded past-due benefits and reinstatement of the claim.

2. Manner and Content of Notification of Benefit Determinations After Appeal

a. In General

Third Circuit

C.E. v. Excellus Blue Cross Blue Shield, No. CV146950FLWDEA, 2017 WL 593492 (D.N.J. Feb. 14, 2017). The Court found that Excellus' failure to adequately explain the grounds for denying the administrative appeals in this matter violated 29 U.S.C. § 1133 and its accompanying regulations, 29 C.F.R. § 2560.503-1(j). The court further found that the appropriate remedy "is to remand to the plan administrator so the claimant gets the benefit of a full and fair review."

Fifth Circuit

Babin v. Quality Energy Servs., Inc., No. 17-30059, __F.3d__, 2017 WL 6374738 (5th Cir. Dec. 14, 2017). The district court granted summary judgment to the employer, in this matter involving a denial of short-term disability benefits and the failure to provide plan documents, which plaintiff appealed. The court held plaintiff's claim alleging failure to provide him with plan documents was a delictual claim subject to the one-year prescriptive period under Louisiana law. The court declined to consider plaintiff's newly raised argument that the prescriptive period for his claim alleging failure to provide him with plan documents should be tolled.

Rapid Tox Screen LLC v. Cigna Healthcare of Texas Inc., No. 3:15-CV-3632, 2017 WL 3658841 (N.D. Tex. Aug. 24, 2017). Plaintiff alleged that Cigna failed to provide a "full and fair review" of denied claims pursuant to 29 U.S.C. § 1133 by, among other actions: refusing to process and report out claims submitted by Rapid Tox; refusing to provide the specific reason or reasons for the denial of claims; refusing to provide the specific plan provisions relied upon to support its denial; refusing to provide the specific rule, guideline, or protocol relied upon in making the decision to deny claims; refusing to describe any additional material or information

necessary to perfect a claim, such as the appropriate diagnosis/treatment code; refusing to notify the relevant parties that they are entitled to have, free of charge, all documents, records, and other information relevant to the claims for benefits; engaging in improper retroactive denial of claims; and refusing to provide a statement describing any voluntary appeals procedure available or a description of all required information to be given in connection with that procedure. The court found that these allegations are sufficient to state a claim under § 1133 and the court denied CIGNA's Motion based on 29 U.S.C. § 1133.

Encompass Office Solutions, Inc. v. Connecticut General Life Insurance Co., 3:11-cv-2487, 2017 WL 3268034 (N.D. Tex. July 31, 2017). Plaintiff was a surgical suite vendor (which had obtained assignment of plan benefits from plan participants) that brought suit against defendant health care service companies for denying claims for surgery services. As to benefit claims, the parties cross-moved for summary judgment. The court found that the claim denials and subsequent reviews of those denials did not comply with ERISA's procedural notice requirements, and remanded the claims to the plan administrator for a full and fair review which may include "additional investigation and supplementation of the administrative record by the parties."

Sixth Circuit

Vest v. Resolute Forest Products Us, Inc., No. 1:17-CV-196, 2017 WL 6375964 (E.D. Tenn. Dec. 13, 2017). Plaintiff claimed that Resolute breached its fiduciary duty under ERISA by failing to provide her late husband with a notice of his conversion rights under a group life insurance policy when his employment ended. The court granted Defendant's motion to dismiss, stating: "After carefully considering the instant complaint and the authorities cited by both parties, the Court concludes that plaintiff has not alleged sufficient facts to place this case in the category with *[Krohn v. Huron Mem'l Hosp.*, 173 F.3d 542 (6th Cir. 1999)]. Were the Court to conclude otherwise, it would be requiring ERISA administrators to provide such information any time a participant's benefits terminated or were reduced. This could include employees who are fired, retire, or simply change from full-time to part-time status. While it would be beneficial for participants to receive such information, Congress has not enacted such a broad requirement on plan administrators and it is not for this Court to do so."

Carlson v. Reliance Standard Life Insurance Company, No. 3:15-CV-0200, 2017 WL 4767660 (M.D. Tenn. Oct. 20, 2017). Reliance Standard did not conduct a full and fair review of Plaintiff's claim regarding the death of Decedent without considering the supplemental information submitted by Plaintiff. Specifically, Reliance Standard failed to follow procedural requirements as set forth in 29 C.F.R. § 2560.503-1(i) and arbitrarily applied deadline and tolling rules, it arbitrarily decided which information to review, and it could not have provided a reasoned explanation for its denial that did not address the supplemental information. The court remanded the claim to the administrator to consider the supplemental evidence. The court declined to decide whether Reliance Standard has a duty to investigate or whether the presumption against suicide applies in this case.

Eighth Circuit

McGillivray v. Wells Fargo & Co. Salary Continuation Pay Plan, No. 15-CV-4347 (SRN/LIB), 2017 WL 3037557 (D. Minn. July 18, 2017). In this case seeking Salary Continuation Plan benefits, the Plan failed to comply with the requirements of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1, and as such, the court found its denial of benefits was an abuse of discretion and must be reversed. The appropriate remedy for a violation of 29 U.S.C. § 1133 and the Claims Regulation is generally not an award of benefits by the court, but rather a remand to the plan administrator so that the claimant gets the benefit of a full and fair review. The court remanded the matter to the Plan for the limited purpose of allowing it to clarify or reconsider its decision to deny Plaintiff's claim for benefits. The court cautioned that should procedural deficiencies noted in this order persist in a future action for administrative review, an award of benefits may be warranted.

b. Notifications of Health Care Benefit Claims Determinations After Appeals

First Circuit

Doe v. Harvard Pilgrim Health Care, Inc., No. CV 15-10672, 2017 WL 4540961 (D. Mass. Oct. 11, 2017). De novo review applied where the plan stated the administrator would "use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care" and the plan's definition of medical necessity pointed to "generally accepted principles of professional medical practice," and not administrator discretion, as the basis for a determination. Discretionary authority "must be expressly provided for," and only when the delegation of such authority is "sufficiently clear and notice of it has been appropriately provided" does the standard of judicial review change from de novo review to abuse of discretion.

c. Notifications of Health Care Benefit Claims Determinations by Non-Grandfathered Health Plans After Appeal

No update.

d. Notifications of Disability Benefit Claims Determinations After Appeal

No update.

F. ACA External Review Procedures

No update.

1. State External Review Requirements

No update.

2. Federal External Review Requirements

No update.

a. Scope

No update.

b. External Review Process Standards: Request and Preliminary Review

No update.

c. External Review Process Standards: Referral for External Review

i. Referral to Independent Review Organization

No update.

ii. Referral to HHS External Review

No update.

G. Failure to Establish or Follow Reasonable Claims Procedures

1. In General

2. Non-Grandfathered Health Care Benefit Plans

No update.

3. Disability Benefit Plans

No update.

H. Remedies for Procedural Violations

Second Circuit

Prof'l Orthopaedic Assocs. v. 1199SEIU Nat'l Benefit Fund, No. 16-4220-CV, __F.App'x__, 2017 WL 3887988 (2d Cir. Sept. 6, 2017). Patient AM's Section 502(c)(1)(B)

claim, to the extent that Plaintiffs seek penalties under that provision for the Fund's failure to provide information required to be furnished under ERISA § 503 and 29 C.F.R. § 2560.503-1, does not give rise to civil penalties under ERISA. Plaintiffs never requested documents under ERISA § 104(b)(4), which does give rise to penalties under Section 502(c)(1)(B).

McFarlane v. First Unum Life Ins. Co., No. 16-CV-7806 (RA), __F.Supp.3d__, 2017 WL 3495394 (S.D.N.Y. Aug. 15, 2017). The court concluded that a plan's time to resolve an appeal is not tolled under 29 C.F.R. § 2560.503–1(i)(4) when the plan determines that an extension is required because a third party, but not the claimant herself, has failed to submit information necessary to decide a claim. Thus, First Unum was not excused from resolving McFarlane's appeal, or notifying her of a specific date by which it would do so, within 45 days of receiving her request for review. McFarlane is therefore deemed to have exhausted the administrative remedies available under the plan.

Third Circuit

Bloomfield Surgical Center v. Cigna Health and Life Insurance Company, No. CV170149, 2017 WL 4330357 (D.N.J. Sept. 29, 2017). The court held that 29 C.F.R. § 2560.503-1 does not give rise to a private right of action. Thus, the court dismissed this count with prejudice.

Kriley v. IBM Corp., No. CV 16-1860, 2017 WL 1927740 (W.D. Pa. May 10, 2017). Plaintiff's claim for severance benefits accrued when he was laid off and offered an allegedly incorrect severance payment. Since the lawsuit was filed more than four years later, it is time-barred. The court rejected Plaintiff's arguments that Defendants waived the statute of limitations defense by not raising it during the administrative process and Defendants are estopped from asserting the limitations defense because IBM did not give him a copy of the SPD or a description of the claims procedure, as required by 29 U.S.C. § 1024(b)(1).

Killebrew v. Prudential Ins. Co. of Am., No. 3:15-CV-01415, 2017 WL 1519500 (M.D. Pa. Apr. 27, 2017). Under the circumstances of this case, the court ascribed relatively little weight to Prudential's decision not to conduct its own IME, its decision not to follow the social security ALJ's rationale, and the inherent structural conflict of interest. The court found that Prudential based its decision on substantial evidence and that the structural and procedural factors accompanying this case were not so substantial so as to otherwise qualify Prudential's decision as arbitrary and capricious.

Bey v. Reliance Standard Life Ins. Co., No. CV 16-2326, 2017 WL 660866 (E.D. Pa. Feb. 17, 2017). Reliance cannot be sued as a *de facto* plan administrator simply because it responded to Plaintiff's attorney's request for documents. Plaintiff cannot seek statutory penalties on the basis of alleged violations of ERISA claims procedures.

C.E. v. Excellus Blue Cross Blue Shield, No. CV146950FLWDEA, 2017 WL 593492 (D.N.J. Feb. 14, 2017). The Court found that Excellus' failure to adequately explain the grounds for denying the administrative appeals in this matter violated 29 U.S.C. § 1133 and its accompanying regulations, 29 C.F.R. § 2560.503-1(j). The court further found that the appropriate remedy "is to remand to the plan administrator so the claimant gets the benefit of a full and fair review."

Fourth Circuit

Turner v. Volkswagen Grp. of Am., Inc., No. 2:16-CV-06570, 2017 WL 3037803 (S.D.W. Va. July 18, 2017). Because Volkswagen failed to comply with 29 C.F.R. § 2560.503-1(g) and denied the plaintiff reasonable review of her life insurance claim, the court found that the pleadings present sufficient allegations to support a showing that the plaintiff's administrative remedies are deemed exhausted for her life insurance benefits claim, and therefore, dismissal is improper at this time.

Shepherd v. Cmty. First Bank, No. CV 8:15-04337-MGL, 2017 WL 735582 (D.S.C. Feb. 24, 2017). In this matter seeking retirement benefits under a SERP plan, the court followed *Gagliano v. Reliance Standard Life Insurance Co.*, 547 F.3d 230 (4th Cir. 2008) and held that the proper remedy for Defendants' failure to timely respond to Plaintiff's claim is to remand to Defendants for a full and complete review of the claim under the Plan's internal review procedures. The court found that the futility exception does not apply.

Fifth Circuit

Rapid Tox Screen LLC v. Cigna Healthcare of Texas Inc., No. 3:15-CV-3632-B, 2017 WL 3658841 (N.D. Tex. Aug. 24, 2017). Plaintiff alleged that Cigna failed to provide a "full and fair review" of denied claims pursuant to 29 U.S.C. § 1133 by, among other actions: refusing to process and report out claims submitted by Rapid Tox; refusing to provide the specific reason or reasons for the denial of claims; refusing to provide the specific plan provisions relied upon to support its denial; refusing to provide the specific rule, guideline, or protocol relied upon in making the decision to deny claims; refusing to describe any additional material or information necessary to perfect a claim, such as the appropriate diagnosis/treatment code; refusing to notify the relevant parties that they are entitled to have, free of charge, all documents, records, and other information relevant to the claims for benefits; engaging in improper retroactive denial of claims; and refusing to provide a statement describing any voluntary appeals procedure available or a description of all required information to be given in connection with that procedure. The court found that these allegations are sufficient to state a claim under § 1133 and the court denied CIGNA's Motion based on 29 U.S.C. § 1133.

Encompass Office Sols., Inc. v. Connecticut Gen. Life Ins. Co., No. 3:11-CV-02487-L, 2017 WL 3268034 (N.D. Tex. July 31, 2017). The court concluded that Cigna's original claims denials and subsequent reviews of those denials did not comply with ERISA's procedural notice

requirements. The court determined that remand is appropriate because this case is not so clear cut that it would be unreasonable for Cigna's plan administrator to deny the claims for benefits "on any ground," and "the administrative record reflects, at minimum, a colorable claim for upholding [Cigna's] denial of benefits" based on its determination that Encompass is not a type of provider recognized under the Plan.

Sixth Circuit

Carlson v. Reliance Standard Life Insurance Company, No. 3:15-CV-0200, 2017 WL 4767660 (M.D. Tenn. Oct. 20, 2017). Reliance Standard did not conduct a full and fair review of Plaintiff's claim regarding the death of Decedent without considering the supplemental information submitted by Plaintiff. Specifically, Reliance Standard failed to follow procedural requirements as set forth in 29 C.F.R. § 2560.503-1(i) and arbitrarily applied deadline and tolling rules, it arbitrarily decided which information to review, and it could not have provided a reasoned explanation for its denial that did not address the supplemental information. The court remanded the claim to the administrator to consider the supplemental evidence. The court declined to decide whether Reliance Standard has a duty to investigate or whether the presumption against suicide applies in this case.

Coontz v. Metropolitan Life Insurance Company, No. 1:17-CV-00015-GNS, 2017 WL 4227656 (W.D. Ky. Sept. 22, 2017). Where Plaintiff filed her lawsuit for denied AD&D benefits when MetLife did not make a decision within 120 days of its receipt of her appeal, the court held that Plaintiff did exhaust administrative remedies since MetLife's extension letter to Plaintiff did not operate to toll its time to decide the appeal under the Plan or 29 C.F.R. § 2560.503-1(i)(4). The extension letter simply stated that additional time was needed to process her appeal because it was necessary for MetLife to obtain additional information, but it does not state that the need for additional information was caused by Plaintiff's failure to provide the information, nor does the letter explicitly request any information from Plaintiff. Since MetLife is not excused from making a timely decision, the court denied MetLife's request for remand.

Greer v. Operating Engineers Local 324 Pension Fund, et al., No. 17-11832, 2017 WL 3891785 (E.D. Mich. Sept. 6, 2017). Here, Plaintiff contends that 29 C.F.R. § 2560.503–1(h)(2)(iii) and (m)(8) establishes a duty under § 1132(c) for the Fund to provide all of the documents relevant to his claim. The court agreed with the Fund that Count I fails to state a claim because the Fund's regulatory obligation to produce claim documents "relevant to" a claimant's claim established under 29 C.F.R.2560.503-1(h)(2)(iii) does not confer a claim under ERISA.

Seventh Circuit

Mesker v. Reliance Standard Life Ins. Co., No. 117CV00085LJMTAB, 2017 WL 2687421 (S.D. Ind. June 22, 2017). Reliance's determination upholding the denial of long term disability benefits, which it made only 15 days after the expiration of the original maximum 90-

day period allowed for its decision, constitutes substantial compliance with the procedural requirements of 29 C.F.R. § 2560.503-1, and Reliance is entitled to an arbitrary and capricious standard of review. The court analyzed and declined to follow the Second Circuit decision in *Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ.*, 819 F.3d 42, 56-57 (2nd Cir. 2016).

Dragus v. Reliance Standard Life Ins. Co., No. 15 C 9135, 2017 WL 1163870 (N.D. Ill. Mar. 29, 2017). Reliance's initial determination was untimely in violation of 29 C.F.R. § 2560.503-1(f)(3) because it did not make a decision on Plaintiff's long term disability claim within 45 days or request any deadline extension. Contrary to Reliance's argument, Section 2560.503-1(i)(4) provides the period for making a benefit determination on appeal to be tolled, but says nothing of tolling the time period for initial determinations. However, because Plaintiff did not file suit immediately, and instead allowed Reliance to decide the claim and appeal, Plaintiff cannot take advantage of 29 C.F.R. § 560.503–1(l)(1) and *de novo* review.

Eighth Circuit

McGillivray v. Wells Fargo & Co. Salary Continuation Pay Plan, No. 15-CV-4347 (SRN/LIB), 2017 WL 3037557 (D. Minn. July 18, 2017). In this case seeking Salary Continuation Plan benefits, the Plan failed to comply with the requirements of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1, and as such, the court found its denial of benefits was an abuse of discretion and must be reversed. The appropriate remedy for a violation of 29 U.S.C. § 1133 and the Claims Regulation is generally not an award of benefits by the court, but rather a remand to the plan administrator so that the claimant gets the benefit of a full and fair review. The court remanded the matter to the Plan for the limited purpose of allowing it to clarify or reconsider its decision to deny Plaintiff's claim for benefits. The court cautioned that should procedural deficiencies noted in this order persist in a future action for administrative review, an award of benefits may be warranted.

Ninth Circuit

Sides v. Cisco Systems, Inc., et al., No. 15-CV-03893-HSG, 2017 WL 4236960 (N.D. Cal. Sept. 25, 2017). The court determined that to the extent Plaintiff is seeking statutory penalties for Cisco's failure to provide documents pursuant to the Claims Regulations in 29 C.F.R. § 2560.503-1, this claim fails. *See Lee v. ING Groep, N.V.*, 829 F.3d 1158, 1162 (9th Cir. 2016).

Kott v. Agilent Techs., Inc., No. 16-CV-03678-BLF, 2017 WL 2903174 (N.D. Cal. July 7, 2017). The court granted Sedgwick's motion for judgment on whether Plaintiff is disabled from any occupation under the terms of a self-funded disability plan. Under abuse of discretion review, the court declined to expand the record to include a letter and appointment log from Plaintiff's treating doctor which contradicts Sedgwick's claim in the final denial letter that there was a conversation between this doctor and one of its doctors. The court determined that this

was not a "procedural irregularity" as described in *Abatie* justifying the consideration of evidence outside of the record.

Colman v. American International Group, Inc., Grp. Benefit Plan, et al., 692 F.App'x 453 (9th Cir. 2017). The Ninth Circuit affirmed the grant of judgment in favor of the group benefit plan and Hartford in this matter involving a denial of long term disability benefits. Several minor procedural errors did not justify de novo review.

Hancock v. Aetna Life Ins. Co., 251 F.Supp.3d 1363 (W.D. Wash. 2017). In this lawsuit involving a denial of disability benefits, the court found that Plaintiff's Section 1132(a)(3) claim is not duplicative because it does not seek relief available to her under Section 1132(a)(1)(B). Here, Plaintiff seeks a two-part injunction requiring Aetna to (1) establish administrative processes and safeguards to ensure and verify appropriately consistent decision making, and (2) train and supervise its employees to ensure they are aware of and follow administrative processes and procedures. The court found that Aetna has not met its initial burden of demonstrating that there is no genuine dispute of material fact whether Aetna unreasonably delayed Plaintiff's s appeal by invoking a 45-day extension, where it assigned a peer review on the twenty-eighth day of the 45-day appeal period.

Sugiyama v. Unum Life Ins. Co. of Am., No. 16-CV-05032-PJH, 2017 WL 1374650 (N.D. Cal. Apr. 17, 2017). ERISA regulation, 29 C.F.R. § 2560.503-1(f), is ambiguous as to whether an administrator's deadline to make a decision runs from the date the employer received the claim for AD&D benefits or when Unum received the claim. Assuming the former and that Unum's written notice of an extension was seven days late, Plaintiff is deemed to have exhausted administrative remedies. However, Plaintiff is not entitled to a limitation on the scope of the administrative record. Unum's procedural violation can be excused under the "substantial compliance" doctrine. Substantive relief based on a procedural violation is appropriate only if there is substantive harm. Even if there was substantive harm here, the court found that the equities favor considering the full record that Unum relied on to make its claim decision, including evidence after the 90-day deadline to make a decision.

Smith v. Reliance Standard Life Insurance Company, 686 F.App'x 446 (9th Cir. 2017). The court vacated the district court's order affirming the denial of Plaintiff's request for short-term disability benefits because it did not apply abuse of discretion standard of review that takes into account the fact that Reliance was responsible both for paying benefits and for administering the claims review process. On remand, the district court should take into account the likelihood that the structural conflict of interest affected Reliance's decision to deny Smith's request for short-term disability benefits, any record of Reliance's self-dealing, and the fact that Reliance relied on a paper review of Smith's medical records rather than an in-person medical evaluation. The court also vacated the award of Plaintiff's long term disability benefits (and attorneys' fees), which the district court awarded due to Reliance's failure to issue a denial of the claim within the 90-day limit imposed by ERISA. 29 C.F.R. § 2650.503-1(f)(1). The district court committed

clear error by failing to determine whether Reliance's procedural violation caused Plaintiff substantive harm.

Tenth Circuit

Dardick v. Unum Life Insurance Company of America, et al., No. 16-CV-02838-LTB-KLM, 2017 WL 4697495 (D. Colo. Oct. 19, 2017). The court granted judgment to Unum after finding that its denial of Plaintiff's claim for ongoing disability benefits was not arbitrary and capricious. Even if it was a procedural irregularity to have the same registered nurse twice review Plaintiff's file, assuming that Plaintiff was entitled to a second appeal, the fact that Unum also had another doctor review Plaintiff's file in connection with the second appeal cures any irregularity resulting from the nurse's second review.

Eleventh Circuit

Laird v. Aetna Life Ins. Co., 263 F. Supp. 3d 1231, 1244 (M.D. Ala. 2017). The court concluded that the Supreme Court's ruling in *Amara* and the lower courts' interpretation of that opinion provide a clear avenue for Laird to bring a breach-of-fiduciary-duty claim against AECOM under § 1132(a)(3) for an alleged violation of its disclosure obligations.

Otero v. Unum Life Ins. Co. of Am., 226 F. Supp. 3d 1242, 1264 (N.D. Ala. 2017). The court noted that the Labor Department has taken the position that a denial occurring without the minimum procedural safeguards provided in the ERISA statutes and regulations should not be reviewed deferentially. The court declined to accord deference to Unum's "deemed exhausted" non-decision and applied *de novo* review.

III. Exhaustion of Administrative Remedies

First Circuit

Fortier v. Hartford Life & Accident Ins. Co. et al., No. CV 16-CV-322-LM, 2017 WL 4011147 (D.N.H. Sept. 11, 2017). Defendant moved to dismiss Plaintiff's claim for long-term disability benefits on the basis that she failed to submit an appeal of the denial of her claim within 180 days. The court determined that the appeals period in this case commenced on the date which Plaintiff received the July 17, 2013 letter notifying her of the future termination of her benefits, not on September 13, 2013, which is the date that benefits stopped being paid. The July letter explained in plain terms that she had to appeal within 180 days. The LTD certificate is not ambiguous about Plaintiff's obligation to appeal. Lastly, the court deferred ruling on the application of New Hampshire's "notice-prejudice" rule to this ERISA appeal until summary judgment. On this basis, the court denied Defendants' motion to dismiss the claim for benefits.

Second Circuit

*Peppiatt v. Aetna Life Insurance Company, et al.***,** No. 217CV02444ADSAKT, 2017 WL 6034641 (E.D.N.Y. Dec. 4, 2017). Plaintiff asserted that Defendants violated ERISA § 502(a)(1)(B) and ERISA § 502(a)(3) seeking unpaid benefits and interest for Defendants refusal to cover a trial implantation of a neurostimulator pulse generator to treat the Plaintiff's severe intractable supraorbital neuralgia. Plaintiff did not appeal the series of EOBs explaining the denial of coverage, which was required by the Plan. The court granted Plaintiff's motion for judgment on the pleadings, dismissing the complaint pursuant to Rule 12(c) for failure to exhaust administrative remedies or demonstrate futility.

Kirkendall v. Halliburton, Inc., et al., No. 07-CV-289-FPG, 2017 WL 4344531 (W.D.N.Y. Sept. 29, 2017. Some of the plaintiffs were not required to exhaust administrative remedies since they all knew of the process undertaken by plaintiff Kirkendall, knew of Halliburton's position on denying participants the ability to "grow in" to early retirement benefits, and reasonably concluded that the only means of vindicating their claims was through a lawsuit. In the Second Circuit, plaintiffs do not have to exhaust their administrative remedies where they make a clear and positive showing that pursuing available administrative remedies would be futile.

McFarlane v. First Unum Life Ins. Co., No. 16-CV-7806 (RA), __F.Supp.3d__, 2017 WL 3495394 (S.D.N.Y. Aug. 15, 2017). "In light of the text, structure, and purpose of Subsection 503–1, the Court concludes that a plan's time to resolve an appeal is not tolled under 29 C.F.R. § 2560.503–1(i)(4) when the plan determines that an extension is required because a third party, but not the claimant herself, has failed to submit information necessary to decide a claim. Accordingly, the tolling provision of Subsection 503–1(i)(4) does not excuse First Unum's failure to resolve McFarlane's appeal, or to notify her of a specific date by which it would do so, within 45 days of receiving her request for review. McFarlane is therefore 'deemed to have exhausted the administrative remedies available under the plan,' and First Unum's motion to dismiss her complaint for failure to exhaust her administrative remedies is denied. 29 C.F.R. § 2560.503–1(l)(1)."

Mcculloch v. Board Of Trustees Of The SEIU Affiliates Officers And Employees Pension Plan, et al., 686 F.App'x 68 (2d Cir. 2017). Because Plaintiff's claim for pension benefits is not statutory, and the district court would need to construe specific terms of the pension plan, Plaintiff was required to exhaust internal administrative remedies. Judge of district court is affirmed.

Neurological Surgery, P.C. v. Northrop Grumman Sys. Corp., No. 15CV4191, 2017 WL 389098 (E.D.N.Y. Jan. 26, 2017). The providers failed to exhaust their administrative remedies as required under the Plans for each of the five claims for which they seek payment. They only alleged "repeated attempts" to communicate with the administrator but no attempts to appeal. They have also failed to clearly and positively demonstrate futility in pursuing those remedies. Their state law claims are preempted by ERISA.

Third Circuit

Rachel B v. Horizon Blue Cross Blue Shield of New Jersey, No. 14-CV-1153, 2017 WL 3670966 (D.N.J. Aug. 25, 2017). For partial hospitalization treatment that Plaintiff received between May 3 to May 12, 2013, the court agreed with Plaintiff that Permedion acted arbitrarily and capriciously by failing to account for her doctor's letter, which repeatedly undermines Permedion's findings. The court remanded this claim for further administrative review. For treatment from May 13 to July 3, 2013, Plaintiff never submitted claims for the treatment and did not exhaust her administrative remedies. Defendant has been prejudiced by Plaintiff's failure to submit claims for treatment so summary judgment is awarded to Defendant on these claims.

Elite Orthopedic & Sports Medicine PA, v. Northern New Jersey Teamsters Benefit Plan, No. CV146932ESMAH, 2017 WL 3718379 (D.N.J. Aug. 29, 2017). Plaintiff's state law claims related to the provision of emergency services for one of Defendant's participants are preempted by ERISA. The Trustees' decision was neither arbitrary nor capricious where it satisfies the *Moench* factors. Plaintiff abandoned its misrepresentation claim and failed to exhaust its administrative remedies with respect to all services rendered by its physicians.

University Spine Center v. Horizon Blue Cross Blue Shield Of New Jersey, et al., No. CV 16-9253, 2017 WL 3610486 (D.N.J. Aug. 22, 2017). On Defendants' motion to dismiss, the court could not determine whether Anthem actually violated 29 C.F.R. § 2560.503-1(g)(1)(iv) and did not dismiss USC's claims due to a failure to exhaust administrative remedies at this time.

U.S. Renal Care, Inc. v. Wellspan Health, No. 1:14-CV-2257, 2017 WL 1062374 (M.D. Pa. Mar. 21, 2017). The court found that an appeal of the adverse benefits determinations would not have been futile. Plaintiff never filed an appeal although Defendants supplied Plaintiff with the relevant portions of the Plan documents, including the appeal procedure, how non-participating providers were paid, and how UCR was calculated. The court found that Plaintiff failed to exhaust its administrative remedies before filing its complaint, and awarded Defendants summary judgment as to Plaintiff's claim for benefits under § 502(a) of ERISA.

Roche v. Aetna, Inc., et al., 681 F.App'x 117 (3d Cir. 2017). In this matter where Aetna claimed that Roche had to reimburse it for medical expenses it paid on behalf of Roche under the relevant benefits plan, Roche reimbursed Aetna but then filed this action, the court affirmed the judgment of the district court dismissing the matter without prejudice for failure to exhaust administrative remedies as unambiguously required by the Plan.

Stampone v. Walker, No. CV 15-6956 (JLL), 2017 WL 517791 (D.N.J. Feb. 8, 2017). The second amended complaint contains no additional allegations regarding futility and Plaintiff does not assert that he has attempted to even start the process nor has he pled that Defendants' have a fixed policy denying benefits. A bare assertion of futility is insufficient. The court found that all claims relating to Plaintiff's pension must be dismissed for failure to exhaust the appropriate administrative remedies under ERISA.

Martino v. Cigna Insurance Company, No. CV 16-05257-SDW-LDW, 2017 WL 385780 (D.N.J. Jan. 27, 2017). This breach of insurance policy claim is dismissed on the basis of ERISA preemption and failure to exhaust administrative remedies. Plaintiff was provided notice on May 24, 2012 that she had been denied payment under the insurance policy and had sixty days to appeal the denial with CIGNA Group Insurance. The Complaint neither states that Plaintiff made an internal appeal, nor provides any basis upon which the court could determine that filing an internal appeal would have been futile. Plaintiffs did not file the Complaint in the Superior Court until July 25, 2016, more than four years after the date of the denial notice.

Fourth Circuit

Turner v. Volkswagen Grp. of Am., Inc., No. 2:16-CV-06570, 2017 WL 3037803 (S.D.W. Va. July 18, 2017). Because there are facts sufficient to support a showing that Volkswagen failed to comply with 29 C.F.R. § 2560.503-1(g) and Volkswagen's failure denied the plaintiff reasonable review of her life insurance claim, the court found that the pleadings present sufficient allegations to support a showing that plaintiff's administrative remedies are deemed exhausted for her life insurance benefits claim, and therefore, dismissal is improper at this time. But, Plaintiff did not exhaust the plan's administrative remedies prior to filing the lawsuit for the survivor benefits claim and she has not alleged facts to support a showing of futility.

Shepherd v. Cmty. First Bank, No. CV 8:15-04337-MGL, 2017 WL 735582 (D.S.C. Feb. 24, 2017). In this matter seeking retirement benefits under a SERP plan, the court followed *Gagliano v. Reliance Standard Life Insurance Co.*, 547 F.3d 230 (4th Cir. 2008) and held that the proper remedy for Defendants' failure to timely respond to Plaintiff's claim is to remand to Defendants for a full and complete review of the claim under the Plan's internal review procedures. The court found that the futility exception does not apply.

Fifth Circuit

Advanced Physicians, S.C. v. Connecticut General Life Insurance Company, et al., No. 3:16-CV-2355-G, 2017 WL 4868180 (N.D. Tex. Oct. 27, 2017). The court granted Defendants' motion to dismiss in part. Based on Fifth Circuit precedent, the court did not find it appropriate at this stage to dismiss AP's claims for failure to allege exhaustion of all administrative remedies.

Rapid Tox Screen LLC v. Cigna Healthcare of Texas Inc., No. 3:15-CV-3632-B, 2017 WL 3658841 (N.D. Tex. Aug. 24, 2017). In this suit by a provider against an insurer seeking payment for services rendered, the court denied the insurer's motion to dismiss for failure to exhaust, finding that the second amended complaint pleads facts indicating an exception to the exhaustion requirement applies. The court also denied the motion with respect to Plaintiff's claims under ERISA Section 502(a)(3) seeking declaratory and injunctive relief and Section 503 for failing to provide a full and fair review.

Bergeron et al. v. Ochsner Health System et al., No. CV 17-519, 2017 WL 3648451 (E.D. La. Aug. 24, 2017). Direct patient care employees brought suit against the hospital for failing to properly calculate and pay employees' wages. The court determined that Ochsner has a fiduciary duty to credit all compensation that the plan documents require it to credit and a failure to do so would violate that duty. Thus, the named plaintiffs have stated claims against Ochsner for breach of fiduciary duty under ERISA. Plaintiffs have also stated claims for ERISA recordkeeping violations against Ochsner for failing to record and report all hours worked by the employees. These ERISA claims don't require exhaustion of administrative remedies.

Walker v. Regence Blue Cross Blue Shield of Oregon, et al., No. CV G-15-064, 2017 WL 2619341 (S.D. Tex. June 16, 2017). Although Plaintiff did not utilize the Plan's available levels of administrative appeals before suing Regence, the court found that there is no evidence in the record that Regence ever communicated to Plaintiff the specific reasoning behind its determination of the disputed claim for air ambulance benefits. The court found that Plaintiff "makes a persuasive argument that Regence's procedural defense" should fail but even assuming Plaintiff were deemed to have exhausted the available administrative remedies, the administrative record supports the conclusion that the plan administrator correctly interpreted the Plan in refusing to cover a higher amount of the air ambulance costs.

Mem'l Hermann Health Sys. v. Sw. LTC, Ltd. Employee Benefits Plan, 683 F.App'x 274, (5th Cir. 2017). In this suit by a medical provider against a health benefit plan seeking payment for medical bills incurred by a patient covered by the plan, the court affirmed the district court's grant of summary judgment in favor of Defendant for Plaintiff's failure to exhaust administrative remedies. Plaintiff failed to provide Defendant with proof of an authorization or assignment from the patient.

Murray v. Fid. Investments Institutional Operations, Co., No. CV 16-14373, 2017 WL 699828 (E.D. La. Feb. 22, 2017). Plaintiff attempted to gain access to her ex-husband's retirement accounts to determine what portion is owed to her as a result of the divorce. She alleged that the accounts with Fidelity have been "hidden and/or withheld in a manner which is contrary to the ERISA statute," and has caused her money damages, loss of benefits, mental and emotional distress, and compensatory and punitive damages. The court granted Defendant's motion to dismiss on the basis that Plaintiff failed to exhaust her administrative remedies and thus fails to state a claim for which relief can be granted.

N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare, No. 4:09-CV-2556, 2017 WL 484108 (S.D. Tex. Feb. 6, 2017). The court denied the parties' motions for reconsideration of its September 28, 2016 Memorandum and Order that Cigna had violated ERISA § 502(a)(1)(B), but that North Cypress could not recover for any claims for which North Cypress failed to exhaust administrative remedies.

Davis v. Aetna Life Ins. Co., No. CV 16-4263, 2017 WL 175779 (E.D. La. Jan. 17, 2017). The court granted Aetna's unopposed motion for summary judgment seeking affirmation of its decision to deny Plaintiff's long-term disability benefit claim. Despite multiple requests from the plan administrator, Plaintiff failed to submit any medical documentation indicating she suffered from a disability that would prevent her from completing any of her job responsibilities, Plaintiff failed to exhaust her administrative remedies, and Plaintiff provided no evidence either to support her claim or rebut Defendants' arguments.

Sixth Circuit

Spectrum Health Hosps. v. Tooling Sys. Grp., Inc., No. 1:17-CV-642, 2017 WL 4868364 (W.D. Mich. Oct. 26, 2017). The court granted summary judgment to Defendant, finding that its notice of denial of payment for the medical expense claim substantially complied with the purposes of § 2560.503–1 but Plaintiff waited nearly a month after the appeal period had expired to contact Tooling.

Coontz v. Metropolitan Life Insurance Company, No. 1:17-CV-00015-GNS, 2017 WL 4227656 (W.D. Ky. Sept. 22, 2017). Where Plaintiff filed her lawsuit for denied AD&D benefits when MetLife did not make a decision within 120 days of its receipt of her appeal, the court held that Plaintiff did exhaust administrative remedies since MetLife's extension letter to Plaintiff did not operate to toll its time to decide the appeal under the Plan or 29 C.F.R. § 2560.503-1(i)(4). The extension letter simply stated that additional time was needed to process her appeal because it was necessary for MetLife to obtain additional information, but it does not state that the need for additional information was caused by Plaintiff's failure to provide the information, nor does the letter explicitly request any information from Plaintiff. Since MetLife is not excused from making a timely decision, the court denied MetLife's request for remand.

Irwin v. Mutual of Omaha Insurance Company, No. 1:16-CV-982, 2017 WL 3599575 (W.D. Mich. Aug. 22, 2017). The court granted summary judgment in favor of Mutual of Omaha. The court found that Plaintiff has not exhausted the administrative review process for her long-term disability claim, and she did exhaust the administrative review process for her short-term disability claim but she did not include her short-term disability claim in her federal complaint. Even so, Plaintiff has failed to satisfy her burden by a preponderance of the evidence that she was entitled to short-term or long-term disability benefits.

Humana Ins. Co. of Kentucky v. O'Neal, No. CV 16-173-DLB-JGW, 2017 WL 3015173 (E.D. Ky. July 14, 2017). In this interpleader action to determine the beneficiary entitled to life insurance proceeds, the court determined that this is not a case in which the insurer has "punted" its decision-making authority to the Court, but instead faces the real threat of multiple liability, and reverse exhaustion is neither appropriate nor necessary.

Kennedy v. Life Ins. Co. of N. Am., No. 3:15-CV-00741-CRS-DW, 2017 WL 2919005 (W.D. Ky. July 7, 2017). The court found that Plaintiff did not exhaust his administrative

remedies with respect to his long term disability claim, where Plaintiff only filed a short-term disability claim and not a long-term disability claim on the expectation that his short term claim would transition into one for long term disability benefits. The court found that because LINA could not have expected that Plaintiff's short term disability claim would reach maximum duration, the insurance company was not required to transition his claim into one for long term disability benefits under LINA's short-term-disability-to-long-term-disability-claims policy. Accordingly, LINA is entitled to summary judgment on Plaintiff's breach of contract and breach of fiduciary duty claims for Plaintiff's failure to exhaust.

Aviation West Charters, LLC v. United Healthcare Insurance Company, et al., No. 1: 16 CV 210, 2017 WL 2838474 (N.D. Ohio June 30, 2017). In this dispute between a provider and insurance company of the payment of air ambulance services, the court found that United failed to comply with the time limits for appeals and wrongly failed to consider Angel MedFlight's second appeal materials. Under the terms of the Plan a "second level appeal request must be submitted within 180 days from receipt of the first level appeal decision." The time for appeal is measured from the day Angel MedFlight *received* the first level appeal decision. Although the record does not show when Angel MedFlight received the decision, since it was sent by first class mail, it was probably received by Angel MedFlight within the usual delivery time of up to 3 business days. 180 days from the assumed receipt date means that the submission of the second level appeal was timely. Case remanded to Defendant to consider the second appeal.

Goines v. Liberty Life Assurance Co. Boston, No. 3:17CV-00103-JHM, 2017 WL 1788669 (W.D. Ky. May 4, 2017). Liberty Life denied Plaintiff's short term disability claim, which she appealed, but Liberty Life denied the claim on appeal. She admittedly did not file a long term disability claim. The court found that Plaintiff failed to establish by a clear and positive indication that the administrative remedies available under the LTD Policy would be inadequate and that filing an LTD benefits claim would have been futile, where the STD and LTD plans have different eligibility requirements and elimination periods.

Decola v. Prudential Ins. Co. of Am., No. 3:16-CV-185-DJH-DW, 2017 WL 1147483 (W.D. Ky. Mar. 27, 2017). The court dismissed Plaintiff's lawsuit for failing to exhaust the denial of her long term disability benefit claim. Prior to the 180-day deadline to appeal, Plaintiff's attorney wrote to Prudential stating "we are appealing the decision" and that the attorney would be sending in current medical records. He further stated, "Again take this letter as an appeal, please allow time for the medical records to be obtained." The attorney wrote another letter stating that "I will continue to send the other records as I receive them." Prior to the deadline to appeal, Plaintiff did not "complete" the appeal. As such, the court agreed with Prudential that Plaintiff failed to exhaust administrative remedies.

The court dismissed Plaintiff's lawsuit for failing to exhaust the denial of her long term disability benefit claim even though prior to the 180-day deadline to appeal, Plaintiff's attorney wrote to Prudential stating "we are appealing the decision" and further stating, "Again take this letter as an appeal, please allow time for the medical records to be obtained." Because Plaintiff did not

"complete" the appeal before the 180-day deadline, Plaintiff failed to exhaust administrative remedies.

Barber v. Lincoln Nat'l Life Ins. Co., No. 3:17-CV-00034-JHM, 2017 WL 2126330 (W.D. Ky. May 16, 2017). The court determined that Lincoln's decision to reduce Plaintiff's monthly benefit due to his political consulting income is supported by the plain text of the policy. It did not matter whether or not the work was done in his own occupation of "litigator." Plaintiff also alleged a violation of ERISA Section 502(a)(3) based on Lincoln's offsetting of Plaintiff's monthly benefit without first waiting until he had reported his other income for federal income tax purposes. The court determined that Plaintiff had standing to bring this claim, but since the claim is policy-based as opposed to statutory-based, exhaustion of administrative remedies is required. Since Plaintiff did not file an appeal within 180 days, which has now passed, the court dismissed this claim with prejudice.

Hitchcock v. Cumberland University 403(b) DC Plan, et al., No. 16-5942, 2017 WL 971790 (6th Cir. Mar. 14, 2017). The court held that there is no exhaustion requirement for ERISA claims alleging statutory, rather than plan-based, violations. Count II, asserting an anti-cutback violation on behalf of the benefits class, in violation of 29 U.S.C. § 1054(g), and Count IV, asserting breach of fiduciary duty, in violation of 29 U.S.C. § 1104, are claims for statutory violations not subject to the exhaustion requirement.
Where the court joined the Third, Fourth, Fifth, Ninth, Tenth, and D.C. Circuits in holding that there is no exhaustion requirement for ERISA claims alleging statutory violations.

Wallace v. Beaumont Healthcare Employee Welfare Benefit Plan, No. CV 16-10625, 2017 WL 193551 (E.D. Mich. Jan. 18, 2017). Plaintiff was not required to exhaust any administrative remedies prior to filing this lawsuit where the insurance policy does not require exhaustion and the letters to the claimant only stated that Plaintiff "may" request a review of Reliance's determination.

Seventh Circuit

Meyer v. Grp. Long Term Disability Plan for Employees of Edward D. Jones & Co., L.P., No. 116CV01282JESJEH, 2017 WL 4518606 (C.D. Ill. Oct. 10, 2017). The court denied Defendants' motion to dismiss for failing to exhaust administrative remedies by not submitting an appeal within 180 days of the disability claim denial. The court explained that viewing the Complaint in a light most favorable to the Plaintiff, she sufficiently alleged that her June 2, 2015 letter to Hartford constituted an appeal. The letter stated, "Hi—Enclosed are my medical records and claim forms from two doctors. Please advise regarding my disability income asap. EDJ [Employer] still has me on part-time, irregular schedule [sic.] leave of absence. My rheumatologist only wants me to work 28 or less hours a week." Further, she he actually sent documentation requested by Hartford as necessary for a determination of her claim and she mailed the June 2 letter to the correct P.O. Box for the appeals department.

Nicodemus v. Life Ins. Co. of N. Am., No. 16 C 6968, 2017 WL 1511475 (N.D. Ill. Apr. 27, 2017). In this matter where LINA approved Plaintiff's long term disability benefit claim after he filed a lawsuit, but where he challenged the amount of benefits paid, the court found that Plaintiff has not yet exhausted his remedies under the policy review process and must first seek internal review of his underpayment claim.

OSF Healthcare Sys. v. Matcor Metal Fabrication (Illinois) Inc, No. 1:16-CV-1052-SLD-JEH, 2017 WL 935158 (C.D. Ill. Mar. 9, 2017). The court granted Defendant's motion to dismiss for failure to exhaust administrative remedies. The Plan provided an unambiguous and reasonable procedure by which OSF could have become authorized to act on behalf of the covered individual, but OSF did not follow that procedure. Just because OSF received direct payment from the Plan for some portion of the services rendered does not make it a beneficiary entitled to an appeal.

Eighth Circuit

Chesterfield Spine Center, LLC v. Gilster-Mary Lee Corp., No. 4:15 CV 1169 RWS, 2017 WL 1477132 (E.D. Mo. Apr. 25, 2017). In this matter where a provider sued a health plan sponsor for its failure to pay for surgical treatment for one of its covered participants, the court found that Defendant was entitled to judgment as a matter of law because Plaintiff failed to exhaust the Plan's internal review procedures because it failed to timely appeal the denial of benefits.

Stover v. Delta Air Lines Optional Insurances Plan, et al., No. CV 16-4122 (RHK/SER), 2017 WL 4277144 (D. Minn. Sept. 25, 2017). In this lawsuit brought by a former flight attendant seeking benefits for job-related injuries under the Delta-sponsored Group Accident Insurance and Private Pilots Accident Insurance, the court denied dismissal of her claim for benefits for being untimely since the Plan's terms are ambiguous as to precisely when she suffered a loss. On the current record, the court also cannot say that it was unreasonable for Plaintiff to believe she had submitted a claim under both programs so the issue of exhaustion requires further record development.

Ninth Circuit

Francisco Ponce De Leon v. International Longshoremen's And Warehousemen's Union-Pacific Maritime Association Welfare Plan, 704 F.App'x 700 (9th Cir. 2017). Where Plaintiff voluntarily agreed to stay his litigation soon after filing his complaint and the Plan paid his claim upon resolution of the administrative claims process, the district court did not abuse its discretion in denying Plaintiff attorneys' fees under ERISA Section 502(g)(1), 29 U.S.C. § 1132(g)(1). Fee recovery under ERISA is not available for pre-litigation administrative activity. *See Cann v. Carpenters' Pension Tr. Fund for N. Cal.*, 989 F.2d 313 (9th Cir. 1993). While fees expended on administrative proceedings after a court-ordered remand may be recoverable, the district court in this case did not compel the parties to go to arbitration, but instead merely entered the parties'

stipulation to do so. "Plaintiffs may not circumvent *Cann* by filing suit before exhausting administrative remedies, in order to get the benefit of fee recovery."

Laura B v. United Health Group Company, et al., (No. 16-CV-01639-JSC, 2017 WL 3670782 (N.D. Cal. Aug. 25, 2017). Defendant Motion Picture Industry Health Plan's motion for summary judgment on the issue of exhaustion and the standard of review is denied. The plan documents governing Plaintiff's mental health inpatient care do not require a second level appeal to Motion Picture to exhaust administrative remedies and Motion Picture has not met its burden to show that abuse of discretion review applies.

Biggar v. Prudential Ins. Co. of Am., No. 15-CV-04825-JST, __F.Supp.3d__, 2017 WL 3453341 (N.D. Cal. Aug. 11, 2017). The 45-day deadline for Prudential to decide Biggar's long term disability claim appeal was tolled from July 9, 2015 to July 27, 2015, when Plaintiff submitted his SSA award, since his July 9th letter asked that the deadline be tolled. But, Prudential's subsequent requests for documents do not further toll the decision deadline since the information requested was not necessary to decide the claim. Prudential did not make a decision within the deadline or within the one-time 45-day extension, thus, the court rejected Prudential's exhaustion argument.

O'Gorman v. Hartford Life & Accident Ins. Co., No. 2:16-CV-01048-RAJ, 2017 WL 3424962 (W.D. Wash. Aug. 9, 2017). In this long term disability case, Hartford argued that Plaintiff has failed to exhaust her administrative remedies by filing an appeal subsequent to receiving Hartford's September 9, 2016 letter. The court agreed with Plaintiff that she was not required to do so. The Ninth Circuit has consistently applied a prudential exhaustion requirement requiring an ERISA plaintiff claiming denial of benefits to avail himself or herself of a plan's own internal review procedures before bringing suit in federal court, but the Ninth Circuit has also held that a claimant need not exhaust when the plan does not require it. Here, the Plan provides only that a participant "may appeal to [Hartford] for a full and fair review," but it does not require that a participant do so. The court determined that it cannot decide the question of disability on the current record so remanded the claim to Hartford to perform a thorough employability analysis.

Jantos v. Prudential Life Ins. Co. of Am., No. 2:15-CV-01530-RAJ, 2017 WL 1408151 (W.D. Wash. Apr. 20, 2017). Plaintiff's lawsuit challenging the calculation of her long term disability benefit is dismissed for failure to exhaust administrative remedies. The court rejected Plaintiff's argument that the approval letter is not an "adverse benefit determination," and she is excused from any exhaustion requirement.

Sugiyama v. Unum Life Ins. Co. of Am., No. 16-CV-05032-PJH, 2017 WL 1374650 (N.D. Cal. Apr. 17, 2017). ERISA regulation, 29 C.F.R. § 2560.503-1(f), is ambiguous as to whether an administrator's deadline to make a decision runs from the date the employer received the claim for AD&D benefits or when Unum received the claim. Assuming the former and that Unum's written notice of an extension was seven days late, Plaintiff is deemed to have exhausted

administrative remedies. However, Plaintiff is not entitled to a limitation on the scope of the administrative record. Unum's procedural violation can be excused under the "substantial compliance" doctrine. Substantive relief based on a procedural violation is appropriate only if there is substantive harm. Even if there was substantive harm here, the court found that the equities favor considering the full record that Unum relied on to make its claim decision, including evidence after the 90-day deadline to make a decision.

Russell v. CVS Caremark Corp., No. CV-16-00284-PHX-PGR, 2017 WL 1090677 (D. Ariz. Mar. 23, 2017). Plaintiff brought suit after her 401(k) funds were deposited in the wrong bank account and CVS' agents allegedly failed or refused to provide her with the requested information for correcting the erroneous distribution. Defendants moved to dismiss for failure to exhaust administrative remedies. The court concluded that dismissal of this action for failure to exhaust is not appropriate at this pleading stage because CVS has not established that non-exhaustion is obvious from the face of the First Amended Complaint.

Norris v. Mazzola, No. 15-CV-04962-JSC, 2017 WL 505970 (N.D. Cal. Feb. 7, 2017). On behalf of a putative class, Plaintiff seeks to recover reciprocity contributions and the earnings thereon which were allegedly improperly withheld by Defendants. The court determined that as a matter of law that any failure to exhaust is excused based on Defendants' refusal to consider Plaintiff's appeal and because pursuing internal plan remedies would be futile.

Soich v. Aetna Life Ins. Co., No. 3:16-CV-88-SI, 2017 WL 449171 (D. Or. Feb. 2, 2017). Following a bench trial on the administrative record, the court concluded that the *pro se* plaintiff is not entitled to reimbursement of funds from a Health Care Spending Account because some of the expenses were already paid, Plaintiff did not exhaust administrative remedies, and Plaintiff submitted requests beyond the clear deadline.

Tenth Circuit

Concilio v. Cigna Health And Life Insurance Company, No. 16-CV-01863-WJM-MJW, 2017 WL 5900345 (D. Colo. Nov. 30, 2017). Dr. Cain did not appeal Cigna's denial of his surgery authorization but the court determined that the merits of the denial are properly before the court since exhaustion would be futile. "In short, there is no doubt that Cigna would have denied any appeal by Dr. Cain requesting a two-level lumbar fusion for degenerative disc disease because this procedure is not covered under the Plan."

Hendrickson v. Prudential Ins. Co. of Am., No. 2:15-CV-565-CW, 2017 WL 4737255 (D. Utah Oct. 19, 2017). Prudential's motion for summary judgment is granted because Plaintiff failed to submit an administrative appeal for his short term disability benefit denial. The court explained that the Tenth Circuit Court of Appeals has not distinguished between permissive and mandatory language in determining whether ERISA exhaustion is required. Thus, exhaustion is required when a plan sets out an administrative review process, even if it provides that a claimant

"may appeal" a denied claim. Further, Plaintiff's long-term disability claim is precluded because qualification for LTD benefits is contingent in part upon receipt of short-term disability benefits.

Eleventh Circuit

Stephens v. Time Customer Service, Inc., Severance Plan & Henry Lescaille, No. 8:17-CV-1338-T-33AEP, 2017 WL 3608275 (M.D. Fla. Aug. 22, 2017). In this lawsuit seeking severance benefits, Defendants argued that Stephens failed to exhaust her administrative remedies for her breach of fiduciary duty and request for documents claims. The court found that it is not clear that Stephens failed to exhaust her administrative remedies and the Complaint alleges that "Stephens has exhausted her administrative remedies." The exhibits to the Motion do not contradict this assertion and this allegation is sufficient to survive the motion to dismiss stage.

Horton v. United of Omaha Life Ins. Co., No. 1:15-CV-0933-JEO, 2017 WL 1105728 (N.D. Ala. Mar. 24, 2017). The court granted summary judgment in favor of United of Omaha where Plaintiff did not submit a timely appeal of the denial of his LTD benefits. Plaintiff submitted an appeal for the life insurance/life waiver of premium benefits denial. He believed he was also appealing the LTD benefit claim denial. The court found that Plaintiff was fully informed of his appeal obligations for the LTD benefit denial and that equitable tolling was not justified. "For starters, Horton has not cited, nor has the court found, any Eleventh Circuit case law acknowledging a hospitalization exception to the ERISA exhaustion requirements."

Stevens v. Sun Life & Health Ins. Co. (U.S.), No. 3:16-CV-76-WKW, 2017 WL 900005 (M.D. Ala. Mar. 7, 2017). In this dispute over short and long term disability benefits, the court agreed with the Magistrate Judge's conclusion that Sun Life's motion for summary judgment should be denied. The question was whether Stevens exhausted administrative remedies based on the following facts:

- November 9, 2015, Stevens appeals the denial of her long term disability claim and termination of her short term disability claim.
- On November 16, 2015, Sun Life wrote to Stevens indicated its inability to access contents of a DVD submitted with the appeal and also requesting Plaintiff's SSDI file.
- On December 8, 2015, Stevens' attorney provided a replacement DVD and a transcript of the DVD.
- On December 15, 2015, Sun Life acknowledged receipt of the DVD and again requested the SSDI file.
- On December 30, 2015, NMR notified Stevens' attorney that an IME was scheduled for January 7, 2016.
- On December 31, 2015, Stevens' attorney informed Sun Life that an IME was improper on appeal but Stevens would consider it if the doctor were truly neutral and if the IME is videotaped by a witness accompanying Stevens at the exam.
- On January 5, 2016, Sun Life wrote to Stevens' attorney insisting that the IME proceed but the exam would not be videotaped.

- On January 7, 2016, Plaintiff showed up to the examination but the doctor refused to allow videotaping in his office, and the examination was cancelled.
- On January 13, 2016, NMR notified Stevens' attorney that it had scheduled another IME for February 5, 2016 with a doctor who would permit videotaping.
- On January 14, 2016, Sun Life wrote to Stevens' attorney claiming that the appeal remains "tolled" for its receipt of the IME and it would inform him in writing if the second 45-day review period is necessary.
- On January 19, 2016, Stevens' attorney wrote to Sun Life objecting to the IME because the second doctor was biased.
- On February 5, 2016, Stevens filed suit.

Sun Life argued that Plaintiff failed to exhaust her administrative remedies for her LTD claim because she failed to attend the IME and because she filed suit before Sun Life issued its letter denying her appeal. The court disagreed. It explained that Sun Life had 45 days to decide the appeal starting from the day that Stevens submitted her appeal. Neither the regulations nor the plan documents provide for intermittent tolling of the initial 45-day period every time Sun Life requested necessary or other information or documents from Stevens (such as the DVD or SSDI file), or for completion of the IME. Sun Life was required to provide Stevens with written notice of the extension prior to December 26, 2015, the date of termination of the initial 45-day period. It was also required to inform Stevens of the special circumstances requiring an extension and the date by which the plan expects to render the determination on review. Stevens was not required to attend the IME with the second doctor because it was scheduled outside the initial 45-day review period and because the second 45-day period had been neither invoked nor tolled. Because Sun Life failed to issue a decision or provide notice of an extension within the time limit for the appeal, Stevens is deemed to have exhausted her administrative remedies.

Otero v. Unum Life Ins. Co. of Am., No. CV-7:14-BE-2253-W, 2017 WL 131568 (N.D. Ala. Jan. 13, 2017). The *de novo* standard of review applies in this case because Unum did not exercise the discretion granted it by the plan and Plaintiff's claim is "deemed exhausted." The court remanded the claim to Unum directing it to obtain the relevant documents to make the appropriate benefit calculations.

D.C. Circuit

Perry v. Int'l Bhd. of Teamsters, 247 F.Supp.3d 1 (D.D.C. 2017). In this lawsuit for lifetime retiree health benefits, the court noted that whether administrative exhaustion is required for ERISA section 510 claims, such that equitable tolling would be appropriate, has not been addressed by the D.C. Circuit, and other Circuits are split on the issue. Given the absence of direct precedent in this Circuit suggests that Plaintiff's belief that exhaustion was required was not unreasonable, but given the circumstances the court declined to exercise equitable tolling and found the Complaint untimely.

IV. Judicial Review

A. Standard of Review

1. Firestone Tire & Rubber Co. v. Bruch and Metropolitan Life Insurance Co. v. Glenn

No update.

2. The Significance of Language Granting Power to Interpret Pan

First Circuit

Rodriguez-Lopez v. Triple-S Vida, Inc., 850 F.3d 14 (1st Cir. 2017). Rodriguez worked for Mova Pharmaceutical Corporation ("Mova") and filed a claim under Mova's ERISA governed LTD plan. Jefferson–Pilot Life Insurance Company ("Jefferson–Pilot") originally issued a group policy to Mova. The summary plan description ("SPD") named Mova as the plan sponsor and administrator, and stated that "[t]he Plan Sponsor is granted the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan." Triple–S Vida, Inc. ("Triple-S") asserted that at some point it replaced Jefferson–Pilot in the contractual relationship between Mova and Jefferson–Pilot and that it notified Mova that Triple–S would pay the benefits provided under the plan, subject to all the policy's provisions. Thereafter, all the things that the plan stated would be performed by Jefferson–Pilot were actually performed by Triple–S. The plan, however, was not amended to reflect this change. No new SPD or summary of material modifications was furnished to plan participants notifying them of this change and naming Triple–S as claims administrator and/or insurer. In assessing whether a plan reflects a clear grant of discretionary authority, the court reviews the language of the plan de novo and, in this case, the court concluded that, based on a careful review of the language of the plan, there was no clear grant of discretionary authority to Triple–S to determine eligibility for benefits. The court would not imply that discretionary authority had been granted to Triple-S even though it was actually making the benefit decisions in place of Mova. De novo review applied to the determination of its benefit decisions.

Tullie v. Prudential Life Ins. Co. of Am., No. CV 16-662-JJM-PAS, 2017 WL 5997405 (D.R.I. Dec. 1, 2017). The Court considered the following language contained in a supplement "which explicitly states that supplement provisions are subordinate to the terms of the insurance policy and the group plan" to be an insufficient grant of discretionary authority warranting discretionary review: "The insurance company has the sole discretionary authority to interpret and apply the terms of the insurance policy. In the event the insurance company determines a benefit is not payable under the terms of the policy, the benefit will not be payable under any other terms of the plan, this Supplement F, or the Summary Plan Description." The Court reasoned that because neither the policy nor the plan included any form of "safe harbor" discretionary language (i.e., "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them"), the supplement provision does not help Prudential to make

its standard of review case as the supplement explicitly states that supplement provisions are subordinate to "the terms of the insurance policy" and the group plan.

Second Circuit

Tietjen v. Unum Life Ins. Co. of Am., No. 16-CV-7021 (JMF), 2017 WL 4286317 (S.D.N.Y. Sept. 26, 2017). According to the Court, there was no dispute that the plan explicitly granted discretionary authority to Unum as it stated that "[w]hen making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy." But, "the rub is that the determinations here were apparently made by employees of Unum Group, an entity that is distinct from Unum." Citing that fact, Tietjen contended that the determinations were made by an unauthorized party and that the Court should therefore apply de novo review. Unum, on the other hand, pointed to the Additional Summary Plan Description ("SPD"), which stated in relevant part that "[t]he Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan." The Court considered both parties' arguments, and found as significant that the SPD further provided that it is part of the Plan, stating, in one instance, that "[i]f this policy provides benefits under a Plan," subject to ERISA, "the following provisions apply," and, in another, that "[t]he summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document." Thus, the Court found that Unum had the better of the argument and that the abuse of discretion standard applied.

Schuman v. Aetna Life Ins. Co., No. 3:15-CV-1006 (SRU), 2017 WL 1053853 (D. Conn. Mar. 20, 2017). The Group Accident and Health Insurance Policy contained a provision stating, in relevant part: "We [Aetna] are a fiduciary with complete authority to review all denied claims for benefits under this Policy.... In exercising such fiduciary responsibility, We shall have discretionary authority to determine whether and to what extent eligible employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under this Policy, the Certificate or any other document incorporated herein. We shall be deemed to have properly exercised such authority unless We abuse our discretion by acting arbitrarily and capriciously." Schuman asserted that the Group Policy was not a part of the applicable plan and, in response, Aetna provided a declaration that the plan consists of two parts: (1) the Group Policy containing general terms that apply to all of the different coverage options; and (2) certificates setting out the specific slate of benefits for each class. Further, the affidavit stated that the Group Policy incorporates the certificates by reference to a "Schedule of Benefits" itemized on its "Policy Contents." And because the Group Policy and certificates are intended to be part of the same document, the latter would not repeat, for instance, a grant of discretionary authority included in the former. The Court found Aetna's explanation of the relationship between the Group Policy and the certificates to be supported by language in each and that, as such, the Group Policy contained an adequate grant of discretion.

Third Circuit

Dowling v. Pension Plan For Salaried Employees of Union Pac. Corp. & Affiliates, 871 F.3d 239 (3d Cir. 2017). If the plan document "gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," then the Court reviews the administrator's decision on a more deferential basis. Here, because the Union Pacific plan explicitly grants the administrator the ability to determine benefit eligibility and to "construe and interpret" the plan's provisions, the Court will not set aside the administrator's interpretations of "unambiguous plan language" as long as those interpretations are "reasonably consistent" with the plan's text, and it will only disturb the administrator's interpretations of ambiguous plan language when those interpretations are "arbitrary and capricious."

Neal v. Life Ins. Co. of N. Am., No. CV 16-1146, 2017 WL 321497 (W.D. Pa. Jan. 23, 2017). The Court found that the plan documents, including the policy itself, the Group Long-Term Disability Insurance Certificate and the ACF, plainly granted LINA discretionary authority to determine plan eligibility and, as such, review of LINA's benefits decision was subject to the deferential arbitrary and capricious standard of review. More specifically, the policy itself stated that LINA has been "appointed ... as the named fiduciary for deciding claims for benefits under the Plan, and for deciding any appeals of denied claims." The Group Long-Term Disability Insurance Certificate stated, in relevant part: "The Plan Administrator [Diebold] has appointed the Insurance Company [LINA] as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law." Likewise, the plan documents included an "Appointment of Claim Fiduciary" form ("ACF"), which reiterated the grant of discretionary authority to LINA as follows: "Claim Fiduciary shall have the authority, in its discretion, to interpret the terms of the Plan, including the Policies; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact."

Killian v. Hartford Life & Accident Ins. Co., No. CV 16-1377, 2017 WL 429905, (E.D. Pa. Jan. 31, 2017). Court rejected Killian's argument that in order for the arbitrary and capricious standard to apply, a benefits plan must contain both a provision delegating decision-making authority and a separate provision allowing the employer to delegate that authority. Here, the plan administrator, PwC, delegated decision-making authority to Hartford but the plan contained no provision allowing PwC to delegate such authority to Hartford. The reiterated the appropriate inquiry as being "whether the plan language vested Hartford with discretionary authority to determine employees' eligibility for benefits" and reasoned that "the Plan explicitly grant[ed] Hartford such authority in at least four different provisions. ('The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.'); ('For purposes of claims administration, the Plan Administrator has assigned fiduciary responsibility for claim determinations to Hartford Life and Accident Company.'); ('The Plan has granted the Insurance Company full discretion and authority

to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.'); ('We [Hartford] have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy.')."

Fourth Circuit

Cline v. Aetna Life Ins. Co., No. 515CV00096RLVDSC, 2017 WL 5490853 (W.D.N.C. Nov. 15, 2017). Depending on the language of the insurance plan at issue, a plan administrator's disability benefit determination can be reviewed either de novo or for abuse of discretion. Here, the Court found that the plan gave discretionary authority to defendant based on the following pertinent plan language: "Aetna is a fiduciary," and "has complete authority to review all denied claims for benefits under this policy." Additionally, the plan stated that "Defendant has the discretionary authority to: determine whether and to what extent employees and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this policy." In part, because there were no allegations that defendant acted outside the scope of its discretion, the Court concluded that the proper standard of review was abuse of discretion.

Sixth Circuit

Tobin v. Hartford Life & Accident Ins. Co., 233 F. Supp. 3d 578 (W.D. Mich. 2017). The Court found that the plan conferred discretionary authority on Hartford by stating that it had "full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy." As such, the Court reviewed Hartford's claim decision under the arbitrary and capricious standard.

Black v. Metro. Life Ins. Co., 244 F. Supp. 3d 625 (W.D. Mich. 2017). Here, the parties disputed the appropriate standard of review. Plaintiff took the positon that the appropriate standard of review is de novo, based on Michigan Administrative Code Rule 500.2202(b), which prohibits provisions granting discretionary authority to insurance companies in group insurance policies issued after July 1, 2007. MetLife, on the other hand, argued that based on the certain plan language (i.e., "For plans covered under an insurance policy (e.g., HMOs, Life insurance, etc.), the carrier had been delegated discretionary authority to construe, interpret, apply and administer the Program. The Court cited *Fontaine v. Metropolitan Life Insurance Co.*, 800 F.3d 883 (7th Cir. 2015), a case in which another court reasoned that the discretionary clause was contained not in an insurance document subject to regulation by the State [], but was in an ERISA plan document that was beyond the reach of the state insurance regulation. Notwithstanding, the Court declined to make a ruling as to whether the statute operated to nullify the grant of discretionary authority sufficient for abuse of discretion review. Instead, the Court held that MetLife's decision should be affirmed even under a de novo standard of review. *But see Chamness v. Liberty Life Assurance Co. of Boston*, 234 F. Supp. 3d 885 (W.D. Mich. 2017), appeal dismissed, No. 17-1299, 2017 WL 4216578 (6th Cir. Apr. 21, 2017) (enforcing the Michigan state ban prohibiting insurers from issuing contracts or policies that contain discretionary clauses, citing *American Council of Life Ins.*

v. Ross, 558 F.3d 600 (6th Cir. 2009) in support, and applying a de novo standard of review to an ERISA civil action for review of denial of benefits challenged under § 1132(a)(1)(B)).

Ninth Circuit

Englert v. Prudential Ins. Co. of Am., No. 15-CV-04814-HSG, 2017 WL 1133380 (N.D. Cal. Mar. 27, 2017). The Court held that because the California Insurance Code § 10110 was not preempted by ERISA, it operated to void any discretionary language contained within the Policy, SPDs, and the plan. The statute became effective January 1, 2012. Defendant first denied plaintiff's benefits in 2013 and subsequently affirmed its December 7, 2014 denial in a letter dated September 15, 2015. Plaintiff's claim was thus filed well after the statute went into effect and, according to the Court, it therefore governed the Court's analysis. Moreover, plaintiff's policy had an anniversary date of "January 1 of each year, beginning in 2012," and so the Court reasoned that it was renewed and continued in force after the effective date of the statute. *See also Monroe v. Metro. Life Ins. Co.*, No. 215CV02079TLNCKD, 2017 WL 2985063, (E.D. Cal. July 13, 2017) (same result); *but see Laura B v. United Health Grp. Co.*, No. 16-CV-01639-JSC, 2017 WL 3670782 (N.D. Cal. Aug. 25, 2017) ("ERISA preempts state laws that regulate self-funded plans.").

Tenth Circuit

Nothing to report.

Eleventh Circuit

Diaz v. Liberty Life Assurance Co. of Boston, No. CV 17-20662-CIV, 2017 WL 3822742 (S.D. Fla. Aug. 30, 2017). The issue before the Court was whether the plan document granted discretionary authority to the employer, JM Family Enterprises, or to Liberty. The plan defined the "Claims Administrator" as "the person or entity providing, to the extent delegated and in connection with the operation of the [Choice Plan] and the payment of claims, administrative services to" JM Family Enterprises. Section 5.1 of the Choice Plan provided that, "Except as provided in Section 5.8 with respect to insured Benefit Options ... the operation and administration of the Plan, the exclusive power and discretion to interpret the Plan, and the responsibility for carrying out the Plan's provisions are vested in the Committee and its delegates...." The Committee referred to JM Family Enterprises' Administrative Committee, which was comprised of individuals designated to perform various plan administration duties. With respect to benefit options that were fully insured, Section 5.8 provided that the insurance company will be the "named fiduciary" within the meaning of ERISA Section 402, and that: "[T]he Claims Administrator of such Benefit Option will have the authority and responsibility for administering and controlling such Benefit Option with all the power and discretion accorded to the Company and the Committee under this Article to carry out its responsibilities. Notwithstanding anything in this Plan to the contrary, this designation will govern and be binding upon the Plan and the insurance company without regard to any conflicting or inconsistent language in any Summary

Plan Description or Schedule of Benefits for that Benefit Option." In the Court's view, "It is difficult to imagine a more clearly worded grant of discretion than that included in the Group Disability Income Policy, which states, "Liberty shall possess the discretionary authority to construe the terms of this policy and to determine benefit eligibility hereunder." Moreover, the Court reasoned that the Choice Plan stated that the terms of the benefit options and their related documents "are hereby incorporated by reference into this plan to the extent they are consistent with this Plan" and that the grant of discretion in the Group Disability Income Policy is consistent with Sections 5.1 and 5.8 of the Choice Plan. Therefore, the Court ruled that it would review Liberty's decision to deny Diaz's claim for LTD benefits under the abuse of discretion standard.

3. Source or Location of Discretionary Authority to Interpret the Plan and Determine Eligibility for Plan Benefits

First Circuit

Rodriguez-Lopez v. Triple-S Vida, Inc., 850 F.3d 14 (1st Cir. 2017). Rodriguez worked for Mova Pharmaceutical Corporation ("Mova") and filed a claim under Mova's ERISA governed LTD plan. Jefferson–Pilot Life Insurance Company ("Jefferson–Pilot") originally issued a group policy to Mova. The summary plan description ("SPD") named Mova as the plan sponsor and administrator, and stated that "[t]he Plan Sponsor is granted the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan." Triple–S Vida, Inc. ("Triple-S") asserted that at some point it replaced Jefferson–Pilot in the contractual relationship between Mova and Jefferson–Pilot and that it notified Mova that Triple–S would pay the benefits provided under the plan, subject to all the policy's provisions. Thereafter, all the things that the plan stated would be performed by Jefferson–Pilot were actually performed by Triple–S. The plan, however, was not amended to reflect this change. Nor was a new SPD or summary of material modifications furnished to plan participants notifying them of this change and naming Triple–S as claims administrator and/or insurer. In assessing whether a plan reflected a clear grant of discretionary authority, the Court reviewed the language of the plan de novo. In this case, the Court concluded that, based on a careful review of the language of the plan, it did not reflect a clear grant of discretionary authority to Triple–S to determine eligibility for benefits, and thus de novo review applied to the determination of its benefit decisions. The Court would not imply that discretionary authority had been granted to Triple-S even though it was actually making the benefit decisions in place of Mova.

Tullie v. Prudential Life Ins. Co. of Am., No. CV 16-662-JJM-PAS, 2017 WL 5997405 (D.R.I. Dec. 1, 2017). The Court considered the following language contained in a supplement "which explicitly states that supplement provisions are subordinate to the terms of the insurance policy and the group plan" to be an insufficient grant of discretionary authority warranting discretionary review: "The insurance company has the sole discretionary authority to interpret and apply the terms of the insurance policy. In the event the insurance company determines a benefit is not payable under the terms of the policy, the benefit will not be payable under any other terms of the plan, this Supplement F, or the Summary Plan Description." The Court reasoned that

because neither the policy nor the plan included any form of "safe harbor" discretionary language (i.e., "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them"), the supplement provision does not help Prudential to make its standard of review case as the supplement explicitly states that supplement provisions are subordinate to "the terms of the insurance policy" and the group plan.

Second Circuit

Tietjen v. Unum Life Ins. Co. of Am., No. 16-CV-7021 (JMF), 2017 WL 4286317 (S.D.N.Y. Sept. 26, 2017). According to the Court, there was no dispute that the plan explicitly granted discretionary authority to Unum as it stated that "[w]hen making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy." But, "the rub is that the determinations here were apparently made by employees of Unum Group, an entity that is distinct from Unum." Citing that fact, Tietjen contended that the determinations were made by an unauthorized party and that the Court should therefore apply de novo review. Unum, on the other hand, pointed to the Additional Summary Plan Description ("SPD"), which stated in relevant part that "[t]he Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan." The Court considered both parties arguments, and found as significant that the SPD further provided that it is part of the Plan, stating, in one instance, that "[i]f this policy provides benefits under a Plan," subject to ERISA, "the following provisions apply," and, in another, that "[t]he summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document." Thus, the Court found that Unum had the better of the argument and that the abuse of discretion standard applied.

Schuman v. Aetna Life Ins. Co., No. 3:15-CV-1006 (SRU), 2017 WL 1053853 (D. Conn. Mar. 20, 2017). The Group Accident and Health Insurance Policy contained a provision stating, in relevant part: "We [Aetna] are a fiduciary with complete authority to review all denied claims for benefits under this Policy.... In exercising such fiduciary responsibility, We shall have discretionary authority to determine whether and to what extent eligible employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under this Policy, the Certificate or any other document incorporated herein. We shall be deemed to have properly exercised such authority unless We abuse our discretion by acting arbitrarily and capriciously." Schuman asserted that the Group Policy was not a part of the applicable plan and, in response, Aetna provided a declaration that the Plan consists of two parts: (1) the Group Policy containing general terms that apply to all of the different coverage options; and (2) certificates setting out the specific slate of benefits for each class. Further, the affidavit stated that the Group Policy incorporates the certificates by reference to a "Schedule of Benefits" itemized on its "Policy Contents." And because the Group Policy and certificates are intended to be part of the same document, the latter would not repeat, for instance, a grant of discretionary authority included in the former. The Court found Aetna's explanation of the relationship between the Group Policy

and the certificates to be supported by language in each and that, as such, the Group Policy contained an adequate grant of discretion.

Third Circuit

Dowling v. Pension Plan For Salaried Employees of Union Pac. Corp. & Affiliates, 871 F.3d 239 (3d Cir. 2017). If the plan document "gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," then the Court reviews the administrator's decision on a more deferential basis. Here, because the Union Pacific plan explicitly grants the administrator the ability to determine benefit eligibility and to "construe and interpret" the plan's provisions, the Court will not set aside the administrator's interpretations of "unambiguous plan language" as long as those interpretations are "reasonably consistent" with the plan's text, and it will only disturb the administrator's interpretations of ambiguous plan language when those interpretations are "arbitrary and capricious."

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Killian v. Hartford Life & Accident Ins. Co., No. CV 16-1377, 2017 WL 429905 (E.D. Pa. Jan. 31, 2017). Court rejected Killian's argument that in order for the arbitrary and capricious standard to apply, a benefits plan must contain both a provision delegating decision-making authority and a separate provision allowing the employer to delegate that authority. Here, the plan administrator, PwC, delegated decision-making authority to Hartford, but the plan contained no provision allowing PwC to delegate such authority to Hartford. The reiterated the appropriate inquiry as being "whether the Plan language vested Hartford with discretionary authority to determine employees' eligibility for benefits" and reasoned that "the Plan explicitly grant[ed] Hartford such authority in at least four different provisions. ('The Plan has granted the Insurance

Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.'); ('For purposes of claims administration, the Plan Administrator has assigned fiduciary responsibility for claim determinations to Hartford Life and Accident Company.'); ('The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.'); ('We [Hartford] have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy.')."

Fourth Circuit

Cline v. Aetna Life Ins. Co., No. 515CV00096RLVDSC, 2017 WL 5490853 (W.D.N.C. Nov. 15, 2017). Depending on the language of the insurance plan at issue, a plan administrator's disability benefit determination can be reviewed either de novo or for abuse of discretion. Here, the Court found that the plan gave discretionary authority to defendant based on the following pertinent plan language: "Aetna is a fiduciary," and "has complete authority to review all denied claims for benefits under this policy." Additionally, the plan stated that "Defendant has the discretionary authority to: determine whether and to what extent employees and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this policy." In part, because there were no allegations that defendant acted outside the scope of its discretion, the Court concluded that the proper standard of review was abuse of discretion.

Sixth Circuit

Tobin v. Hartford Life & Accident Ins. Co., 233 F. Supp. 3d 578 (W.D. Mich. 2017). The Court found that the plan conferred discretionary authority on Hartford by stating that it had "full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy." As such, the Court reviewed Hartford's claim decision under the arbitrary and capricious standard.

Black v. Metro. Life Ins. Co., 244 F. Supp. 3d 625, 633–34 (W.D. Mich. 2017). Here, the parties disputed the appropriate standard of review. Plaintiff took the positon that the appropriate standard of review is de novo, based on Michigan Administrative Code Rule 500.2202(b), which prohibits provisions granting discretionary authority to insurance companies in group insurance policies issued after July 1, 2007. MetLife, on the other hand, argued that based on the certain plan language (i.e., "For plans covered under an insurance policy (e.g., HMOs, Life insurance, etc.), the carrier had been delegated discretionary authority to construe, interpret, apply and administer the Program. The Court cited *Fontaine v. Metropolitan Life Insurance Co.*, 800 F.3d 883 (7th Cir. 2015), a case in which another court reasoned that the discretionary clause was contained not in an insurance document subject to regulation by the State [], but was in an ERISA plan document that was beyond the reach of the state insurance regulation. Notwithstanding, the Court declined to make a ruling as to whether the statute operated to nullify the grant of discretionary authority sufficient for abuse of discretion review. Instead, the Court held that MetLife's decision should be affirmed even under a de novo standard of review. *But see Chamness*

v. Liberty Life Assurance Co. of Boston, 234 F. Supp. 3d 885 (W.D. Mich. 2017), appeal dismissed, No. 17-1299, 2017 WL 4216578 (6th Cir. Apr. 21, 2017) (enforcing the Michigan state ban prohibiting insurers from issuing contracts or policies that contain discretionary clauses, citing *American Council of Life Ins. v. Ross*, 558 F.3d 600 (6th Cir. 2009) in support, and applying a de novo standard of review to an ERISA civil action for review of denial of benefits challenged under § 1132(a)(1)(B)).

Seventh Circuit

Nothing to report.

Eighth Circuit

Nothing to report.

Ninth Circuit

Englert v. Prudential Ins. Co. of Am., No. 15-CV-04814-HSG, 2017 WL 1133380 (N.D. Cal. Mar. 27, 2017). The Court held that because the California Insurance Code § 10110 was not preempted by ERISA, it operated to void any discretionary language contained within the policy, SPDs, and the plan. The statute became effective January 1, 2012. Defendant first denied plaintiff's benefits in 2013 and subsequently affirmed its December 7, 2014 denial in a letter dated September 15, 2015. Plaintiff's claim was thus filed well after the statute went into effect and, according to the Court, it therefore governed the Court's analysis. Moreover, plaintiff's policy had an anniversary date of "January 1 of each year, beginning in 2012," and so the Court reasoned that it was renewed and continued in force after the effective date of the statute. *See also Monroe v. Metro. Life Ins. Co.*, No. 215CV02079TLNCKD, 2017 WL 2985063, (E.D. Cal. July 13, 2017) (same result); *but see Laura B v. United Health Grp. Co.*, No. 16-CV-01639-JSC, 2017 WL 3670782 (N.D. Cal. Aug. 25, 2017) ("ERISA preempts state laws that regulate self-funded plans.").

Tenth Circuit

Nothing to report.

Eleventh Circuit

Diaz v. Liberty Life Assurance Co. of Boston, No. CV 17-20662-CIV, 2017 WL 3822742 (S.D. Fla. Aug. 30, 2017). The issue before the Court was whether the plan document granted discretionary authority to the employer, JM Family Enterprises, or to Liberty. The plan defined the "Claims Administrator" as "the person or entity providing, to the extent delegated and in connection with the operation of the [Choice Plan] and the payment of claims, administrative services to" JM Family Enterprises. Section 5.1 of the Choice Plan provided that, "Except as

provided in Section 5.8 with respect to insured Benefit Options ... the operation and administration of the Plan, the exclusive power and discretion to interpret the Plan, and the responsibility for carrying out the Plan's provisions are vested in the Committee and its delegates...." The Committee referred to JM Family Enterprises' Administrative Committee, which was comprised of individuals designated to perform various plan administration duties. With respect to benefit options that were fully insured, Section 5.8 provided that the insurance company will be the "named fiduciary" within the meaning of ERISA Section 402, and that: "[T]he Claims Administrator of such Benefit Option will have the authority and responsibility for administering and controlling such Benefit Option with all the power and discretion accorded to the Company and the Committee under this Article to carry out its responsibilities. Notwithstanding anything in this Plan to the contrary, this designation will govern and be binding upon the Plan and the insurance company without regard to any conflicting or inconsistent language in any Summary Plan Description or Schedule of Benefits for that Benefit Option." In the Court's view, "It is difficult to imagine a more clearly worded grant of discretion than that included in the Group Disability Income Policy, which states, "Liberty shall possess the discretionary authority to construe the terms of this policy and to determine benefit eligibility hereunder." Moreover, the Court reasoned that the Choice Plan stated that the terms of the benefit options and their related documents "are hereby incorporated by reference into this plan to the extent they are consistent with this Plan" and that the grant of discretion in the Group Disability Income Policy is consistent with Sections 5.1 and 5.8 of the Choice Plan. Therefore, the Court ruled that it would review Liberty's decision to deny Diaz's claim for LTD benefits under the abuse of discretion standard.

D.C. Circuit

Nothing to report.

4. What Language Sufficiently Conveys Discretion?

First Circuit

Rodriguez-Lopez v. Triple-S Vida, Inc., 850 F.3d 14 (1st Cir. 2017). Insurance company, Jefferson–Pilot Life Insurance Company, originally issued a group policy (the "Plan") to Mova. At some point, Triple–S claims that it replaced Jefferson–Pilot in the contractual relationship, subject to all the policy's provisions. Thereafter, all the things that the Plan stated would be performed by Jefferson–Pilot were actually performed by Triple–S. The Plan, however, was not amended to reflect this change. No new SPD or summary of material modifications was furnished to plan participants notifying them of this change and naming Triple–S as claims administrator and/or insurer. Case law requires that the delegation of discretionary authority to an administrator or fiduciary be clearly stated in the plan, which was not done following the change. Nevertheless, the original provisions convey power to determine whether or not "benefits ... are due." The power to decide does not necessarily imply the existence of discretion. De novo review applied.

Doe v. Harvard Pilgrim Health Care, Inc., No. CV 15-10672, 2017 WL 4540961 (D. Mass. Oct. 11, 2017). De novo review applied where the plan stated the administrator would "use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care" and the plan's definition of medical necessity pointed to "generally accepted principles of professional medical practice," and not administrator discretion, as the basis for a determination. Discretionary authority "must be expressly provided for," and only when the delegation of such authority is "sufficiently clear and notice of it has been appropriately provided" does the standard of judicial review change from de novo review to abuse of discretion.

Tullie v. Prudential Life Ins. Co. of Am., No. CV 16-662-JJM-PAS, 2017 WL 5997405 (D.R.I. Dec. 1, 2017). Because the default standard is de novo, the burden is on the administrator to establish that its discretionary authority was explicit and that the claimant was given notice of same. While there are no magic words that make this inquiry fool-proof, the "safe harbor" language that the Seventh Circuit proposed should be included in ERISA plans in order to explicitly establish fiduciary discretionary authority is "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."

Second Circuit

Elizabeth W. v. Empire HealthChoice Assurance, Inc., No. 16-3463-CV, 2017 WL 4387182 (2d Cir. Oct. 3, 2017). Deferential review was applied where the plan documents provided administrator with "all ... powers necessary or appropriate" including the "power to construe this Contract, to determine all questions arising under this Contract, and to make and establish (and thereafter change) rules and regulations and procedures with respect to this Contract." The district court correctly noted that "magic words such as 'discretion' and 'deference'" are not necessary to confer discretionary authority, *citing Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999) (citation omitted).

E.R. v. UnitedHealthcare Ins. Co., 248 F. Supp. 3d 348, 361 (D. Conn. 2017), appeal withdrawn, No. 17-1036, 2017 WL 4575303 (2d Cir. July 27, 2017). Deferential review applied where plan language stated that a Mental Health/Substance Use Disorder Designee would determine "coverage for all levels of care" and that administrator has discretion to make factual determinations relating to benefits and to interpret benefits and the terms, limitations, and exclusions set out in the policy. The plan further provides that administrator may delegate this discretionary authority to others and that to receive benefits policyholders must cooperate with those service providers. The Court agreed that the plan's discretionary language grants an administrator the right to adopt such policies and guidelines as required to interpret the provisions set out in the plan and to make benefits determinations

Third Circuit

Dowling v. Pension Plan For Salaried Employees of Union Pac. Corp. & Affiliates, 871 F.3d 239, 245 (3d Cir. 2017). An arbitrary and capricious standard of review applied because

"plan explicitly grants the administrator the ability to determine benefit eligibility and to 'construe and interpret' the plan's provisions."

Elite Orthopedic & Sports Med. PA v. N. New Jersey Teamsters Benefit Plan, No. CV146932ESMAH, 2017 WL 3718379 (D.N.J. Aug. 29, 2017). Arbitrary and capricious standard applied where the plan vested the board of trustees with "sole authority and discretion to interpret and construe the terms of this Plan ... including provisions establishing eligibility for benefits ... as well as all other matters." The plan also stated that "[a]ny determination made by the Board of Trustees with respect to a Participant's rights or benefits will be entitled to the maximum deference permitted by law and will be final and binding upon all Participants and beneficiaries." Similarly, the "ERISA and Appeal Rights" section Description grants the trustees "absolute discretionary authority to ... decide questions, including legal and factual questions, relating to the payment of benefits under the Plan."

Killebrew v. Prudential Ins. Co. of Am., No. 3:15-CV-01415, 2017 WL 1519500 (M.D. Pa. Apr. 27, 2017). Applying discretionary standard of review. The wrap document states: "Benefits under the Program or a Plan will be paid only if the Program Administrator or its delegate decides in its discretion that a Participant is entitled to them. The Program Administrator may delegate this authority to ... one or more Claims Administrators." This Section further states that "[t]he Program Administrator and its authorized delegate(s) shall perform their duties, and, in their sole discretion, determine appropriate courses of action in light of the reason and purpose for which this Program is established and maintained." Further, the document informs that whenever benefits are provided under an insurance policy, as is the case here, "the Insurer shall be the designated Claims Administrator for such benefits, and the Program, Program Administrator and the Committee assume[ ] no liability or responsibility for any coverage or benefits provided under such plan or Plan Option." Therefore, because the claims administrator in this case is Prudential, the plan documents clearly grant Prudential discretion to decide whether claimant is entitled to LTD benefits.

Killian v. Hartford Life & Accident Ins. Co., No. CV 16-1377, 2017 WL 429905 (E.D. Pa. Jan. 31, 2017). Plaintiff argued that, for the arbitrary and capricious standard to apply, a benefits plan must contain both a provision delegating decision-making authority and a separate provision allowing the employer to delegate that authority. The policy conveys discretion to the insurer in four separate places. Further, other courts have concluded that the same or similar policy language warranted arbitrary and capricious review regardless of the absence of a wrap document or a separate provision giving the employer power to delegate authority to determine eligibility. Therefore, claimant's argument is insufficient to raise a genuine issue of material fact as to insurer's discretionary authority to make benefits determinations, and the appropriate standard of review is the arbitrary and capricious standard.

Neal v. Life Ins. Co. of N. Am., No. CV 16-1146, 2017 WL 321497 (W.D. Pa. Jan. 23, 2017). Discretion applied where the policy itself states that insurer has been "appointed ... as the named fiduciary for deciding claims for benefits under the Plan, and for deciding any appeals of

denied claims." Although this language alone may be insufficient to confer discretion, other plan documents consistently and unambiguously provide for such discretion. Specifically, the Group Long-Term Disability Insurance Certificate and the Appointment of Claim Fiduciary forms. Although plaintiff argued that the Court should not consider the ACF in determining whether the plan provides discretionary authority, the court disagreed.

Neurosurgical Assocs. of NJ, P.C. v. Aetna Ins. Co., No. CV 14-3882 (BRM), 2017 WL 3273648 (D.N.J. Aug. 1, 2017). In ERISA governed cases such as this, where the plan grants the claims administrator "the full power and authority in its absolute discretion to determine whether a claim is payable under the Plan and to interpret and construe the terms of the Plan and make factual determination [sic] with respect to claims and appeals for benefits and is a named fiduciary for such purposes," a claim for benefits is reviewed under the arbitrary and capricious standard

Aicher v. IBEW Local Union No. 269 Joint Tr. Funds Office, No. CV 12-1781 (FLW), 2017 WL 2364191 (D.N.J. May 31, 2017). Trustees are designated as the named fiduciary by the plan. The plan endows the Trustees with the sole discretion to establish rules, make claims determinations and, more importantly, the Trustees have the authority to interpret the terms of the plan, and they "are the sole judges of the standard of proof required in any case, and they may adopt such formulas, methods and procedures as they consider advisable." Based on the authority, the deferential standard of review applies to any claim determinations and/or plan interpretations made by the Trustees.

Fourth Circuit

Coleman v. Metro. Life Ins. Co., 262 F. Supp. 3d 295 (E.D.N.C. 2017). The plan language stated "[i]n carrying out their respective responsibilities under the Plans, the Plan Administrator and other of the Plans' fiduciaries shall have discretionary authority to make any findings necessary or appropriate for any purpose under the plans, including, to interpret the terms of the plans and to determine eligibility for and entitlement to benefits under the plans. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the determination was arbitrary and capricious." Although the plan referenced an arbitrary-and-capricious standard of review more deferential than the abuse-of-discretion standard, the language cannot alter the standard of review that applies to ERISA claims. Thus, notwithstanding the plan's "arbitrary and capricious" language, the court still reviews the denial of benefits for abuse of discretion. Administrator's decision was reasonable if it resulted from a deliberate, principled reasoning process and was supported by substantial evidence.

Fifth Circuit

Manuel v. Turner Indus. Grp. LLC, No. CV 14-599-SDD-RLB, 2017 WL 4150945 (M.D. La. Sept. 19, 2017). Plaintiff's contention that the plan documents must state that the administrator had "sole discretion" to determine eligibility in order for the abuse of discretion standard to apply is contrary to United States Supreme Court precedent. Plaintiff based this argument on an apparent

discrepancy between the SPD and the plan documents. The SPD provided that the "Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility of benefits." However, the "sole discretion" provision was not in the plan documents.

Sixth Circuit

McLaren v. Tr. of Grp. Ins. Tr. for Employers in the Mfg. Indus., No. 1:16-CV-1164, 2017 WL 4417704 (S.D. Ohio Oct. 4, 2017). Language in each Accidental Death and Dismemberment policy provided that "Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made." Although several courts of appeals have found that "satisfactory proof" language does not unambiguously confer discretion on the plan administrator, the Sixth Circuit has not overruled its holdings that "satisfactory proof" language confers discretion upon the plan administrator such that an arbitrary and capricious standard of review is appropriate. The statement on the front page of the policy that the 'policy shall be governed by the laws of the state in which it is delivered' does not alter the default rule that in evaluating questions of policy interpretation under ERISA, federal courts must develop and apply a body of substantive federal common law."). As such, this Court is bound by the law of the Sixth Circuit determining the standard of review and must apply the arbitrary and capricious standard of review to defendant's decision in this case.

Johnston v. Dow Employees' Pension Plan, 703 F. App'x 397 (6th Cir. 2017). Plaintiff argued the grant of discretion here is too vague because it gave discretionary authority to multiple individuals. "But there is nothing wrong with having multiple fiduciaries with discretionary authority within a plan."

Gilrane v. Unum Life Ins. Co. of Am., No. 1:16-CV-403, 2017 WL 4018853 (E.D. Tenn. Sept. 12, 2017). Discretionary review applied where the plan documents stated the plan administrator "has discretionary authority to determine [employees'] eligibility for benefits and to interpret the terms and provisions of the Summary of Benefits." The section that is specific to ERISA, moreover, provided "the Plan Administrator, and any designee (which shall include Unum as a claims fiduciary) will have the broadest discretion permissible under ERISA and any other applicable laws....Benefits under this Plan will be paid only if the Plan Administrator or its designee (including Unum), decides in its discretion that the applicant is entitled to them." Plaintiff argued the administrator is not a fiduciary because no actual plan document in the Administrative Record identifies it as such. According to the plaintiff, the document by which defendant claimed fiduciary authority, i.e., the plan, is not a plan document, but merely a plan summary. Plaintiff asserts that the plan cannot be a controlling ERISA plan because it refers to a separate policy. Plaintiff relied heavily on the Supreme Court's decision in *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), to assert that a plan summary cannot confer discretion upon a fiduciary. Plaintiff misreads the Amara decision. Here, the provisions in the documents clearly indicate that the plan is not just a summary description of the terms of the plan, but instead a controlling ERISA plan document.

Moreover, the Sixth Circuit has determined that a plan summary "functions as the controlling ERISA plan in the absence of a separate plan document."

Buchanan v. Sun Life Health Ins. Co., (US), 2017 WL 816990 (E.D. Tenn. Feb. 1, 2017), report and recommendation adopted sub nom, 2017 WL 818463 (E.D. Tenn. Mar. 1, 2017). Plaintiff argued that when a change occurred in the insurance company acting as claims fiduciary, the grant of discretionary authority to the original company does not transfer to the new company. Based on precedent, the arbitrary and capricious standard applied.

Eighth Circuit

Zaeske v. Liberty Life Assurance Co. of Boston, 261 F. Supp. 3d 928 (W.D. Ark. 2017). The Court found abuse of discretion to be the proper standard of review because the policy conferred upon plan administrator the binding "authority, in its sole discretion, to construe the terms of this policy and to determine benefit eligibility [there]under."

Cassidy v. Union Sec. Ins. Co., 2017 WL 6061620 (D. Minn. Dec. 6, 2017). *Firestone* only says administrators and fiduciaries lack inherent discretionary authority absent an express grant. It does not say that a plan sponsor lacks the authority to make such an express grant to an administrator or fiduciary. Here, like in *Firestone*, the plan sponsor and plan administrator are the same. But unlike in *Firestone*, a third party is involved. The plan sponsor, included in the plan a provision purporting to grant the third party the authority to determine eligibility for benefits and to interpret the plan's terms. Because this grant of authority falls under the wide net of "any discretionary authority," the party meets the statutory definition of "fiduciary." *See* 29 U.S.C. § 1002(21)(A)(i).

Ninth Circuit

Englert v. Prudential Ins. Co. of Am., No. 15-CV-04814-HSG, 2017 WL 1133380 (N.D. Cal. Mar. 27, 2017). Because the California discretionary ban applies and is not preempted by ERISA, any discretionary language contained within the Policy, SPDs, and the plan is void. The Court thus finds de novo review appropriate. Defendant argued that because the plan and SPDs are not part of the actual insurance policy, and the employer is not an insurer, any discretionary language contained in those documents falls outside the purview of § 10110.6. The court found the argument unpersuasive. While § 10110.6(c) defines discretionary authority as a "policy provision" that has the effect of conferring discretion, this Court, along with numerous other courts in this circuit, has extended § 10110.6 to void discretionary language in related documents other than the insurance policy itself.

Nieves v. Prudential Ins. Co. of Am., 233 F. Supp. 3d 755 (D. Ariz. 2017). De novo review applied because the plan does not contain an unambiguous grant of discretion. Although there is a purported grant of discretion in the Summary Plan Description ("SPD"), the grant is insufficient because the discretionary language is contained only in the SPD and is not binding, unless it is

incorporated into the plan. Here, the SPD was not incorporated into the plan, and the SPD cover page stated in large bold font that "The Summary Plan Description is not part of the Group Insurance Certificate. It has been provided by your Employer and included in your Booklet–Certificate upon the Employer's request." No provision in the plan cited by the parties or found by this Court incorporates the SPD into the plan.

Romanchuk v. Bd. of Trustees of the S. California United Food & Commercial Workers Joint Pension Tr. Fund, 2017 WL 4679269, at *7–8 (C.D. Cal. June 29, 2017). The plan contained a provision conferring discretion to a Board of Trustees to interpret the plan and adjudicate benefit determinations, however, the Appeals Committee rendered the ultimate decision on the benefits claim. The plan stated that when any benefits appeal application is received, the Board of Trustees will fully and fairly review the claim, however, the provision also states it may delegate this function to a subcommittee. The Appeals Committee is a subcommittee comprised of members of the Board of Trustees, which is tasked with hearing appeals. Accordingly, the Court reviewed defendants' denial of plaintiff's benefits claim for abuse of discretion.

Grace F. v. Aetna Life Ins. Co., No. 12-CV-02819-MMC, 2017 WL 1549334 (N.D. Cal. May 1, 2017). Each booklet states the plan "pays benefits only for services and supplies described in this Booklet as covered expenses that are medically necessary" and excludes coverage for services that are "not medically necessary, as determined by Aetna." The Court agrees with Aetna that such language suffices to confer the requisite discretion.

Masuda-Cleveland v. Life Ins. Co. of N. Am., No. CV 16-00057 LEK-RLP, 2017 WL 427497 (D. Haw. Jan. 31, 2017). The policy stated that the "Plan Administrator of the Employer's employee welfare benefit plan (the Plan) has appointed the Insurance Company as the plan fiduciary under federal law for the review of claims for benefits provided by this policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion, to interpret the terms of the plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact." Because the plan properly delegates discretionary authority to defendant, and because discretionary clauses are not barred by Hawaii law, the abuse of discretion standard applies.

Tenth Circuit

Owings v. United of Omaha Life Ins. Co., 873 F.3d 1206 (10th Cir. 2017). The policy expressly afforded United with "the discretion and final authority to construe and interpret the Policy." The court applied a deferential standard of review.

Tracy O. v. Anthem Blue Cross Life & Health Ins. Co., No. 2:16-CV-422-DB, 2017 WL 3437672 (D. Utah Aug. 10, 2017). Clear delegations of discretionary authority were sufficient to trigger arbitrary and capricious review. Here, the plan delegated discretionary authority to the plan administrator. The Group Benefit Agreement expressly incorporates "all Combined Evidence of Coverage and Disclosure Forms" applicable to the group. The Combined Evidence of Coverage

and Disclosure Form for the applicable time period prominently states: "THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT WE DETERMINE TO BE MEDICALLY NECESSARY." It further details Utilization Review Requirements to be used when determining medical necessity, the very steps taken by defendants in this case. That process clearly establishes: "We will determine if services are medically necessary and appropriate. For inpatient hospital and residential treatment center stays, we will, if appropriate, specify a specific length of stay for services."

Eleventh Circuit

Diaz v. Liberty Life Assurance Co. of Boston, No. CV 17-20662-CIV, 2017 WL 3822742 (S.D. Fla. Aug. 30, 2017). Abuse of discretion standard of review applied where the Group Disability Income Policy, which states, "Liberty shall possess the discretionary authority to construe the terms of this policy and to determine benefit eligibility hereunder." The Choice Plan states that the terms of the benefit options and their related documents "are hereby incorporated by reference into this plan to the extent they are consistent with this Plan." Plaintiff argued that the grant of discretion in the Choice Plan is not express because it does not name a specific entity to which the discretion is granted but provided no authority to support this proposition. The court concluded that "it simply does not make sense to interpret the Choice Plan in that manner since the plan governs multiple benefit options that are likely to change over time."

Miller v. PNC Fin. Servs. Grp., Inc., No. 1:16-CV-25142-KMM, 2017 WL 4404469 (S.D. Fla. Oct. 2, 2017). The court concluded that the insurer was not granted sufficient discretion by the plan. In relevant part, the SPD vested the "Plan Administrator" with "the exclusive discretionary authority to determine eligibility for benefits under the plan, to construe the terms of the plan and to determine any question which may arise in connection with its operation or administration, except to the extent that the plan administrator has authorized the claims administrator to make such determinations." The SPD defines the "Plan Administrator" as the "Plan Sponsor," which is "The PNC Financial Services Group, Inc." The SPD explains that the "Plan Administrator" "may allocate or delegate fiduciary responsibilities to other persons (including insurance companies and third party administrators)." The SPD also states that the "Plan Administrator has delegated certain administrative functions to the claims administrator," which is defined as "The Liberty Life Assurance Company." The SPD specified that the "claims administrator determines whether [a claimant's] disability meets" the definitions of disabled under the plan. However, this clause also failed to invoke an abuse of discretion review. Also, the court noted that delegation of authority to a third party through a contract not referenced in the plan document cannot grant discretion such that judicial review is for an abuse of discretion.

Metro. Life Ins. Co. v. Waddell, 697 F. App'x 989 (11th Cir. 2017). Deferential review applied where the plan vested the plan administrator with "specific discretionary powers, duties and authorities" and gave the plan administrator the "discretion to delegate to any other person or persons (including, but not limited to, the Insurance Company) authority to act on behalf of the plan administrator, including, but not limited to, the authority to make any determination or to sign

checks or other instruments incidental to the operation of the Plan for which the plan administrator is responsible." The plans named the employer as the plan administrator and named MetLife as the Insurance Company.

D.C. Circuit

Marcin v. Reliance Standard Life Ins. Co., 861 F.3d 254 (D.C. Cir. 2017). The ERISA policy provides that Reliance "shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits." Thus, the deferential standard of review applied.

White v. Hilton Hotels Ret. Plan, 263 F. Supp. 3d 8 (D.D.C. 2017). A deferential standard of review applied because the administrator is granted "the discretionary authority to grant or deny benefits under the Plan[,]" and "the authority to act with respect to any appeal from a denial of a claim for benefits."

5. Identifying the Party that has the Discretionary Authority.

First Circuit

Rodriguez-Lopez v. Triple-S Vida, Inc., 850 F.3d 14 (1st Cir. 2017). Insurance company, Jefferson–Pilot Life Insurance Company, originally issued a group policy (the "Plan") to Mova. At some point, Triple–S claims that it replaced Jefferson–Pilot in the contractual relationship, subject to all the policy's provisions. Thereafter, all the things that the Plan stated would be performed by Jefferson–Pilot were actually performed by Triple–S. The Plan, however, was not amended to reflect this change. Nor was a new SPD or summary of material modifications furnished to plan participants notifying them of this change. Case law requires that the delegation of discretionary authority to an administrator or fiduciary be clearly stated in the plan, which was not done following the change. Nevertheless, the original provisions convey power to determine whether or not "benefits ... are due." The power to decide does not necessarily imply the existence of discretion. De novo review applied.

Second Circuit

E.R. v. UnitedHealthcare Ins. Co., 248 F. Supp. 3d 348 (D. Conn. 2017), appeal withdrawn, No. 17-1036, 2017 WL 4575303 (2d Cir. July 27, 2017). Deferential review applied where plan language stated that a Mental Health/Substance Use Disorder Designee would determine "coverage for all levels of care" and that administrator has discretion to make factual determinations relating to benefits and to interpret benefits and the terms, limitations, and exclusions set out in the policy. The plan further provides that administrator may delegate this discretionary authority to others and that to receive benefits policyholders must cooperate with those service providers. The Court agreed that the plan's discretionary language grants an

administrator the right to adopt such policies and guidelines as required to interpret the provisions set out in the plan and to make benefits determinations

Third Circuit

Potts v. Hartford Life & Accident Ins. Co., No. CV 3:16-35, 2017 WL 4339675 (W.D. Pa. Sept. 28, 2017). Plaintiff argued defendant improperly delegated its decision-making employees of Harford Fire Insurance Company. The policy at issue stated that "We have full discretion and authority to determine eligibility benefits and to construe and interpret all terms and provisions of The Policy." "We" was defined as "the insurance company named on the face page of The Policy," which was "Hartford Life & Accident Insurance Company." However, the people who made the claim decision were formally employed by Hartford Fire Insurance Company. defendant noted that Hartford Life and Hartford Fire are subsidiaries of the same holding company, Hartford Fire pays the salaries of all employees of subsidiary and affiliate companies, persons who terminated benefits and upheld that decision on appeal were "solely responsible for adjudicating LTD claims under insurance policies issued by HLAIC," and "were not responsible for adjudicating any claims under insurance policies issued by Hartford Fire." Based on the evidence, the court determined that Hartford Life—not Hartford Fire—made the benefits decisions and applied discretion.

Elite Orthopedic & Sports Med. PA v. N. New Jersey Teamsters Benefit Plan, No. CV146932ESMAH, 2017 WL 3718379 (D.N.J. Aug. 29, 2017). Arbitrary and capricious standard applied where the plan vested the board of trustees with "sole authority and discretion to interpret and construe the terms of this Plan ... including provisions establishing eligibility for benefits ... as well as all other matters." The plan also stated that "[a]ny determination made by the Board of Trustees with respect to a Participant's rights or benefits will be entitled to the maximum deference permitted by law and will be final and binding upon all Participants and beneficiaries." Similarly, the "ERISA and Appeal Rights" section Description grants the trustees "absolute discretionary authority to ... decide questions, including legal and factual questions, relating to the payment of benefits under the Plan."

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documents clearly grant Prudential discretion to decide whether claimant is entitled to LTD benefits.

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Fourth Circuit

Coleman v. Metro. Life Ins. Co., 262 F. Supp. 3d 295 (E.D.N.C. 2017). The plan language stated "[i]n carrying out their respective responsibilities under the Plans, the Plan Administrator and other of the Plans' fiduciaries shall have discretionary authority to make any findings necessary or appropriate for any purpose under the Plans, including, to interpret the terms of the Plans and to determine eligibility for and entitlement to benefits under the Plans. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the determination was arbitrary and capricious." Although the plan referenced an arbitrary-and-capricious standard of review more deferential than the abuse-of-discretion standard, the language cannot alter the standard of review that applies to ERISA claims.

Thus, notwithstanding the Plan's "arbitrary and capricious" language, the court still reviews the denial of benefits for abuse of discretion. Administrator's decision was reasonable if it resulted from a deliberate, principled reasoning process and was supported by substantial evidence.

Fifth Circuit

Manuel v. Turner Indus. Grp. LLC, No. CV 14-599-SDD-RLB, 2017 WL 4150945 (M.D. La. Sept. 19, 2017). Plaintiff's contention that the plan Documents must state that the administrator had "sole discretion" to determine eligibility in order for the abuse of discretion standard to apply is contrary to United States Supreme Court precedent. Plaintiff based this argument on an apparent discrepancy between the SPD and the plan Documents. The SPD provided that the 'Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility of benefits." However, the "sole discretion" provision was not in the plan documents.

Sixth Circuit

Gilrane v. Unum Life Ins. Co. of Am., No. 1:16-CV-403, 2017 WL 4018853 (E.D. Tenn. Sept. 12, 2017). Discretionary review applied where the plan documents stated the plan administrator "has discretionary authority to determine [employees'] eligibility for benefits and to interpret the terms and provisions of the Summary of Benefits." The section that is specific to ERISA, moreover, provided "the plan administrator, and any designee (which shall include Unum as a claims fiduciary) will have the broadest discretion permissible under ERISA and any other applicable laws....Benefits under this Plan will be paid only if the Plan Administrator or its designee (including Unum), decides in its discretion that the applicant is entitled to them."

Plaintiff argued the administrator is not a fiduciary because no actual plan document in the Administrative Record identifies it as such. According to the plaintiff, the document by which defendant claimed fiduciary authority, i.e., the plan, is not a plan document, but merely a plan summary. Plaintiff asserts that the plan cannot be a controlling ERISA plan because it refers to a separate policy. Plaintiff relies heavily on the Supreme Court's decision in CIGNA Corp. v. Amara, 563 U.S. 421 (2011), to assert that a plan summary cannot confer discretion upon a fiduciary. Plaintiff misreads the Amara decision. Here, the provisions in the documents clearly indicate that the plan is not just a summary description of the terms of the plan, but instead a controlling ERISA plan document. Moreover, the Sixth Circuit has determined that a plan summary "functions as the controlling ERISA plan in the absence of a separate plan document."

Buchanan v. Sun Life Health Ins. Co., (US), 2017 WL 816990 (E.D. Tenn. Feb. 1, 2017), report and recommendation adopted sub nom, 2017 WL 818463 (E.D. Tenn. Mar. 1, 2017). Plaintiff argued that when a change occurred in the insurance company acting as claims fiduciary, the grant of discretionary authority to the original company does not transfer to the new company. Based on precedent, the arbitrary and capricious standard applied.

Wagner v. Am. United Life Ins. Co., No. 2:16-CV-084, 2017 WL 4099216 (S.D. Ohio Sept. 15, 2017). Applying de novo review because the plan did not give a clear grant of discretion to the entity that held itself out to plaintiff as the administrator for the plan—DRMS. Defendant did not identify any plan provisions mentioning DRMS, and has not identified any plan provisions granting authority to delegate plan administration, to DRMS or to anyone else. Because there was no "clear grant of discretion" to DRMS, the Court reviews the administrator's decision de novo.

Seventh Circuit

Nothing to report.

Eighth Circuit

Cassidy v. Union Sec. Ins. Co., 2017 WL 6061620 (D. Minn. Dec. 6, 2017). *Firestone* only says administrators and fiduciaries lack inherent discretionary authority absent an express grant. It does not say that a plan sponsor lacks the authority to make such an express grant to an administrator or fiduciary. Here, like in *Firestone*, the plan sponsor and plan administrator are the same. But unlike in *Firestone*, a third party is involved. The plan sponsor, included in the plan a provision purporting to grant the third party the authority to determine eligibility for benefits and to interpret the plan's terms. Because this grant of authority falls under the wide net of "any discretionary authority," the party meets the statutory definition of "fiduciary." *See* 29 U.S.C. § 1002(21)(A)(i).

Ninth Circuit

Nieves v. Prudential Ins. Co. of Am., 233 F. Supp. 3d 755 (D. Ariz. 2017). Do novo review applied because the plan does not contain an unambiguous grant of discretion. Although there is a purported grant of discretion in the Summary Plan Description ("SPD"), the grant is insufficient because the discretionary language is contained only in the SPD and is not binding, unless it is incorporated into the plan. Here, the SPD was not incorporated into the plan, and the SPD cover page stated in large bold font that "The Summary Plan Description is not part of the Group Insurance Certificate. It has been provided by your Employer and included in your Booklet–Certificate upon the Employer's request." No provision in the plan cited by the parties or found by this Court incorporates the SPD into the plan.

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the Board of Trustees, which is tasked with hearing appeals. Accordingly, the Court reviews defendants' denial of plaintiff's benefits claim for abuse of discretion.

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Tenth Circuit

Nothing to report.

Eleventh Circuit

Diaz v. Liberty Life Assurance Co. of Boston, No. CV 17-20662-CIV, 2017 WL 3822742 (S.D. Fla. Aug. 30, 2017). Abuse of discretion standard of review applied where the Group Disability Income Policy, which states, "Liberty shall possess the discretionary authority to construe the terms of this policy and to determine benefit eligibility hereunder." The Choice Plan states that the terms of the benefit options and their related documents "are hereby incorporated by reference into this Plan to the extent they are consistent with this Plan." Plaintiff argued that the grant of discretion in the Choice Plan is not express because it does not name a specific entity to which the discretion is granted but provided no authority to support this proposition. The court concluded that "it simply does not make sense to interpret the Choice Plan in that manner since the plan governs multiple benefit options that are likely to change over time."

Miller v. PNC Fin. Servs. Grp., Inc., No. 1:16-CV-25142-KMM, 2017 WL 4404469 (S.D. Fla. Oct. 2, 2017). The court concluded that the insurer was not granted sufficient discretion by the plan. In relevant part, the SPD vested the "Plan Administrator" with "the exclusive discretionary authority to determine eligibility for benefits under the plan, to construe the terms of the plan and to determine any question which may arise in connection with its operation or administration, except to the extent that the Plan Administrator has authorized the claims administrator to make such determinations." The SPD defines the "Plan Administrator" as the

"Plan Sponsor," which is "The PNC Financial Services Group, Inc." The SPD explains that the "Plan Administrator" "may allocate or delegate fiduciary responsibilities to other persons (including insurance companies and third party administrators)." The SPD also states that the "Plan Administrator has delegated certain administrative functions to the claims administrator," which is defined as "The Liberty Life Assurance Company." The SPD specified that the "claims administrator determines whether [a claimant's] disability meets" the definitions of disabled under the plan. However, this clause also failed to invoke an abuse of discretion review. Also, the court noted that delegation of authority to a third party through a contract not referenced in the plan document cannot grant discretion such that judicial review is for an abuse of discretion.

Metro. Life Ins. Co. v. Waddell, 697 F. App'x 989 (11th Cir. 2017). Deferential review applied where the plan vested the plan administrator with "specific discretionary powers, duties and authorities" and gave the plan administrator the "discretion to delegate to any other person or persons (including, but not limited to, the Insurance Company) authority to act on behalf of the plan administrator, including, but not limited to, the authority to make any determination or to sign checks or other instruments incidental to the operation of the plan for which the Plan Administrator is responsible." The plans named the employer as the plan administrator and named MetLife as the Insurance Company.

D.C. Circuit

Marcin v. Reliance Standard Life Ins. Co., 861 F.3d 254 (D.C. Cir. 2017). The ERISA policy provides that Reliance "shall serve as the claims review fiduciary with respect to the insurance policy and the plan. The claims review fiduciary has the discretionary authority to interpret the plan and the insurance policy and to determine eligibility for benefits." Thus, the deferential standard of review applied.

6. Scope of Power-Granting Language.

First Circuit

Rodriguez-Lopez v. Triple-S Vida, Inc., 850 F.3d 14 (1st Cir. 2017). Insurance company, Jefferson–Pilot Life Insurance Company, originally issued a group policy (the "Plan") to Mova. At some point, Triple–S claims that it replaced Jefferson–Pilot in the contractual relationship, subject to all the policy's provisions. Thereafter, all the things that the Plan stated would be performed by Jefferson–Pilot were actually performed by Triple–S. The Plan, however, was not amended to reflect this change. Nor was a new SPD or summary of material modifications furnished to plan participants notifying them of this change. Case law requires that the delegation of discretionary authority to an administrator or fiduciary be clearly stated in the plan, which was not done following the change. Nevertheless, the original provisions convey power to determine whether or not "benefits ... are due." The power to decide does not necessarily imply the existence of discretion. De novo review applied.

Doe v. Harvard Pilgrim Health Care, Inc., No. CV 15-10672, 2017 WL 4540961 (D. Mass. Oct. 11, 2017). De novo review applied where the plan stated the administrator would "use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care" and the plan's definition of medical necessity pointed to "generally accepted principles of professional medical practice," and not administrator discretion, as the basis for a determination. Discretionary authority "must be expressly provided for," and only when the delegation of such authority is "sufficiently clear and notice of it has been appropriately provided" does the standard of judicial review change from de novo review to abuse of discretion.

Second Circuit

Elizabeth W. v. Empire HealthChoice Assurance, Inc., No. 16-3463-CV, 2017 WL 4387182 (2d Cir. Oct. 3, 2017). Deferential review was applied where the plan documents provided administrator with "all ... powers necessary or appropriate" including the "power to construe this Contract, to determine all questions arising under this Contract, and to make and establish (and thereafter change) rules and regulations and procedures with respect to this Contract." The district court correctly noted that "magic words such as 'discretion' and 'deference'" are not necessary to confer discretionary authority, *citing Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 251 (2d Cir. 1999) (citation omitted).

E.R. v. UnitedHealthcare Ins. Co., 248 F. Supp. 3d 348 (D. Conn. 2017), appeal withdrawn, No. 17-1036, 2017 WL 4575303 (2d Cir. July 27, 2017). Deferential review applied where plan language stated that a Mental Health/Substance Use Disorder Designee would determine "coverage for all levels of care" and that administrator has discretion to make factual determinations relating to benefits and to interpret benefits and the terms, limitations, and exclusions set out in the policy. The plan further provides that administrator may delegate this discretionary authority to others and that to receive benefits policyholders must cooperate with those service providers. The Court agreed that the plan's discretionary language grants an administrator the right to adopt such policies and guidelines as required to interpret the provisions set out in the plan and to make benefits determinations

Third Circuit

Elite Orthopedic & Sports Med. PA v. N. New Jersey Teamsters Benefit Plan, No. CV146932ESMAH, 2017 WL 3718379 (D.N.J. Aug. 29, 2017). Arbitrary and capricious standard applied where the plan vested the board of trustees with "sole authority and discretion to interpret and construe the terms of this Plan ... including provisions establishing eligibility for benefits ... as well as all other matters." The plan also stated that "[a]ny determination made by the Board of Trustees with respect to a Participant's rights or benefits will be entitled to the maximum deference permitted by law and will be final and binding upon all Participants and beneficiaries." Similarly, the "ERISA and Appeal Rights" section Description grants the trustees "absolute discretionary authority to ... decide questions, including legal and factual questions, relating to the payment of benefits under the Plan."

Killebrew v. Prudential Ins. Co. of Am., No. 3:15-CV-01415, 2017 WL 1519500 (M.D. Pa. Apr. 27, 2017). Applying discretionary standard of review. The wrap document states: "Benefits under the Program or a Plan will be paid only if the Program Administrator or its delegate decides in its discretion that a Participant is entitled to them. The Program Administrator may delegate this authority to ... one or more Claims Administrators." This Section further states that "[t]he Program Administrator and its authorized delegate(s) shall perform their duties, and, in their sole discretion, determine appropriate courses of action in light of the reason and purpose for which this Program is established and maintained." Further, the document informs that whenever benefits are provided under an insurance policy, as is the case here, "the Insurer shall be the designated Claims Administrator for such benefits, and the Program, Program Administrator and the Committee assume[ ] no liability or responsibility for any coverage or benefits provided under such Plan or Plan Option." Therefore, because the claims administrator in this case is Prudential, the Plan documents clearly grant Prudential discretion to decide whether claimant is entitled to LTD benefits.

Neal v. Life Ins. Co. of N. Am., No. CV 16-1146, 2017 WL 321497 (W.D. Pa. Jan. 23, 2017). Discretion applied where the policy itself states that insurer has been "appointed ... as the named fiduciary for deciding claims for benefits under the plan, and for deciding any appeals of denied claims." Although this language alone may be insufficient to confer discretion, other plan documents consistently and unambiguously provide for such discretion. Specifically, the Group Long-Term Disability Insurance Certificate and the Appointment of Claim Fiduciary forms. Although plaintiff argued that the Court should not consider the ACF in determining whether the plan provides discretionary authority, the court disagreed.

Neurosurgical Assocs. of NJ, P.C. v. Aetna Ins. Co., No. CV 14-3882 (BRM), 2017 WL 3273648 (D.N.J. Aug. 1, 2017). In ERISA governed cases such as this, where the plan grants the claims administrator "the full power and authority in its absolute discretion to determine whether a claim is payable under the Plan and to interpret and construe the terms of the Plan and make factual determination [sic] with respect to claims and appeals for benefits and is a named fiduciary for such purposes," a claim for benefits is reviewed under the arbitrary and capricious standard

Aicher v. IBEW Local Union No. 269 Joint Tr. Funds Office, No. CV 12-1781 (FLW), 2017 WL 2364191 (D.N.J. May 31, 2017). Trustees are designated as the named fiduciary by the plan. The plan endows the Trustees with the sole discretion to establish rules, make claims determinations and, more importantly, the Trustees have the authority to interpret the terms of the plan, and they "are the sole judges of the standard of proof required in any case, and they may adopt such formulas, methods and procedures as they consider advisable." Based on the authority, the deferential standard of review applies to any claim determinations and/or plan interpretations made by the Trustees.

Fourth Circuit

Coleman v. Metro. Life Ins. Co., 262 F. Supp. 3d 295 (E.D.N.C. 2017). The plan language stated "[i]n carrying out their respective responsibilities under the Plans, the Plan Administrator and other of the Plans' fiduciaries shall have discretionary authority to make any findings necessary or appropriate for any purpose under the Plans, including, to interpret the terms of the Plans and to determine eligibility for and entitlement to benefits under the Plans. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the determination was arbitrary and capricious." Although the plan referenced an arbitrary-and-capricious standard of review more deferential than the abuse-of-discretion standard, the language cannot alter the standard of review that applies to ERISA claims. Thus, notwithstanding the plan's "arbitrary and capricious" language, the court still reviews the denial of benefits for abuse of discretion. Administrator's decision was reasonable if it resulted from a deliberate, principled reasoning process and was supported by substantial evidence.

Fifth Circuit

Manuel v. Turner Indus. Grp. LLC, No. CV 14-599-SDD-RLB, 2017 WL 4150945 (M.D. La. Sept. 19, 2017). Plaintiff's contention that the plan documents must state that the administrator had "sole discretion" to determine eligibility in order for the abuse of discretion standard to apply is contrary to United States Supreme Court precedent. Plaintiff based this argument on an apparent discrepancy between the SPD and the documents. The SPD provided that the 'Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility of benefits." However, the "sole discretion" provision was not in the plan documents.

Sixth Circuit

McLaren v. Tr. of Grp. Ins. Tr. for Employers in the Mfg. Indus., No. 1:16-CV-1164, 2017 WL 4417704 (S.D. Ohio Oct. 4, 2017). Language in each Accidental Death and Dismemberment policy provided that "Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made." Although several courts of appeals have found that "satisfactory proof" language does not unambiguously confer discretion on the plan administrator, the Sixth Circuit has not overruled its holdings that "satisfactory proof" language confers discretion upon the plan administrator such that an arbitrary and capricious standard of review is appropriate. The statement on the front page of the policy that the 'policy shall be governed by the laws of the state in which it is delivered' does not alter the default rule that in evaluating questions of policy interpretation under ERISA, federal courts must develop and apply a body of substantive federal common law."). As such, this Court is bound by the law of the Sixth Circuit determining the standard of review and must apply the arbitrary and capricious standard of review to defendant's decision in this case.

Gilrane v. Unum Life Ins. Co. of Am., No. 1:16-CV-403, 2017 WL 4018853 (E.D. Tenn. Sept. 12, 2017). Discretionary review applied where the plan documents stated the plan administrator "has discretionary authority to determine [employees'] eligibility for benefits and to

interpret the terms and provisions of the Summary of Benefits." The section that is specific to ERISA, moreover, provided "the Plan Administrator, and any designee (which shall include Unum as a claims fiduciary) will have the broadest discretion permissible under ERISA and any other applicable laws....Benefits under this Plan will be paid only if the Plan Administrator or its designee (including Unum), decides in its discretion that the applicant is entitled to them." Here, the provisions in the documents clearly indicate that the plan is not just a summary description of the terms of the plan, but instead a controlling ERISA plan document. Moreover, the Sixth Circuit has determined that a plan summary "functions as the controlling ERISA plan in the absence of a separate plan document."

Eighth Circuit

Zaeske v. Liberty Life Assurance Co. of Boston, 261 F. Supp. 3d 928 (W.D. Ark. 2017). The Court found abuse of discretion to be the proper standard of review because the policy conferred upon plan administrator the binding "authority, in its sole discretion, to construe the terms of this policy and to determine benefit eligibility [there]under."

Hillenbrand v. Wellmark of S. Dakota, Inc., 262 F. Supp. 3d 904 (D.S.D. 2017). Deferential review applied where the plan provided: "We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this coverage manual."

Ninth Circuit

Grace F. v. Aetna Life Ins. Co., No. 12-CV-02819-MMC, 2017 WL 1549334 (N.D. Cal. May 1, 2017). Each booklet states the plan "pays benefits only for services and supplies described in this Booklet as covered expenses that are medically necessary" and excludes coverage for services that are "not medically necessary, as determined by Aetna." The Court agrees with Aetna that such language suffices to confer the requisite discretion.

Masuda-Cleveland v. Life Ins. Co. of N. Am., No. CV 16-00057 LEK-RLP, 2017 WL 427497 (D. Haw. Jan. 31, 2017). The policy stated that the "Plan Administrator of the Employer's employee welfare benefit plan (the Plan) has appointed the Insurance Company as the plan fiduciary under federal law for the review of claims for benefits provided by this policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion, to interpret the terms of the plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact." Because the plan properly delegates discretionary authority to defendant, and because discretionary clauses are not barred by Hawaii law, the abuse of discretion standard applies.

Tenth Circuit

Nothing to report.

Eleventh Circuit

Bryant v. Cmty. Bankshares, Inc., 265 F. Supp. 3d 1307 (M.D. Ala. 2017). Plan language giving the plan administrator "full and exclusive authority to determine all questions of coverage and eligibility," as well as "full power to construe the provisions of [the] Trust," confers the requisite discretionary authority on the plan administrator to trigger review under the arbitrary-and-capricious standard of review.

Diaz v. Liberty Life Assurance Co. of Boston, No. CV 17-20662-CIV, 2017 WL 3822742 (S.D. Fla. Aug. 30, 2017). Abuse of discretion standard of review applied where the Group Disability Income Policy, which states, "Liberty shall possess the discretionary authority to construe the terms of this policy and to determine benefit eligibility hereunder." The Choice Plan states that the terms of the benefit options and their related documents "are hereby incorporated by reference into this Plan to the extent they are consistent with this Plan." Plaintiff argued that the grant of discretion in the Choice Plan is not express because it does not name a specific entity to which the discretion is granted but provided no authority to support this proposition. The court concluded that "it simply does not make sense to interpret the Choice Plan in that manner since the plan governs multiple benefit options that are likely to change over time."

Miller v. PNC Fin. Servs. Grp., Inc., No. 1:16-CV-25142-KMM, 2017 WL 4404469 (S.D. Fla. Oct. 2, 2017). The court concluded that the insurer was not granted sufficient discretion by the plan. In relevant part, the SPD vested the "Plan Administrator" with "the exclusive discretionary authority to determine eligibility for benefits under the Plan, to construe the terms of the Plan and to determine any question which may arise in connection with its operation or administration, except to the extent that the Plan Administrator has authorized the claims administrator to make such determinations." The SPD defines the "Plan Administrator" as the "Plan Sponsor," which is "The PNC Financial Services Group, Inc." The SPD explains that the "Plan Administrator" "may allocate or delegate fiduciary responsibilities to other persons (including insurance companies and third party administrators)." The SPD also states that the "Plan Administrator has delegated certain administrative functions to the claims administrator," which is defined as "The Liberty Life Assurance Company." The SPD specified that the "claims administrator determines whether [a claimant's] disability meets" the definitions of disabled under the plan. However, this clause also failed to invoke an abuse of discretion review. Also, the court noted that delegation of authority to a third party through a contract not referenced in the plan document cannot grant discretion such that judicial review is for an abuse of discretion.

Metro. Life Ins. Co. v. Waddell, 697 F. App'x 989 (11th Cir. 2017). Deferential review applied where the plan vested the plan administrator with "specific discretionary powers, duties and authorities" and gave the plan administrator the "discretion to delegate to any other person or persons (including, but not limited to, the Insurance Company) authority to act on behalf of the Plan Administrator, including, but not limited to, the authority to make any determination or to sign checks or other instruments incidental to the operation of the Plan for which the Plan

Administrator is responsible." The Plans named the employer as the plan administrator and named MetLife as the Insurance Company.

D.C. Circuit

Marcin v. Reliance Standard Life Ins. Co., 861 F.3d 254 (D.C. Cir. 2017). The ERISA policy provides that Reliance "shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the plan and the insurance policy and to determine eligibility for benefits." Thus, the deferential standard of review applied.

White v. Hilton Hotels Ret. Plan, 263 F. Supp. 3d 8 (D.D.C. 2017). A deferential standard of review applied because the administrator is granted "the discretionary authority to grant or deny benefits under the Plan[,]" and "the authority to act with respect to any appeal from a denial of a claim for benefits."

7. Other Considerations That Bear on the Effectiveness of Power-Granting Language

First Circuit

Rodriguez-Lopez v. Triple-S Vida, Inc., 850 F.3d 14 (1st Cir. 2017). Rodriguez worked for Mova Pharmaceutical Corporation ("Mova") and filed a claim under Mova's ERISA governed LTD Plan ("the Plan"). Jefferson–Pilot Life Insurance Company ("Jefferson–Pilot") originally issued the group policy to Mova. The summary plan description ("SPD") named Mova as the Plan sponsor and administrator, and stated that "[t]he Plan Sponsor is granted the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan." Triple–S Vida, Inc. ("Triple-S") asserted that at some point it replaced Jefferson–Pilot in the contractual relationship between Mova and Jefferson–Pilot and that it notified Mova that Triple–S would pay the benefits provided under the Plan, subject to all the policy's provisions. Thereafter, all the things that the Plan stated would be performed by Jefferson–Pilot were actually performed by Triple–S. The Plan, however, was not amended to reflect this change. Nor was a new SPD or summary of material modifications furnished to plan participants notifying them of this change and naming Triple–S as claims administrator and/or insurer. In assessing whether a plan reflects a clear grant of discretionary authority, the Court reviews the language of the Plan de novo and, in this case, the Court concluded that, based on a careful review of the language of the Plan, it does not reflect a clear grant of discretionary authority to Triple–S to determine eligibility for benefits, and thus de novo review applied to the determination of its benefit decisions. The Court would not imply that discretionary authority had been granted to Triple-S even though it was actually making the benefit decisions in place of Mova.

Second Circuit

Hafford v. Aetna Life Ins. Co., No. 16-CV-4425 (VEC)(SN), 2017 WL 4083580 (S.D.N.Y. Sept. 13, 2017). The court rejected, in part, the Magistrate Judge's report and recommendation, finding that de novo review applied because Aetna had violated the ERISA regulations and administrative requirements. The parties agreed that the plan at issue provided Aetna discretionary authority; thus, ordinarily, the standard of review would be whether Aetna's decision was arbitrary and capricious where Aetna also complied with the Department of Labor's regulatory requirements. *Citing Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016). The court found that Aetna's letter to plaintiff explaining the circumstances necessitating a 45-day extension of the appeal process was adequate under the applicable regulation (e.g. plaintiff's remote resident and challenges scheduling and functional capacity evaluation), 29 C.F.R. §§ 2560.503-1(i)(1)(i), (i)(3)(i) (if the plan administrator determines special circumstances warrant an extension it must "indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination" in writing). Thus, the Magistrate Judge had improperly stripped Aetna of the more deferential standard of review. Under the arbitrary and capricious standard, the district court found that Aetna's denial of long-term disability benefits was supported by substantial evidence and granted summary judgment in its favor.

Salisbury v. Prudential Ins. Co. of Am., 238 F. Supp. 3d 444 (S.D.N.Y. 2017). Because the claim administrator violated the Department of Labor's ("DOL") regulation governing the processing of claims under ERISA, de novo standard of review applied. Prudential requested an extension of time to render a decision on appeal, but only stated that it needed additional time to allow for review of the information in participant's file which remained under physician and vocational review. The court found that this notice did not identify any unusual difficulties associated with the claim or special circumstances for seeking the extension of time to render a decision on appeal, as required by DOL regulation governing the processing of claims under ERISA. Thus, de novo standard of review, even though the plan expressly vested discretion with the administrator.

Third Circuit

Nothing to report.

Fourth Circuit

Nothing to report.

Fifth Circuit

Ariana M. v. Humana Health Plan of Texas, Inc., 854 F.3d 753 (5th Cir.), *reh'g en banc granted*, 869 F.3d 354 (5th Cir. 2017). The Texas statute precluding discretionary clauses in health and medical insurance policies did not require de novo review of ERISA plan administrator's factual findings in terminating payments for beneficiary's partial hospitalization for mental health treatment, since plain text of Texas statute did not mandate a standard of review. However, all of

the judges prepared a special concurrence which highlighted the Fifth Circuit's departure from six other Circuits that have weighed in on the issue of applying deference to factual determinations made by an ERISA administrator when the plan does not vest them with that discretion. The court granted a rehearing *en banc*.

Unum Life Ins. Co. of Am., v. Mohedano et al, No. 3:13-CV-446, 2017 WL 713791 (S.D. Tex. Feb. 23, 2017). In a dispute over accidental death and dismemberment ("AD&D") insurance benefits, the policy at issue stated that Maine was the governing jurisdiction and Maine allows discretionary clauses like the one contained in the plan. However, the defendants argued that Texas law—rather than Maine law—should apply pursuant to the Texas court's federal question jurisdiction. Thought the defendants averred that the policyholder and beneficiaries lived in Texas, and the employer participating the plan was domiciled in Texas, where the benefits will be paid and the case is being litigated, the court held that defendants failed to meet their burden of proof, and show that the Texas discretionary clause ban was fundamental policy or that Texas's interest in determining whether to permit the discretionary clause in the policy was materially greater than Maine's interest.

Jacob v. Unum Life Ins. Co. of Am., No. CV 16-17666, 2017 WL 4764357 (E.D. La. Oct. 20, 2017). Because the plan's discretionary clause is not valid under Texas law, the court reviewed the plan administrator's interpretations of the plan de novo. The law of the Fifth Circuit requires courts to review factual determinations made by an ERISA claims administrator under an abuse of discretion standard regardless of whether the policy contains a discretionary clause.

Connecticut Gen. Life Ins. Co. v. Humble Surgical Hosp., L.L.C., No. 16-20398, 2017 WL 6460150 (5th Cir. Dec. 19, 2017). The court agreed with the claim administrator that the district court erred by concluding its affirmative defense of the interpretation of the exclusionary language of the plans as an affirmative defense failed as a matter of law. The court found that the district court had failed to consider whether Cigna's interpretation was arbitrary or whether it was supported by substantial evidence.

Sixth Circuit

Black v. Metro. Life Ins. Co., 244 F. Supp. 3d 625 (W.D. Mich. 2017). The parties disputed the appropriate standard of review. Plaintiff took the positon that the appropriate standard of review is de novo, based on Michigan's ban on discretionary clauses, effective July 1, 2007. *See* Administrative Code Rule 500.2202(b). MetLife argued that based on the certain plan language (i.e., "For plans covered under an insurance policy (e.g., HMOs, Life insurance, etc.), the carrier had been delegated discretionary authority to construe, interpret, apply and administer the Program. The Court cited *Fontaine v. Metropolitan Life Insurance Co.*, 800 F.3d 883 (7th Cir. 2015), a case in which another court reasoned that the discretionary clause was contained not in an insurance document subject to regulation by the State [], but was in an ERISA plan document that was beyond the reach of the state insurance regulation. Notwithstanding, the Court declined to make a ruling as to whether the statute operated to nullify the grant of discretionary authority

sufficient for abuse of discretion review. Instead, the Court held that MetLife's decision should be affirmed even under a de novo standard of review. *But see Chamness v. Liberty Life Assurance Co. of Boston*, 234 F. Supp. 3d 885 (W.D. Mich. 2017), appeal dismissed, No. 17-1299, 2017 WL 4216578 (6th Cir. Apr. 21, 2017) (enforcing the Michigan state ban prohibiting insurers from issuing contracts or policies that contain discretionary clauses, citing *American Council of Life Ins. v. Ross*, 558 F.3d 600 (6th Cir. 2009) in support, and applying a de novo standard of review to an ERISA civil action for review of denial of benefits challenged under § 1132(a)(1)(B)).

Buchanan v. Sun Life Health Ins. Co., (US), 2017 WL 816990 (E.D. Tenn. Feb. 1, 2017), report and recommendation *adopted sub nom*, 2017 WL 818463 (E.D. Tenn. Mar. 1, 2017). Plaintiff unsuccessfully argued that when a name change occurred in the insurance company acting as claims fiduciary, the grant of discretionary authority to the original company does not transfer to the new company. *Citing Ray v. Sun Life & Health Ins. Co.*, the court held the arbitrary and capricious standard applied. 443 Fed. Appx. 529, 531 (11th Cir. 2011) (plaintiff had offered no evidence suggesting the first entity and the newly named entity were not the same entity).

Holmes v. Aetna Life Ins. Co., No. 16-CV-11538, 2017 WL 3287633 (E.D. Mich. Aug. 2, 2017). Plaintiff sought reconsideration, in part, because he argued the court applied the wrong standard of review and should have conducted de novo review rather than discretionary review. The court had carefully considered whether or not the Michigan ban on discretionary clauses applied were there was a choice of law provision calling for the law of Georgia to apply in the policy. The court previously held that the Michigan ban did not apply, because Georgia law applied under the policy's choice-of-law provision and conflict of law analysis because the master group policy was issued to UPS, a corporation with its principal place of business in Georgia, and was delivered in Georgia. The court denied plaintiff's motion to reconsider, and reasoned that if the choice-of-law clause in the policy was not honored, then the administrator potentially must adhere to the laws of 50 states, which would undermine Congress' goal of achieving uniformity and efficiency in the administration of ERISA plans.

Seventh Circuit

Nothing to report.

Eighth Circuit

Nothing to report.

Ninth Circuit

Orzechowski v. Boeing Company Non-Union Long-Term Disability Plan, Plan Number 625, 856 F.3d 686 (9th Cir. 2017). The Ninth Circuit held that the California regulation that invalidated discretionary clauses in insurance plans was not preempted by ERISA under two-prong test of savings clause in that it was (1) specifically directed toward entities engaged in insurance,"

and (2) substantially affected risk pooling arrangement between insurer and insured; statute applied to ERISA plan, not just policies.

Williby v. Aetna Life Ins. Co., 867 F.3d 1129 (9th Cir. 2017). First, the court held that the employer's STD plan was insurance because its principal purpose was to shirt the risk of financial loss due to injury or illness from employees to the employer, and therefore the California statute that invalidated discretionary clauses in insurance plans applied to plan, even though plan was self-funded. Nevertheless, the Court of Appeals remanded the case back to the district court, because it held that ERISA preempted the California statute that invalidated discretionary clauses in insurance plans as applied to employer's self-funded STD plan under the deemer clause of ERISA, and therefore the plan's discretionary clause had to be honored and denial of benefits to participant had to be reviewed for abuse of discretion.

Masuda-Cleveland v. Life Ins. Co. of N. Am., No. CV 16-00057 LEK-RLP, 2017 WL 427497 (D. Haw. Jan. 31, 2017). In this lawsuit for accidental death benefits, the SPD and the plan were the same document. The plan references the policy which contained the discretionary language. Thus, abuse of discretion review applies. There was no applicable Hawaii insurance regulation barring discretionary clauses in insurance policies.

Bergman v. Fed. Express Corp. Long Term Disability Plan, No. 16-CV-1179-BAS (KSC), 2017 WL 4310751 (S.D. Cal. Sept. 27, 2017). Following the precedent set in *Williby*, the court held that though the California ban on discretionary clauses applied, it was fell within the deemer clause and was preempted by ERISA. 867 F.3d 1129 (9th Cir. 2017).

Williams v. Standard Ins. Co., No. 115CV00416DADEPG, 2017 WL 1398819 (E.D. Cal. Apr. 19, 2017). The court applied de novo review after a dispute over the application of California's regulation banning discretionary clauses, which turned on the meaning of "anniversary date." The court agreed with the reasoning of *Curran v. United of Omaha Life Ins. Co.*, 38 F. Supp. 3d 1184 (S.D. Cal. 2014), that "anniversary date" refers to the annual recurrence of the policy's effective date. The policy was issued on January 1, 2010 and remained in effect for a term of four years. Thus, the policy "renewed," pursuant to the California discretionary ban upon its continuance in force beyond its "anniversary date" of January 1, 2012. Because the California discretionary ban went into effect on January 1, 2012, the policy fell within the statute's scope. Since there is no dispute that plaintiff's claim accrued after January 1, 2012, the policy in effect therefore included a void and unenforceable discretionary clause.

Englert v. Prudential Ins. Co. of Am., No. 15-CV-04814-HSG, 2017 WL 1133380 (N.D. Cal. Mar. 27, 2017). Defendant challenged the effect of the California ban on discretionary clauses because its discretionary authority came from language appearing in plan documents and various SPDS, which were not part of the actual insurance policy, nor were the plan documents incorporated as a policy document by any policy provision. Because the employer was not the insurer, any discretionary language contained in its documents feel outside the purview of the California ban on discretionary clauses. The court found defendant's argument unpersuasive. The

court stated that the defendant could not "sidestep" ban's reach by including such language in the Plan rather than in the policy itself. The court also noted that multiple courts in Ninth Circuit have rejected arguments similar to defendant's argument, and defendant failed to proffers any contrary authority. Additionally, while the Ninth Circuit has not specifically addressed the application of ban in the ERISA context, it has examined a similar Montana state practice of disapproving of discretionary clauses in ERISA plans. *Citing Standard Ins. Co. v. Morrison*, 584 F. 3d 837, 842 (9th Cir. 2009). The court held that the California ban was saved from preemption because it satisfied both prongs on the savings clause: (1) the ban was directed toward entities engaged in insurance because it prohibited insurers from including discretionary clauses in ERISA policies, thereby "limiting what [insurers] can and cannot include in their [ ] policies[]"; and (2) the ban substantially affected risk pooling arrangements by preventing bargaining over discretionary clauses in exchange for lower premiums. *See* 29 U.S.C. § 1144(b).

Tenth Circuit

Stone v. Unum Life Ins. Co. of Am., No. 15-CV-0630-CVE-PJC, 2017 WL 57831 (N.D. Okla. Jan. 5, 2017). The parties agreed that defendant acted as an ERISA fiduciary with discretionary authority to administer the policy. However, plaintiff argued that her suit for benefits should be reviewed under a de novo standard because Texas's discretionary clause ban applied to the policy. First, the court determined that policy forms filed with the Texas Department of Insurance and amended after the effective date of the ban did not trigger the discretionary clause ban, because the amended forms did not apply to the policy at issue. Second, the court relied on *Rogers v. Reliance Standard Life Ins. Co.*, to conclude that the policy was last amended in 2002 and terminated in 2007, and the discretionary clause ban did not apply to a contract terminated four years before the law went into effect. No. 14–cv–4029, 2015 WL 2148406 at *7 (N.D. Ill. May 6, 2015) (applying Texas law found that the discretionary clause ban did not apply because there was no evidence "showing the parties agreed to material or significant changes" to the policy after June 1, 2011 and the law is not retroactive.)

B. Plan Interpretation and Standard of Review

1. Contra Proferentem

Second Circuit

Monefiore Medical Center v. Local 272 Welfare Fund, No. 14-CV-10229 (RA), 2017 WL 1194704 (S.D.N.Y. March 31, 2017). Plaintiff hospital alleged that the Defendant welfare fund violated ERISA by reimbursing the fund's members at lower rates than provided for under the plan. After finding that the de novo standard of review applied to the claim due to the fund's failure to comply with the Department of Labor's claims regulations, the court found that the plan terms were unambiguous in the hospital's favor. In the alternative, the court held that to the extent the language was ambiguous, any ambiguity would be construed against the fund pursuant

to the doctrine of contra proferentem, as the fund had not submitted any relevant extrinsic evidence about the meaning of the plan provisions.

Fifth Circuit

Ramirez v. United of Omaha Life Insurance Co., 872 F.3d 721 (5th Cir. 2017). Plaintiff plan participant sought benefits from a group accidental death and dismemberment policy from Defendant United of Omaha after an infection resulted in the removal of one of his eyes. The Court of Appeals affirmed the grant of summary judgment in favor of the insurer, holding that the doctrine of contra proferentem did not apply, and the Plaintiff would lose regardless of which standard of review applied, because the policy terms were unambiguous in favor of United of Omaha.

Thomason v. Metropolitan Life Insurance Co., 703 Fed.Appx. 247 (5th Cir. 2017). Plaintiff, a participant in long-term disability plan, brought an action against his employer and the claims administrator, challenging an offset taken against his disability benefits due to a lump sum pension payment he had received which he rolled over into an individual retirement account. The disability plan incorporated a summary plan description by reference, and the summary provided, "Your LTD benefit is reduced by ... [p]ension benefits from a Verizon pension plan, if you elect to receive them." Although the plan gave the claims administrator, MetLife, the discretion to interpret the Plan's terms, the court held that discretion did not extend to the summary plan description because ERISA requires that summary plan descriptions be "written in a manner to be understood by the average plan participant, and ... sufficiently accurate and comprehensive to reasonable apprise such participants and beneficiaries of their rights and obligations under the plan." Accordingly, the court construed ambiguities in the summary against the claims administrator and found and abuse of discretion, affirming the judgment in favor of the participant.

Crawford v. Metropolitan Life Insurance Co., No. 3:16-CV-2402-B, 2017 WL 3531682 (N.D. Texas August 17, 2017). Plaintiff brought a claim for benefits under a group life insurance plan after his wife died. Defendant MetLife, which insured the plan, denied the claim. MetLife determined that Plaintiff's wife had designated her great-nephew as her beneficiary before marrying Plaintiff, and never changed or revoked that designation prior to her death. Plaintiff argued that statements in the summary plan description that beneficiary designations must be completed through MetLife's website and that paper designation forms would no longer be accepted, invalidated the participant's prior beneficiary designation and that he was entitled to the benefits as the default beneficiary under the plan. The court recognized that ambiguities in the summary plan description had to be interpreted in favor of the beneficiary, even when the summary is a verbatim copy of a plan document that gives an administrator discretion to interpret the plan terms. Ultimately, the court found the summary plan description to be unambiguous in favor of MetLife, and granted summary judgment to the insurer.

Jackson v. Aetna Life Insurance Co., No. 16-15837, 2017 WL 6501599 (E.D. La. December 19, 2017). Plaintiff was enrolled in a group insurance policy provided by his employer, which provided disability and life insurance benefits under an ERISA-governed plan. After being diagnosed with several conditions, Plaintiff took disability leave and was awarded long-term disability benefits, and waiver of life insurance premium benefits, under the plan. Defendant Aetna denied Plaintiff's claim for accelerated death benefits, however, and also offset the amount of Plaintiff's disability benefits by the amount of social security benefits that were awarded to both him and his son as a result of his disability. Plaintiff filed a benefit claim under ERISA which the court reviewed under the de novo standard even though the plan document purported to give Aetna discretionary authority to interpret the plan terms, since Texas law governed and prohibited the use of a discretionary clause. The court noted that "[o]nly if plan terms remain ambiguous after applying ordinary principles of contract interpretation are we compelled to apply the rule of contra proferentem and construe the terms strictly in favor of the insured." However, the court found that the language that Plaintiff was relying upon was unambiguous in Aetna's favor and granted summary judgment for the insurer.

Ninth Circuit

Doe v. Prudential Insurance Co. of America, 245 F.Supp.3d 1172 (C.D. Cal. 2017). Plan participant brought action challenging claims administrator's termination of long-term disability benefits. The policy in question capped at 24 months benefits for a disability "due in whole or part to mental illness." Prudential awarded benefits initially, but then terminated them after 24 months pursuant to the mental illness limitation. Applying the de novo standard of review, the court applied the doctrine of contra proferentem in determining whether a mental illness limitation applied to defeat the participant's claim. The court held the meaning of the clause was not self-evident, but in view of the doctrine of contra proferentem and consistent with cases from other courts that construed similar limitations to require "but for" causation, the court construed the limitation as applying only if the participant's mental illness was a but-for cause of his disability. The court determined mental illness was not a but-for cause of the participant's disability, and granted judgment to the participant following trial.

Hart v. Unum Life Insurance Co. of America, No. 15-cv-5392-TEH, 2017 WL 565026 (N.D. Cal. February 13, 2017). Plaintiff had received long-term disability benefits from Defendant Unum for eight years, when Unum informed her that her benefits would be terminated. On cross-motions for summary judgment, the court analyzed whether policy language requiring a claimant to provide "proof of continuing disability" triggered a contractual limitations period stating that an individual has "up to three years from the time proof of claim is required" to bring a legal claim. The court held the limitations period was not triggered because the letter terminating benefits included both a 45-day deadline to submit proof of continuing disability, and a 180-day deadline for requesting review of the decision. The court held that including both dates made the termination letter ambiguous, and that "ambiguities in insurance contracts must be construed against the insurer." The court explained that "insurance policies are almost always drafted by specialists employed by the insurer," and therefore "the insurer should

be expected to set forth any limitations on its liability" and "should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence."

Vaccaro v. Liberty Life Assurance Co. of Boston, No. 16-cv-03220-BLF, 2017 WL 5564910 (N.D. Cal. November 11, 2017). Plaintiff filed an ERISA action after Defendant Liberty denied her claim for long-term disability benefits under a group insurance policy. The court applied the de novo standard of review and found that the policy provisions were unambiguous in favor of the Plaintiff. In the alternative, the court held that the even if the policy terms were ambiguous, the Plaintiff would prevail under the rule of contra proferentem, which it described as "if, after applying the normal principles of contract construction, the insurance contract is fairly susceptible of two different interpretations, ... the interpretation most favorable to the insured will be adopted."

Tenth Circuit

Caldwell v. Unum Life Insurance Co. of America, No. 2:16-CV-0236-SWS, 2017 WL 4281116 (D. Wy. September 21, 2017). Beneficiaries sought to recover accidental death benefits arising out a plan participant's death in a single car accident. The court upheld the insurer's denial of benefits based on a crime exclusion in the policy, finding the denial was not arbitrary and capricious. The court held that the doctrine of contra proferentem was inapplicable because Unum had discretion to interpret the plan and the arbitrary and capricious standard of review applied.

Michael P. v. Aetna Life Insurance Co., No. 2:16-cv-00439-DS, 2017 WL 4011153 (D. Utah September 11, 2017). Plaintiff, a participant in a self-funded group health plan, sought to recover benefits for his daughter's residential treatment for mental, behavioral, and emotional disorders. Aetna, which administered the plan, denied the claim on the grounds that the facility in question did not meet the plan's definition of a residential treatment facility. The court determined that, despite the presence of language conferring discretionary authority on Aetna, the de novo standard of review applied due to procedural irregularities in Aetna's processing of Plaintiff's claims. In granting summary judgment to Aetna, the court declined to apply the doctrine of contra proferentem as Plaintiff urged, however, because the plan terms were not ambiguous.

Eleventh Circuit

Lucas v. General Motors LLC, No. 1:16-CV-489-AT, 2017 WL 4883567 (N.D. Ga. September 27, 2017). Plaintiff brought a claim for disability benefits under GM's self-funded benefit plan. GM denied Plaintiff's claim after initially paying benefits for a limited time. Under the first step in the Eleventh Circuit's framework to review an ERISA plan administrator's benefit decision, the court applied the de novo standard to determine whether the administrator's decision was "wrong." In doing so, the court found the plan's definition of "totally disabled" to be ambiguous, and construed the ambiguity in favor of Plaintiff under the doctrine of contra

proferentem. Even though the court found GM's decision to be de novo wrong, under the Eleventh Circuit's framework it proceeded to determine whether GM's decision was arbitrary and capricious. At this later stage, the court found the doctrine of contra proferentem did not apply and it adopted GM's reasonable interpretation of "totally disabled" in granting summary judgment to GM.

2. Reasonable Expectations

Ninth Circuit

Goetz v. Life Insurance Co. of North America, No. 2:16-CV-0441-SMJ, 2017 WL 4185473 (E.D. Wash. September 21, 2017). Plaintiff brought a claim for accidental death benefits from an ERISA-covered group accident policy issued by Defendant LINA. At issue in the case was a "sole-cause" clause in the policy that require covered accidents or losses result "directly and independently of all other causes." Under the Ninth Circuit's approach to interpreting "sole-clause" provisions, the test to be applied differs depending on whether the policy language is conspicuous. If the language is conspicuous, a claimant cannot recover if a pre-existing condition substantially contributed to the loss. If the language is inconspicuous, however, the loss is covered so long as the accident was the "predominant, as opposed to remote, cause of the inquiry." This more lenient test is meant to protect the reasonable expectations of the insured "even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intent of the insured." The court determined that the policy language was conspicuous, such that the stricter "substantially caused" test applied to Plaintiff's claims.

Hart v. Unum Life Insurance Co. of America, No. 15-cv-5392-TEH, 2017 WL 565026 (N.D. Cal. February 13, 2017). Plaintiff had received long-term disability benefits from Defendant Unum for eight years, when Unum informed her that her benefits would be terminated. On cross-motions for summary judgment, the court analyzed whether policy language requiring a claimant to provide "proof of continuing disability" triggered a contractual limitations period stating that an individual has "up to three years from the time proof of claim is required" to bring a legal claim. The court held the limitations period was not triggered because policy provisions are expected to be "clear, plain, and conspicuous," and must be interpreted in a way that protects the "reasonable expectations of the insured" even if "such expectations are contrary to the expressed intention of insurer." The court ruled that because the terms "proof of claim" and "proof of continuing disability" were found in the same section, Unum had failed to make it "clear, plain, and conspicuous" that there was no distinction between the two terms.

Sliwa v. Lincoln National Life Insurance Co., No. 2:13-cv-01433-APG-VCF, 2017 WL 536827 (D. Nev. February 8, 2017). Plaintiff applied for long-terms disability benefits. Defendant Lincoln, which insured and served as claims administrator for the plan, denied the claim on the grounds that the policy's pre-existing condition exclusion applied. Plaintiff sought judgment on the grounds that Lincoln was forbidden to enforce the pre-existing condition

exclusion because she had never received a copy of the policy. The court recognized that the reasonable expectations doctrine required a claims administrator to "either ensure policyholders receive a copy of the policy or are otherwise put on notice of its provisions before claims administrators can apply an exclusion." The court held that Lincoln did not abuse its discretion in concluding that Plaintiff received a copy of the policy, finding that Lincoln's finding that the employer's declaration attesting to its practice of forwarding plan documents to the employee, outweighed the Plaintiff's statement that she did not receive the policy.

Vaccaro v. Liberty Life Assurance Co. of Boston, No. 16-cv-03220-BLF, 2017 WL 5564910 (N.D. Cal. November 11, 2017). Plaintiff filed an ERISA action after Defendant Liberty denied her claim for long-term disability benefits under a group insurance policy issued by Liberty. The court held that under the doctrine of reasonable expectations, the court must "protect the reasonable expectations of applicants, insureds, and intended beneficiaries regarding the coverage afforded by insurance carriers even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer." The court found that the policy provisions were unambiguous in favor of the Plaintiff, but also held that Plaintiff would prevail under the reasonable expectations doctrine. The court held that an insured reading the policy reasonably would understand the term "Manager" to cover employees with the job title "Manager," and that the objectively reasonable expectation of the insured controls even if the resulting interpretation is contrary to the expressed intention of the insurer. The court rejected Liberty's argument that the reasonable expectations doctrine requires proof of the insured's subjective expectations. The court held that Ninth Circuit cases addressing the doctrine do not look to the claimant's subjective intent but rather to "the claimant's objectively reasonable expectations of coverage," and therefore the absence of evidence regarding the insured's subjective expectations did not preclude application of the doctrine.

C. Evidentiary Issues

1. What is the Administrative Record?

First Circuit

Doe v. Harvard Pilgrim Health Care Inc., 15-10672, 2017 WL 4540961 (D. Mass. Oct. 11, 2017). Plaintiff filed suit alleging that defendants wrongfully withheld coverage for residential mental health treatment. After the suit was filed, the parties moved to stay the case pending further administrative review, but ultimately affirmed the denial of plaintiff's claim. The parties thereafter disagreed as to which decision marked the end of the administrative process – defendants claimed it was the initial, pre-litigation decision to deny her claims, while plaintiff argued that it was the post-litigation decision to affirm the denial of benefits. The court agreed with defendants that the earlier decision was the final one, and thus, even though the parties had stipulated that additional documents submitted during the post-litigation review "will be part of the Administrative record," the court held that it was bound to only consider the records that were before the administrative reviewer at the time of the final decision.

Santana-Diaz v. Metropolitan Life Insurance Co., Civ. No. 13-1628 (ADC), 2017 WL 1180489 (D. P.R. Mar. 29, 2017). Plaintiff argued that the plan administrator wrongfully denied him long term disability benefits, and both sides moved for summary judgment on the administrative record. Applying an arbitrary and capricious standard of review, the district court found in favor of MetLife. The court rejected the plaintiff's effort to rely upon a transcription of an "illegible" progress note, where the note appeared in the administrative record but the transcription did not, concluding that it was "post-denial evidence" that could not be considered.

Second Circuit

Pruter v. Local 201's Pension Trust Fund, 858 F.3d 753 (2d. Cir. 2017). Plan participants appealed the district court's ruling granting multiemployer pension plan's motion to dismiss ERISA claims. On appeal to the Circuit Court, plaintiffs argued that the district court's decision was in error because the administrative record was incomplete, but the court rejected the argument, noting that plaintiffs "were afforded multiple opportunities to supplement the administrative record with evidence to support their claim to benefits under the Plan, and failed to do so."

Donlick v. Standard Insurance Co., 3:16-cv-617 (FJS/DEP), 2017 WL 1683060 (N.D.N.Y. May 2, 2017). Plaintiff filed suit alleging wrongful termination of long term disability benefits. The parties cross moved for summary judgment, and plaintiff moved to submit evidence from outside the administrative record. Reviewing the decision under the arbitrary and capricious standard of review, the court found that plaintiff had not made the requisite showing of "good cause" to permit expansion of the record. While plaintiff had argued that defendants' "structural conflict of interest" justified going outside of the administrative record, the court noted that while a demonstrated conflict of interest may constitute "good cause," plaintiff's allegations were "devoid of [the] specifics" necessary to satisfy that standard.

Third Circuit

Felker v. USW Local 10-901, 697 Fed.Appx. 746, 63 EB Cases 1389 (3d Cir. 2017). The plaintiff employees had challenged the denial of severance benefits, and the district court rendered summary judgment in favor of the plan. The plaintiffs appealed, and the Court of Appeals held that the denial of benefits was not arbitrary and capricious. The Third Circuit also rejected plaintiffs' argument that the district court had improperly excluded certain evidence when considering the denial, noting that the district court correctly limited its review to the administrative record and documents that could have had bearing on potential conflicts of interest.

Rachel B v. Horizon Blue Cross Blue Shield of New Jersey, 14-cv-1153, 2017 WL 3670966 (D.N.J. Aug. 25, 2017). The plaintiff brought suit to challenge defendant's decision to deny coverage under a health plan for treatment relating to an eating disorder. Plaintiff also

asked the court to "determine the administrative record" consisted of a series of documents that plaintiff contended comprised the record. The court noted that the administrative record "simply consists of the evidence that was before the plan administrator when it made the decision being reviewed," and observed that any evidence that was not before the administrator at the time of its decision would not be considered by the court in determining whether the decision to deny benefits was arbitrary and capricious. Plaintiff's motion to determine the record was denied.

Fourth Circuit

Wilkinson v. Sun Life and Health Insurance Co., 674 Fed.Appx. 294 (4th Cir. 2017). Plaintiff challenged the termination of long term disability benefits, and after he was granted summary judgment in district court, the plan administrator defendant appealed. Among other things, Sun Life challenged the district court's reliance on an FMLA form that was not part of the administrative record when it determined that Sun Life abused its discretion when it decided to terminate benefits. The Court of Appeals found that while it is generally inappropriate to consider such extrinsic evidence, the form was properly considered in this case because Sun Life knew that the plaintiff had taken FMLA leave at the time of its decision, and further, because evidence of the form was "necessary to adequately address" three relevant factors under the Fourth Circuit's analysis drawn from *Booth v. Wal-Mart Stores, Inc. Associates Health and Welfare Plan*, 201 F.3d 335 (4th Cir. 2000): (1) the adequacy of the materials Sun Life relied upon in making its decision, (2) whether the decision was "reasoned and principled," and (3) the conflict of interest inherent because of Sun Life's dual role in evaluating and paying benefits claims. The Court of Appeals upheld the decision in favor of the plaintiff.

Fifth Circuit

Himel v. Deere & Company, 16-6712, 2017 WL 931292 (E.D. La. Mar. 9, 2017). Plaintiff brought suit claiming that he was wrongfully denied long term disability benefits. The parties cross-moved for summary judgment, and the plaintiff moved to supplement the administrative record with evidence that he asserted he supplied during the claims process but was not included in the administrative record that the defendant identified in the litigation. The court first found that the defendant had not abused its discretion in denying plaintiff's claim for benefits. As to plaintiff's motion to supplement, the district court relied upon the Fifth Circuit's decision in *Anderson v. Cytec Industries, Inc.*, 619 F.3d 505 (5th Cir. 2013). That case involved a dispute as to whether material a claimant had submitted after the decision had been made to deny benefits could be included in the administrative record to be reviewed by the court; the district court characterized *Anderson* as "avoid[ing] the timing issue" by finding that the additional evidence, if included, would not have rendered the denial an abuse of discretion anyway. Relying upon *Anderson*, the district court noted that since the plaintiff had not pointed to any new "smoking gun" evidence, "even if the additional records were included in the administrative record, we would still find that Defendant's denial was not an abuse of discretion."

Wilson v. Blue Cross and Blue Shield of Texas, 4:16-cv-0436, 2017 WL 1215430 (S.D. Tex. Mar. 31, 2017). Plaintiff challenged a decision denying coverage for a gastric bypass. The district court granted defendant's motion for summary judgment. The court also granted defendant's motion to strike an article plaintiff relied upon in her response brief, noting that while a court may consider evidence outside of the administrative record if it "assists the district court in understanding the medical terminology or practice related to a claim," the article did not do so and thus was inadmissible.

Sixth Circuit

Johnston v. Dow Employees' Pension Plan, 703 Fed.Appx. 397, 2017 EB Cases 249, 479 (6th Cir. 2017). Pension plan participant sued to challenge an alleged miscalculation of his pension benefit. The district court found in favor of the defendant, and plaintiff appealed. The Court of Appeals affirmed. In doing so, the court noted that the district court was not incorrect to have considered certain documents submitted by the administrator, even though the parties disputed whether they were part of the administrative record, where the relevant decision-makers had submitted affidavits indicating that such documents were taken into account regarding their decision as to the proper calculation of plaintiff's pension benefit. The court noted that "[t]his court has previously upheld the use of ERISA decision makers' affidavits in determining what evidence was before the board and should thus be part of the administrative record on the district court's, as well as this court's, review."

Grabowski v. QBE Americas, Inc., 15-12318, 2017 WL 1077667 (E.D. Mich. Mar. 22, 2017). Plaintiff filed suit alleging that defendants improperly denied her proceeds from her husband's life insurance policy, based on the conclusion that he was not eligible for such benefits at the time of death. The plaintiff sought to admit evidence outside of the administrative record to show that she never received notice of her husband's right to convert his group policy to an individual one. The court noted that it would limit its review of the decision to the administrative record, because the plaintiff's argument was "after-the-fact," and had not been raised in her administrative appeal. The court concluded that the benefit denial was not arbitrary and capricious.

Seventh Circuit

Dragus v. Reliance Standard Life Insurance Co., 15-C-9135, 2017 WL 1163870 (N.D. Ill. Mar. 29, 2017). Plaintiff challenged the denial of long term disability benefits. On motions for summary judgment, the court found that benefits had been properly denied. The district court also denied plaintiff's motion to supplement the administrative record with a favorable decision by the Social Security Administration, noting that because the arbitrary and capricious standard of review applied, its review was limited to the administrative record.

Eighth Circuit

Jones v. Aetna Life Insurance Co., 856 F.3d 541, 63 EB Cases 1149 (8th Cir. 2017). Plaintiff challenged the denial of disability benefits, and the district court granted summary judgment against her and in favor of the plan administrator. Plaintiff appealed, arguing, among other things, that the district court had erred by granting Aetna's motion to strike a "supplemental administrative record" that Jones had sought to admit into evidence on summary judgment, which included evidence Jones provided to the administrator after its decision to deny benefits, including a letter from the Social Security Administration granting benefits. The Court of Appeals dismissed this argument, noting that because "[w]hen applying abuse-of-discretion review, a court reviewing a denial of benefits should not consider information that was not before the plan administrator," the district court's decision to strike was correct.

Ninth Circuit

Popovich v. Metro. Life Ins. Co., No. CV1509791ABMRWX, __F.Supp.3d__, 2017 WL 6546920 (C.D. Cal. Dec. 21, 2017). On de novo review, the court determined the plaintiff submitted reliable evidence that he suffers from a significant heart condition and that he was unable to work at a physically and mentally stressful occupation, including his own occupation as an assistant news editor. The court considered a doctor's letter outside of the "administrative record" but declined to admit a letter from the Social Security Administration granting the plaintiff disability benefits. The court found that MetLife incorrectly denied the plaintiff LTD benefits under the "Usual Occupation" definition and ordered MetLife to pay those benefits. The court remanded the case back to MetLife to assess whether plaintiff is disabled under the "Any Occupation" definition of disability.

Romanchuk v. Board of Trustees of the Southern California United Food & Commercial Workers Joint Pension Trust Fund, 15-8180-AB (KS), 2017 WL 4679269 (C.D. Cal. June 29, 2017). Plaintiff filed suit, bringing claims arising from the allegedly wrongful denial of disability retirement benefits. Defendants moved for summary judgment. On an objection to the defendant's reliance upon an affidavit, the court noted that the extra-record evidence would be disregarded when reviewing the benefit claim, but that it may be considered when analyzing whether defendants had discretion to interpret the plan, operating under a conflict of interest, or committed procedural violations during the administrative process.

Bergman v. Federal Express Corporation Long Term Disability Plan, 2017 WL 4310751, 2017 EB Cases 345, 165 (S.D. Cal. Sept. 27, 2017). Plaintiff brought a claim for long term disability benefits, and both sides moved for summary judgment. The plaintiff sought to admit the Social Security Administration's decision to grant her disability benefits, and defendants objected to the inclusion of evidence outside of the administrative record. The court noted that even under an abuse of discretion standard, extrinsic evidence could be considered if a procedural irregularity prevented the full development of the administrative record. While it was unclear to the court whether such an irregularity occurred in the case, the court found that because the plaintiff had established an entitlement to disability benefits even without relying on the decision, it would not consider the evidence.

Kott v. Agilent Technologies, Inc., 16-cv-3678-BLF, 2017 WL 2903174 (N.D. Cal. July 7, 2017). Plaintiff sought to include several documents from outside of the administrative record that she contended showed procedural irregularities in the administrative review, specifically, that certain phone calls with the administrator regarding the plaintiff, as referenced in the denial of benefits letter, did not actually occur. The court held that the "mere mention" of such a call was not so vital to the administrator's rationale (which was based on a review of all of the medical records) so as to justify the admission of the extrinsic evidence plaintiff requested.

Tenth Circuit

Blair v. Alcatel-Lucent Long Term Disability Plan, 688 Fed.Appx. 568, 63 EB Cases 1189 (10th Cir. 2017). Blair sued to challenge the termination of long term disability benefits. The district court entered summary judgment for the defendant plan, finding that the decision was not arbitrary and capricious, and Blair appealed. Blair argued that the district court improperly refused to take judicial notice of certain exhibits that were outside of the administrative record. The Court of Appeals rejected this argument, noting that "it would be unfair to say that an administrator abused its discretion by not considering evidence that was not of record."

Eleventh Circuit

Lucas v. General Motors LLC, 1:16-cv-489-AT, 2017 WL 4883567 (N.D. Ga. Sept. 27, 2017). Plaintiff brought a claim alleging the wrongful denial of long term disability benefits, and the parties moved for summary judgment. In support of their motion, defendants relied upon a deposition of plaintiff. Plaintiff argued that it should excluded, as it was outside of the administrative record. Defendants claimed to require plaintiff's deposition testimony to authentic certain exhibits that were part of the administrative record to avoid hearsay objections, but the court rejected this argument, noting that the argument was improper and that "the Court is solely concerned with determining whether the plan administrator's denial decision was correct based on the record in front of it at the time—regardless of whether that record contains otherwise inadmissible hearsay or unauthenticated documents."

Carr v. John Hancock Life Insurance Company (USA), 703 Fed.Appx. 733 (11th Cir. 2017). The plaintiff brought suit to recover long term disability benefits which were denied. The district court granted summary judgment to the defendant, finding that its decision to deny benefits was not arbitrary and capricious, and plaintiff appealed. On appeal, Carr challenged the district court's refusal to consider evidence that he had submitted regarding a subsequent second claim for benefits that was approved, but the Court of Appeals held that the district court was correct in doing so, since "review of the plan administrator's denial of benefits is limited to consideration of the material submitted to the administrator at the time it made its decision."

DC Circuit

Dullea v. Pension Benefit Guaranty Corp., 241 F.Supp.3d 155, 62 EB Cases 2637 (D.D.C. Mar. 20, 2017). Participant in ERISA pension plan brought action against PBGC as plan administrator, challenging the administrator's refusal to change the form of benefits paid to his ex-wife. The court construed plaintiff's motion to compel the production of certain documents as a motion to supplement the administrative record, and concluded that the motion would be denied because plaintiff had not shown that the documents in question were reviewed when the agency reached its decision.

2. Scope of Evidence in Arbitrary and Capricious Review Cases

First Circuit

Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc., 852 F.3d 105 (1st Cir. 2017). This decision was the second by the Court of Appeals in the case. The participant brought a claim challenging the denial of reimbursement of medical expenses. The district court, reviewing the denial under an abuse of discretion standard, granted summary judgment to the plan. The participant appealed, and the Court of Appeals found that the district court should have used a *de novo* standard and remanded. The participant lost again in the district court under the *de novo* standard, and appealed again to the Court of Appeals. The Court found that the denial of coverage was merited under the language of the plan at issue. Although neither party sought to expand the administrative record, the Court noted in a footnote that "the record in an ERISA benefit-denial case may be expanded" beyond the administrative record "for good reason," including "when a beneficiary challenges the procedure used to deny benefits or claims a plan administrator acted unfairly because of personal bias."

Santana-Diaz v. Metropolitan Life Insurance Co., Civ. No. 13-1628 (ADC), 2017 WL 1180489 (D. P.R. Mar. 29, 2017). Plaintiff argued that the plan administrator wrongfully denied him long term disability benefits, and both sides moved for summary judgment on the administrative record. Applying an arbitrary and capricious standard of review, the district court found in favor of MetLife. The court rejected the plaintiff's effort to rely upon a transcription of an "illegible" progress note, where the note appeared in the administrative record but the transcription did not, concluding that it was "post-denial evidence" that could not be considered.

Second Circuit

Pruter v. Local 201's Pension Trust Fund, 858 F.3d 753 (2d. Cir. 2017). Plan participants appealed the district court's ruling granting multiemployer pension plan's motion to dismiss ERISA claims. On appeal to the Circuit Court, plaintiffs argued that the district court's decision was in error because the administrative record was incomplete, but the court rejected the argument, noting that plaintiffs "were afforded multiple opportunities to supplement the

administrative record with evidence to support their claim to benefits under the Plan, and failed to do so."

Donlick v. Standard Insurance Co., 3:16-cv-617 (FJS/DEP), 2017 WL 1683060 (N.D.N.Y. May 2, 2017). Plaintiff filed suit alleging wrongful termination of long term disability benefits. The parties cross moved for summary judgment, and plaintiff moved to submit evidence from outside the administrative record. Reviewing the decision under the arbitrary and capricious standard of review, the court found that plaintiff had not made the requisite showing of "good cause" to permit expansion of the record. While plaintiff had argued that defendants' "structural conflict of interest" justified going outside of the administrative record, the court noted that while a demonstrated conflict of interest may constitute "good cause," plaintiff's allegations were "devoid of [the] specifics" necessary to satisfy that standard.

Third Circuit

Felker v. USW Local 10-901, 697 Fed.Appx. 746, 63 EB Cases 1389 (3d Cir. 2017). The plaintiff employees had challenged the denial of severance benefits, and the district court rendered summary judgment in favor of the plan. The plaintiffs appealed, and the Court of Appeals held that the denial of benefits was not arbitrary and capricious. The Third Circuit also rejected plaintiffs' argument that the district court had improperly excluded certain evidence when considering the denial, noting that the district court correctly limited its review to the administrative record and documents that could have had bearing on potential conflicts of interest.

Rachel B v. Horizon Blue Cross Blue Shield of New Jersey, 14-cv-1153, 2017 WL 3670966 (D.N.J. Aug. 25, 2017). The plaintiff brought suit to challenge defendant's decision to deny coverage under a health plan for treatment relating to an eating disorder. Plaintiff also asked the court to "determine the administrative record" consisted of a series of documents that plaintiff contended comprised the record. The court noted that the administrative record "simply consists of the evidence that was before the plan administrator when it made the decision being reviewed," and observed that any evidence that was not before the administrator at the time of its decision would not be considered by the court in determining whether the decision to deny benefits was arbitrary and capricious. Plaintiff's motion to determine the record was denied.

Hansen v. International Painters and Allied Trades Industry Pension Plan, 16-5028, 2017 WL 4359217 (E.D. Pa. Oct. 11, 2017). Plaintiff sued to recover disability pension benefits that he claimed were wrongfully denied by a multi-employer pension plan and its administrator. The parties disagreed over whether defendants failed to credit plaintiff with "hours of service in covered employment" arising from workers' compensation, unemployment compensation, and vacation time. Defendants contended that such hours were not "in covered employment," which, under the terms of the plan, were defined as hours for which an employer is obligated to make contributions to the plan. The court noted that this argument "begs the . . . question [of] who or what determines whether contributions are paid or payable to the [pension plan] for workers'

compensation, unemployment compensation, and vacation time?" Noting that the administrative record suggested that such contributions "are made by employers in accordance with collective bargaining agreements," the court observed that "the CBA between the union and the employer would answer the question of whether the hours sought were included in "Covered employment." However, such CBA was not part of the administrative record. Conceding that it could not consider evidence outside of the administrative record, the court nevertheless found the benefits decision to be arbitrary and capricious, noting that the administrator "cannot simply state there is no evidence . . . that the employers were obligated to make contributions for the additional hours that Plaintiff seeks, when the answer to that inquiry is found in the CBA[.]" The court remanded for consideration of the CBA.

McKay v. Board of Trustees of Bakery Drivers and Salesmen Local 194 Pension Fund, 2:17-02193, 2017 WL 6021859 (D.N.J. Dec. 5, 2017). Plaintiff brought suit to challenge the suspension of his pension benefit from a multi-employer plan. The parties disputed whether plaintiff had engaged in "disqualifying employment" under the plan rules. In attempting to explain the meaning of the plan rules, defendant offered the affidavits of two trustees who had voted to suspend plaintiff's benefit. The court noted that because neither affidavit were part of the administrative record, they would not be considered as evidence in the case.

Fourth Circuit

Wilkinson v. Sun Life and Health Insurance Co., 674 Fed.Appx. 294 (4th Cir. 2017). Plaintiff challenged the termination of long term disability benefits, and after he was granted summary judgment in district court, the plan administrator defendant appealed. Among other things, Sun Life challenged the district court's reliance on an FMLA form that was not part of the administrative record when it determined that Sun Life abused its discretion when it decided to terminate benefits. The Court of Appeals found that while it is generally inappropriate to consider such extrinsic evidence, the form was properly considered in this case because Sun Life knew that the plaintiff had taken FMLA leave at the time of its decision, and further, because evidence of the form was "necessary to adequately address" three relevant factors under the Fourth Circuit's analysis drawn from *Booth v. Wal-Mart Stores, Inc. Associates Health and Welfare Plan*, 201 F.3d 335 (4th Cir. 2000): (1) the adequacy of the materials Sun Life relied upon in making its decision, (2) whether the decision was "reasoned and principled," and (3) the conflict of interest inherent because of Sun Life's dual role in evaluating and paying benefits claims. The Court of Appeals upheld the decision in favor of the plaintiff.

Hooper v. United Healthcare Insurance Co., 694 Fed.Appx. 902 (4th Cir. 2017). Plaintiff challenged the district court's grant of summary judgment in favor of defendants, which had denied him reimbursement for knee injections under a health plan. On appeal, plaintiff argued that the district court had improperly excluded certain evidence that he submitted in the litigation but was outside of the administrative record. The Court of Appeals found that the evidence was properly excluded because it was not known to the administrator at the time the challenged decision was made.

Sutherland v. Sun Life Assurance Co., 3:16-cv-182-FDW-DSC, 2017 WL 833061 (W.D.N.C. Mar. 2, 2017). The plaintiff challenged the termination of a partial disability benefit; the parties' dispute concerned the proper calculation of the plaintiffs' pre-disability earnings. Plaintiff asked the court to consider information contained it Sun Life's training website which it contended was inconsistent with the administrator's methodology. The district court noted that while a court may make an exception to the general rule that it should limit its review to the administrative record, a party seeking the admission of such evidence must show that it was known to the administrator at the time it rendered its decision. Because there was no evidence of such knowledge here, plaintiff could not rely upon the training website. The court found that Sun Life did not abuse its discretion.

Fifth Circuit

Himel v. Deere & Company, 16-6712, 2017 WL 931292 (E.D. La. Mar. 9, 2017). Plaintiff brought suit claiming that he was wrongfully denied long term disability benefits. The parties cross-moved for summary judgment, and the plaintiff moved to supplement the administrative record with evidence that he asserted he supplied during the claims process but was not included in the administrative record that the defendant identified in the litigation. The court first found that the defendant had not abused its discretion in denying plaintiff's claim for benefits. As to plaintiff's motion to supplement, the district court relied upon the Fifth Circuit's decision in *Anderson v. Cytec Industries, Inc.*, 619 F.3d 505 (5th Cir. 2013). That case involved a dispute as to whether material a claimant had submitted after the decision had been made to deny benefits could be included in the administrative record to be reviewed by the court; the district court characterized *Anderson* as "avoid[ing] the timing issue" by finding that the additional evidence, if included, would not have rendered the denial an abuse of discretion anyway. Relying upon *Anderson*, the district court noted that since the plaintiff had not pointed to any new "smoking gun" evidence, "even if the additional records were included in the administrative record, we would still find that Defendant's denial was not an abuse of discretion."

Wilson v. Blue Cross and Blue Shield of Texas, 4:16-cv-0436, 2017 WL 1215430 (S.D. Tex. Mar. 31, 2017). Plaintiff challenged a decision denying coverage for a gastric bypass. The district court granted defendant's motion for summary judgment. The court also granted defendant's motion to strike an article plaintiff relied upon in her response brief, noting that while a court may consider evidence outside of the administrative record if it "assists the district court in understanding the medical terminology or practice related to a claim," the article did not do so and thus was inadmissible.

Turner v. Hartford Life and Accident Insurance Co., 4:15-cv-81-DMB-JMV, 2017 WL 1017656 (N.D. Miss. Mar. 10, 2017). Plaintiff challenged the termination of long term disability benefits, and the parties cross-moved for summary judgment. Defendant moved to strike references in plaintiff's briefing to evidence outside of the administrative record. The court

denied the motion as moot, noting that it would simply disregard such evidence. The court found that the decision to terminate was not arbitrary and capricious.

Senegal v. Reliance Standard Life Insurance Co., 16-1961, 2017 WL 175768 (E.D. La. Jan. 17, 2017). Plaintiff challenged the termination of long term disability benefits. The court permitted plaintiff to supplement the administrative record with a functional capacity evaluation because he had sent it to Reliance and provided it with a fair opportunity to consider it, thus the evidence was admissible under the standard arising from *Vega v. National Life Insurance Inc.*, 188 F.3d 287 (5th Cir. 1999) (because it was "made available to the plan administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it."). The court remanded to the plan administrator to actually consider the evaluation, staying the case pending that review.

Sixth Circuit

Johnston v. Dow Employees' Pension Plan, 703 Fed.Appx. 397, 2017 EB Cases 249, 479 (6th Cir. 2017). Pension plan participant sued to challenge an alleged miscalculation of his pension benefit. The district court found in favor of the defendant, and plaintiff appealed. The Court of Appeals affirmed. In doing so, the court noted that the district court was not incorrect to have considered certain documents submitted by the administrator, even though the parties disputed whether they were part of the administrative record, where the relevant decision-makers had submitted affidavits indicating that such documents were taken into account regarding their decision as to the proper calculation of plaintiff's pension benefit. The court noted that "[t]his court has previously upheld the use of ERISA decision makers' affidavits in determining what evidence was before the board and should thus be part of the administrative record on the district court's, as well as this court's, review."

Kovacs v. American General Life Insurance Co., 15-11581, 2017 WL 74397 (E.D. Mich. Jan. 9, 2017). Plaintiff brought suit challenging the denial of benefits under a life insurance policy. The parties cross-moved for summary judgment, and the court found that the denial of benefits was not arbitrary and capricious. The court rejected plaintiff's attempt to rely on affidavit that was not part of the administrative record.

Grabowski v. QBE Americas, Inc., 15-12318, 2017 WL 1077667 (E.D. Mich. Mar. 22, 2017). Plaintiff filed suit alleging that defendants improperly denied her proceeds from her husband's life insurance policy, based on the conclusion that he was not eligible for such benefits at the time of death. The plaintiff sought to admit evidence outside of the administrative record to show that she never received notice of her husband's right to convert his group policy to an individual one. The court noted that it would limit its review of the decision to the administrative record, because the plaintiff's argument was "after-the-fact," and had not been raised in her administrative appeal. The court concluded that the benefit denial was not arbitrary and capricious.

Seventh Circuit

Dragus v. Reliance Standard Life Insurance Co., 15-C-9135, 2017 WL 1163870 (N.D. Ill. Mar. 29, 2017). Plaintiff challenged the denial of long term disability benefits. On motions for summary judgment, the court found that benefits had been properly denied. The district court also denied plaintiff's motion to supplement the administrative record with a favorable decision by the Social Security Administration, noting that because the arbitrary and capricious standard of review applied, its review was limited to the administrative record.

Eighth Circuit

Jones v. Aetna Life Insurance Co., 856 F.3d 541, 63 EB Cases 1149 (8th Cir. 2017). Plaintiff challenged the denial of disability benefits, and the district court granted summary judgment against her and in favor of the plan administrator. Plaintiff appealed, arguing, among other things, that the district court had erred by granting Aetna's motion to strike a "supplemental administrative record" that Jones had sought to admit into evidence on summary judgment, which included evidence Jones provided to the administrator after its decision to deny benefits, including a letter from the Social Security Administration granting benefits. The Court of Appeals dismissed this argument, noting that because "[w]hen applying abuse-of-discretion review, a court reviewing a denial of benefits should not consider information that was not before the plan administrator," the district court's decision to strike was correct.

Cooper v. Metropolitan Life Insurance Co., 862 F.3d 654 (8th Cir. 2017). Plaintiff brought suit challenging the denial of disability benefits. The district court entered judgment for MetLife, finding that it had not abused its discretion. Plaintiff appealed. While plaintiff argued that the district court had incorrectly refused to permit her to introduce affidavits of her doctors, the Court of Appeals found that they were properly excluded as not part of the administrative record.

Ninth Circuit

Romanchuk v. Board of Trustees of the Southern California United Food & Commercial Workers Joint Pension Trust Fund, 15-8180-AB (KS), 2017 WL 4679269 (C.D. Cal. June 29, 2017). Plaintiff filed suit, bringing claims arising from the allegedly wrongful denial of disability retirement benefits. Defendants moved for summary judgment. On an objection to the defendant's reliance upon an affidavit, the court noted that the extra-record evidence would be disregarded when reviewing the benefit claim, but that it may be considered when analyzing whether defendants had discretion to interpret the plan, operating under a conflict of interest, or committed procedural violations during the administrative process.

Bergman v. Federal Express Corporation Long Term Disability Plan, 2017 WL 4310751, 2017 EB Cases 345, 165 (S.D. Cal. Sept. 27, 2017). Plaintiff brought a claim for long term disability benefits, and both sides moved for summary judgment. The plaintiff sought to admit

the Social Security Administration's decision to grant her disability benefits, and defendants objected to the inclusion of evidence outside of the administrative record. The court noted that even under an abuse of discretion standard, extrinsic evidence could be considered if a procedural irregularity prevented the full development of the administrative record. While it was unclear to the court whether such an irregularity occurred in the case, the court found that because the plaintiff had established an entitlement to disability benefits even without relying on the decision, it would not consider the evidence.

Kott v. Agilent Technologies, Inc., 16-cv-3678-BLF, 2017 WL 2903174 (N.D. Cal. July 7, 2017). Plaintiff sought to include several documents from outside of the administrative record that she contended showed procedural irregularities in the administrative review, specifically, that certain phone calls with the administrator regarding the plaintiff, as referenced in the denial of benefits letter, did not actually occur. The court held that the "mere mention" of such a call was not so vital to the administrator's rationale (which was based on a review of all of the medical records) so as to justify the admission of the extrinsic evidence plaintiff requested.

Tenth Circuit

Blair v. Alcatel-Lucent Long Term Disability Plan, 688 Fed.Appx. 568, 63 EB Cases 1189 (10th Cir. 2017). Blair sued to challenge the termination of long term disability benefits. The district court entered summary judgment for the defendant plan, finding that the decision was not arbitrary and capricious, and Blair appealed. Blair argued that the district court improperly refused to take judicial notice of certain exhibits that were outside of the administrative record. The Court of Appeals rejected this argument, noting that "it would be unfair to say that an administrator abused its discretion by not considering evidence that was not of record."

Eleventh Circuit

Lucas v. General Motors LLC, 1:16-cv-489-AT, 2017 WL 4883567 (N.D. Ga. Sept. 27, 2017). Plaintiff brought a claim alleging the wrongful denial of long term disability benefits, and the parties moved for summary judgment. In support of their motion, defendants relied upon a deposition of plaintiff. Plaintiff argued that it should excluded, as it was outside of the administrative record. Defendants claimed to require plaintiff's deposition testimony to authentic certain exhibits that were part of the administrative record to avoid hearsay objections, but the court rejected this argument, noting that the argument was improper and that "the Court is solely concerned with determining whether the plan administrator's denial decision was correct based on the record in front of it at the time—regardless of whether that record contains otherwise inadmissible hearsay or unauthenticated documents."

Carr v. John Hancock Life Insurance Company (USA), 703 Fed.Appx. 733 (11th Cir. 2017). The plaintiff brought suit to recover long term disability benefits which were denied. The district court granted summary judgment to the defendant, finding that its decision to deny

benefits was not arbitrary and capricious, and plaintiff appealed. On appeal, Carr challenged the district court's refusal to consider evidence that he had submitted regarding a subsequent second claim for benefits that was approved, but the Court of Appeals held that the district court was correct in doing so, since "review of the plan administrator's denial of benefits is limited to consideration of the material submitted to the administrator at the time it made its decision."

DC Circuit

Dullea v. Pension Benefit Guaranty Corp., 241 F.Supp.3d 155, 62 EB Cases 2637 (D.D.C. Mar. 20, 2017). Participant in ERISA pension plan brought action against PBGC as plan administrator, challenging the administrator's refusal to change the form of benefits paid to his ex-wife. The court construed plaintiff's motion to compel the production of certain documents as a motion to supplement the administrative record, and concluded that the motion would be denied because plaintiff had not shown that the documents in question were reviewed when the agency reached its decision.

3. Scope of Evidence in De Novo Review Cases

First Circuit

Doe v. Harvard Pilgrim Health Care Inc., 15-10672, 2017 WL 4540961 (D. Mass. Oct. 11, 2017). Plaintiff filed suit alleging that defendants wrongfully withheld coverage for residential mental health treatment. After the suit was filed, the parties moved to stay the case pending further administrative review, but ultimately affirmed the denial of plaintiff's claim. The parties thereafter disagreed as to which decision marked the end of the administrative process – defendants claimed it was the initial, pre-litigation decision to deny her claims, while plaintiff argued that it was the post-litigation decision to affirm the denial of benefits. The court agreed with defendants that the earlier decision was the final one, and thus, even though the parties had stipulated that additional documents submitted during the post-litigation review "will be part of the Administrative record," the court held that it was bound to only consider the records that were before the administrative reviewer at the time of the final decision.

Second Circuit

Babino v. Gesualdi, 15-cv-3575 (ADS)(AKT), 2017 WL 4443571 (E.D.N.Y. Oct. 4, 2017). The plaintiff was a participant in union benefit trust funds, and brought suit against the funds' trustees and administrator to recover pension, welfare, and other benefits he claimed were owed. The court found that because the trustees had violated the Department of Labor's ERISA claims regulations in denying plaintiff's claim for benefits, their decision would be reviewed under the *de novo* standard. In moving for summary judgment and an order reversing the decision to deny benefits, the plaintiff asked the court to look at various evidence outside of the administrative record. The court held that while it would typically be limited to reviewing evidence in the administrative record, if "good cause" were shown it could consider additional

evidence that was not before the trustees at the time of their decision. Rejecting most of the evidence outside of the administrative record that plaintiff sought to submit, the court did consider certain evidence that was outside of the administrative record where the trustees admittedly "implicitly considered" that evidence in making their decision.

Tedesco v. IBEW Local 1249 Insurance Fund, 14-cv-3367 (KBF), 2017 WL 3608246 (S.D.N.Y. Aug. 21, 2017). Plaintiff sought coverage for treatment by a social worker and a psychiatrist under a health plan, which was denied. In a decision issued in 2015, the district court entered summary judgment for the defendants, finding that the decision to deny coverage was not "arbitrary and capricious." On appeal, the Second Circuit remanded, instructing the district court to consider whether procedural deficiencies in the claims procedures mandated *de novo* review, under the ruling in *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016). On remand, the district court found that the de novo standard would apply. The plaintiff sought to supplement the administrative record with a declaration from the psychiatrist. The district court noted that while, "at first blush," it appeared that there was "good cause" to admit the declaration in light of the procedural violations of the claims procedures, it observed that it had "reservations" about doing so since the plaintiff had heretofore "maintained the position that the administrative record was complete." Noting that the case presented a "close call" on the issue of supplementing the record with the additional evidence, the court held that there was no dispute that plaintiff was properly denied coverage for the shrink even if the declaration were considered, and thus granted summary judgment to the defendant on that claim.

Galuszka v. Reliance Standard Life Insurance Co., 2:15-cv-241, 2017 WL 78889 (D. Vt. Jan. 9, 2017). Plaintiff challenged the termination of long term disability benefits. The parties cross-moved for summary judgment, and plaintiff sought, over defendant's objection, to supplement the administrative record with a letter from his SSDI claim representative to the Social Security Administration, as well as the Social Security Administration's favorable decision awarding him benefits. The court held that good cause existed to supplement the record, finding that Reliance could not claim unfair prejudice because it was aware of the SSA's determination before its final claims decision and considered it in its decision, and further because Reliance had a duty to insure that the record before it was complete, which included obtaining the letter and decision. Utilizing a *de novo* standard of review, the court entered summary judgment for the plaintiff.

Salisbury v. Prudential Insurance Co. of America, 238 F.Supp.3d 444, 63 EB Cases 1239 (S.D.N.Y. Feb. 28, 2017). Plaintiff sued to recover long term disability benefits. The court held that the de novo standard would apply, as a result of Prudential's failure to strictly comply with the Department of Labor's claims regulations. The court denied plaintiffs' motion for plenary discovery, but held that while discovery in denial of benefits cases is generally limited to the administrative record, the plaintiff would have the opportunity to later demonstrate that "good cause" existed to take additional discovery.

Third Circuit

Verhagen v. Life Insurance Company of North America, 1:17-cv-577, 2017 WL 4280563 (M.D. Pa. Sept. 26, 2017). Plaintiff brought suit for long term disability benefits, and sought discovery beyond the administrative record. Both sides agreed that the *de novo* standard of review would apply. The court noted that where *de novo* review applied, a court "is not limited to or constricted by the administrative record, and may pursue whatever further inquiry it finds necessary or proper to the exercise of the court's independent judgment." However, the court found that plaintiff had failed to demonstrate her entitlement to discovery beyond the administrative record because she had requested information concerning whether a conflict of interest existed in the review process. The court noted that the alleged conflict of interest is only relevant, "thus warranting pre-trial discovery," when the standard of review is arbitrary and capricious, and denied plaintiff's request.

Sixth Circuit

Mokbel-Aljahmi v. United Omaha Life Insurance Co., 706 Fed.Appx. 854 (6th Cir. 2017). Plaintiff challenged the termination of long term disability benefits. The district court granted summary judgment for the plaintiff, and United appealed. United argued that the district court had failed to consider that the plaintiff's Social Security disability claim had been denied. The Court of Appeals was not persuaded, noting that United itself had already successfully argued that the plaintiff could not rely upon documents from his Social Security proceedings to buttress his claim for disability benefits, because such documents were outside of the administrative record. The Court of Appeals affirmed the district court's ruling.

Seventh Circuit

Druhot v. Reliance Standard Life Insurance Co., 16-cv-2053, 2017 WL 4310653 (N.D. Ill. Sept. 28, 2017). Plaintiff, an attorney, sought to recover long term disability benefits. The court reviewed the decision to deny benefits under the de novo standard of review, and found that plaintiff was entitled to benefits. While defendant had objected to the plaintiff's reference to documents outside of the administrative record, including affidavits from the plaintiff and her husband and evidence from Social Security Administration proceedings, the district court held that such evidence could be considered to ensure that the court rendered an informed and independent judgment.

Ninth Circuit

Haddad v. SMG Long Term Disability Plan, 16-cv-1700-WHO, 2017 WL 3620143 (E.D. Cal. Aug. 23, 2017). Plaintiff brought suit regarding denial of short term disability benefits as a result of the administrator's decision that the policy in question limited said benefits because the disability resulted from a pre-existing condition. On cross-motions for summary judgment, defendant relied on factual allegations that plaintiff made in a lawsuit against a hotel regarding the dates of his injury. Plaintiff objected to the reliance on that evidence because it was outside

of the administrative record, but the court found that the lawsuit was subject to judicial notice as a court record.

Dorsey v. Metropolitan Life Insurance Co., 2:15-cv-2126-KJM-CKD, 2017 WL 3720346 (E.D. Cal. Aug. 29, 2017). Plaintiff filed suit after being denied long term disability benefits. The parties cross-moved for judgment under Fed. R. Civ. P. 52. In support of her motion, plaintiff submitted a copy of a letter from the Social Security Administration awarding her disability benefits. The court noted that while ordinarily limited to the administrative record, under *de novo* review it could admit additional evidence when necessary. However, the court held that because the letter did not clarify the basis on which plaintiff was considered disabled, it would be unhelpful to the court's judgment. The court granted judgment to the defendant.

Williams v. Standard Insurance Co., 1:15-cv-416-DAD-EPG, 2017 WL 1398819 (E.D. Cal. April 19, 2017). In a case in which he challenged the defendant's decision to deny him disability benefits, the plaintiff moved to admit several pieces of evidence from outside the administrative record, including deposition testimony of defendant's reviewing doctor from another case and printouts from internet websites defining certain medical terms. The court noted that while it may be inappropriate to utilize extrinsic evidence where a plaintiff could demonstrate that the insurer was operating under a conflict of interest, there was nothing in the deposition transcripts that was inconsistent with the information already in the administrative record, nor would they otherwise help the court adequately conduct a *de novo* review. The court held the same was true of the printouts, and denied plaintiff's motion as to all of the extrinsic evidence.

Fowkes v. Metropolitan Life Insurance Co., 2:15-cv-546-KJM-CKD, 2017 WL 363155 (E.D. Cal. Jan. 25, 2017). Plaintiff sought long term disability benefits. The parties cross-moved for summary judgment, and the court found that the de novo standard would apply. Plaintiff sought to admit two pieces of evidence from outside the administrative record: a Social Security Administration determination that she is disabled and report from a social worker. The court noted that such evidence could only be submitted in "exceptional circumstances" and that it would not admit the post-denial SSA determination in part because to do so would "effectively allow supplementation of the administrative record without limit." The court found that because neither piece of evidence would be necessary or relevant to the court's *de novo* review of the denial, they would not be admitted.

Carey v. United of Omaha Life Insurance Co., SACV 13-740-CJC(AJWx), 2017 WL 1045077 (C.D. Cal. Jan. 31, 2017). Plaintiff sued to recover long term disability benefits. On motions for summary judgment, the court admitted into evidence plaintiff's declaration regarding his efforts to find employment and the Social Security Administration's determination that he was disabled. Finding that both pieces of evidence went to issues relevant to the denial, and the record lacked medical evidence and evidence regarding his efforts to find employment, the court held that they would be admitted. The court found that plaintiff was disabled from 2009 through

2011, and remanded the case to permit United to seek additional evidence as to whether he remained disabled thereafter.

Eleventh Circuit

Castanon v. UPS/IBT Full-Time Employee Pension Plan, 1:16-cv-621-AT, 2017 WL 4863238 (N.D. Ga. Aug. 4, 2017). Plaintiff brought suit to recover survivor pension benefits that she claimed she was entitled to through her ex-husband. Relying upon *Blankenship v. Metro Life Insurance Co.*, 644 F.3d 1350 (11th Cir. 2011), the court announced that its review of the benefits decision would be "limited to consideration of the material available to the administrator at the time it made its decision," but noted "that there is earlier and contrary Eleventh Circuit authority that seems to permit district courts to consider evidence not in the administrative record when conducting a de novo review of a benefits denial."

Otero v. Unum Life Insurance Company of America, 226 F.Supp.3d 1242 (N.D. Ala. 2017). The case was the second lawsuit brought the plaintiff, arising out of claims for long term disability benefits. Otero's first suit resulted in the court granting judgment in favor of Unum on the administrative record, holding that Unum's decision to deny of his claim for benefits was not arbitrary and capricious. Subsequently, Otero made another request for benefits, but Unum treated it as an attempt to reopen his first claim and did not consider any new information submitted. In the second lawsuit, Otero claimed that he should have been provided benefits as a result of his second claim. Noting that while Unum had been provided with discretionary authority in its decision-making, the *de novo* standard of review would apply because it never actually rendered a decision on Otero's second claim. Therefore, the court noted that in considering the relevant evidence, it was "not limited to the facts available to the administrator at the time of the determination." Thus the court found that it could consider evidence outside of the administrative record, including evidence that had previously been inadmissible in the first lawsuit. Ultimately, while the court found that Otero had established that he was incapable of working his "regular occupation" (and thus the first prong of the disability determination under the policy), the record evidence was unclear as to whether he had suffered the requisite loss of income for him to qualify for benefits. Attributing the lack of information to the "confusion [Unum] created" by refusing to consider Otero's second benefit claim, the court remanded the case, directing it to obtain the relevant financial information and make a determination on that point.

4. Remands to the Plan Administrator to Consider New Evidence

Second Circuit

*Franzese v. United Health Care/*Oxford, 232 F.Supp.3d 267 (E.D.N.Y. Jan. 5, 2017). Plaintiffs brought suit against a health plan administrator, claiming that administrator improperly refused payment for private duty nursing services, which it claimed were not covered under the plan. Plaintiffs asked that the court find that private duty nursing services sought were covered

under the health plan, or that, in the alternative, they should be entitled to compensation as "home health care services" that defendants admitted were covered under the plan. The court found that while private duty nursing services were not covered, the administrator's decision to deny payment for home health care services was not supported by evidence in the record, where no evidence indicated that the administrator actually considered the possibility that that provision of the plan could apply. The court remanded for the administrator to give due consideration to the medical evidence.

Schuman v. Aetna Life Ins. Co., 3:15-cv-1006 (SRU), 2017 WL 1053853 (D. Conn. Mar. 30, 2017). Plaintiff filed suit alleging that he was wrongfully denied long term disability benefits. On the parties' cross-motions for summary judgment, the district court held that while the plan granted discretion to the claims administrator, the administrator was nevertheless guilty of a series of violations of the Department of Labor's claims regulations, including the failure to consider a vocation assessment that plaintiff submitted on review, a failure to furnish internal policy guidelines, a failure to set up administrative processes, a failure to identify vocational experts. The court held that these violations would trigger *de novo* review of the defendants' decision to deny benefits. However, observing that the administrative record lacked evidence from either side as to whether plaintiff met the requirements of proving he was disabled under the "reasonable occupation" standard of the plan, it remanded the case to the administrator for further development, noting that to do otherwise would require the court "to consider significant evidence outside of the Administrative Record and, in a meaningful sense, to become the decision maker in the first instance rather than a reviewer of the decisions made by the Claims Administrator."

Third Circuit

Hansen v. International Painters and Allied Trades Industry Pension Plan, 16-5028, 2017 WL 4359217 (E.D. Pa. Oct. 11, 2017). Plaintiff sued to recover disability pension benefits that he claimed were wrongfully denied by a multi-employer pension plan and its administrator. The parties disagreed over whether defendants failed to credit plaintiff with "hours of service in covered employment" arising from workers' compensation, unemployment compensation, and vacation time. Defendants contended that such hours were not "in covered employment," which, under the terms of the plan, were defined as hours for which an employer is obligated to make contributions to the plan. The court noted that this argument "begs the . . . question [of] who or what determines whether contributions are paid or payable to the [pension plan] for workers' compensation, unemployment compensation, and vacation time?" Noting that the administrative record suggested that such contributions "are made by employers in accordance with collective bargaining agreements," the court observed that "the CBA between the union and the employer would answer the question of whether the hours sought were included in "Covered employment." However, such CBA was not part of the administrative record. Conceding that it could not consider evidence outside of the administrative record, the court nevertheless found the benefits decision to be arbitrary and capricious, noting that the administrator "cannot simply state there is no evidence . . . that the employers were obligated to make contributions for the

additional hours that Plaintiff seeks, when the answer to that inquiry is found in the CBA[.]" The court remanded for consideration of the CBA.

Fifth Circuit

Encompass Office Solutions, Inc. v. Connecticut General Life Insurance Co., 3:11-cv-2487-L, 2017 WL 3268034 (N.D. Tex. July 31, 2017). Plaintiff was a surgical suite vendor (which had obtained assignment of plan benefits from plan participants) that brought suit against defendant health care service companies for denying claims for surgery services. As to benefit claims, the parties cross-moved for summary judgment. The court found that the claim denials and subsequent reviews of those denials did not comply with ERISA's procedural notice requirements, and remanded the claims to the plan administrator for a full and fair review which may include "additional investigation and supplementation of the administrative record by the parties."

Dialysis Newco Inc. v. Community Health Systems Trust Health Plan, 5:15-cv-272, 2017 WL 2591806 (S.D. Tex. June 14, 2017). Plaintiff sought reimbursement for dialysis treatments that were denied. The court found that defendant had abused its discretion by incorrectly interpreting the plan at issue, and further noted that as a result of defendant's reading, the administrative record had not been sufficiently developed. The court remanded for consideration of the evidence outside of the administrative record that the plaintiff submitted during the litigation, noting that the court could not consider it because to do so in the first instance "would stand ERISA on its head."

Senegal v. Reliance Standard Life Insurance Co., 16-1961, 2017 WL 175768 (E.D. La. Jan. 17, 2017). Plaintiff challenged the termination of long term disability benefits. The court permitted plaintiff to supplement the administrative record with a functional capacity evaluation because he had sent it to Reliance and provided it with a fair opportunity to consider it, thus the evidence was admissible under the standard arising from *Vega v. National Life Insurance Inc.*, 188 F.3d 287 (5th Cir. 1999) (because it was "made available to the plan administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it."). The court remanded to the plan administrator to actually consider the evaluation, staying the case pending that review.

Sixth Circuit

Rowe v. United of Omaha Life Insurance, 3:15-cv-256-TAV-CCS, 2017 WL 1047602 (E.D. Tenn. Feb. 1, 2017). Plaintiff sought long term disability benefits, which had been denied. Upon review of the administrative record, the court found that defendant had failed to articulate its reasons for finding that plaintiff was not disabled in light of medical opinions respecting plaintiff's limitations. Because of the lack of clarity, the court remanded to the plan administrator, giving plaintiff 60 days to provide supporting evidence, and directing the administrator to detail "non-arbitrary reasons for denying benefits."

Carlson v. Reliance Standard Life Insurance Co., 3:15-cv-200, 2017 WL 4767660 (M.D. Tenn. Oct. 20, 2017). Plaintiff, a widow, brought claims for life insurance benefits under a policy that covered her deceased husband. The court found that the defendant had violated the Department of Labor's procedural regulations during the administrative process, and as a result, plaintiff had been unable to introduce an amended report of the medical examiner regarding the cause of her husband's death. As a result, the court remanded to the plan administrator to consider the additional information.

Seventh Circuit

Suson v. PNC Financial Services Group, Inc., 15-cv-10817, 2017 WL 3234809 (N.D. Ill. July 31, 2017). Plaintiff filed suit to challenge the denial of long term disability benefits, based on her claim that bipolar disorder, depression, fibromyalgia, and other disorders, including carpal tunnel syndrome. The parties cross moved for summary judgment. While accepting the administrator's conclusions as to many of the plaintiff's arguments, the court found that the administrator failed to consider the impact of plaintiff's carpal tunnel on her ability to work, and therefore its failure to consider those effects rendered its decision arbitrary and capricious. The court remanded for further consideration, noting that the plaintiff must also have the opportunity to respond to the administrator's occupational analysis.

Ninth Circuit

Aviation West Charters, LLC v. UnitedHealthcare Insurance Co., 2:16-436 WBS AC, 2017 WL 5526569 (E.D. Cal. Nov. 16, 2017). An individual plaintiff brought claims alleging that defendants violated ERISA by failed to cover ambulatory services for a flight from Mexico to the state of Washington. Defendant moved to strike an affidavit of the plaintiff that was not part of the administrative record. The court noted that while a court is typically limited to the administrative record when determining whether an administrator abused its discretion, it could consider such extrinsic evidence to determine the nature of a conflict of interest. However, because the defendant admitted the nature of its conflict, the court held that it need not look beyond the administrative record. The court found that the administrator had failed to engage in a meaningful dialogue with the plaintiff about her claim, and that if it had, she may have had the opportunity to provide the evidence needed to have the claim approved. The court remanded the case to the administrator to consider whatever information would have been developed had it "sought it out in the first instance."

Carey v. United of Omaha Life Insurance Co., SACV 13-740-CJC(AJWx), 2017 WL 1045077 (C.D. Cal. Jan. 31, 2017). Plaintiff sued to recover long term disability benefits. On motions for summary judgment, the court admitted into evidence plaintiff's declaration regarding his efforts to find employment and the Social Security Administration's determination that he was disabled. Finding that both pieces of evidence went to issues relevant to the denial, and the record lacked medical evidence and evidence regarding his efforts to find employment, the court

held that they would be admitted. The court found that plaintiff was disabled from 2009 through 2011, and remanded the case to permit United to seek additional evidence as to whether he remained disabled thereafter.

Tenth Circuit

Brende v. Reliance Standard Life Insurance Co., 1:15-9711-JAR-TJJ, 2017 WL 4222982 (D. Kan. Sept. 22, 2017). Plaintiff sued to recover long term disability benefits. The court found that the denial of benefits was arbitrary and capricious because it only addressed whether plaintiff was capable of performing the sedentary aspects of her occupation, and failed to consider her actual job duties. The court remanded for a full and fair review, allowing the plaintiff the opportunity to present additional evidence supporting her claim.

Anderson-Posey v. Unum Life Insurance Co. of America, 237 F.Supp.3d 1144, 63 EB Cases 1181 (N.D. Okla. Feb. 23, 2017). Plaintiff, a pharmacist, challenged the termination of her long term disability benefits. The court ultimately concluded that the decision to terminate was arbitrary and capricious. The court found that while the evidence in the administrative record established that plaintiff was cognitively disabled as a result of taking narcotics to treat her pain, regardless of whether plaintiff was actually impaired, "common sense dictates that a pharmacist working with any narcotics in her system is not practicing with reasonable skill or safety." However, Unum's second basis for denying benefits was the assertion that plaintiff could have treated her condition without narcotics. Noting that because this issue "arose late in the proceedings," the court remanded to the plan administrator to allow plaintiff to respond.

Eleventh Circuit

Otero v. Unum Life Insurance Company of America, 226 F.Supp.3d 1242 (N.D. Ala. 2017). The case was the second lawsuit brought the plaintiff, arising out of claims for long term disability benefits. Otero's first suit resulted in the court granting judgment in favor of Unum on the administrative record, holding that Unum's decision to deny of his claim for benefits was not arbitrary and capricious. Subsequently, Otero made another request for benefits, but Unum treated it as an attempt to reopen his first claim and did not consider any new information submitted. In the second lawsuit, Otero claimed that he should have been provided benefits as a result of his second claim. Noting that while Unum had been provided with discretionary authority in its decision-making, the *de novo* standard of review would apply because it never actually rendered a decision on Otero's second claim. Therefore, the court noted that in considering the relevant evidence, it was "not limited to the facts available to the administrator at the time of the determination." Thus the court found that it could consider evidence outside of the administrative record, including evidence that had previously been inadmissible in the first lawsuit. Ultimately, while the court found that Otero had established that he was incapable of working his "regular occupation" (and thus the first prong of the disability determination under the policy), the record evidence was unclear as to whether he had suffered the requisite loss of income for him to qualify for benefits. Attributing the lack of information to the "confusion

[Unum] created" by refusing to consider Otero's second benefit claim, the court remanded the case, directing it to obtain the relevant financial information and make a determination on that point.

Campbell v. United of Omaha Life Insurance Co., 247 F.Supp.3d 1255 (N.D. Ala. Mar. 30, 2017). Campbell brought suit seeking short term and long term benefits. In an earlier ruling, the court determined that the defendant improperly denied plaintiff's claims and ordered defendant to pay benefits through a certain date, when the court held that they properly terminated. Plaintiff moved for reconsideration, arguing that the court's prior ruling had "prejudiced" him because it limited his duration of benefits, and that had the court remanded instead, he would have been permitted to introduce new evidence that would have permitted a longer duration of benefits. The court agreed, remanding the case to the administrator for further proceedings, and noting that Campbell could present additional evidence as to the proper duration of benefits.

5. Scope of Evidence Relating to Conflict of Interest Assertions

First Circuit

Kamerer v. Unum Life Insurance Co. of America, 251 F.Supp.3d 349 (D. Mass. 2017). Plaintiff brought suit to challenge the wrongful termination of long term disability benefits. Noting that there must be "some very good reason" to allow plaintiff to take discovery outside of the administrative record, the court rejected plaintiff's arguments that such a reason could be Unum's "history of unfair claims practices." However, the court did permit plaintiff to take the deposition of a reviewing physician who had "spoken publicly about how it is his job to assist employers and insurance companies to unmask insurance fraud," noting that since he "has made comments that indicate he may favor insurers and employers, his deposition testimony would aid the court in determining his credibility, and the appropriate weight to be given to his opinions."

Second Circuit

Donlick v. Standard Insurance Co., 3:16-cv-617 (FJS/DEP), 2017 WL 1683060 (N.D.N.Y. May 2, 2017). Plaintiff filed suit alleging wrongful termination of long term disability benefits. The parties cross moved for summary judgment, and plaintiff moved to submit evidence from outside the administrative record. Reviewing the decision under the arbitrary and capricious standard of review, the court found that plaintiff had not made the requisite showing of "good cause" to permit expansion of the record. While plaintiff had argued that defendants' "structural conflict of interest" justified going outside of the administrative record, the court noted that while a demonstrated conflict of interest may constitute "good cause," plaintiff's allegations were "devoid of [the] specifics" necessary to satisfy that standard.

Gosselin v. Sheet Metal Workers' National Pension Fund, 16-4391 (ADS) (AKT), 2017 WL 3382070 (E.D.N.Y. Aug. 4, 2017). In plaintiff's suit to recover pension benefits, he sought

discovery beyond the administrative record as it pertained to an alleged conflict of interest. Over defendant's objection, the court accepted the premise that a structural conflict of interest was present, but noted that plaintiff had failed to provide anything more than "conclusory assertions" about how that conflict impacted defendant's denial of plaintiff's claims. While plaintiff had attempted to rely on the allegation the plan was in "endangered status" as thus the administrator was particularly motivated to deny his claim, the court found that in this instance, that allegation "amounts to little more than mere speculation." The court declined to permit discovery beyond the administrative record

Third Circuit

Felker v. USW Local 10-901, 697 Fed.Appx. 746, 63 EB Cases 1389 (3d Cir. 2017). The plaintiff employees had challenged the denial of severance benefits, and the district court rendered summary judgment in favor of the plan. The plaintiffs appealed, and the Court of Appeals held that the denial of benefits was not arbitrary and capricious. The Third Circuit also rejected plaintiffs' argument that the district court had improperly excluded certain evidence when considering the denial, noting that the district court correctly limited its review to the administrative record and documents that could have had bearing on potential conflicts of interest.

Verhagen v. Life Insurance Company of North America, 1:17-cv-577, 2017 WL 4280563 (M.D. Pa. Sept. 26, 2017). Plaintiff brought suit for long term disability benefits, and sought discovery beyond the administrative record. Both sides agreed that the *de novo* standard of review would apply. The court noted that where *de novo* review applied, a court "is not limited to or constricted by the administrative record, and may pursue whatever further inquiry it finds necessary or proper to the exercise of the court's independent judgment." However, the court found that plaintiff had failed to demonstrate her entitlement to discovery beyond the administrative record because she had requested information concerning whether a conflict of interest existed in the review process. The court noted that the alleged conflict of interest is only relevant, "thus warranting pre-trial discovery," when the standard of review is arbitrary and capricious, and denied plaintiff's request.

Fourth Circuit

Wilkinson v. Sun Life and Health Insurance Co., 674 Fed.Appx. 294 (4th Cir. 2017). Plaintiff challenged the termination of long term disability benefits, and after he was granted summary judgment in district court, the plan administrator defendant appealed. Among other things, Sun Life challenged the district court's reliance on an FMLA form that was not part of the administrative record when it determined that Sun Life abused its discretion when it decided to terminate benefits. The Court of Appeals found that while it is generally inappropriate to consider such extrinsic evidence, the form was properly considered in this case because Sun Life knew that the plaintiff had taken FMLA leave at the time of its decision, and further, because evidence of the form was "necessary to adequately address" three relevant factors under the

Fourth Circuit's analysis drawn from *Booth v. Wal-Mart Stores, Inc. Assoc. Health and Welfare Plan*, 201 F.3d 335 (4th Cir. 2000): (1) the adequacy of the materials Sun Life relied upon in making its decision, (2) whether the decision was "reasoned and principled," and (3) the conflict of interest inherent because of Sun Life's dual role in evaluating and paying benefits claims. The Court of Appeals upheld the decision in favor of the plaintiff.

Reidy v. Unum Life Insurance Co. of America, PX-16-2926, 2017 WL 6368659 (D. Md. Dec. 13, 2017). Plaintiff file suit against Unum for disability benefits. In discovery, plaintiff sought information concerning Unum's reviewing doctors' compensation and their history of adjudicating other benefit claims. The court refused to permit such discovery, noting that "[t]he critical flaw in Plaintiff's Motion is her failure to assert particularized facts that render extra-record discovery necessary to explore Unum's conflict of interest in adjudication of *her particular claim*," rather than Unum's general practices. The court further noted that plaintiff herself had argued that the administrative record demonstrated the impact of Unum's structural conflict of interest, implying that extrinsic evidence would be unhelpful to the court on that point.

Sixth Circuit

Duncan v. Minnesota Life Insurance Co., 3:17-cv-25, 2018 WL 306609, 2018 EB Cases 4014 (S.D. Ohio Jan. 5, 2018). Plaintiff brought suit seeking to recover accidental death benefits, and sought discovery directed at the defendants' conflict of interest in both underwriting and administering the plan. Defendant opposed. The district court observed that the result of such discovery disputes varied, but noted that while courts have "leeway" to permit discovery beyond the administrative record in ERISA cases, that leeway is circumscribed by "three concrete rules: (1) plaintiffs seeking procedural or conflict-of-interest discovery must do more than merely allege bias; (2) plaintiffs are not required to meet any evidentiary-threshold showing to obtain such discovery; and, (3) plaintiffs are not automatically entitled to such discovery." The court found that because plaintiffs had presented some evidence to suggest that the administrator's review was tainted by bias, namely, that it ignored the opinions of plaintiff's treating provider, they were entitled to take discovery on the matter.

McLaren v. Trustee of Group Insurance Trust for Employers in the Manufacturing Industry, 1:16-cv-1164, 2017 WL 4417704 (S.D. Ohio Oct. 4, 2017). Plaintiff brought sued to collect death and dismemberment benefits. Plaintiff sought discovery concerning the plan administrator's conflict of interest in both paying and administering claims. The court held that because the defendant had conceded that a structural conflict existed, and because plaintiff offered additional evidence of bias (including the administrator's reliance upon an interpretation of an undefined policy term and change of position in the administrative position), discovery into alleged conflict of interest was warranted.

Seventh Circuit

Geiger v. Aetna Life Insurance Co., 845 F.3d 357 (7th Cir. 2017). Plaintiff appealed the district court's ruling granting summary judgment for the defendant in a case arising out of the termination of disability benefits. The Court of Appeals held that the district court did not abuse its discretion in refusing to permit Geiger to take depositions aimed at addressing the adminstrator's conflict of interest in denying his claim. The court noted that the district court had correctly concluded that Aetna had reasonable procedures to safeguard against detrimental conflicts, and thus had properly denied the discovery request.

Harding v. Hartford Life and Accident Insurance Co., 16-cv-6700, 2017 WL 1316264 (N.D. Ill. April 10, 2017). In a suit brought by a plaintiff claiming disability benefits, the plaintiff moved to compel the depositions of defendant's claim manager who denied her benefit claim and an independent medical consultant who had prepared a medical report. The parties agreed that the *de novo* standard of review would apply, which the court noted meant that it would be permitted to either limit its review to the administrative record or permit additional information if necessary for an informed and independent judgment. The court held that the medical consultant could be deposed because her medical report was part of the evidence that the court would review, and as such, her "potential biases and conflicts of interest" could affect the court's judgment as to the credibility of her medical opinions. The court did not permit plaintiff to depose the claims manager, since the court would not be deferring to her decision, and as such any of her supposed biases would be irrelevant.

Eighth Circuit

Barnes v. Ascension Health Alliance, 4:16-cv-2170 (CEJ), 2017 WL 3006882 (E.D. Mo. July 14, 2017). Plaintiff brought suit to recover ongoing disability benefits, and sought to conduct discovery outside of the administrative record regarding the administrator's conflict of interest, as well as procedural irregularities. Specifically, plaintiff sought internal manuals as well as depositions of corporate representatives. While the defendant ultimately agreed to produce the manuals, the court refused to permit the plaintiff to take the requested depositions, noting that she had failed to demonstrate good cause in order to show that the deposition would actually be anything more than a "fishing expedition."

Collins v. 3M Company, 17-529 (DSD/DTS), 2017 WL 4535921 (D. Minn. Oct. 11, 2017). Plaintiff brought suit to challenge a denial of short term disability benefits, and asked for discovery into whether a conflict of interest existed between the claims administrator, Sedgwick, and the plan sponsor, 3M. The court noted that plaintiff's reliance on two voicemails from 3M supervisors to Sedgwick inquiring as to her leave status did not constitute evidence that those supervisors attempted to influence Sedgwick, and held that additional discovery was not merited, since "the existence of a possible or actual conflict of interest does not automatically justify additional discovery."

Ninth Circuit

Aviation West Charters, LLC v. UnitedHealthcare Insurance Co., 2:16-436 WBS AC, 2017 WL 5526569 (E.D. Cal. Nov. 16, 2017). An individual plaintiff brought claims alleging that defendants violated ERISA by failed to cover ambulatory services for a flight from Mexico to the state of Washington. Defendant moved to strike an affidavit of the plaintiff that was not part of the administrative record. The court noted that while a court is typically limited to the administrative record when determining whether an administrator abused its discretion, it could consider such extrinsic evidence to determine the nature of a conflict of interest. However, because the defendant admitted the nature of its conflict, the court held that it need not look beyond the administrative record. The court found that the administrator had failed to engage in a meaningful dialogue with the plaintiff about her claim, and that if it had, she may have had the opportunity to provide the evidence needed to have the claim approved. The court remanded the case to the administrator to consider whatever information would have been developed had it "sought it out in the first instance."

Longinotti v. Aetna Life Insurance Co., 16-7564 GW (RAOx), 2017 WL 2999029 (C.D. Cal. June 20, 2017). In a suit seeking disability benefits, the plaintiff sought discovery regarding potential conflict of interest or bias on behalf of Aetna's physician reviewers. The court noted that while a district court may consider evidence that speaks to a medical reviewers' credibility to conduct an adequate de novo review, "discovery to this end is not automatically allowed." The court found that plaintiff had failed to make the necessary showing to permit such discovery, where the only basis for potential bias was the divergence of opinion between Aetna's reviewers and his own physician, and the fact that the reviewers were paid by Aetna.

Tenth Circuit

Boothe v. Deseret Mutual Benefit Administrators, 1:16-CV-8-DN, 2017 WL 2787748 (D. Utah. June 27, 2017). Plaintiff claimed that disability benefits were wrongfully denied. Ruling on cross-motions for summary judgment, the court permitted plaintiff to supplement the record in part, allowing her to submit her affidavit which addressed a conflict of interest between the payor of benefits and the plan administrator that she claimed infected the decision to deny her benefits. However, the court rejected her attempt to submit an extrinsic notice of an award of disability benefits for the Social Security Administration, which went to the question of whether she should have been awarded benefits by the defendants. The court ultimately rendered judgment for the defense.

Paquin v. Prudential Insurance Company of America, 16-cv-2142-RBJ, 2017 WL 3189550 (D. Colo. July 10, 2017). Plaintiff challenged the termination of long term disability benefits, which were cut off after 11 years of payment. Plaintiff sought to conduct discovery pertaining to Prudential's relationships with medical reviewers who had reviewed plaintiff's claim file, and defendants opposed. The court noted at the outset that it would resolve the case on the administrative record, and that discovery for the purpose of supplementing the record was inappropriate. However, the court acknowledged that Prudential's structural conflict of interest would play into its consideration of whether it abused its discretion in denying benefits, thus

permitting discovery concerning the conflict. Noting that while plaintiff's claims of bias were "essentially based on speculation and surmise," the court held that the defendant could not reasonably object to "any and discovery notwithstanding its dual role conflict of interest" and the fact that it had changed its position on plaintiff's entitlement to benefits. The court permitted the plaintiff to take limited discovery on the issue.

Eleventh Circuit

Johnston v. Aetna Life Insurance Co., 17-20996-CIV, 2017 WL 4654431 (S.D. Fl. Oct. 16, 2017). Plaintiff brought an action challenging the termination of short term disability benefits. The plaintiff further sought discovery beyond the administrative record, which the defendant opposed, including information regarding the administrator's apparent structural conflict of funding plan and evaluating benefits claims and impact. The court recited a lengthy analysis of relevant Eleventh Circuit law on the topic, ultimately ruling plaintiff was permitted to obtain discovery regarding a conflict of interest, but reserving any ruling on the admissibility of such extrinsic evidence at trial or on summary judgment.

D. Standards for Deviation from Terms of Formal Plan Documents

Fourth Circuit

Hartquist v. Emerson Electric Co., No. 1:11CV1067, 2017 U.S. Dist. LEXIS 47611 (M.D. N.C. March 30, 2017). The Court granted defendant's motion for summary judgment. The Court stated that the fact that the defendants invited plaintiff to submit a claim to the plan in 2011 and according to plaintiff "aided him in doing so" could not alter the clear terms of the plan which stated the plaintiff's time for presenting a proof of claim had passed six years earlier and defendants' actions in 2011 did not cause plaintiff to miss that deadline. The Court noted that plaintiff failed to present any fact to support the conclusion that defendant made a material misrepresentation to plaintiff that would require the court in equity to modify the terms of the ERISA plan to extend the deadlines that had long since passed.

Carroll v. Continental Automotive, Inc., No. 16-1152, 2017 U.S. App. LEXIS 7119 (4th Cir. April 24, 2017). The Court, citing *Amara*, stated "[t]o the extent Appellants claim, that language in the SPD conflicts with the language of the Plan, these arguments are improper" and "[t]he SPD is not considered part of a plan, and any terms in the SPD that conflict with the terms of the plan are not enforced."

Hooper v. UnitedHealthcare Ins. Co., No. 15-2157, 2017 U.S. App. LEXIS 10482 (4th Cir. June 13, 2017). The Court found that the Plan did not abuse its discretion in relying on a CPT codebook, to interpret undefined terms in the plan. The Court noted that the CPT notebook is the "most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs." The CPT codes were referenced in the SPD, but was not referenced in the plan document.

Sixth Circuit

Butler v. FCA US, LLC, No. 16-2726, 2017 U.S. App. LEXIS 16302 (6th Cir. 2017). In affirming the district court's grant of summary judgment for plan administrator, the Sixth Circuit quoted *Amara*, noting that if a summary would lead an average plan participant to believe that a benefit is included when it is not, then a participant can recover under ERISA Section 502(a)(3), which authorizes district courts to remedy "false or misleading" statements in summaries with "appropriate equitable relief."

Tenth Circuit

Blair v. Alcatel-Lucent Long Term Disability Plan, 688 Fed. Appx. 568, 577-578, 2017 U.S. App. LEXIS 8198, 63 Employee Benefits Cas. (BNA) 1189, 2017 WL 1906615 (10th Cir. May 9, 2017). Plaintiff argued that CIGNA was judicially estopped from contending that plaintiff was not disabled because that position was inconsistent with the position CIGNA took when it required plaintiff to apply for SSA benefits, paid for her SSA representation, and benefitted from her receiving those benefits. The Court quoted *New Hampshire v. Maine*, 532 U.S. 742, 749 (2001) as the standard for judicial estoppel: "Where a party assumes a certain position in a legal proceeding, and succeeds in maintaining that position, he may not thereafter, simply because his interests have changed, assume a contrary position, especially if it be to the prejudice of the party who has acquiesced in the position formerly taken by him." Because judicial estoppel is a "harsh remedy," the Tenth Circuit applies it "both narrowly and cautiously." *Asarco, LLC v. Noranda Mining, Inc.*, 844 F.3d 1201, 1207-08 (10th Cir. 2017).

The Tenth Circuit found that judicial estoppel did not apply because the Plan's position in finding that plaintiff was not disabled under the Plan was not inconsistent with the Plan's position that plaintiff was disabled for purposes of SSA benefits. The ERISA standard for disability benefits is different from that for SSA benefits. ERISA owes no deference to treating physician's opinions whereas the SSA must give them special weight. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003). Moreover, the SSA made its determination in May 2012 without the benefit of later treatment notes showing plaintiff's condition had improved. CIGNA had the benefit of the later notes, as well as subsequent independent reviews, when it made its decision to terminate benefits.

Chen v. CenturyLink, 2017 U.S. Dist. LEXIS 76511, *16-19, 2017 WL 2199008 (D. Col. May 18, 2017. Plaintiff argued that it was arbitrary for the Plan to deny disability benefits after paying them for nineteen years. She objected to the fact that during the time she was receiving benefits, the Plan accepted the opinions of Dr. Mooney with little question. The court rejected this argument because new medical and vocational evidence was obtained before the Plan's decision to terminate her benefits. ERISA does not prevent a plan administrator from reversing course and finding a claimant no longer entitled to disability benefits. *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1099 (10th Cir. 1999). A denial of benefits, even after many years

during which benefits were paid, is not arbitrary and capricious if it is supported by new medical or other information. *See, e.g., Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 382 (10th Cir. 1992).

William G. v. United Healthcare, 2017 U.S. Dist. LEXIS 85182 (D. Utah June 2, 2017). The Plan's limitations period is unenforceable against plaintiff because defendants failed to comply with 29 C.F.R. §§ 2560.503-1(g)(1)(iv) by not including the Plan's civil action limitations period in their denial letters to Bill. Prejudice is presumed, and the applicable state six-year statute of limitations applies to the plaintiff's claim for ERISA medical benefits.

The First, Third, and Sixth Circuits have interpreted Subsection (g)(1)(iv) to require disclosure of the time limit in denial letters. *Santana-Dias v. Metropolitan Life Insurance Company*. 816 F.3d 172, 180 (1st Cir. 2016); *Mirza v. Insurance Administrator of America, Inc.*, 800 F.3d 129, 134 (3d Cir. 2015); *Moyer v. Metropolitan Life Insurance Company*, 762 F.3d 503, 505 (6th Cir. 2014). The cases defendants rely on are inapplicable and unpersuasive. In *Wilson v. Standard Ins. Co.*, the Eleventh Circuit's analysis did not rely on an interpretation of Subsection (g)(1)(iv). Rather, the court determined Subsection (g)(1)(iv) was ambiguous and simply assumed the regulation required denial letters to "notify the claimant of her time for filling a lawsuit under ERISA [.]" It then decided the case on equitable tolling grounds. Likewise, *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F. 3d 899 (9th Cir. 2009) is inapplicable and unpersuasive because its analysis does not reference or rely on Subsection (g)(1)(iv). In *Scharff*, after the plaintiff conceded that the plan administrator had met its obligations under ERISA, and the Ninth Circuit did not interpret Subsection (g)(1)(iv).

This interpretation is supported by the Supreme Court's discussion of ERISA's "two-tiered remedial scheme" in *Heimeshoff v. Hartford Life & Acc. Ins. Co.* 571 US __, 134 S. Ct. 604, 187 L. Ed. 2d 529 (Dec. 16, 2013), encompassing both the internal appeals procedures and judicial review, indicating that judicial review is an equal, albeit secondary, partner to the internal appeals procedures in ERISA's review process. A reading of Subsection (g)(1)(iv) that requires a denial letter's disclosure of the plan's civil action limitations periods supports the goal of full and fair review. The importance of protecting plan participants under ERISA and providing them a fair opportunity for both internal appeals procedures and judicial review outweighs the relatively small burden the disclosure requirement places on plan administrators.

John H. v. United HealthCare, 2017 U.S. Dist. LEXIS 73593 (D. Utah April 26, 2017). Plaintiffs argued that they were excused from the Plan's one-year time limit for bringing suit because the Plan failed to disclose the time limit in its denial letters, in violation of ERISA's regulations in 29 C.F.R. § 2560.503-1(g)(1). The Court agreed, noting that the First, Third, and Sixth Circuits have interpreted Subsection (g)(1)(iv) as requiring disclosure of the time limit in denial letters. The remedy for the failure to disclose the time limits for bringing a civil suit in any adverse benefit determination is to ignore the time limit so that the claimant may receive judicial review.

1. Unambiguous SPD Provisions Providing More Generous Benefits

Second Circuit

Tietjen v. Unum Life Ins. Co. of Am., No. 16-CV-7021, 2017 U.S. Dist. LEXIS 157721 (S.D.N.Y. Sept. 26, 2017). The district court affirmed the denial of a participant's claim for long-term disability benefits. The plaintiff argued review of her claim should be subject to a *de novo* standard of review because an affiliate of Unum, which was not authorized in the plan document, rendered final review of her appeal. The court applied an abuse of discretion standard of review, however, because the SPD, which incorporated itself into the plan document, specifically granted the Unum affiliate with discretionary authority as to deciding appeals. The court noted that even after *Amara*, courts have found that SPDs are enforceable if they are explicitly incorporated into their plans – even if the incorporating language appears only in the SPDs themselves.

Third Circuit

Huffman v. Prudential Ins. Co. of Am., No. 2:10-cv-05135, 2017 U.S. Dist. LEXIS 201440 (E.D. Pa. Dec. 6, 2017). The district court reviewed the following issue: when the terms of a life insurance policy included in an ERISA plan provide that payment shall be made to the beneficiary in "one sum," does the insurer violate ERISA by choosing to pay the beneficiary by giving him access to a retained asset account, which allows the insurer to retain the funds and earn interest on them until the beneficiary withdraws them? The district court granted summary judgment on liability in favor of the class action plaintiffs, in part, because the terms of the SPD (allowing the retained asset account) conflicted with the terms of the applicable plan document, which required payments be made in one sum.

Fourth Circuit

Barton v. Constellium Rolled Products-Ravenswood, LLC, No. 16-1103, 856 F.3d 348 (4th Cir. May 11, 2017). Plaintiffs argued that the district court erred in granting summary judgment for defendant on grounds that their retiree health benefits were vested. In support of their argument they relied on letters concerning retiree health benefits, statements in the summary plan description that benefits would cease upon an individual's death, the payment of retiree medical benefits during a lockout, and other extrinsic writings. On rehearing, the Court affirmed summary judgment for defendant finding that the durational clauses of the collective bargaining agreements were clear and unambiguous and thus the retiree health benefits were not vested.

Fifth Circuit

Thomason v. Metro. Life Ins. Co., 703 F. App'x 247 (5th Cir. 2017). The Court held that the summary plan description for a long-term disability benefit was ambiguous because it stated that the benefit amount would be offset by pension benefits, "if [the beneficiary] elect[s] to

receive them" but gave no indication of whether a direct rollover constituted an election to receive benefits. The plaintiff elected a direct rollover of his pension plan benefit to an IRA, believing this would not result in any offset because he would not actually receive his pension benefits until he withdrew them from the IRA. The Court held that because the summary plan description language was ambiguous, it must be interpreted in favor of the plaintiff.

Sixth Circuit

Butler v. FCA US, LLC, No. 16-2726, 2017 U.S. App. LEXIS 16302 (6th Cir. 2017). The Sixth Circuit agreed with a district court's determination that claim was not entitled to total and permanent disability benefits under a plan's accident insurance policy because the policy did not list such benefits and even if the summary plan description stated that it covered such benefits, upon reading the entire summary and interpreting its provisions in context, the claimant should have known that the total permanent disability benefit was no longer part of the policy.

Eleventh Circuit

Owens v. Metro. Life Ins. Co., No. 2:14-CV-00074-RWS, 2017 WL 6302384 (N.D. Ga. Sept. 29, 2017). In the context of a renewed motion for class certification, the court concluded that language in a SPD that permitted life insurance benefit payments through a total control account conflicted with the unambiguous terms of the governing plan documents, and therefore was unenforceable. *See* * 8-9.

2. Where an SPD's Silence Fails to Notify Participants of Important Rules

Second Circuit

Osberg v. Foot Locker, Inc., 862 F.3d 198 (2d Cir. 2017). Second Circuit affirmed district court's award of equitable relief under ERISA § 502(a)(3), holding, *inter alia*, that the district court did not abuse its discretion by awarding reformation of the plan. Pension plan participants brought a class action against their employer under ERISA §§ 102 and 404(a), claiming that the employer failed to disclose that conversion to a cash balance plan from a defined benefit plan would cause wear-away that, in some cases, amounted to a benefits freeze. The employer failed to describe the wear-away in all communications concerning the transition to the new cash balance plan. The employer also deliberately left out a description of the wear-away in the SPD. The district court found that the employer's communications—including the SPD—were designed to conceal any indication of wear-away or a benefits freeze.

Fifth Circuit

Crawford v. Metro. Life Ins. Co., No. 3:16-CV-2402, 2017 U.S. Dist. LEXIS 131242 (N.D. Tex. Aug. 17, 2017). In a dispute over the proper beneficiary of life insurance proceeds, the district court upheld a plan administrator's interpretation of SPD language which decedent's

husband alleged was ambiguous. Citing Fifth Circuit precedent, the court noted that, unlike a plan, ambiguities in plan summaries are resolved against the drafter, and administrative discretion does not extend to SPDs. Ultimately, however, the court found there was no ambiguities in the SPD language and upheld the plan administrator's denial of the husband's claim.

Seventh Circuit

Tuhey v. Ill. Tool Works, Inc., Case No. 17 C 3313, 2017 U.S. Dist. LEXIS 121802 (N.D. Ill Aug. 2, 2017). Plaintiff alleged that Defendant breached its fiduciary duties by failing to disclose participants' rights to convert vested benefits under a long-term disability policy. The court explained that there is no general fiduciary obligation to "provide specific information about conversion rights." *Id*. at *22. The court held that Plaintiff had failed to demonstrate that Defendant "failed to disclose material information which they knew the beneficiary did not have or affirmatively misinformed the plan participant . . . concerning plan benefits." *Id* at *23-24. Therefore, Plaintiff's allegations were insufficient to survive Defendant's motion to dismiss.

St. Alexius Med. Ctr. v. Roofers' Unions Welfare Tr. Fund, No. 14 C 8890, 2017 U.S. Dist. LEXIS 15588 (N.D. Ill. Jan. 31, 2017). The parties disputed whether the SPD or a 1996 Plan document constituted the Plan document from 2011 forward. *Id*. at *2. Plaintiff relied upon a 2011 notice to participants, which stated that the "Summary Plan Description . . . and subsequently issued Summaries of Material Modifications . . . serve as the Welfare Plan's Plan document" as support for its contention that the SPD's terms governed. *Id*. at *3 (citation omitted). The primary material difference between the two documents was that the SPD did "not contain any limitations period for filing suit to challenge an adverse benefits determination." *Id*. at *6. The court determined, "[a]fter careful review of the record," that the SPD was the operative Plan document, in part based upon the language of the 2011 notice, and therefore the SPD's limitations terms, or lack thereof, governed. *Id*. at *19.

Ninth Circuit

Laura B v. United Health Grp. Co., No. 16-cv-01639-JSC, 2017 U.S. Dist. LEXIS 137174 (N.D. Cal. Aug. 25, 2017). Plaintiff brought suit alleging wrongful denial of coverage of inpatient mental health care. Defendant moved for summary judgment on grounds that Plaintiff had failed to exhaust administrative remedies. *Id*. at *1. In support of this argument, Defendants cited a disclosure document which stated that a claimant had "a right to request a Second-Level appeal review of any" coverage denial. *Id*. at *3. The court found that the SPD did not state that a claimant was "required to make a second level appeal" and therefore denied Defendant's motion for summary judgment. *Id*. at *13.

Romanchuk v. Bd. of Trs. of the S. Cal. United Food & Commercial Workers Joint Pension Trust Fund, No. CV 15-08180-AB (KS), 2017 U.S. Dist. LEXIS 209636 (C.D. Cal. June 29, 2017). Plaintiff brought a claim for breach of fiduciary duty, alleging that Defendant

failed to disclose participant rights under a "Grandfather Clause" in the SPD. The court denied Defendant's motion for summary judgment, holding that Plaintiff established a triable issue of fact as to whether this failure to disclose constituted a breach of fiduciary duties owed to plan participants. *Id*. at *55-58.

Zelhofer v. Metro. Life Ins. Co., No. 2:16-cv-00773 TLN AC, 2017 U.S. Dist. LEXIS 47069 (E.D. Cal. Mar. 29, 2017). Plaintiff argued that Defendants could not enforce a contractual limitations period contained in the Plan provisions because it was ambiguous and not contained in the SPD. *Id*. at *16. The court held that dismissal was not appropriate pursuant to the contractual limitations period because under Ninth Circuit precedent, "failure to properly disclose a limitations provision in an SPD, as required by 29 U.S.C. § 1022(b), renders the provision unenforceable." *Id*. at *20 (citing *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Ariz.*, 770 F.3d 1282, 1294 (9th Cir. 2014)).

King v. Blue Cross and Blue Shield of Ill., 871 F.3d 730 (9th Cir. 2017). Plaintiff alleged wrongful denial of medical benefits and that the SPD violated ERISA disclosure requirements because it failed to notify plan participants of a lifetime maximum benefit provision. *Id*. at 740. The Ninth Circuit applied its *Spinedex* "reasonable plan participant" standard in reaching its conclusion that the SPD, which was comprised of a 2006 SPD and a series of summaries of material modifications, was "at bottom" not "written in a manner calculated to be understood by the average plan participant." *Id*. at 741-42 (quoting 29 U.S.C. § 1022(a)). The Ninth Circuit held that the lower court's grant of summary judgment to Defendants was therefore improper and reversed and remanded for further proceedings.

Eleventh Circuit

Laird v. Aetna Life Ins. Co., 263 F. Supp. 3d 1231 (M.D. Ala. 2017). Plaintiff argued that her husband's employer, life insurance benefit provider, and life insurance plan administrator, all breached their fiduciary duties by failing to furnish accurate plan information (and making material misrepresentations about plan benefits) that would have guided her husband's benefit elections. Plaintiff alleged that the defendants failed to disclose (and intentionally misled the Plaintiff and her husband to believe otherwise) the fact that her husband's life insurance benefit would reduce from a 100% payout to a 65% payout once he turned 70. Plaintiff claimed that neither she nor her husband ever received a SPD from the employer or plan administrator. The court concluded that under *Amara* precedent, the Plaintiff had a viable breach of fiduciary duty claim under ERISA § 502(a)(3) for a failure to disclose required plan information since Plaintiff and her husband would have elected additional coverage had they been properly informed of the plan's terms concerning the reduced payout.

3. Non-SPD Representations That Are Inconsistent With Unambiguous Written Plan Provisions

Third Circuit

Erwood v. Life Ins. Co. of N. Am., No. 14-1284, 2017 U.S. Dist. LEXIS 56348 (W.D. Pa. Apr. 13, 2017). The district court concluded that plaintiff life insurance beneficiaries proved, by a preponderance of the evidence, that defendant life insurance company and plan violated ERISA Section 502(a)(3). The court issued a verdict in favor of plaintiff and awarded monetary damages in the amount of $750,000 (the value of lost life insurance proceeds), plus interest, attorney's fees and other costs. The court found representatives of the life insurer had failed issue a conversion brochure and to otherwise communicate the need for conversion of group life insurance following post-FMLA leave.

Fifth Circuit

Murillo v. Reliance Standard Life Ins. Co., Civil Action No. 1:16-49, 2017 U.S. Dist. LEXIS 55896 (S.D. Tex. Mar. 22, 2017). Plaintiff signed up for an employer sponsored life insurance policy but mistakenly believed the policy was for "family" coverage when it actually only insured the plaintiff. Plaintiff asserted that an AFLAC representative told her she had signed up for "family" coverage and that her husband's life was also insured. The court held that, even if an AFLAC representative did make this assertion, plaintiff could not prove reasonable reliance because she received a copy of the signed application and policy indicating individual coverage shortly after issuance and was charged premiums solely based on insuring her life.

Seventh Circuit

Advanced Ambulatory Surgical Ctr., Inc. v. Conn. Gen. Life Ins. Co., 261 F.Supp.3d 889 (N.D. Ill. 2017). An outpatient surgery center brought an action for reimbursement of surgery expenses against a health care insurance plan administrator. The court granted Defendant's motion for partial summary judgment finding that an insurance agent's "mere verification of a patient's benefits" over the phone did not constitute an unambiguous promise to pay for services. *Id.* at 896. The court held that summary judgment was especially warranted given that each patient caller was greeted with a pre-recorded disclaimer at the beginning of each call that stated that covered services information did not "guarantee coverage or payment," and that callers should "refer to the Summary Plan Description for coverage." *Id.* at 892, 897.

Ninth Circuit

Salyers v. Metro. Life Ins. Co., 871 F.3d 934 (9th Cir. 2017). Plaintiff brought an action challenging denial of her application for dependent life insurance benefits. In 2013, Plaintiff elected a $20,000 policy, which did not require submission of evidence of insurability. *Id.* at 936. In 2014, Plaintiff elected $250,000 in life insurance coverage, and Plaintiff's premiums were adjusted to account for the new election. *Id.* Although Plaintiff's increased coverage required evidence of insurability, Defendant never requested such evidence. *Id.* at 937. When Plaintiff's spouse passed away, Defendant realized its error and only paid $30,000 in benefits—

an amount equal to Plaintiff's initial election of a $20,000 policy plus a $10,000 coverage increase permitted annually by the plan. *Id*. The district court entered judgment in Defendant's favor, and Plaintiff appealed. The Ninth Circuit reversed, finding that, in spite of unambiguous language in the plan documents stating that a participant was required to submit evidence of insurability for coverage over a specified amount, Defendant had waived its right to enforce the evidence of insurability requirement because it had failed to request the evidence over a period of months after the coverage election and accepted premium payments for $250,000 in coverage. *Id*. at 941.

Rappa v. Mut. of Omaha Ins. Co., No. 2:16-cv-02984-KJM-CKD, 2017 U.S. Dist. LEXIS 125530 (E.D. Cal. Aug. 8, 2017). Plaintiff alleged that Defendant breached fiduciary duties by erroneously advising her to first exhaust her employer's workers compensation process before submitting a claim for long-term disability benefits. According to Plaintiff, as a result of Defendant's advice, she waited for nearly three years before filing her disability claim. *Id*. at *2. The court denied Defendant's motion to dismiss. It held that Plaintiff's allegation that Defendant materially misrepresented the plan's terms was enough to plead a plausible fiduciary breach, and that Plaintiff plausibly alleged actual harm by asserting that Defendant's conduct "left her in limbo for years … unsure of what, if any, disability benefits she would receive." *Id*. at *7-9.

4. Representations Contrary to the Plan's Interpretation of Ambiguous Written Plan Provisions

Fourth Circuit

Barton v. Constellium Rolled Products-Ravenswood, LLC, No. 16-1103, 856 F.3d 348 (4th Cir. May 11, 2017). Plaintiffs argued that the district court erred in granting summary judgment for defendant on grounds that their retiree health benefits were vested. In support of their argument they relied on letters concerning retiree health benefits, statements in the summary plan description that benefits would cease upon an individual's death, the payment of retiree medical benefits during a lockout, and other extrinsic writings. The Court affirmed summary judgment for defendant finding that the durational clauses of the collective bargaining agreements were clear and unambiguous and thus the retiree health benefits were not vested.

Hooper v. UnitedHealthcare Ins. Co., No 15-2157, 2017 U.S. App. LEXIS 10482 (4th Cir. June 13, 2017). The Court rejected plaintiff's argument that the plan acted improperly by failing to consider information from United Healthcare's website. The Court found that the SPD referenced the website, but did not incorporate the website into the terms of the Plan. The court also noted that this information was not submitted to the plan for consideration during the administrative review process.

Fifth Circuit

Rhea v. Alan Ritchey, Inc. Welfare Benefits Plan, 858 F.3d 340 (5th Cir. 2017). The Fifth Circuit affirmed summary judgment for employee welfare benefit plan seeking to enforce an equitable lien for reimbursement over funds paid to a plan beneficiary who recovered from a medical malpractice settlement. Contrary to written representations in the SPD, the SPD constituted the formal plan document. The Fifth Circuit affirmed, holding that the SPD's errant disclaimer that a separate "official" plan document existed did not tip the balance of the equities in the beneficiary's favor.

5. Misrepresentation Made Prior to Plan Establishment

No update.

E. Conflict of Interest

1. Circumstances Giving Rise to a Conflict

a. Insurance Company Serving Dual Roles

No update.

b. Employer Serving Dual Roles

No update.

2. Effect of Conflict of Interest on the Standard of Review

a. De Novo Standard of Review

No update.

b. Sliding-Scale Standard of Review

No update.

c. Burden-Shifting Analysis

No update.

3. Establishing Causation and the Seriousness of a Conflict

Second Circuit

Johnson v. The Guardian Life Insurance Company of America, No. 3:16-CV-01141, 2017 WL 4870909 (D. Conn. Oct. 27, 2017). "After weighing the relevant factors, the Court concludes that Defendant's decision to terminate Plaintiff's benefits was arbitrary and capricious. After repeatedly finding Plaintiff disabled for a period of five years, Defendant decided, unprompted, to conduct a new review of Plaintiff's eligibility shortly after learning that it was underpaying Plaintiff; Defendant encouraged Plaintiff to argue her disability case to the SSA, but then did not—or failed to adequately explain why it did not—consider the SSA's ruling in Plaintiff's favor; Defendant has a conflict of interest as the decision maker and payor of benefits; Defendant's denial rested primarily on the opinions of two non-treating physicians who did not examine Plaintiff and whose opinions were not supported by key parts of the record; Defendant singled out a PCE and single progress note from Plaintiff's treating orthopedist from a lengthy medical history put forth by at least three treating physicians, including the same orthopedist that documented substantial impairments over a long period; Defendant gave an inadequate explanation for its reversal of course after five years of finding Plaintiff to be disabled; and Defendant failed to consider adequately Plaintiff's upper extremity limitations—a key difference between Plaintiff's functional capability to perform sedentary work and no work."

McFarlane v. First Unum Life Insurance Company, No. 16-CV-7806, 2017 WL 4564928 (S.D.N.Y. Oct. 12, 2017). In this long-term disability matter, the court overruled plaintiff's objections to the Magistrate Judge's denial of the plaintiff's motion to compel discovery. The court found that the denial of the motion to compel the production of statistics regarding First Unum's liability acceptance rates was not clearly erroneous or contrary to law. Although two courts in this district have ordered defendants to produce statistics of claim determination rates in ERISA cases, the Magistrate Judge did not err in finding the plaintiff's request for similar statistics was not proportional to her needs.

Fourth Circuit

Reidy v. Unum Life Ins. Co. of Am., No. CV PX-16-2926, 2017 WL 6368659 (D. Md. Dec. 13, 2017). The court denied plaintiff's motion to compel defendants' responses to interrogatories and requests for production of documents on the doctors that reviewed Plaintiff's claim, Dr. Kletti and Dr. Shipko. The court determined that the administrative record is sufficient for the court to determine whether and the extent to which Unum's conflict of interest improperly influenced Plaintiff's benefits decision.

Eleventh Circuit

Johnston v. Aetna Life Insurance Company, No. 17-20996-CIV, 2017 WL 4654431 (S.D. Fla. Oct. 16, 2017). The court granted the plaintiff's request for discovery outside of the administrative record, including a Rule 30(b)(6) deposition and other discovery aimed at discovering oral communications concerning the claim decision, employee financial incentive information, and relevant portions of the claims manual and guidelines.

4. Effect of Conflict of Interest Assertions on the Scope of the Record to Be Considered by the Court

Second Circuit

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F. Factors Used to Determine Abuse of Discretion Other Than Conflict of Interest

First Circuit

Doe v. Standard Insurance Co., 852 F.3d 118 (1st Cir. 2017). Plaintiff, an attorney who suffered from depression, sought additional long-term disability benefits under an "own occupation" group insurance policy, for which an additional premium was paid. The district court ruled in favor of the plan administrator, finding that its denial of benefits was not an abuse of discretion. The Court of Appeals reversed. It found that the administrator's reliance on generic definition of "lawyer" in the Dictionary of Occupational Titles, rather than a job description that fully and accurately encompassed the material duties of Plaintiff's specialized area of practice in environmental law, was unreasonable—particularly given that Standard

charged an additional premium for own occupation coverage. The court found that the record did not contain substantial evidence that Plaintiff was unable to perform the material duties of her own occupation.

Second Circuit

Fisher v. Aetna Life Insurance Co., No. 16-cv-144 (RJS), 2017 WL 1246133 (S.D.N.Y. March 31, 2017). Plaintiff, a beneficiary under her husband's employer's group health plan, filed an action seeking benefits for a named brand prescription drug prescribed to her to treat her depression. Although Aetna initially applied the cost of the drug to Plaintiff's deductible, it subsequently stopped doing so without explanation. The district court determined that Aetna's denial of benefits for the drug was arbitrary and capricious, because from Aetna's claims letters the court could not determine the basis for Aetna's denials, whether Aetna's decisions were based on substantial evidence, or whether Aetna had considered all of the relevant factors and circumstances, such as the medical necessity request Plaintiff had submitted, in reaching its determinations. The court denied Aetna's motion for summary judgment, and remanded Plaintiff's claim back to the plan administrator.

Franzese v. United Health Care/Oxford, 232 F.Supp.3d 267 (E.D.N.Y. 2017). Plaintiffs, participant and beneficiaries of a group health plan, brought suit against the plan administrator seeking benefits for private duty nursing services and home health care services. Applying the abuse of discretion standard, the court determined that the administrator did not abuse its discretion in denying benefits for private duty nursing services, as no plan provision required the administrator to treat private duty nursing services as a covered service, and other provisions specifically excluded such services from coverage. In contrast, the court found that the administrator's denial of home health care services was arbitrary and capricious because the denial was not supported by substantial evidence. Specifically, at all stages of the claims process the administer considered and addressed only whether services were covered if they were private duty nursing services, without considering whether the services in question would qualify as home health services that would be covered by the policy. Accordingly, the court denied the administrator's motion for summary judgment and remanded the claim to the administrator for further consideration.

Third Circuit

Van Arsdel v. Liberty Life Assurance Co. of Boston, 267 F.Supp.3d 539 (E.D. Pa. 2017). Plaintiff, who suffered from morbid obesity and osteoarthritis, brought suit after Defendant Liberty denied long-term disability payments on the grounds that plaintiff's occupation was performed as a sedentary or light duty occupation in the national economy. The parties filed cross-motions for summary judgment. In deciding the matter under the abuse of discretion standard, the court found that Liberty's interpretation of the language of "Own Occupation" was unreasonable insofar as the insurer appeared to claim that the language did not require it to consider Plaintiff's actual job description when determining how his occupation is performed in

the national economy. The court found that Liberty's determination that Plaintiff's occupation as a less demanding form sedentary work despite information in the record showing his actual job requirements were more demanding "appears to be the type of selective interpretation that would constitute an abuse of discretion." The court remanded the case back to the administrator to reevaluate whether Plaintiff was entitled to the long-term disability benefits.

Fourth Circuit

Cline v. Aetna Life Insurance Co., No. 5:15-CV-00096-RLV-DSC, 2017 WL 5490853 (W.D.N.C. November 15, 2017). Plaintiff was a commercial pilot who sought long-term disability benefits from his employer's disability plan. Aetna, the claims administrator and insurer of the plan, denied Plaintiff's claim based on its assessment of the "objective evidence," consisting of the results of a nerve conduction study and an ultrasound. The court found that Aetna abused its discretion in denying the claim, because it limited its assessment of the claim to the "objective evidence," and ignored subjective in the record. The court also found that Aetna gave scant attention to the medical and raw testing evidence in the record. Ultimately, the court determined that Aetna's denials were not supported by substantial evidence and were not the result of a reasoned and principled process.

Wiwel v. IBM Medical and Dental Benefit Plans, No. 5:15-CV-504-FL, 2018 WL 526988 (E.D.N.C. January 18, 2018). Plaintiffs sought residential treatment for psychiatric care from a self-funded health plan, which the plan denied. In the second level of administrative review, the plan referred the claim to an independent peer review organization (IPRO) which relied on the American Psychiatric Association (APA) practice guidelines for the treatment of adult patients with major depressive disorders, which counsel that practitioners should use the "least restrictive level of care for safe and effective treatment" available to adult patients. The IPRO report did not set forth reasons to conclude the patient's improved behavior would continue if she were discharged from the residential treatment facility, nor did it explain what medical evidence was found to be determinative or why. The court held the administrator abused its discretion. It found that there was no evidence that the IPRO considered opinion evidence from five reports in the record, or the patient's self-report as to the reason for her improved behavior. The court also faulted the IPRO for recommending denial of benefits based on the APA guidelines, when by their own terms the guidelines did not apply to children but instead refer to a different source of medical authority for cases involving children. The court granted Plaintiffs' motion for summary judgment and remanded the claim to the administrator for a reevaluation of the claim.

Fifth Circuit

Rittinger v. Healthy Alliance Life Insurance Co., No. 4:16-CV-639, 2017 WL 4071153, 2017 EB Cases (BNA) 325 (S.D. Tex. September 17, 2017). Plaintiff was a beneficiary of an ERISA-covered group health plan insured by Defendant HALIC. Plaintiff had gastric bypass surgery and several days later complications from that surgery necessitated follow-up surgery and intensive care thereafter. After the surgery, HALIC denied preauthorization for the surgery,

under exclusions for bariatric surgery and complications from non-covered procedures that are set forth in the plan. However, the exclusion for bariatric surgery contained an exception for surgeries to address "excessive nausea/vomiting," that Plaintiff contended applied to her initial surgery. Plaintiff supplied records showing she had long suffered from GERD, a condition that caused frequent nausea and vomiting, and that she underwent the initial surgery to address these problems. After several rounds of administrative appeals and denials, Plaintiff brought suit against HALIC challenging the denial of benefits. The court found that HALIC's decision not to apply the "excessive nausea/vomiting" exception was an abuse of discretion. The court first found HALIC's interpretation of the exclusion—i.e., that it excludes coverage for any surgery if weight loss is among its purposes—to contradict the plan terms which clearly contemplated covering surgeries addressing both obesity and the listed health conditions, since all bariatric surgeries involve obesity. The court next determined that declarations, doctors' letters, medical records, and scholarly literature in the record showed that remediation of her discomfort and symptoms from GERD and esophagitis was the main aim of Plaintiff and her doctors. The court held that HALIC's decision amounted to suspicions unsupported by concrete evidence, and that as such it was not owed any deference. The court ordered HALIC to pay the benefits.

Sixth Circuit

Brunelle v. Mid America Associates, Inc., No. 16-cv-13446, 2017 WL 3588055 (E.D. Mich. August 21, 2017). Plaintiff was a participant in his employer's group health plan that was administered by Defendant Mid America. Plaintiff submitted a claim for medical benefits after suffering from an uncontrollable nose bleed, that treatment including surgery could not stop. Doctors at the hospital where the initial surgery was performed recommended that Plaintiff be transported to the University of Michigan where more specialized treatment would be available. Further, the hospital recommended that Plaintiff be transported by air ambulance because the University of Michigan was more than an eight-hour ambulance ride, the patient was at risk for severe anemia, acute MI, flash pulmonary edema, and even death. The plan administrator covered most of the services, but denied the claim for air ambulance as not medically necessary, relying on an independent physician reviewer who determined that ground transport would not have placed Plaintiff's health in jeopardy and the University of Michigan was not the closest appropriate facility to treat Plaintiff's condition. Following two denials, Plaintiff appealed and Mid America obtained an external review from an independent review organization, which reached the same conclusions. The court determined that Mid America abused its discretion in denying Plaintiff's claim by failing to address or adequately explain several significant pieces of evidence in the record, and by arbitrarily limiting the independent reviewers in the scope of their by asking them only whether Plaintiff needed specific lab tests at the University of Michigan, when the records also indicated that Plaintiff may have needed surgery services only available at the University of Michigan and that it was the closes facility to treat Plaintiff's coagulation problems. Finally, the court found that the reports from the independent reviewers, addressing the issue of medical necessity in only five or six sentences, were underdeveloped and unclear. The court granted judgment to Plaintiff and remanded the claim to the administrator for reevaluation.

Seventh Circuit

Sadowski v. Tuckpointers Local 52 Health & Welfare Trust, No. 16 C 11014, 2017 WL 6549759 (N.D. Ill. December 20, 2017). Plaintiff brought an action seeking health benefits for surgery to remove a spinal cord stimulator and subsequent complications from the surgery. The defendant health fund had previously covered the implant of the spinal cord stimulator to address injuries from a car accident in which Plaintiff was involved. Plaintiff had brought a personal injury lawsuit related to the earlier accident that resulted in a settlement, and Plaintiff and the health fund agreed to settle the fund's reimbursement lien for the medical bills paid by the fund from the accident. The need to remove the spinal cord stimulator followed Plaintiff becoming injured after falling down stairs, and that injury becoming infected over the following weeks. The fund denied benefits for the removal of the spinal cord stimulator based on a plan provision stating, "Once a settlement is reached, additional bills cannot be submitted with respect to the same injury." The court determined that this interpretation was arbitrary and capricious because finding "that broadly interpreting 'same injury' to include injuries caused by a distinct, independent event is unreasonable." The court next considered the fund's factual determination that the infection was caused by the earlier car accident, rather than Plaintiff's fall down the stairs. The court recounted the evidence submitted by Plaintiff that the fall caused the infection, and determined that, while the fund did not have to accept the evidence, it must provide specific reasons for rejecting the evidence, especially in the absence of contrary evidence. The court held the fund also acting arbitrarily and capricious by failing to provide a rational basis for rejecting the Plaintiff's factual evidence concerning the cause of the infection.

Eighth Circuit

Donaldson v. National Union Fire Insurance Co. of Pittsburgh, PA, 863 F.3d 1036 (8th Cir. 2017). Plaintiff sought accidental death and spousal benefits under an ERISA-covered welfare plan after her husband was killed on his delivery route, when his truck was struck by an oncoming vehicle that crossed the center divider. The plan administrator, National Union, denied the participant's claim for benefits on the grounds that, while the policy covered injury sustained to a person operating a conveyance or by being struck down by a conveyance, it excluded from coverage "any such conveyance the Insured Person has been hired to operate." Plaintiff brought suit against National Union, arguing that the same provision actually required coverage because, although her husband had been operating a conveyance at the time of the accident, the vehicle that struck and killed him was also a conveyance that he had not been hired to operate and was not operating at the time of his death. The Court of Appeals affirmed the district court's judgment in favor of National Union, finding the plan exclusion to be ambiguous and therefore National Union's interpretation not to be an abuse of discretion. The court analyzed the five factors the Eight Circuit has stated are relevant to an abuse of discretion determination and found all of the factors either favored National Union or were neutral.

Ninth Circuit

Bergman v. Federal Express Corporation Long Term Disability Plan, No. 16-cv-1179-BAS(KSC), 2017 WL 4310751 (C.D. Cal. September 27, 2017). Plaintiff filed suit after her long-term disability benefits were discontinued. The court found that Aetna, the claims administrator for the plan, abused its discretion by arbitrarily refusing to credit Plaintiff's objective evidence in support of her disability, without rebutting the objective findings with any credible evidence. The court also found that Aetna abused its discretion by refusing to credit Plaintiff's subjective, continuing, and at times verified pain symptoms. While under the plan pain alone cannot prove disability, Aetna arbitrarily prohibited or excluded pain from the analysis of the claim when other objective findings were present.

Young v Sun Life and Health Insurance Co., No. 1:16-cv-00822-LJO-JLT, 2018 WL 332911 (E.D. Cal. January 9, 2018). Plaintiff suffered from fibromyalgia and received benefits from her employer's long-term disability plan from September 2010 until March 2015, at which time Sun Life, the administrator and insurer of the plan, terminated her benefits. The court found that Sun Life abused its discretion in terminating the benefits and entered judgment in favor of Plaintiff. In doing so, the court found that Sun Life failed to credit objective evidence that it never found was unreliable, selectively interpreted Plaintiff's evidence without seeking clarification, and disregarded Plaintiff's consistent reports of pain contrary to controlling Ninth Circuit precedent.

Tenth Circuit

Van Steen v. Life Insurance Co. of North America, 878 F.3d 994 (10th Cir. 2018). Defendant LINA terminated Plaintiff's long-term disability benefits. LINA initially granted benefits to Plaintiff following a mild traumatic brain injury he sustained after being physically assaulted. About one year later, LINA reviewed Plaintiff's file and contacted his doctor's office for more information about Plaintiff's condition and restrictions. Shortly thereafter, LINA terminated Plaintiff's benefits stating that "the medical documentation on file does not continue to support the current restrictions and limitations to preclude you from resuming a full-time work schedule. The plan language required a determination as to whether Plaintiff was able to perform each and every material duty of his job on a full-time basis. Plaintiff was already working part-time such that clear support and analysis were required to show that his restrictions and limitations did not prevent him from performing his material job duties full-time. Despite the record containing extensive descriptions of Plaintiff's cognitive fatigue from working part-time, LINA determined that Plaintiff had the stamina to work an eight-hour day yet offered no evidence to support that conclusion. In contrast, the physicians and experts who did analyze the distinction between a part-time and full-time work schedule all concluded Plaintiff was not capable of working an eight-hour day with his limitations. The Court of Appeals held that while LINA has discretion in interpreting and administering the plan, that discretion did not stretch so far as to ignore the plain language of the plan. The court thus affirmed the district court's holding that LINA's decision was unsupported by substantial evidence and was, therefore, arbitrary and capricious.

Eleventh Circuit

Bryant v. Community Bankshares, Inc., 265 F.Supp.3d 1307 (M.D. Ala. 2017). Participants in Employer Stock Ownership Plan (ESOP) brought an action challenging the plan administrator's decision to suspend the implementation of diversification elections pending an interim stock valuation. The court determined that the plan administrator's decision was arbitrary and capricious because no plan provision permitted an interim valuation or allowed the administrator the discretion to fail to implement a diversification election upon a proper election. The court also found the administrator's finding of a waiver of benefits under the plan from forms submitted by the participants was unreasonable and arbitrary and capricious.

D.C. Circuit

Marcin v. Reliance Standard Life Insurance Co., 861 F.3d 254 (D.C. Cir. 2017). Plan participant, who had been diagnosed with kidney cancer and portal vein thrombosis, brought an action under ERISA challenging the denial of her claim for long-term disability benefits. The district court entered judgment for the participant and Defendants appealed. The Court of Appeals affirmed, finding that the claims administrator, Reliance, abused its discretion. Specifically, the court found that the independent medical reviewer on which Reliance relied did not render a decision that was reliable because the reviewer did not examine all of the pertinent evidence and did not link his conclusions to the patient's medical history. The court determined that, when viewed in totality, the medical record and Plaintiff's work history showed that she could not sustain a full-time work schedule and therefore was partially disabled.

G. Manner of Adjudication: Summary Trial Judgment and Bench Trial Proceedings

Fourth Circuit

Frank v. Liberty Life Assurance Co. of Boston, No. GJH-15-124, 2017 WL 2172320 (D. Md. March 1, 2017). Plan participant brought action against the administrator and insurer of long-term disability plan challenging the termination of her LTD benefits. The parties jointly requested the court to evaluate their cross-motions for judgment under Rule 52(a), rather than under the summary judgment standard of Rule 56. The court noted that, while the Fourth Circuit had not yet opined on the proper approach to evaluating benefit claims under de novo review, other courts within the district had applied Rule 52 or suggested that such approach would be proper. In contrast, courts that had commented that applying Rule 52 would be improper had done so in the context of reviewing a benefit decision under the abuse of discretion standard where the independent fact-finding called for by Rule 52 would be inappropriate. Because the court was conducting a de novo review it agreed with the parties that applying Rule 52 was the appropriate analytical route.

Sixth Circuit

Mokbel-Aljahmi v. United Omaha Life Insurance Co., 706 Fed.Appx. 854 (6th Cir. 2017). The district court granted summary judgment to a plan beneficiary who brought an action under ERISA following the plan administrator's termination of his long-term disability benefits. In affirming the district court's judgment, the Court of Appeals stated that ERISA cases are procedurally unique and neither Rule 56 nor Rule 52 applies, and instead such cases are to be decided on the administrative record. The court noted that while the district court recited the Rule 56 summary judgment standard and did not explicitly render findings of fact and conclusions of law, the oversight was inconsequential as its findings and reasoning were sufficiently clear to allow for appellate review.

Seventh Circuit

Druhot v. Reliance Standard Life Insurance Co., No. 16-cv-2053, 2017 WL 4310653 (N.D. Ill. September 28, 2017). In this disability benefits case to be decided under the de novo standard, the parties filed cross-motions for asking the court to conduct a trial on the papers under Rule 52(a) and enter judgment. The court agreed and noted that "Courts routinely resolve ERISA benefit cases under Rule 52," and that "A 'trial on the papers' under Rule 52 'is well-suited to ERISA cases in which the court reviews a closed record.'" The court further noted that applying Rule 52 would allow it to weigh the evidence and resolve factual disputes based on the record properly before it.

Ninth Circuit

Murphy v. California Physicians Service, No. 14-cv-2581-PJH, 2017 WL 1330636 (N.D. Cal. April 11, 2017). In deciding cross-motions for summary judgment in this ERISA benefits case, the court explained that while a request to reach judgment prior to trial would typically be made under Rule 56, such a motion forbids the court to make factual findings or weigh evidence. As an alternative, when applying the de novo standard in an ERISA benefits case, the court can conduct a trial on the administrative record under Rule 52, which permits it to make factual findings, evaluate credibility, and weigh evidence. The court proceeded under Rule 52 and entered judgment in favor of the plaintiff.

Tenth Circuit

Coats v. Reliance Standard Life Insurance Policy, No. 16-CV-233-TCK-tlw, 2017 WL 5071311 (N.D. Okla. May 18, 2017). In a pre-trial order, the court addressed a dispute between the parties concerning the procedural rule under which this ERISA benefits case should be decided. The court explained that it generally "does not permit dispositive motions in ERISA administrative review proceedings" and that it instead "rules on the briefing" and enters a judgment under Rule 54. In its order, the court determined rejected the plaintiff's position that application of the de novo review made the Rule 56 summary judgment appropriate. The court reasoned that regardless of the standard of review the court's evidentiary purview is limited to

the record, and it is "entirely unhelpful to frame the Court's review of the [administrative record] (de novo or otherwise) in terms of summary judgment, which has the purpose of determining whether a 'question of fact' exists necessitating trial." The court noted that the Tenth Circuit had not expressly disallowed summary judgment briefs in ERISA benefit cases, but citing circuit cases explained that such briefs are legally imprecise and "summary judgment" briefs in name only, because they are actually briefs akin to appellate briefs that will necessarily result in judgment for one side or the other.

Eleventh Circuit

Bauman v. Publix Super Markets, Inc. Employee Stock Ownership Plan, No. 3:15-cv-75-WSD, 2017 WL 5236148 (N.D. Ga. March 17, 2017). In deciding a claim for reinstatement of benefits in an employee stock ownership plan, the court explained Eleventh Circuit law as follows: "The 'standard of review [in the ERISA context] does not neatly fit under either Rule 52 or 56, but is a specially fashioned rule designed to carry out Congress's intent under ERISA." The court noted that in ERISA benefit cases the court acts more like an appellate tribunal than as a trial court in that it does not take evidence, but rather evaluates the reasonableness of an administrative record compiled before the plan fiduciary. Accordingly, unresolved factual issues in the administrative record will not preclude summary judgment as they normally would unless the administrator's decision was wrong or arbitrary and capricious. Citing the rule from the First Circuit, the court held that summary judgment motions "are nothing more than vehicles for teeing up ERISA cases for decision on the administrative record," and proceeded to review the administrative record "taking into account the arguments presented by the parties in their briefs.

H. Remand as Judicial Remedy

1. Basis for Remand

First Circuit

Doe v. Standard Insurance Company, 852 F.3d 118 (1st Cir. 2017). Doe was an equity partner at a Maine law firm for more than 25 years before she became a non-equity partner in August 2011 and remained in that position for the next six months before she stopped working altogether. At the end of 2011, Doe was diagnosed with Major Depressive Disorder, including suicidal ideation and diminished attention, concentration, and memory. Her last day of logging work at the firm was January 27, 2012. Doe worked as an environmental lawyer, but when considering her claim for long term disability benefits, Standard evaluated her vocation as a "generic" lawyer. Because it did so, Standard determined that after November 2011, Doe was not working in her own legal specialty but she was performing the work of a lawyer on a reasonably continuous basis. Standard denied Doe's benefit claim and appeal. The district court ruled in Standard's favor. However, the First Circuit Court of Appeals reversed, finding that Standard acted arbitrarily and capriciously in relying on the DOT description of a generic lawyer rather than a job description that accurately encompassed the material duties of Doe's specialized

area of practice. Further, there was no evidence in the record supporting the assumption that an "environmental lawyer" and "lawyer" are equivalent terms that may be used interchangeably. The court found that the appropriate remedy is an award of benefits rather than a remand to Standard.

Second Circuit

*Franzese v. United Health Care/*Oxford, 232 F.Supp.3d 267 (E.D.N.Y. Jan. 5, 2017). Plaintiffs brought suit against a health plan administrator, claiming that administrator improperly refused payment for private duty nursing services, which it claimed were not covered under the plan. Plaintiffs asked that the court find that private duty nursing services sought were covered under the health plan, or that, in the alternative, they should be entitled to compensation as "home health care services" that defendants admitted were covered under the plan. The court found that while private duty nursing services were not covered, the administrator's decision to deny payment for home health care services was not supported by evidence in the record, where no evidence indicated that the administrator actually considered the possibility that that provision of the plan could apply. The court remanded for the administrator to give due consideration to the medical evidence.

Schuman v. Aetna Life Ins. Co., No. 3:15-CV-1006 (SRU), 2017 WL 1053853 (D. Conn. Mar. 20, 2017). Aetna's various violations of the ERISA regulations are sufficient to trigger *de novo* review. The court found that to make a proper determination it would be required to consider significant evidence outside of the record and determined that the appropriate remedy is a remand to Aetna.

Third Circuit

Hansen v. International Painters and Allied Trades Industry Pension Plan, 16-5028, 2017 WL 4359217 (E.D. Pa. Oct. 11, 2017). Plaintiff sued to recover disability pension benefits that he claimed were wrongfully denied by a multi-employer pension plan and its administrator. The parties disagreed over whether defendants failed to credit plaintiff with "hours of service in covered employment" arising from workers' compensation, unemployment compensation, and vacation time. Defendants contended that such hours were not "in covered employment," which, under the terms of the plan, were defined as hours for which an employer is obligated to make contributions to the plan. The court noted that this argument "begs the . . . question [of] who or what determines whether contributions are paid or payable to the [pension plan] for workers' compensation, unemployment compensation, and vacation time?" Noting that the administrative record suggested that such contributions "are made by employers in accordance with collective bargaining agreements," the court observed that "the CBA between the union and the employer would answer the question of whether the hours sought were included in "Covered employment." However, such CBA was not part of the administrative record. Conceding that it could not consider evidence outside of the administrative record, the court nevertheless found the benefits decision to be arbitrary and capricious, noting that the administrator "cannot simply state

there is no evidence . . . that the employers were obligated to make contributions for the additional hours that Plaintiff seeks, when the answer to that inquiry is found in the CBA[.]" The court remanded for consideration of the CBA.

Rachel B v. Horizon Blue Cross Blue Shield of New Jersey, No. 14-CV-1153, 2017 WL 3670966 (D.N.J. Aug. 25, 2017). For partial hospitalization treatment that Plaintiff received between May 3 to May 12, 2013, the court agreed with Plaintiff that Permedion acted arbitrarily and capriciously by failing to account for her doctor's letter, which repeatedly undermines Permedion's findings. The court remanded this claim for further administrative review.

Arsdel v. Liberty Life Assurance Co. of Boston, No. CV 14-2579, 2017 WL 1177174 (E.D. Pa. Mar. 30, 2017). The court concluded that Liberty Life abused its discretion in denying long-term disability benefits in this case. Under *Miller v. American Airlines, Inc.*, 632 F. 3d 837, 856-57 (3d Cir. 2011), the appropriate remedy in a case such as this one where benefits were improperly denied at the outset, is to remand the case to the plan administrator to reevaluate whether the plaintiff is entitled to LTD benefits under the plan.

C.E. v. Excellus Blue Cross Blue Shield, No. CV146950FLWDEA, 2017 WL 593492 (D.N.J. Feb. 14, 2017). The Court found that Excellus' failure to adequately explain the grounds for denying the administrative appeals in this matter violated 29 U.S.C. § 1133 and its accompanying regulations, 29 C.F.R. § 2560.503-1(j). The court further found that the appropriate remedy "is to remand to the plan administrator so the claimant gets the benefit of a full and fair review."

Fourth Circuit

Love v. Eaton Corporation Disability Plan For U.S. Employees, No. 5:16-CV-860-FL, 2017 WL 6373979 (E.D.N.C. Dec. 12, 2017). The court granted summary judgment to Plaintiff and held that the long-term disability plan does not require a claimant to apply for and receive six months of short-term disability benefits before applying for long-term disability benefits. The court remanded the case for Defendant to consider Plaintiff's application for LTD benefits.

Coleman v. Metropolitan Life Insurance Company, No. 5:15-CV-654-D, 2017 WL 2781523 (E.D.N.C. June 26, 2017). The court found that MetLife was arbitrary and capricious in denying accidental death benefits to Plaintiff where the insured died following a fall but MetLife found that the insured's cancer substantially contributed to his death. The court found that the record contains no indication that the insured's cancer contributed to his death in any quantifiable or substantial way. "The record reveals at most that Mr. Coleman's cancer or overall frailty resulted in a predisposition or susceptibility to suffering an adverse outcome from a fall; any causal relationship is a 'mere relationship of undetermined degree.'" The court awarded the benefits rather than a remand to MetLife.

Timothy & Sharon Wiwel; v. IBM Medical And Dental Benefit Plans For Regular Full-Time And Part-Time Employees, No. 5:15-CV-504-FL, 2017 WL 1184066 (E.D.N.C. Mar. 29, 2017). It was an abuse of discretion for the self-funded health plan to deny payment for Plaintiffs' child's residential treatment for self-cutting and suicidal ideation. But, the court rejects the recommendation of the M&R to reverse for an award of benefits and finds the proper remedy is remand for the limited purpose of allowing defendant an opportunity to clarify or reconsider its decision to deny Plaintiffs' application for benefits.

Shepherd v. Cmty. First Bank, No. CV 8:15-04337-MGL, 2017 WL 735582 (D.S.C. Feb. 24, 2017). In this matter seeking retirement benefits under a SERP plan, the court followed *Gagliano v. Reliance Standard Life Insurance Co.*, 547 F.3d 230 (4th Cir. 2008) and held that the proper remedy for Defendants' failure to timely respond to Plaintiff's claim is to remand to Defendants for a full and complete review of the claim under the Plan's internal review procedures. The court found that the futility exception does not apply.

Fifth Circuit

Encompass Office Solutions, Inc. v. Connecticut General Life Insurance Co., 3:11-cv-2487-L, 2017 WL 3268034 (N.D. Tex. July 31, 2017). Plaintiff was a surgical suite vendor (which had obtained assignment of plan benefits from plan participants) that brought suit against defendant health care service companies for denying claims for surgery services. As to benefit claims, the parties cross-moved for summary judgment. The court found that the claim denials and subsequent reviews of those denials did not comply with ERISA's procedural notice requirements, and remanded the claims to the plan administrator for a full and fair review which may include "additional investigation and supplementation of the administrative record by the parties."

Dialysis Newco Inc. v. Community Health Systems Trust Health Plan, 5:15-cv-272, 2017 WL 2591806 (S.D. Tex. June 14, 2017). Plaintiff sought reimbursement for dialysis treatments that were denied. The court found that defendant had abused its discretion by incorrectly interpreting the plan at issue, and further noted that as a result of defendant's reading, the administrative record had not been sufficiently developed. The court remanded for consideration of the evidence outside of the administrative record that the plaintiff submitted during the litigation, noting that the court could not consider it because to do so in the first instance "would stand ERISA on its head."

Jackson v. NFL Disability & Neurocognitive Benefit Plan, et al., No. CV H-16-1278, 2017 WL 2573404 (S.D. Tex. June 14, 2017). The court granted Defendants' motion for judgment on Plaintiff's claim for Line of Duty benefits for injuries he suffered during his football career. The court denied Plaintiff's motion to supplement the administrative record since Plaintiff's proposed supplements to the administrative record do not contain any information that the Disability Board used in making its final adverse determination nor do any of the proposed supplements assist the court's review of the Disability Board's decision. The

court found that the Disability Board did not abuse its discretion by denying Plaintiff's disability benefits for not meeting the required 25% WPI threshold or by relying on a combined WPI rating without an additive or excessive pain. The court denied Plaintiff's motion for a remand to the plan administrator and granted Defendants leave to file a motion for attorneys' fees.

Senegal v. Reliance Standard Life Ins. Co., No. CV 16-1961, 2017 WL 175768 (E.D. La. Jan. 17, 2017). The court granted Plaintiff's request to include an FCE report as part of the administrative record since Plaintiff presented the FCE to Reliance requesting a reconsideration of the denial, and gave Reliance a reasonable amount of time to consider it before he filed suit. Under *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287 (5th Cir. 1999), the FCE is deemed part of the administrative record. The court denied Plaintiff's request to strike from the record a medical review done after Plaintiff submitted his LTD appeal. The court remanded the matter to Reliance Standard to consider the FCE, Plaintiff's rebuttal to a ground for termination of benefits it raised in the final denial letter, the SSA's and VA's favorable determinations, and Plaintiff's claim for an underpayment of benefits that he did not exhaust.

Sixth Circuit

Carlson v. Reliance Standard Life Insurance Company, No. 3:15-CV-0200, 2017 WL 4767660 (M.D. Tenn. Oct. 20, 2017). Reliance Standard did not conduct a full and fair review of Plaintiff's claim regarding the death of Decedent without considering the supplemental information submitted by Plaintiff. Specifically, Reliance Standard failed to follow procedural requirements as set forth in 29 C.F.R. § 2560.503-1(i) and arbitrarily applied deadline and tolling rules, it arbitrarily decided which information to review, and it could not have provided a reasoned explanation for its denial that did not address the supplemental information. The court remanded the claim to the administrator to consider the supplemental evidence. The court declined to decide whether Reliance Standard has a duty to investigate or whether the presumption against suicide applies in this case.

Coontz v. Metropolitan Life Insurance Company, No. 1:17-CV-00015-GNS, 2017 WL 4227656 (W.D. Ky. Sept. 22, 2017). Where Plaintiff filed her lawsuit for denied AD&D benefits when MetLife did not make a decision within 120 days of its receipt of her appeal, the court held that Plaintiff did exhaust administrative remedies since MetLife's extension letter to Plaintiff did not operate to toll its time to decide the appeal under the Plan or 29 C.F.R. § 2560.503-1(i)(4). The extension letter simply stated that additional time was needed to process her appeal because it was necessary for MetLife to obtain additional information, but it does not state that the need for additional information was caused by Plaintiff's failure to provide the information, nor does the letter explicitly request any information from Plaintiff. Since MetLife is not excused from making a timely decision, the court denied MetLife's request for remand.

Hanson v. American Electric Service Corporation, et al., No. 2:16-CV-755, 2017 WL 4011201 (S.D. Ohio Sept. 12, 2017). In this long-term disability matter, the court determined that Prudential's review of Plaintiff's medical records was arbitrary and capricious because it

emphasized the opinions of its reviewing professionals and failed to acknowledge or distinguish the opinions of Plaintiff's treating medical professionals. Prudential's reviewers acknowledge many of Plaintiff's conditions and limitations but conclusorily assert that she can work. Prudential's failure to conduct a physical examination of Plaintiff raises questions about the accuracy of the review process. Failure to give any deference to the findings of the SSA is concerning but does not require a finding of abuse of discretion; it is just one factor, along with others, that weigh in finding Prudential's decision was arbitrary and capricious. The court found that the proper remedy is a remand to Prudential to reassess Plaintiff's long-term disability claim. Court grants in part Plaintiff's motion for judgment on the administrative record.

Brunelle v. Mid-Am. Assocs., Inc., & Liberty Union Life Assurance Co., No. 16-CV-13446, 2017 WL 3588055 (E.D. Mich. Aug. 21, 2017). The court found that Defendants failed to adequately consider and explain the conflicting evidence in the record, and as such, the adverse determinations are not the result of a deliberate principled reasoning process, and Defendants acted arbitrarily and capriciously in denying Plaintiff's claim for air ambulance services. Given the amount of evidence potentially favorable to Plaintiff, Defendants' decision is not supported by substantial evidence. Case remanded to administrator for further consideration.

Aviation West Charters, LLC v. United Healthcare Insurance Company, et al., No. 1: 16 CV 210, 2017 WL 2838474 (N.D. Ohio June 30, 2017). In this dispute between a provider and insurance company of the payment of air ambulance services, the court found that United failed to comply with the time limits for appeals and wrongly failed to consider Angel MedFlight's second appeal materials. Under the terms of the Plan a "second level appeal request must be submitted within 180 days from receipt of the first level appeal decision." The time for appeal is measured from the day Angel MedFlight *received* the first level appeal decision. Although the record does not show when Angel MedFlight received the decision, since it was sent by first class mail, it was probably received by Angel MedFlight within the usual delivery time of up to 3 business days. 180 days from the assumed receipt date means that the submission of the second level appeal was timely. Case remanded to Defendant to consider the second appeal.

Rowe v. United of Omaha Life Ins., No. 3:15-CV-256-TAV-CCS, 2017 WL 1047332 (E.D. Tenn. Mar. 17, 2017). The Magistrate Judge granted in part Plaintiff's motion for judgment on the administrative record, to which United of Omaha objected. The court agrees with the Magistrate Judge's determination that Defendant's failure to articulate whether and to what extent nurse practitioner opinions were credited, and to what extent the opined limitations impact the determination of whether Plaintiff is disabled under the plan, is indicative of Defendant's decision failing to result from a "deliberate, principled reasoning process." Plaintiff's alleged failure to apply for Social Security benefits is not relevant to whether Defendant's denial decision was arbitrary and capricious. On remand, Plaintiff may submit any argument to Defendant as to why she is disabled but cannot reopen and supplement the administrative record because Plaintiff had the opportunity to submit additional documentation with her administrative appeal.

Carlson v. Reliance Standard Life Insurance Co., 3:15-cv-200, 2017 WL 4767660 (M.D. Tenn. Oct. 20, 2017). Plaintiff, a widow, brought claims for life insurance benefits under a policy that covered her deceased husband. The court found that the defendant had violated the Department of Labor's procedural regulations during the administrative process, and as a result, plaintiff had been unable to introduce an amended report of the medical examiner regarding the cause of her husband's death. As a result, the court remanded to the plan administrator to consider the additional information.

Seventh Circuit

Suson v. The PNC Financial Services Group, Inc. And Affiliates Long Term Disability Plan & The PNC Financial Services Group, Inc., No. 15-CV-10817, 2017 WL 3234809 (N.D. Ill. July 31, 2017). The case involves a denial of long term disability benefits by a self-funded disability plan administered by Liberty Life Assurance Company of Boston. The court agreed with Suson in part and held that Liberty Life abused its discretion by "moving the target" when it used an occupational analysis to deny Suson's appeal without giving her the opportunity to respond and by failing to consider the effects of Suson's carpel tunnel syndrome. The court determined that the claim must be remanded for further findings or explanations. On remand, Liberty Life must address the effect of Plaintiff's carpal tunnel syndrome on computer use as a relevant factor for her ability to perform the material or essential duties of her occupation. Plaintiff must also have the ability to respond to Liberty's occupational analysis.

Miller v. The Hartford Life And Accident Insurance Co., & Springleaf Finance, Inc. Disability Plan, No. 116CV00166TWPDML, 2017 WL 2214938 (S.D. Ind. May 19, 2017). The court granted Defendants' motion for administrative remand and to stay proceedings in order for Hartford to consider the first two pages of a three-page Physician's Statement that were not considered by Hartford (or included in its claim file) due to a scanning error of its vendor, Xerox. The court noted that Plaintiff's objection to the remand on the basis that Hartford was negligent in failing to notice the missing pages is immaterial to the issue of whether Hartford failed to provide Plaintiff a full and fair review by not considering the two pages.

Eighth Circuit

McGillivray v. Wells Fargo & Co. Salary Continuation Pay Plan, No. 15-CV-4347 (SRN/LIB), 2017 WL 3037557 (D. Minn. July 18, 2017). In this case seeking Salary Continuation Plan benefits, the Plan failed to comply with the requirements of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1, and as such, the court found its denial of benefits was an abuse of discretion and must be reversed. The appropriate remedy for a violation of 29 U.S.C. § 1133 and the Claims Regulation is generally not an award of benefits by the court, but rather a remand to the plan administrator so that the claimant gets the benefit of a full and fair review. The court remanded the matter to the Plan for the limited purpose of allowing it to clarify or reconsider its decision to deny Plaintiff's claim for benefits. The court cautioned that should procedural

deficiencies noted in this order persist in a future action for administrative review, an award of benefits may be warranted.

Zaeske v. Liberty Life Assurance Co. of Boston, No. 5:15-CV-5305, 2017 WL 2438039 (W.D. Ark. June 5, 2017). Considering the five *Shelton* factors recognized by the Eighth Circuit, Liberty Life abused its discretion in terminating Plaintiff's long term disability benefits. Liberty Life's reviewing physicians either ignored objective medical data in the file, failed to appreciate that his condition had not improved over time, or did not consider whether Plaintiff could perform the duties of his occupation given his limitations. Liberty Life's doctors did not address how uncontrolled pain would affect Plaintiff's ability to walk, sit, lift heavy things, or travel. The court reversed the claim decision and remanded to Liberty Life for the correct calculation of past-due benefits.

Domingues v. Liberty Life Assurance Co. of Boston, No. 5:15-CV-5128, 2017 WL 1906916 (W.D. Ark. May 8, 2017). The court found that Liberty Life abused its discretion in denying the long term disability benefits because it did not tell Plaintiff that he needed to submit additional information—objective medical evidence of hepatic encephalopathy and/or chronic fatigue—to perfect his claim. It also upheld the denial based on a paper review of the record that it previously determined to be insufficient. The court remanded the claim back to Liberty Life for determination as to whether he is disabled from "any occupation."

Ninth Circuit

Popovich v. Metro. Life Ins. Co., No. CV1509791ABMRWX, __F.Supp.3d__, 2017 WL 6546920 (C.D. Cal. Dec. 21, 2017). On *de novo* review, the court determined that Plaintiff submitted reliable evidence that he suffers from a significant heart condition and that he is unable to work at a physically and mentally stressful occupation, including his own occupation as an assistant news editor. The court considered a doctor's letter outside of the "administrative record" but declined to admit a letter from SSA granting Plaintiff disability benefits. The court found that MetLife incorrectly denied Plaintiff LTD benefits under the "Usual Occupation" definition and ordered MetLife to pay those benefits. The court remanded the case back to MetLife to assess whether Plaintiff is disabled under the "Any Occupation" definition of disability.

Aviation West Charters, LLC d/b/a Angel Medflight v. Unitedhealthcare Insurance Company, No. CV 2:16-436 WBS AC, 2017 WL 5526569 (E.D. Cal. Nov. 16, 2017). This is a lawsuit by a health plan participant against her insurance company for not paying for air ambulance services for her minor child. The court determined that Plaintiff's declaration, which was not submitted to the administrator before it made a final determination, is inadmissible. Because the administrator did not conduct a reasonable investigation of the claim, the court remanded the matter to United for reconsideration.

O'Gorman v. Hartford Life & Accident Ins. Co., No. 2:16-CV-01048-RAJ, 2017 WL 3424962 (W.D. Wash. Aug. 9, 2017). In this long term disability case, Hartford argued that Plaintiff has failed to exhaust her administrative remedies by filing an appeal subsequent to receiving Hartford's September 9, 2016 letter. The court agreed with Plaintiff that she was not required to do so. Here, the Plan provides only that a participant "may appeal to [Hartford] for a full and fair review," but it does not require that a participant do so. The court determined that it cannot decide the question of disability on the current record so remanded the claim to Hartford to perform a thorough employability analysis.

Roberts v. Anthem Life Ins. Co., No. CV1600571BROGJSX, 2017 WL 2469354 (C.D. Cal. June 7, 2017). The court granted Plaintiff's motion to remand to Anthem on the basis that Plaintiff did not have a meaningful opportunity to offer neurocognitive testing results prior to Anthem's final denial of Plaintiff's appeal. The court explained that the factual deficiencies in the underlying record may impede the court's evaluation of the dispute and this weighs in favor of remand for further development of factual, objective evidence regarding Plaintiff's medical condition.

Gallegos v. Prudential Ins. Co. of Am., No. 16-CV-01268-BLF, 2017 WL 2418008 (N.D. Cal. June 5, 2017). On *de novo* review of a long term disability denial for Plaintiff disabled by systemic lupus erythematosus, the court granted Plaintiff's motion for judgment in part and denied Prudential's motion. The court found that Prudential's prior finding of disability for five months weighs in favor of finding disability. It also found that Plaintiff's treating doctors and the functional capacity evaluations support that she was "more likely than not" disabled under the terms of the ERISA plan. Prudential's doctors failed to take into account the side effects of Plaintiff's medication and stress of her job, which contribute to her disability. The court also explained that the sporadic nature of lupus flares precludes consistent work capacity. Additionally, the SSA found Plaintiff disabled. The court remanded the claim to Prudential to make a determination about "any occupation" disability.

Carey v. United of Omaha Life Insurance Co., SACV 13-740-CJC(AJWx), 2017 WL 1045077 (C.D. Cal. Jan. 31, 2017). Plaintiff sued to recover long term disability benefits. On motions for summary judgment, the court admitted into evidence plaintiff's declaration regarding his efforts to find employment and the Social Security Administration's determination that he was disabled. Finding that both pieces of evidence went to issues relevant to the denial, and the record lacked medical evidence and evidence regarding his efforts to find employment, the court held that they would be admitted. The court found that plaintiff was disabled from 2009 through 2011, and remanded the case to permit United to seek additional evidence as to whether he remained disabled thereafter.

Tenth Circuit

Brende v. Reliance Standard Life Insurance Company, No. 15-9711-JAR-TJJ, 2017 WL 4222982 (D. Kan. Sept. 22, 2017). Here, the record shows that Plaintiff suffers from an

undiagnosed condition characterized by numbness, dizziness, weakness, and fatigue. The court found that it was well within Reliance's discretion to require objective evidence that Plaintiff lacked the ability to engage in work as an attorney. But, Reliance's decision to deny long term disability benefits was unreasonable because it failed to consider Plaintiff's actual job duties in defining her regular occupation. The court remanded the claim to Reliance to provide a full and fair review. On the mental or nervous disorder limitation, the court construed the limitation as applying only if Plaintiff's mental or nervous disorder was a "but-for" cause of her disability. But since there are outstanding issues related to the claimed physical disability, the court cannot determine whether Reliance's application of the limitation was reasonable.

Lynn R. v. Valueoptions, et al., No. 215CV00362RJSPMW, 2017 WL 3610477 (D. Utah Aug. 22, 2017). The court granted Plaintiff's motion for summary judgment, finding that Defendants ValueOptions (VO), AT&T, and SBC Umbrella Benefit Plan No. 1 wrongfully denied her benefits claim for her daughter's stay at Equine Journeys, a residential mental health treatment center. VO cannot assert precertification as a basis for denial during litigation since it did not assert this reason as a denial pre-litigation. VO acted arbitrarily and capriciously in denying the claim on the basis that Equine Journeys was not nationally accredited through The Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Remand would be inappropriate; judgment awarded to Lynn R.

Anderson–Posey v. Unum Life Ins. Co. of Am., No. 16-CV-0086-CVE-FHM, 2017 WL 723898 (N.D. Okla. Feb. 23, 2017). In this long-term disability dispute subject to abuse of discretion review, the court determined that Defendant's decision that Plaintiff could return to her job as a pharmacist while on narcotics was arbitrary and capricious because it was unreasonable and not supported by substantial evidence. Additionally, substantial evidence did not support Unum's contention that Plaintiff has a disabling condition requiring the use of narcotic pain medication. The court remanded the claim to Unum for reconsideration.

Eleventh Circuit

Otero v. Unum Life Ins. Co. of Am., No. CV-7:14-BE-2253-W, 2017 WL 131568 (N.D. Ala. Jan. 13, 2017). The *de novo* standard of review applies in this case because Unum did not exercise the discretion granted it by the plan and Plaintiff's claim is "deemed exhausted." Unum accepted premium payments on behalf of Dr. Otero while knowing that he was working part-time and ineligible for coverage. The court determined that Unum has waived its right to assert the defense that Dr. Otero was not eligible for coverage after the termination of disability benefits in March of 2010 because Dr. Otero was not working the minimum number of hours per week. The court remanded the claim to Unum directing it to obtain the relevant documents to make the appropriate benefit calculations.

Campbell v. United of Omaha Life Insurance Co., 247 F.Supp.3d 1255 (N.D. Ala. Mar. 30, 2017). Campbell brought suit seeking short term and long term benefits. In an earlier ruling,

the court determined that the defendant improperly denied plaintiff's claims and ordered defendant to pay benefits through a certain date, when the court held that they properly terminated. Plaintiff moved for reconsideration, arguing that the court's prior ruling had "prejudiced" him because it limited his duration of benefits, and that had the court remanded instead, he would have been permitted to introduce new evidence that would have permitted a longer duration of benefits. The court agreed, remanding the case to the administrator for further proceedings, and noting that Campbell could present additional evidence as to the proper duration of benefits.

2. When Remand is Appropriate

First Circuit

Doe v. Standard Insurance Company, 852 F.3d 118 (1st Cir. 2017). Doe was an equity partner at a Maine law firm for more than 25 years before she became a non-equity partner in August 2011 and remained in that position for the next six months before she stopped working altogether. At the end of 2011, Doe was diagnosed with Major Depressive Disorder, including suicidal ideation and diminished attention, concentration, and memory. Her last day of logging work at the firm was January 27, 2012. Doe worked as an environmental lawyer, but when considering her claim for long term disability benefits, Standard evaluated her vocation as a "generic" lawyer. Because it did so, Standard determined that after November 2011, Doe was not working in her own legal specialty but she was performing the work of a lawyer on a reasonably continuous basis. Standard denied Doe's benefit claim and appeal. The district court ruled in Standard's favor. However, the First Circuit Court of Appeals reversed, finding that Standard acted arbitrarily and capriciously in relying on the DOT description of a generic lawyer rather than a job description that accurately encompassed the material duties of Doe's specialized area of practice. Further, there was no evidence in the record supporting the assumption that an "environmental lawyer" and "lawyer" are equivalent terms that may be used interchangeably. The court found that the appropriate remedy is an award of benefits rather than a remand to Standard.

Second Circuit

Schuman v. Aetna Life Ins. Co., No. 3:15-CV-1006 (SRU), 2017 WL 1053853 (D. Conn. Mar. 20, 2017). Aetna's various violations of the ERISA regulations are sufficient to trigger *de novo* review. The court found that to make a proper determination it would be required to consider significant evidence outside of the record and determined that the appropriate remedy is a remand to Aetna.

Third Circuit

Rachel B v. Horizon Blue Cross Blue Shield of New Jersey, No. 14-CV-1153, 2017 WL 3670966 (D.N.J. Aug. 25, 2017). For partial hospitalization treatment that Plaintiff received between May 3 to May 12, 2013, the court agreed with Plaintiff that Permedion acted arbitrarily and capriciously by failing to account for her doctor's letter, which repeatedly undermines Permedion's findings. The court remanded this claim for further administrative review.

Arsdel v. Liberty Life Assurance Co. of Boston, No. CV 14-2579, 2017 WL 1177174 (E.D. Pa. Mar. 30, 2017). The court concluded that Liberty Life abused its discretion in denying long-term disability benefits in this case. Under *Miller v. American Airlines, Inc.*, 632 F. 3d 837, 856-57 (3d Cir. 2011), the appropriate remedy in a case such as this one where benefits were improperly denied at the outset, is to remand the case to the plan administrator to reevaluate whether the plaintiff is entitled to LTD benefits under the plan.

C.E. v. Excellus Blue Cross Blue Shield, No. CV146950FLWDEA, 2017 WL 593492 (D.N.J. Feb. 14, 2017). The Court found that Excellus' failure to adequately explain the grounds for denying the administrative appeals in this matter violated 29 U.S.C. § 1133 and its accompanying regulations, 29 C.F.R. § 2560.503-1(j). The court further found that the appropriate remedy "is to remand to the plan administrator so the claimant gets the benefit of a full and fair review."

Fourth Circuit

Love v. Eaton Corporation Disability Plan For U.S. Employees, No. 5:16-CV-860-FL, 2017 WL 6373979 (E.D.N.C. Dec. 12, 2017). The court granted summary judgment to Plaintiff and held that the long-term disability plan does not require a claimant to apply for and receive six months of short-term disability benefits before applying for long-term disability benefits. The court remanded the case for Defendant to consider Plaintiff's application for LTD benefits.

Coleman v. Metropolitan Life Insurance Company, No. 5:15-CV-654-D, 2017 WL 2781523 (E.D.N.C. June 26, 2017). The court found that MetLife was arbitrary and capricious in denying accidental death benefits to Plaintiff where the insured died following a fall but MetLife found that the insured's cancer substantially contributed to his death. The court found that the record contains no indication that the insured's cancer contributed to his death in any quantifiable or substantial way. "The record reveals at most that Mr. Coleman's cancer or overall frailty resulted in a predisposition or susceptibility to suffering an adverse outcome from a fall; any causal relationship is a 'mere relationship of undetermined degree.'" The court awarded the benefits rather than a remand to MetLife.

Timothy & Sharon Wiwel; v. IBM Medical And Dental Benefit Plans For Regular Full-Time And Part-Time Employees, No. 5:15-CV-504-FL, 2017 WL 1184066 (E.D.N.C. Mar. 29, 2017). It was an abuse of discretion for the self-funded health plan to deny payment for Plaintiffs' child's residential treatment for self-cutting and suicidal ideation. But, the court rejects the recommendation of the M&R to reverse for an award of benefits and finds the proper

remedy is remand for the limited purpose of allowing defendant an opportunity to clarify or reconsider its decision to deny Plaintiffs' application for benefits.

Shepherd v. Cmty. First Bank, No. CV 8:15-04337-MGL, 2017 WL 735582 (D.S.C. Feb. 24, 2017). In this matter seeking retirement benefits under a SERP plan, the court followed *Gagliano v. Reliance Standard Life Insurance Co.*, 547 F.3d 230 (4th Cir. 2008) and held that the proper remedy for Defendants' failure to timely respond to Plaintiff's claim is to remand to Defendants for a full and complete review of the claim under the Plan's internal review procedures. The court found that the futility exception does not apply.

Fifth Circuit

Jackson v. NFL Disability & Neurocognitive Benefit Plan, et al., No. CV H-16-1278, 2017 WL 2573404 (S.D. Tex. June 14, 2017). The court granted Defendants' motion for judgment on Plaintiff's claim for Line of Duty benefits for injuries he suffered during his football career. The court denied Plaintiff's motion to supplement the administrative record since Plaintiff's proposed supplements to the administrative record do not contain any information that the Disability Board used in making its final adverse determination nor do any of the proposed supplements assist the court's review of the Disability Board's decision. The court found that the Disability Board did not abuse its discretion by denying Plaintiff's disability benefits for not meeting the required 25% WPI threshold or by relying on a combined WPI rating without an additive or excessive pain. The court denied Plaintiff's motion for a remand to the plan administrator and granted Defendants leave to file a motion for attorneys' fees.

Senegal v. Reliance Standard Life Ins. Co., No. CV 16-1961, 2017 WL 175768 (E.D. La. Jan. 17, 2017). The court granted Plaintiff's request to include an FCE report as part of the administrative record since Plaintiff presented the FCE to Reliance requesting a reconsideration of the denial, and gave Reliance a reasonable amount of time to consider it before he filed suit. Under *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287 (5th Cir. 1999), the FCE is deemed part of the administrative record. The court denied Plaintiff's request to strike from the record a medical review done after Plaintiff submitted his LTD appeal. The court remanded the matter to Reliance Standard to consider the FCE, Plaintiff's rebuttal to a ground for termination of benefits it raised in the final denial letter, the SSA's and VA's favorable determinations, and Plaintiff's claim for an underpayment of benefits that he did not exhaust.

Sixth Circuit

Carlson v. Reliance Standard Life Insurance Company, No. 3:15-CV-0200, 2017 WL 4767660 (M.D. Tenn. Oct. 20, 2017). Reliance Standard did not conduct a full and fair review of Plaintiff's claim regarding the death of Decedent without considering the supplemental information submitted by Plaintiff. Specifically, Reliance Standard failed to follow procedural requirements as set forth in 29 C.F.R. § 2560.503-1(i) and arbitrarily applied deadline and tolling rules, it arbitrarily decided which information to review, and it could not have provided a

reasoned explanation for its denial that did not address the supplemental information. The court remanded the claim to the administrator to consider the supplemental evidence. The court declined to decide whether Reliance Standard has a duty to investigate or whether the presumption against suicide applies in this case.

Coontz v. Metropolitan Life Insurance Company, No. 1:17-CV-00015-GNS, 2017 WL 4227656 (W.D. Ky. Sept. 22, 2017). Where Plaintiff filed her lawsuit for denied AD&D benefits when MetLife did not make a decision within 120 days of its receipt of her appeal, the court held that Plaintiff did exhaust administrative remedies since MetLife's extension letter to Plaintiff did not operate to toll its time to decide the appeal under the Plan or 29 C.F.R. § 2560.503-1(i)(4). The extension letter simply stated that additional time was needed to process her appeal because it was necessary for MetLife to obtain additional information, but it does not state that the need for additional information was caused by Plaintiff's failure to provide the information, nor does the letter explicitly request any information from Plaintiff. Since MetLife is not excused from making a timely decision, the court denied MetLife's request for remand.

Hanson v. American Electric Service Corporation, et al., No. 2:16-CV-755, 2017 WL 4011201 (S.D. Ohio Sept. 12, 2017). In this long-term disability matter, the court determined that Prudential's review of Plaintiff's medical records was arbitrary and capricious because it emphasized the opinions of its reviewing professionals and failed to acknowledge or distinguish the opinions of Plaintiff's treating medical professionals. Prudential's reviewers acknowledge many of Plaintiff's conditions and limitations but conclusorily assert that she can work. Prudential's failure to conduct a physical examination of Plaintiff raises questions about the accuracy of the review process. Failure to give any deference to the findings of the SSA is concerning but does not require a finding of abuse of discretion; it is just one factor, along with others, that weigh in finding Prudential's decision was arbitrary and capricious. The court found that the proper remedy is a remand to Prudential to reassess Plaintiff's long-term disability claim. Court grants in part Plaintiff's motion for judgment on the administrative record.

Brunelle v. Mid-Am. Assocs., Inc., & Liberty Union Life Assurance Co., No. 16-CV-13446, 2017 WL 3588055 (E.D. Mich. Aug. 21, 2017). The court found that Defendants failed to adequately consider and explain the conflicting evidence in the record, and as such, the adverse determinations are not the result of a deliberate principled reasoning process, and Defendants acted arbitrarily and capriciously in denying Plaintiff's claim for air ambulance services. Given the amount of evidence potentially favorable to Plaintiff, Defendants' decision is not supported by substantial evidence. Case remanded to administrator for further consideration.

Aviation West Charters, LLC v. United Healthcare Insurance Company, et al., No. 1: 16 CV 210, 2017 WL 2838474 (N.D. Ohio June 30, 2017). In this dispute between a provider and insurance company of the payment of air ambulance services, the court found that United failed to comply with the time limits for appeals and wrongly failed to consider Angel MedFlight's second appeal materials. Under the terms of the Plan a "second level appeal request must be

submitted within 180 days from receipt of the first level appeal decision." The time for appeal is measured from the day Angel MedFlight *received* the first level appeal decision. Although the record does not show when Angel MedFlight received the decision, since it was sent by first class mail, it was probably received by Angel MedFlight within the usual delivery time of up to 3 business days. 180 days from the assumed receipt date means that the submission of the second level appeal was timely. Case remanded to Defendant to consider the second appeal.

Rowe v. United of Omaha Life Ins., No. 3:15-CV-256-TAV-CCS, 2017 WL 1047332 (E.D. Tenn. Mar. 17, 2017). The Magistrate Judge granted in part Plaintiff's motion for judgment on the administrative record, to which United of Omaha objected. The court agrees with the Magistrate Judge's determination that Defendant's failure to articulate whether and to what extent nurse practitioner opinions were credited, and to what extent the opined limitations impact the determination of whether Plaintiff is disabled under the plan, is indicative of Defendant's decision failing to result from a "deliberate, principled reasoning process." Plaintiff's alleged failure to apply for Social Security benefits is not relevant to whether Defendant's denial decision was arbitrary and capricious. On remand, Plaintiff may submit any argument to Defendant as to why she is disabled but cannot reopen and supplement the administrative record because Plaintiff had the opportunity to submit additional documentation with her administrative appeal.

Seventh Circuit

Suson v. The PNC Financial Services Group, Inc. And Affiliates Long Term Disability Plan & The PNC Financial Services Group, Inc., No. 15-CV-10817, 2017 WL 3234809 (N.D. Ill. July 31, 2017). The case involves a denial of long term disability benefits by a self-funded disability plan administered by Liberty Life Assurance Company of Boston. The court agreed with Suson in part and held that Liberty Life abused its discretion by "moving the target" when it used an occupational analysis to deny Suson's appeal without giving her the opportunity to respond and by failing to consider the effects of Suson's carpel tunnel syndrome. The court determined that the claim must be remanded for further findings or explanations. On remand, Liberty Life must address the effect of Plaintiff's carpal tunnel syndrome on computer use as a relevant factor for her ability to perform the material or essential duties of her occupation. Plaintiff must also have the ability to respond to Liberty's occupational analysis.

Miller v. The Hartford Life And Accident Insurance Co., & Springleaf Finance, Inc. Disability Plan, No. 116CV00166TWPDML, 2017 WL 2214938 (S.D. Ind. May 19, 2017). The court granted Defendants' motion for administrative remand and to stay proceedings in order for Hartford to consider the first two pages of a three-page Physician's Statement that were not considered by Hartford (or included in its claim file) due to a scanning error of its vendor, Xerox. The court noted that Plaintiff's objection to the remand on the basis that Hartford was negligent in failing to notice the missing pages is immaterial to the issue of whether Hartford failed to provide Plaintiff a full and fair review by not considering the two pages.

Eighth Circuit

McGillivray v. Wells Fargo & Co. Salary Continuation Pay Plan, No. 15-CV-4347 (SRN/LIB), 2017 WL 3037557 (D. Minn. July 18, 2017). In this case seeking Salary Continuation Plan benefits, the Plan failed to comply with the requirements of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1, and as such, the court found its denial of benefits was an abuse of discretion and must be reversed. The appropriate remedy for a violation of 29 U.S.C. § 1133 and the Claims Regulation is generally not an award of benefits by the court, but rather a remand to the plan administrator so that the claimant gets the benefit of a full and fair review. The court remanded the matter to the Plan for the limited purpose of allowing it to clarify or reconsider its decision to deny Plaintiff's claim for benefits. The court cautioned that should procedural deficiencies noted in this order persist in a future action for administrative review, an award of benefits may be warranted.

Zaeske v. Liberty Life Assurance Co. of Boston, No. 5:15-CV-5305, 2017 WL 2438039 (W.D. Ark. June 5, 2017). Considering the five *Shelton* factors recognized by the Eighth Circuit, Liberty Life abused its discretion in terminating Plaintiff's long term disability benefits. Liberty Life's reviewing physicians either ignored objective medical data in the file, failed to appreciate that his condition had not improved over time, or did not consider whether Plaintiff could perform the duties of his occupation given his limitations. Liberty Life's doctors did not address how uncontrolled pain would affect Plaintiff's ability to walk, sit, lift heavy things, or travel. The court reversed the claim decision and remanded to Liberty Life for the correct calculation of past-due benefits.

Domingues v. Liberty Life Assurance Co. of Boston, No. 5:15-CV-5128, 2017 WL 1906916 (W.D. Ark. May 8, 2017). The court found that Liberty Life abused its discretion in denying the long term disability benefits because it did not tell Plaintiff that he needed to submit additional information—objective medical evidence of hepatic encephalopathy and/or chronic fatigue—to perfect his claim. It also upheld the denial based on a paper review of the record that it previously determined to be insufficient. The court remanded the claim back to Liberty Life for determination as to whether he is disabled from "any occupation."

Ninth Circuit

Popovich v. Metro. Life Ins. Co., No. CV1509791ABMRWX, __F.Supp.3d__, 2017 WL 6546920 (C.D. Cal. Dec. 21, 2017). On *de novo* review, the court determined that Plaintiff submitted reliable evidence that he suffers from a significant heart condition and that he is unable to work at a physically and mentally stressful occupation, including his own occupation as an assistant news editor. The court considered a doctor's letter outside of the "administrative record" but declined to admit a letter from SSA granting Plaintiff disability benefits. The court found that MetLife incorrectly denied Plaintiff LTD benefits under the "Usual Occupation" definition and ordered MetLife to pay those benefits. The court remanded the case back to

MetLife to assess whether Plaintiff is disabled under the "Any Occupation" definition of disability.

Aviation West Charters, LLC d/b/a Angel Medflight v. Unitedhealthcare Insurance Company, No. CV 2:16-436 WBS AC, 2017 WL 5526569 (E.D. Cal. Nov. 16, 2017). This is a lawsuit by a health plan participant against her insurance company for not paying for air ambulance services for her minor child. The court determined that Plaintiff's declaration, which was not submitted to the administrator before it made a final determination, is inadmissible. Because the administrator did not conduct a reasonable investigation of the claim, the court remanded the matter to United for reconsideration.

O'Gorman v. Hartford Life & Accident Ins. Co., No. 2:16-CV-01048-RAJ, 2017 WL 3424962 (W.D. Wash. Aug. 9, 2017). In this long term disability case, Hartford argued that Plaintiff has failed to exhaust her administrative remedies by filing an appeal subsequent to receiving Hartford's September 9, 2016 letter. The court agreed with Plaintiff that she was not required to do so. Here, the Plan provides only that a participant "may appeal to [Hartford] for a full and fair review," but it does not require that a participant do so. The court determined that it cannot decide the question of disability on the current record so remanded the claim to Hartford to perform a thorough employability analysis.

Roberts v. Anthem Life Ins. Co., No. CV1600571BROGJSX, 2017 WL 2469354 (C.D. Cal. June 7, 2017). The court granted Plaintiff's motion to remand to Anthem on the basis that Plaintiff did not have a meaningful opportunity to offer neurocognitive testing results prior to Anthem's final denial of Plaintiff's appeal. The court explained that the factual deficiencies in the underlying record may impede the court's evaluation of the dispute and this weighs in favor of remand for further development of factual, objective evidence regarding Plaintiff's medical condition.

Gallegos v. Prudential Ins. Co. of Am., No. 16-CV-01268-BLF, 2017 WL 2418008 (N.D. Cal. June 5, 2017). On *de novo* review of a long term disability denial for Plaintiff disabled by systemic lupus erythematosus, the court granted Plaintiff's motion for judgment in part and denied Prudential's motion. The court found that Prudential's prior finding of disability for five months weighs in favor of finding disability. It also found that Plaintiff's treating doctors and the functional capacity evaluations support that she was "more likely than not" disabled under the terms of the ERISA plan. Prudential's doctors failed to take into account the side effects of Plaintiff's medication and stress of her job, which contribute to her disability. The court also explained that the sporadic nature of lupus flares precludes consistent work capacity. Additionally, the SSA found Plaintiff disabled. The court remanded the claim to Prudential to make a determination about "any occupation" disability.

Tenth Circuit

Brende v. Reliance Standard Life Insurance Company, No. 15-9711-JAR-TJJ, 2017 WL 4222982 (D. Kan. Sept. 22, 2017). Here, the record shows that Plaintiff suffers from an undiagnosed condition characterized by numbness, dizziness, weakness, and fatigue. The court found that it was well within Reliance's discretion to require objective evidence that Plaintiff lacked the ability to engage in work as an attorney. But, Reliance's decision to deny long term disability benefits was unreasonable because it failed to consider Plaintiff's actual job duties in defining her regular occupation. The court remanded the claim to Reliance to provide a full and fair review. On the mental or nervous disorder limitation, the court construed the limitation as applying only if Plaintiff's mental or nervous disorder was a "but-for" cause of her disability. But since there are outstanding issues related to the claimed physical disability, the court cannot determine whether Reliance's application of the limitation was reasonable.

Lynn R. v. Valueoptions, et al., No. 215CV00362RJSPMW, 2017 WL 3610477 (D. Utah Aug. 22, 2017). The court granted Plaintiff's motion for summary judgment, finding that Defendants ValueOptions (VO), AT&T, and SBC Umbrella Benefit Plan No. 1 wrongfully denied her benefits claim for her daughter's stay at Equine Journeys, a residential mental health treatment center. VO cannot assert precertification as a basis for denial during litigation since it did not assert this reason as a denial pre-litigation. VO acted arbitrarily and capriciously in denying the claim on the basis that Equine Journeys was not nationally accredited through The Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Remand would be inappropriate; judgment awarded to Lynn R.

Anderson–Posey v. Unum Life Ins. Co. of Am., No. 16-CV-0086-CVE-FHM, 2017 WL 723898 (N.D. Okla. Feb. 23, 2017). In this long-term disability dispute subject to abuse of discretion review, the court determined that Defendant's decision that Plaintiff could return to her job as a pharmacist while on narcotics was arbitrary and capricious because it was unreasonable and not supported by substantial evidence. Additionally, substantial evidence did not support Unum's contention that Plaintiff has a disabling condition requiring the use of narcotic pain medication. The court remanded the claim to Unum for reconsideration.

Eleventh Circuit

Otero v. Unum Life Ins. Co. of Am., No. CV-7:14-BE-2253-W, 2017 WL 131568 (N.D. Ala. Jan. 13, 2017). The *de novo* standard of review applies in this case because Unum did not exercise the discretion granted it by the plan and Plaintiff's claim is "deemed exhausted." Unum accepted premium payments on behalf of Dr. Otero while knowing that he was working part-time and ineligible for coverage. The court determined that Unum has waived its right to assert the defense that Dr. Otero was not eligible for coverage after the termination of disability benefits in March of 2010 because Dr. Otero was not working the minimum number of hours per week. The court remanded the claim to Unum directing it to obtain the relevant documents to make the appropriate benefit calculations.