No.

In the
Supreme Court of the United States

BEATRIZ MARTINEZ-CLAIB, M.D.
Petitioner,
v.
BUSINESS MEN'S ASSURANCE COMPANY OF AMERICA,
METROPOLITAN LIFE INSURANCE COMPANY,
Respondents

Petition for a Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

ERISA and its enabling regulations require an administrator to clearly communicate "the specific reasons" to the claimant when it denies a benefits claim. Here the plan document required the same thing. The Eleventh Circuit, deciding an issue on which the various circuits are not only split but splintered, allowed the administrator to defend this benefits action based on a reason it never raised until after litigation had already commenced. The questions presented are:

1. Do ERISA's statutory and regulatory requirements limit the grounds on which an administrator may defend a benefits action to the reasons it timely communicated to the claimant?

2. Does a contractual provision imposing like requirements limit the grounds on which an administrator may defend a benefits action to the reasons it timely communicated to the claimant?

3. When a plan administrator, having knowledge of grounds for claim denial, fails to communicate them to a claimant when it denies a claim, do waiver principles preclude it from defending a benefits action based on those undisclosed grounds?

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STATEMENT OF JURISDICTION

Dr. Martinez-Claib timely moved for a panel rehearing under Fed.R.App.P. 40. The Eleventh Circuit denied the petition on February 26, 2013. Pet.App. 30a-31a. Dr. Martinez-Claib invokes this Court's jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

Title 29, United States Code, section 1133(1), provides in pertinent part:

> In accordance with regulations of the Secretary, every employee benefit plan shall 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….

Title 29, Code of Federal Regulations, section 2560.503-1(g), provides in pertinent part:

> [T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. … The notification shall set forth, in a manner calculated to be understood by the claimant —
>
> > (i) The specific reason or reasons for the adverse determination;
> >
> > (ii) Reference to the specific plan provisions on which the determination is based….

Title 29, Code of Federal Regulations, section 2560.503-1(j), provides in pertinent part:

> The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. ... In the case of an adverse benefit determination, the notification shall set forth, in a manner

calculated to be understood by the claimant —

> (1) The specific reason or reasons for the adverse determination;
>
> (2) Reference to the specific plan provisions on which the benefit determination is based....

INTRODUCTION

ERISA imposes emphatic requirements on plan administrators, requiring that they convey to claimants, upon denial of a benefits claim, the specific grounds for the denial. The Act itself provides they "shall" provide notice describing "the specific reasons" the claim was denied. Regulations provide administrators "shall" describe to a disappointed claimant not only "the specific reason or reasons" for a denial, but "the specific plan provisions on which the determination is based." This Court has explained that ERISA was enacted to protect the interests of employees, and to further that aim administrators "must" describe in writing "the specific reasons" for a claim denial. *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 830 (2003).

The circuits are not only split but splintered in how they apply these requirements when an administrator seeks to defend a benefits action on grounds it never mentioned when it denied the underlying claim (an apt and frequent term for which is "post-hoc rationale"). In that context, despite all the "shalls" and "musts," some circuits apply essentially inconsequential "shoulds" and "mays." Those circuits which do enforce the requirements do so to considerably varying degrees.

The result is a disordered system where identical cases produce irreconcilable results, based on nothing more than a given circuit's inclination — or disinclination — to apply ERISA's provisions as they are written:

- Some circuits do enforce the provisions as written, and prohibit administrators from raising grounds in court they failed to raise when denying the claim, holding them to the reasons they timely provided to their claimants.

- Some, like the Eleventh Circuit here, prohibit post-hoc rationales only in cases where judicial analysis is deferential, and freely allow them if judicial analysis is de novo.

- Some remand the case back to the administrator so that it may apply, after the fact, the grounds it was required to raise in the first place.

- One abstains from any definitive rule, applying ERISA's requirements on a case-by-case basis.

- Some apply waiver principles, and there a further split obtains: some circuits, including the Eleventh here, require affirmative proof of the administrator's intentional relinquishment of a known right; one presumes intent where the underlying facts are known to the administrator.

Alexander Hamilton observed it is "essential to the idea of a law, that it be attended with a sanction…." Otherwise, "the resolutions or commands which pretend to be laws will, in fact, amount to nothing more than advice or recommendation." Hamilton, The Federalist No. 15, p. 110 (Clinton

Rossiter ed., 1961). Depending on the circuit, ERISA's denial-explanation requirements run the gamut from duly enforced laws to precatory Hamiltonian "recommendations." This Court should decide whether, indeed, ERISA means what it says.

In addition, the Eleventh Circuit's decision contravenes an intervening ruling of this Court, as here the "the specific reasons" requirement was not just statutory and regulatory — it was contractual as well. Thus the Eleventh Circuit excused the administrator from complying with the terms of its own policy, a result at odds with this Court's decision in *US Airways, Inc. v. McCutchen,* 133 S.Ct. 1537 (2013). On this issue, therefore, at a minimum the Court should grant this petition, vacate the Eleventh Circuit's judgment, and remand for reconsideration in light of *McCutchen.*

For these reasons and those discussed below, petitioner Beatriz Martinez-Claib, M.D., respectfully prays that this Court grant a writ of certiorari to review the judgment of the Eleventh Circuit.

STATEMENT OF THE CASE

I. Dr. Martinez-Claib's employer provides coverage under a MetLife group disability insurance policy

Dr. Martinez-Claib enjoyed coverage under a policy purchased by her employer, Family Health Care Centers of Southwest Florida, Inc. ("FHC"). MetLife issued and administered the policy. C.A.App.[1] Doc. 1, pg. 2; Doc. 20, pg. 1.[2]

The policy considered an employee to be disabled and therefore entitled to benefits if she was unable to perform the duties of "her regular occupation." C.A.App. Doc. 20-2, pg.14. It included a pre-existing condition ("PEC") exclusion, *id.* at 18, and conferred discretionary authority on BMA. *Id.* at 23.

And, MetLife's policy promised that, if a benefits claim was denied, "the claimant will receive a written notification setting forth … The specific reason or reasons for the denial" and "Specific reference to pertinent Plan or Policy provision(s) on which the denial is based." Pet.App. 32a.

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[1] "C.A.App." cites are to the Eleventh Circuit appendix n this matter.

[2] The policy was initially issued by BMA, and administered by MetLife. C.A.App. Doc. 1, pg. 2; Doc. 20, pg. 1. According to its Eleventh Circuit brief, MetLife "purchased the group policy at issue, assumed the defense of BMA, and is fully responsible for any judgment which may be entered in this action." Thus this brief generally refers to MetLife.

II. Dr. Martinez-Claib's condition causes a grand mal brain seizure, forces her to stop working as a physician in May 2002, and forces her to stop working altogether in April 2003

Dr. Martinez-Claib suffered a grand mal brain seizure on December 2, 2001, and had brain surgery later that month. Pet.App. 12a. She returned to work in February 2002, but in May 2002 her condition forced her to give up her work as a physician. Pet.App. 12a-13a. Consequently FHC reassigned her as a bilingual health educator. Pet.App. 13a.

Her condition continued to deteriorate, however, and in April 2003 she had to stop working altogether. *Id.* Meanwhile, in March 2003, the MetLife policy canceled. *Id.*

III. Dr. Martinez-Claib submits a claim to MetLife based on her inability to work as a physician in May 2002, and MetLife denies the claim based solely on her inability to work at all starting in April 2003

Dr. Martinez-Claib submitted her disability claim to MetLife in March 2004. Pet.App. 13a.[3] She

[3] As the Eleventh Circuit calculated it, this was approximately four months after the policy's last notice-of-claim deadline. Pet.App. 7a. Once the court had determined to consider the question, the battle was joined on the application of Florida's version of the notice-prejudice rule. Pet.App. 7a-8a. That issue, in turn, was the subject of Dr. Martinez-Claib's November 2009 petition for rehearing, which the Eleventh Circuit finally denied in February 2013. Pet.App. 30a-31a.

expressly based the claim on her inability to work as a physician starting in May 2002 (i.e. the "regular occupation" MetLife's policy insured). C.A.App. 28-2, pg. 3. She also submitted a letter stating "I returned to work during the 1st week of Feb. 2002 and worked until the last week of May 2002, when I was released of my duties as a physician due to slow brain syndrome." C.A.App. Doc. 28-2, pg. 2.

MetLife spent all of one day on Dr. Martinez-Claib's claim. Despite the information on the face of her claim form and elsewhere in its file materials, MetLife decided her date of disability had not been until April 2003, when she was forced to stop working altogether. C.A.App. Doc. 23-3, pgs. 4-5.

MetLife's November 2004 denial letter discussed starting and ending dates of Dr. Martinez-Claib's coverage, and then concluded:

> The Family Health Ctrs cancelled their Long Term Disability Plan with MetLife effective March 31, 2003. Since your last day of work was April 8, 2003, the Long Term Disability plan from MetLife was no longer in effect. [¶] Therefore, based on all available information we have, there is no qualifying period of disability under the Long Term Disability Plan with MetLife and you are not eligible to receive benefits under this Plan.

Pet.App. 33a-35a.[4]

Dr. Martinez-Claib timely submitted an administrative appeal to MetLife, but MetLife lost the file and never issued a decision on her appeal. Pet.App 12. She then filed her lawsuit in district court, which had jurisdiction under 29 U.S.C. § 1132(e) and 28 U.S.C. § 1367(a).

IV. Both the district court and the Eleventh Circuit allow MetLife to defend the case based on grounds it never raised in its denial letter

Both parties sought summary judgment in district court. Pet.App. 11a.

Before reaching the merits, as in any other ERISA case, the parties and the court had to consider the level of judicial scrutiny to be applied. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101,

[4] Because this letter did also mention MetLife's views on when coverage started, MetLife argued to the Eleventh Circuit that it sufficiently raised the PEC exclusion. The letter never actually cited the exclusion, however, and Dr. Martinez-Claib argued it failed to provide this "specific reason … in a manner calculated to be understood by the participant." She also doggedly contested the PEC issue on the merits in case the court did consider it. It was mooted, however, when the court based its decision on a ground MetLife had indisputably omitted from its denial letter — untimely notice of claim — and so never evaluated whether the letter had sufficiently raised the PEC issue, nor whose position was correct on the merits. Thus this case squarely raises the issue whether a wholly omitted ground for denial may later form a basis for an administrator's defense.

115 (1989). The policy arguably conferred discretion,[5] but MetLife's losing the file meant judicial analysis would be de novo. *See* C.A.App. Doc. 29, pg. 8-9 (MetLife's summary judgment motion, endorsing de novo analysis because of issues about transfer of authority from BMA to MetLife, and "more significantly, … MetLife's failure to complete its appellate review subjects it to the *de novo* standard under a 'deemed denial' rationale."). The upshot: de novo analysis here is in no sense a penalty for MetLife's failure to timely describe "the specific reasons" for denying the claim.

In the R&R conveying the substance of the district court's decision, the court cited *Tippitt v. Reliance Standard Life Ins. Co.,* 276 Fed.Appx. 912 (11th Cir. 2008), and concluded it was proper "for the district court to specifically consider and examine post-hoc explanations provided by the insurer in ERISA cases." Pet.App 24a. It then proceeded to consider, and decide adversely to Dr. Martinez-Claib, the untimely-notice argument MetLife had raised only after litigation had begun. Pet.App. 19a-23a. The district court conducted a like analysis, and reached the same result, respecting the PEC defense. Pet.App. 25a-29a.

The Eleventh Circuit applied a deferential – de novo dichotomy in disposing of the issue:

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[5] "Arguably" because it conferred discretion on BMA by name, not MetLife. As noted in the text, that quickly became a moot point.

> The bar to post-hoc arguments referenced in *Tippitt* applies only in cases reviewing the plan administrator's decision under the deferential arbitrary and capricious standard of review. It does not apply in de novo review cases such as this. The rationale for the post-hoc rule is that the court cannot defer to a plan interpretation that was not offered in the administrative process. Such a concern is not present where we are asked to review the denial of benefits de novo. Because this context does not provoke application of such a rule, it cannot operate to prevent MetLife from relying on reasons for denying Martinez-Claib's claim that it did not originally include in its denial letter.

Pet.App. 5a. The court also addressed waiver principles, concluding MetLife did not intentionally relinquish a known right because:

> If MetLife had framed her claim as Martinez-Claib submitted it, using the last day worked as a physician as the date of disability, it could not make the argument that the policy was no longer in effect at the time of disability.[6] Then it could have considered other bases for denying the claim.

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[6] Necessarily, then, the reason adduced by MetLife in its denial letter was invalid: it "could not make the argument" had it framed the claim "as Martinez-Claib presented it."

Pet.App. 6a.

Having concluded MetLife could raise its post-hoc rationales, the court held its untimely-notice argument was meritorious, and affirmed the district court on that basis. Pet.App. 7a-8a. It never reached the merits of the PEC exclusion. Pet.App. 4a.

Both the district and circuit courts omitted any mention of one significant issue Dr. Martinez-Claib argued vigorously at both levels — that MetLife's own policy also required it to provide "the specific reasons" for claim denial. Pet.App. 36a-38a; *supra* at 8. This independent, contractual basis for precluding the assertion of post-hoc rationales has yet to be addressed by any court, at all, in this case.

REASONS FOR ALLOWING THE WRIT

I. The circuits are splintered regarding post-hoc rationales and the application of waiver principles

A. The circuits conflict directly and irreconcilably about the consequences, if any, of an administrator's violation of ERISA's denial-explanation requirements

All circuits acknowledge ERISA's statutory and regulatory requirements that administrators provide the reasons and policy provisions on which a denial is based. They have never agreed, however, on what the consequences should be — or whether there should be

meaningful consequences at all — when an administrator violates those requirements.

Nine years ago, the First Circuit described no less than five disparate approaches among the circuits (and even within some of them) when an ERISA administrator tried to raise a post-hoc rationale. *See Glista v. Unum Life Ins. Co. of America,* 378 F.3d 113, 130-131 (1st Cir. 2004). Those approaches ranged from such things as limiting the grounds for decision to those timely articulated by the administrator; to applying de novo analysis where it would otherwise be deferential; to remanding the matter back to the administrator. *See generally id.*

While the law has evolved since *Glista* issued, it has not coalesced. This case, compared with an identical case from the Tenth Circuit, *Kellogg v. Metropolitan Life Ins. Co.,* 549 F.3d 818 (10th Cir. 2008), well illustrates one aspect of the circuits' present differences. The facts of the two cases are utterly indistinguishable on any material point. The dispositive issue is identical. And the results are irreconcilable.

In *Kellogg,* MetLife denied an accidental-death claim based on the sole contention Mr. Kellogg died as a result of a physical illness, an excluded cause under its policy. 549 F.3d at 823, 829. In court, MetLife's defense was different: Mr. Kellogg's death had not been an "accident." *Id.* at 828. The trial court applied de novo analysis despite the policy's grant of discretionary authority, because MetLife had failed to

render a decision on Ms. Kellogg's administrative appeal. *Id.* at 827-828.

Here, MetLife denied Dr. Martinez-Claib's disability claim based on the sole contention its policy terminated before her last day of work. *Supra* at 9. In court, MetLife's defense was different: Dr. Martinez-Claib's claim was untimely, and the PEC exclusion applied. *Supra* at 11. The trial court applied de novo analysis, despite an arguable grant of discretionary authority, because MetLife had failed to render a decision on Dr. Martinez-Claib's administrative appeal. *Supra* at 10-11.

Both Ms. Kellogg and Dr. Martinez-Claib, invoking ERISA's statutory and regulatory provisions,[7] objected to judicial consideration of MetLife's respective post-hoc rationales. 549 F.3d at 828-829; Pet.App. 4a-5a.

And there the similarity ends.

The Tenth Circuit held it had been "error for the district court to have granted summary judgment in favor of MetLife on the [post-hoc] grounds that Brad Kellogg did not die as a result of an 'accident.'" *Id.* at 829. Then, having "rejected the sole basis upon which MetLife grounded its denial of AD&D benefits," *id.* at

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[7] Ms. Kellogg invoked these provisions through her citation to *Flinders v. Workforce Stabilization Plan of Philips Petroleum Co.,* 491 F.3d 1180 (10th Cir. 2007), which discusses them at length and holds post-hoc rationales are impermissible. *Id* at 1190. *See* 549 F.3d at 828.

833, the Tenth Circuit ordered judgment in Ms. Kellogg's favor.

The Eleventh Circuit held the post-hoc rationale prohibition, because it "applies only in cases reviewing the plan administrator's decision under the deferential arbitrary and capricious standard of review," could not "operate to prevent MetLife from relying on reasons for denying Martinez-Claib's claim that it did not originally include in its denial letter." *See supra* at 12. And based on one of those newly-raised reasons, the Eleventh Circuit affirmed summary judgment in MetLife's favor. *Supra* at 13.

The only reason these two factually indistinguishable cases produced such diametrically contrary results is a direct and irreconcilable circuit split: the Tenth Circuit enforces ERISA's denial-explanation requirements in de novo cases, and the Eleventh Circuit does not. This particular conflict envelops five of the circuits, and additional conflicts splinter the circuits even more.

1. The Seventh through Eleventh Circuits disagree about the impact of the level of judicial scrutiny on the permissibility of post-hoc rationales

a. The Ninth and Tenth Circuits always prohibit post-hoc rationales

Both the Ninth and Tenth Circuits give teeth to ERISA's denial-explanation requirements by prohibiting post-hoc rationales in all cases, de novo and deferential alike. *See Harlick v. Blue Shield of Cal.,* 686 F.3d 699, 719-720 (9th Cir. 2012) (*cert. den.,* 133 S.Ct 1492 (2013)) (deferential analysis), *Hyder v. Kemper Nat'l Services, Inc.,* 302 Fed.Appx. 731, 733 (9th Cir. 2008) (de novo analysis); *Spadley v. Owens-Illinois Hourly Employees Welfare Ben. Plan,* 686 F.3d 1135, 1140-1141 (10th Cir. 2012) (deferential analysis), *Kellogg, supra,* 549 F.3d at 828-829 (de novo analysis).

b. The Seventh, Eighth and Eleventh Circuits enforce denial-explanation requirements only in deferential-analysis cases

The Seventh Circuit prohibits post-hoc rationales only in deferential-analysis cases. *See*

Marantz v. Permanente Med. Group, Inc. Long Term Disability Plan, 687 F.3d 320, 328 (7th Cir. 2012) (de novo case; because court conducts independent review, administrator's procedural violations are "irrelevant"; post-hoc rationale "would be proper in the district court even if LINA had violated ERISA by failing to note [it] in its decision letters"); *Reich v. Ladish Co. Inc.,* 306 F.3d 519, 522, 524 n.1 (7th Cir. 2002) (deferential-analysis case; post-hoc rationale "comes too late"; "Ladish was required to give Reich every reason for its denial of benefits at the time of the denial. … It may not add new reasons as the litigation proceeds.").

The Eighth Circuit applies the same distinction. See *Hillstrom v. Kenefick,* 484 F.3d 519, 528 (8th Cir. 2007), (in de novo case "a trial court *must* consider all of the provisions of the policy in question, … even where not relied upon by the plan administrator at the time the denial was made") (internal citation and punctuation omitted; emphasis in original); *Marolt v. Alliant Techsystems, Inc.,* 146 F.3d 617, 620 (8th Cir. 1998) (deferential analysis; ERISA claimants "denied the timely and specific explanation to which the law entitles them" may not be "sandbagged by after-the-fact plan interpretations devised for purposes of litigation.").

And, as we have seen in this case, the Eleventh Circuit applies a like rule. *See supra* at 11-12.

2. The Fourth, Fifth and Sixth Circuits remand the case to the plan administrator to consider post-hoc rationales in the first instance

The Fourth Circuit imposes no meaningful consequence on errant administrators; it merely remands cases back to them for another try. *See Gagliano v. Reliance Standard Life Ins. Co.,* 547 F.3d 230, 239-240 (4th Cir. 2008) ("defective notice" cannot lead to "a substantive remedy," so matter must be remanded to administrator to apply post-hoc rationale in the first instance).

The Fifth Circuit concurs. *See Lafluer v. Louisiana Health Service and Indem. Co.,* 563 F.3d 148, 157-158 (5th Cir. 2009) (no substantive remedy for denial-explanation violation; default rule of remand applies unless case is so clear cut denial on any ground would be unreasonable; no alteration of level of judicial scrutiny or striking of evidence because violation not sufficiently egregious).[8]

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[8] While *Lafluer* is the Fifth Circuit's latest case on point, earlier cases suggest a somewhat different approach. *Vega v. Nat'l Life Ins. Services, Inc.,* 188 F.3d 287, 302 (5th Cir. 1999) *(en banc.),* refused to allow either claimants or administrators to shore up their cases with evidence not surfaced during the administrative process. *Robinson v. Aetna Life Ins. Co.,* 443 F.3d 389, 395 n.4, (5th Cir. 2006), interpreted *Vega* to require an inquiry limited to "the actual 'basis for [the administrator's] denial,' not its post-hoc rationalization," and refused to remand the matter to the administrator for a second try. Resolving any internal conflict in the Fifth Circuit, in any case, would not alter the conclusion that a definitive inter-circuit conflict exists.

The Sixth Circuit also remands matters to plan administrators when they violate denial-explanation requirements, unless remand would be a "useless formality." *McCartha v. National City Corp.,* 419 F.3d 437, 444 (6th Cir. 2005).

3. The First Circuit applies a case-by-case approach, allowing an "array of possible responses"

Glista, after discussing the disparate approaches among its sister circuits, *see supra,* ended up establishing a case-by-case approach, and avoided a definitive rule. 378 F.3d at 130. Although that court did preclude the administrator from raising a post-hoc rationale, it stressed that was but one of "an array of possible responses when the plan administrator relies in litigation on a reason not articulated to the claimant." *Id.* at 131. A subsequent case reached a similar result, without altering the First Circuit's expressed rule. *See Bard v. Boston Shipping Ass'n,* 471 F.3d 229, 244-245 (1st Cir. 2006) (due to violation of denial-explanation requirements, administrator prohibited from "using Bard's earlier medical evidence against him"; court allowed in "other circumstances, it might be an appropriate remedy to remand to a plan administrator for reconsideration.").[9]

[9] We omit discussion of the Third Circuit, which apparently allows post-hoc rationales, if reluctantly so. *See Skretvedt v. E.I. DuPont Nemours and Co.,* 268 F.3d 167, 177-178 n.8 and accompanying text (3rd Cir. 2001) (assuming *arguendo* it was

B. The circuits disagree about whether waiver principles apply to a denial-explanation violation, and if so how they are applied

Whether a denial-explanation violation is to be evaluated through a prism of waiver principles also divides the circuits. *See Thornton v. Western & Southern Fin. Group Beneflex Plan,* 797 F.Supp.2d 796, 806 (W.D. Ky. 2011) (discussing varying approaches). This Court's decision in *CIGNA Corp. v. Amara,* 131 S.Ct. 1866, 1878-1879 (2011) strongly suggests waiver analysis does apply, but just how it might apply remains the subject of a conflict among the circuits.

Of the circuits employing a waiver principle, all but one require an aggrieved claimant to prove an intentional relinquishment of a known right on the part of the administrator. The Second Circuit invokes a presumption of intent when the administrator knows of facts supporting a ground for denial and fails to convey it to the claimant when the claim is denied.

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proper to consider post-hoc rationale, but discussing significant policy concerns about doing so). *But see Connor v. Sedgwick Claims Mgt. Services, Inc.,* 796 F.Supp.2d 568, 576-577 (D.N.J. 2011) (refusing to consider post-hoc rationale).

1. The Fourth Circuit does not apply waiver principles to denial-explanation violations

The Fourth Circuit, in *Gagliano, supra,* rejected waiver doctrine in stark terms indeed. There, Reliance Standard had failed to cite a PEC exclusion in its initial denial letter to Ms. Gagliano. 547 F.3d at 236. The court ordered a remand to Reliance Standard so it could apply its post-hoc rationale after the fact, and in so doing held "the district court was without authority to direct the plan administrator to administer the Plan contrary to its terms by injecting the prohibited concepts of waiver and estoppel." *Id.* at 239.

2. The Second Circuit applies waiver principles if a finding of waiver would not expand the underlying coverage, and presumes intent if the administrator has knowledge of the underlying facts

The Second Circuit, in *Juliano v. Health Maint. Org. of N.J., Inc.,* 221 F.3d 279 (2d Cir. 2000), foreclosed the application of a waiver analysis if it would result in an expansion of the underlying coverage: waiver doctrine did not apply to "the existence or nonexistence of coverage (e.g., the insuring clause and exclusions)." *Id.* at 288 (citation omitted).

The latest word from the Second Circuit is *Lauder v. First UNUM Life Ins. Co.,* 284 F.3d 375 (2d Cir. 2002). That court revisited *Juliano,* which it considered to have left the waiver issue open, *id.* at 381, and this time the post-hoc rationale was deemed waived.

Addressing *Juliano's* point that waiver could not be applied in a manner to extend the scope of the underlying coverage, *Lauder* reasoned that concern was not implicated in the case before it, as "Lauder's disability is exactly the type contemplated by the policy." *Id.* In that light, the better rule was:

> An insurer is deemed, as a matter of law, to have intended to waive a defense to coverage where other defenses are asserted, and where the insurer possesses sufficient knowledge (actual or constructive) of the circumstances regarding the unasserted defense.

Id. at 382 (citation omitted).

Thus the Second Circuit applies waiver analysis, provided it would not cause the underlying coverage to be unduly expanded. And in those instances it presumes intent where the administrator has knowledge of the underlying facts.

3. The Fifth, Seventh, Eighth and Eleventh Circuits apply waiver principles and require a claimant to prove the administrator intentionally relinquished a known right

The Eleventh Circuit, as in this case, requires that a claimant prove either "an intentional relinquishment of a right or that the insurer was unjustly benefitted by its conduct." Pet.App. 5a. It went on to find that, as a function of its own negligence in failing to "frame[ ] her claim as Martinez-Claib submitted it," MetLife's failure to adduce its post-hoc rationales was not an "intentional relinquishment." Pet.App. 6a.

Several other circuits follow suit in requiring proof of intentional relinquishment of the post-hoc rationale. *See High v. E-Systems, Inc.,* 459 F.3d 573, 581 (5th Cir. 2006); *Thomason v. Aetna Life Ins. Co.,* 9 F.3d 645, 647-648 (7th Cir. 1993); *Farley v. Benefit Trust Ins. Co.,* 979 F.2d 653, 659 (8th Cir. 1992).

C. The conflicts among the circuits are intractable and require this Court's resolution

Given the foregoing there is no question but that the circuits are in disarray, and have been for some time, on the question of post-hoc rationales in ERISA cases. On a number of levels Supreme Court review is fitting on this issue and at this time.

First, by resolving these questions the Court will further one of ERISA's principal goals: the establishment of a "uniform administrative scheme." *See Egelhoff v. Egelhoff,* 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

Second, as *Glista, supra,* noted, this is a "question[ ] of general import." 378 F.3d at 115. It is akin to the issues at stake in recent cases such as *Nord, supra,* 538 U.S. at 825 (application of "treating physician rule"); *MetLife v. Glenn,* 554 U.S. 105, 115-119 (2008) (judicial application of conflict-of-interest issues in conducting deferential analysis); and *McCutchen, supra,* 133 S.Ct. at 1549 (interplay between contract terms and equitable principles). It bears importance in the administration of ERISA, *cf. U.S. v. Ruzicka,* 329 U.S. 287, 288 (1946), and merits this Court's resolution.

Third, the issue is mature and there is no reason to await further development in the crucible of the circuits. It has been nine years since *Glista* described the variant law then obtaining. And, as demonstrated by the foregoing, the conflict persists.

Fourth, this case provides an apt vehicle for the Court to address the issues. The Eleventh Circuit's reasoning is clear, the facts well-developed and the issues clearly defined.

D. The Eleventh Circuit's decision was erroneous

The approach used by the Eleventh Circuit — prohibiting post-hoc rationales only in deferential-analysis cases — is defeated first and foremost by the governing statutory and regulatory text. Neither section 1133(1) nor the regulations contemplate any qualification on their compulsory language, based on the level of judicial scrutiny or otherwise. To the contrary, they leave no doubt the denial-explanation requirements apply across the board: section 1133, for example, applies to "every employee benefit plan."

And, the statutory and regulatory requirements of "the specific reasons" and "the specific plan provisions" limit the court's inquiry to the explanations timely adduced by the administrator: this case is largely about what the meaning of "the" is. The term is, of course, the definite article, and it "particularizes the subject which it precedes": it is a "word of limitation as opposed to the indefinite or generalizing force of 'a' or 'an.'" *American Bus. Ass'n v. Slater,* 231 F.3d 1, 4-5 (D.C.Cir. 2000). The requirement that administrators timely adduce "the" reason or reasons effectively subjects denial letters to the historic canon *expressio unius est exclusio alterius* — the expression of one thing implies the exclusion of others. In short, it necessarily omits from the universe of cognizable grounds any reasons not timely adduced.

The requirement is patently directed at administrators, and is forward-looking: it attaches at the time of claim denial, before any legal dispute has

arisen. The Eleventh Circuit approach, however, inappropriately degrades the statutory and regulatory text based on a judicial perspective after a matter is in court: "the court cannot defer to a plan interpretation that was not offered in the administrative process," but "[s]uch a concern is not present where we are asked to review the denial of benefits de novo."

Appropriateness aside, the panel is simply incorrect about the policy underpinnings of the post-hoc rationale bar; Congress had things other than the eventual level of judicial scrutiny in mind. First, denial-explanation requirements are intended (in de novo and deferential-analysis cases alike) to "afford the beneficiary an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial." *Glista,* 378 F.3d at 129. Not providing an explanation at all until after the matter is in court, for obvious reasons, defeats that purpose.

Judicial consideration of post-hoc rationales, in fact, undermines a number of important ERISA policies: minimizing frivolous lawsuits; promoting consistent treatment of claims; providing a non-adversarial dispute resolution process; and decreasing the cost and time of claims settlement. *Id.* As the *Glista* court put it, these goals are:

> …undermined where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to

> the beneficiary. Such conduct prevents ERISA plan administrators and beneficiaries from having a full and meaningful dialogue regarding the denial of benefits.

Id. (citing *Juliano, supra).* And *Glista* barely scratched the surface in its discussion of undermined goals. No reduction in frivolous lawsuits can reasonably be expected if post-hoc rationales are allowed, as the arguments tested for "frivolousness" before proceeding to court do not have to be the arguments presented to the court itself. And costs will not diminish; proceedings will be more costly if arguments have to be litigated from scratch with no previous administrative winnowing.

And all those things are true in both de novo and deferential-analysis cases.[10]

None of this imposes any undue burden on plan administrators, who after all are held to "higher than

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[10] Those circuits that simply remand a case to the administrator, of course, do not enforce the denial-explanation requirements in any meaningful way. In those circuits the requirements are indeed precatory Hamiltonian "recommendations," to be observed or not by an administrator with no meaningful consequence for noncompliance.

Those circuits that apply to post-hoc rationales de novo analysis, when analysis would otherwise be deferential, *see Glista,* 378 F.3d at 131, fail to address circumstances where analysis would be de novo to begin with, or, as in this case, where de novo analysis is applied as a result of other procedural violations.

marketplace" standards, *Glenn,* 554 U.S. at 106, and are required to conduct a "deliberate, principled reasoning process" even under the most deferential standard of judicial evaluation. *See Glenn v. MetLife,* 461 F.3d 660, 666 (6th Cir. 2006); *Glenn,* 554 U.S. at 120 ("We can find nothing improper in the way in which the court conducted its review"). An essential aspect of that process is an obligation to fully investigate a claim before denying benefits. *Capone v. Aetna Life Ins. Co.,* 592 F.3d 1189, 1199-1200 (11th Cir. 2010). Any administrator who complies with these requirements would find it easy to compose a clear and comprehensive explanation of the conclusions that process would produce.

For those reasons as well, the Eleventh Circuit's analysis of waiver principles[11] is incorrect; the approach used by the Second Circuit is much more fitting. Given all these well-established obligations, it is quite appropriate to presume intent when an administrator, who is expected to conduct a thorough and complete investigation, chooses to omit grounds for denial.

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[11] The waiver issue may well be mooted depending on the outcome of the argument that ERISA's statutory and regulatory text independently bars consideration of post-hoc rationales.

E. The Eleventh Circuit's disregard for the contractual denial-explanation requirement contravenes this Court's decision in *McCutchen*

MetLife's policy included a promise that, in case of claim denial, the claimant would "receive a written notification setting forth … The specific reason or reasons for the denial" and "Specific reference to pertinent Plan or Policy provision(s) on which the denial is based." Neither the district court nor the Eleventh Circuit ever took account of this fact.

"The plan, in short, is at the center of ERISA." *McCutchen,* 133 S.Ct. at 1548. ERISA's end and aim is to protect "contractually defined" benefits, and the statutory scheme is "built around reliance on the face of written plan documents." *Id.*

Here, on the face of the written plan document, MetLife expressly undertook denial-explanation obligations. And, after all, MetLife "could hardly be caught by surprise by an insistence that it comply with its own plan." *Glista,* 378 F.3d at 132. The Eleventh Circuit overlooked that point, even as it relied on cases such as *Farley, supra,* Pet.App. 4a-5a, which rejected a bar on post-hoc rationales because "the practical result of such a rule would be to permit the oral modification of an ERISA plan, a result manifestly in conflict with the intent of the statute and the case law governing it." 979 F.2d at 660. Neither the district nor circuit courts took heed that disregarding these contractual denial-explanation

requirements "orally modified" the terms of the plan no less.

Therefore, this Court should either consider this question on certiorari, or vacate the Eleventh Circuit's decision and remand for consideration of the impact of the contractual denial-explanation requirement in light of *McCutchen.*

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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APPENDIX

APPENDIX A: Decision of the Eleventh Circuit, October 21, 2009

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 08-16781

D.C. Docket No. 06-00479-CV-FTM-99-SPC

BEATRIZ MARTINEZ-CLAIB, M.D.,
Plaintiff-Appellant,

versus

BUSINESS MEN'S ASSURANCE COMPANY OF AMERICA,
METROPOLITAN LIFE INSURANCE COMPANY,
Defendants-Appellees

Appeal from the United States District Court
For the Middle District of Florida

(October 21, 2009)

Before EDMONDSON, BLACK and SILER,[*] Circuit Judges

SILER, Circuit Judge:

INTRODUCTION

Plaintiff Beatriz Martinez-Claib appeals from the district court's order granting summary judgment in favor of defendant MetLife in this ERISA suit. The district court found Martinez-Claib's claim was time-barred, and that, even if it were timely, the preexisting condition exclusion applied. Martinez-Claib appeals, and for the following reasons, we affirm.

I.

In September 2001, Martinez-Claib contracted with Family Health Care Centers of Southwest Florida (FHC) to provide physician's services. The contract covered a period of employment between November 2001 through November 2003 and required FHC to provide long-term disability insurance. Martinez-Claib began employment as a physician with FHC in early November 2001. A month later, she suffered a grand mal brain seizure. She was subsequently diagnosed with a brain tumor, and underwent surgery later that month. She did not return to work until February 2002. In May, due to her deteriorating health, she was reassigned within FHC to be a bilingual health educator, a position she held until April 2003, when she could no longer work. In March 2003, FHC cancelled its benefits policy with

[*] Honorable Eugene E. Siler, Jr., United States Circuit Judge for the Sixth Circuit, sitting by designation.

MetLife, which was before Martinez-Claib's last day of work at FHC.

In March 2004, Martinez-Claib submitted her claim for long-term disability benefits. The claim was denied in a November 2004 letter which explained that her coverage did not become effective until February 2002 (after the brain seizure). It also explained that her last day of work in April 2003 was beyond the March 31 date when FHC cancelled its plan with MetLife. It implied that it was considering her last day of work as a health educator as the date of disability, and concluded that coverage was precluded because that date was outside the coverage period. Although she filed an appeal with MetLife in May 2005, the appeal file was lost and never processed. She filed this ERISA suit in September 2006.

The parties cross-motioned for summary judgment, and the district court granted MetLife's motion because Martinez-Claib's claim was time-barred. It also held, in the alternative, that even if it were timely, the preexisting condition exclusion applied. Martinez-Claib timely appeals.

II.

"We review the district court's grant of summary judgment de novo, applying the same legal standards as the district court." *Sierra Club, Inc. v. Leavitt,* 488 F.3d 904, 911 (11th Cir. 2007). Here, the district court found that because MetLife failed to act on Martinez-Claib's appeal within the required time period, it would deem its inaction an implicit denial.

It applied a de novo standard of review and both parties agree this is the proper standard.

Because we find that Martinez-Claib's claim was time-barred, and she has failed to make a showing that MetLife was not prejudiced by her delay in filing her claim, we affirm the district court. Finding it determinative of the case, we do not reach Martinez-Claib's argument about the preexisting condition exclusion.

III.

A.

As a threshold matter, Martinez-Claib claims that MetLife may not argue any rationale for claim denial that it did not raise prior to litigation. Therefore, she argues, the court erred in considering MetLife's arguments that she failed to give timely notice of her claim and that the preexisting condition exclusion applied, because the denial letter did not mention either of these reasons for denying coverage. Instead, the letter relied on finding that her last day of work was the date of disability, and since that date was after the date FHC cancelled its long-term disability plan with MetLife, there was "no qualifying period of coverage." The district court allowed MetLife to raise these arguments, relying on *Tippitt v. Reliance Standard Life Insurance Co.,* which recognized that although a district court may discount or reject these tardy explanations, it was not erroneous for a district court to consider "post-hoc explanations about why an insurer denied the plaintiff's claim." 276 F. App'x 912, 915 (11th Cir. 2008). It also relied on *Farley v. Benefit Trust Life*

Insurance Co., which held that arguments that coverage does not exist cannot be waived. 979 F.2d 653, 660 (8th Cir. 1992).

The bar to post-hoc arguments referenced in *Tippitt* applies only in cases reviewing the plan administrator's decision under the deferential arbitrary and capricious standard of review. It does not apply in de novo review cases such as this. The rationale for the post-hoc rule is that the court cannot defer to a plan interpretation that was not offered in the administrative process. Such a concern is not present where we are asked to review the denial of benefits de novo. Because this context does not provoke application of such a rule, it cannot operate to prevent MetLife from relying on reasons for denying Martinez-Claib's claim that it did not originally include in its denial letter.

Martinez-Claib also argues that MetLife waived these arguments it did not raise in its denial letter. We have considered waiver in the context of ERISA in *Glass v. United of Omaha Life Insurance Co.,* 33 F.3d 1341 (11th Cir. 1994). In our discussion of waiver, we defined the term as "the voluntary, intentional relinquishment of a known right," and noted that it is "a common law principle whose applicability under ERISA is an issue of first impression in this circuit." *Id.* at 1347.

Given that the issue was new to the circuit, we looked at two circuit court opinions to frame the issue, *Pitts by and Through Pitts v. American Security Life Insurance Co.,* 931 F.2d 351, 357 (5th Cir. 1991); and *Thomason v. Aetna Life*

Insurance Co., 9 F.3d 645, 648 (7th Cir. 1993), and ultimately followed *Thomason.* Thomason "left open whether waiver principles might apply, as part of the federal common law in the ERISA context, under other circumstances, but rejected the waiver argument made by the plaintiff in that case." *Glass,* 33 F.3d at 1348. We rejected waiver in the specific context of the case because the claimant had not shown either that there was an intentional relinquishment of a known right or that the insurer was unjustly benefitted by its conduct. *Id.*

Here, MetLife denied the benefits because it assumed Martinez-Claib's final day of work at FHC was the "date of disability" and therefore after the policy had been cancelled between MetLife and FHC. Thus, it did not intentionally give up the right to argue the other grounds for denying benefits based on the correct date of disability, Martinez-Claib's last day working as a physician. If MetLife had framed her claim as Martinez-Claib submitted it, using the last day worked as a physician as the date of disability, it could not make the argument that the policy was no longer in effect at the time of the disability. Then it could have considered other bases for denying the claim. In addition, although it was MetLife's fault that there was no opportunity to correct this through the appeals process, there is no evidence in the record that MetLife knew, at that time that the denial letter was sent, that it would be its last opportunity to address Martinez-Claib's claim.

Therefore, because there is no evidence that MetLife intentionally gave up the right to raise these arguments, or that MetLife was unjustly benefitted by

its conduct, the arguments MetLife raises were not waived.

B.

The district court found Martinez-Claib's claim was time-barred because she failed to comply with the notice provisions of the policy. Martinez-Claib states that she became disabled in May 2002, when she was reassigned to the position of health educator. She filed her claim in March 2004. As the district court found, even under the most generous notice provisions of the policy, Martinez-Claib's claim is time-barred. The last deadline for filing a claim is one year from the time the proof of claim was required to be filed, which was November 2003, and the claim was filed four months later.

Martinez-Claib argues that despite the untimely notice, Florida's notice-prejudice rule applies. *In UNUM Life Insurance Co. of America v. Ward,* the Supreme Court found that California's notice-prejudice rule was not preempted by ERISA because it fell within the statutory savings clause which exempts from preemption any state law which regulates insurance. 526 U.S. 358, 363-64 (1999). Therefore, it is likely that Florida's law would not be preempted. Florida's law was articulated in *Tiedtke v. Fidelity & Casualty Co. of New York,* a case concerning a car insurance policy with a notice provision requiring the insured to provide written notice of any accident "as soon as practicable." 222 So.2d 206, 207 (Fla. Sup. Ct. 1969). The court held that "while prejudice to the insurer is presumed, if the insured can demonstrate that the insurer has not been

prejudiced thereby, then the insurer will not be relieved of liability merely by a showing that notice was not given 'as soon as practicable.'" *Id.* at 209. *See also Lane v. Provident Life & Accident Ins. Co.,* 178 F.Supp.2d 1281 (S.D. Fla. 2001) (considering the rule in the context of a disability claim.)

Here, Martinez-Claib has not sufficiently created a genuine issue of material fact with respect to whether her evidence rebuts the presumption that MetLife was prejudiced by her delay. If Martinez-Claib had complied with the deadlines for filing the notice of claim or the time limit for filing proof of claim, MetLife would most likely have had notice of the claim before Martinez-Claib's last day of work as a health educator. Therefore, it would have understood she was basing her disability claim on the last date worked as a physician and not the last date worked as a health educator.

AFFIRMED.

APPENDIX B: District Court Order adopting Report & Recommendation, October 28, 2008

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF FLORIDA

FORT MYERS DIVISION

BEATRIZ MARTINEZ-CLAIB, M.D.,
Plaintiff,

v.

BUSINESS MEN'S ASSURANCE COMPANY OF AMERICA, and METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

ORDER

THIS CAUSE came on for consideration upon the Report and Recommendation filed by United States Magistrate Judge Sheri Polster Chappell on September 9, 2008 (Dkt. 53) recommending that Defendants' Motion for Summary Judgment (Dkt. 29) be granted and Plaintiff's Motion for Summary Judgment (Dkt. 31) be denied. Plaintiff filed written objections to the Report and Recommendation (Dkt. 54), Defendants filed a response to the objections (Dkt. 57), and Plaintiff filed a reply. (Dkt. 60). After careful consideration of the Report and Recommendation of the Magistrate Judge in conjunction with an independent examination of the court file, the Court

is of the opinion that the Magistrate Judge's Report and Recommendation should be adopted, confirmed, and approved in all respects, with one exception.[1]

s/ Richard A. Lazzara

United States District Judge

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[1] The "heightened" standard of review afforded conflict of interest cases under ERISA, which was considered even stricter than the *de novo* standard, is no longer employed in this Circuit. *See Doyle v. Liberty Life Assurance Co. of Boston,* 2008 WL 4272748, * 6 (11th Cir. Sept. 18, 2008). A conflict of interest is now simply a factor to be weighed in the determination of whether the administrator's decision was reasonable. *Doyle,* 2008 WL 4272748, *7-8; *Miller v. Prudential Ins. Co. of America,* 2008 WL 4540998 (S.D. Fla. Oct. 9, 2008). The burden of proof of showing that an administrator's decision was arbitrary and capricious rests with the plaintiff. *Doyle,* 2008 WL 4272748, *7.

When the administrator has discretion to determine eligibility for benefits, as MetLife in this case, then the arbitrary and capricious standard is applied. *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 115, 109 S.Ct. 948, 957, 103 L.Ed.2d 80 (1989). The analysis always begins, however, with a *de novo* review of whether the administrator's decision was "wrong" and, if so, whether it was nevertheless reasonable. After this initial determination, if the decision was "wrong," then, under the arbitrary and capricious standard, all of the various factors, including a conflict of interest, are weighed.

The Court finds that this clarification does not change the outcome recommended in the report and recommendation.

APPENDIX C: District Court Magistrate Judge Report & Recommendation, September 9, 2008

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF FLORIDA

FORT MYERS DIVISION

BEATRIZ MARTINEZ-CLAIB, M.D.,
Plaintiff,

v.

BUSINESS MEN'S ASSURANCE COMPANY OF AMERICA, and METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

REPORT AND RECOMMENDATION

TO THE UNITED STATES DISTRICT COURT

This matter comes before the Court on the Defendants Business Men's Assurance Company of America, and Metropolitan Life Insurance Company's Motion for Summary Judgment (Doc. #29) filed on April 30, 2007, and the Plaintiff Beatriz Martinez-Claib, M.D.'s Motion for Summary Judgment (Doc. # 31) filed on April 30, 2007. On June 19, 2007, the Court issued a Report and Recommendation (R&R) which the District Court Recommitted on March 31, 2008.

FACTS

On September 23, 2001, the Plaintiff signed a letter of intent to accept employment with the Family Health Care Centers of Southwest Florida (FHC). (STD:11).[1] On September 24, 2001, she entered into a Professional Services Agreement (PSA) with FHC to provide physician services. (STD: 12, 18). FHC signed the PSA on September 25, 2001. (STD:18). The terms of the PSA, were scheduled to become effective on or about November 5, 2001, and continue through November 4, 2003. (STD:16). Under the terms of the PSA, FHC was required to provide the Plaintiff with specified benefits including long term disability insurance. (STD:15). The PSA also provides the term of this agreement shall begin on or about November 5, 2001, and continue until November 4, 2003. (STD:16). On November 6, 2001, the Plaintiff began her work as a physician with FHC. (LTD:14).

The Plaintiff suffered a grand mal brain seizure on December 2, 2001. (LTD:14). The Plaintiff was subsequently diagnosed with a brain tumor, and underwent surgery later in December of 2001. (LTD:14). The Plaintiff was off work until early February. On February 4, 2002, the Plaintiff resumed her duties at FHC. (LTD:14). In May of 2002, the Plaintiff's health had deteriorated to the point where

[1] For the purposes of this Report and Recommendation citations to the Short Term Disability Administrative Record will be designated (STD), citations to the Long Term Disability Record will be designated (LTD), and citations to the Plan will be designated as (BMA).

she was no longer able to work as physician and she was reassigned as a Bilingual Health Educator. (LTD:14). The Plaintiff remained in that position until April 8, 2003, when she could no longer continue to work. (LTD:14, 81-83). The Plaintiff never returned to work in any capacity. (LTD:14).

On March 31, 2003, FHC cancelled its policy with MetLife. (LTD:81). In March of 2004, the Plaintiff submitted a claim for disability benefits with MetLife. (LTD:14). The Plaintiff's claim was denied on November 23, 2004. (LTD:14). In a letter denying the Plaintiff's claim, the Defendant stated the benefits were denied noting her coverage was not effective under the terms of the policy until February 3, 2002, and further that FHC cancelled its long term disability policy with MetLife on March 31, 2003, prior to the Plaintiff's last day of work on April 8, 2003. (LTD:14, 71). As a result, MetLife denied the Plaintiff's claims arguing there had been no qualifying period of disability under the term of the long term disability Plan. (LTD: 71). On November 23, 2004, Metlife sent the Plaintiff its decision denying her long term disability benefits. (LTD: 71-72).

The Plaintiff filed an appeal with MetLife on May 20, 2005, however, the appeal file was apparently lost and no final determination was ever completed on the Plaintiff's file. In response to MetLife's final determination denying her LTD benefits, and a "no decision" on the Plaintiff's appeal, the Plaintiff filed the instant lawsuit pursuant to the Employee Retirement Income Security Act of 1974 29 U.S.C. § 1001 *et seq.* (ERISA).

STANDARD OF REVIEW

ERISA claims are subject to three standards of review. *Yochum v. Barnett Banks, Inc. Severance Pay Plan,* 234 F.3d 541, 543 (11th Cir. 2000). A brief discussion of those standards is appropriate here. In *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1984), the U.S. Supreme Court held that ERISA claims should be reviewed *de novo* unless the plan's administrator was also in a position to deny a claim for the benefits. *Brown v. Blue Cross Blue Shield of Alabama, Inc.,* 898 F.2d 1556, 1559 (11th Cir. 1990). In circumstances where the plan's administrator also has the discretion to deny the claim, the Court should review the plan administrators or fiduciary's decision under the "arbitrary and capricious" standard. *Yochum,* 234 F.3d at 544. "Finally, if the plan grants the fiduciary or administrator discretion, but the court finds a conflict of interest between the fiduciary or administrator and the company, a 'heighten arbitrary and capricious' standard applies." *Id.* If the Court finds such a conflict of interest, "the court will consider this conflict in its analysis." *Id.* The Eleventh Circuit Court of Appeals has held when an insurance company is the ERISA plan administrator and also responsible for paying claims that "a strong conflict of interest exists making application of the heightened arbitrary and capricious standard appropriate."[2]

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[2] When considering a conflict of interest the Eleventh Circuit has held: The beneficiary need only show that the fiduciary allowed

Brown v. Bellsouth Telecommunications Inc., 73 F. Supp. 2d 1308, 1319 (M.D. Fla. 1999) (citing *Brown v. Blue Cross Blue Shield of Alabama,* 898 F.2d at 1562)).

Regardless of whether the regular or heightened arbitrary and capricious review applies, the Court must first review *de novo* the administrator's decision to determine whether the decision was right or wrong. *HCA Health Servs. of Georgia, Inc. v. Employers Health Ins. Co.,* 240 F.3d 982, 993 (11th Cir. 2001) (citing *Godfrey v. Bell Telecommunications, Inc.,* 89 F.3d 755, 758 (11th Cir. 1996) (holding that a *de novo* review must first be held to decide if the administrator's determination was wrong). When assessing the correctness of the administrator's decision, the Court's inquiry is limited

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himself to be placed in a position where his personal interest might conflict with the interest of the beneficiary. A conflicted fiduciary may favor, consciously or unconsciously its interest over the interest of the plan beneficiaries. The standard of review for a fiduciary operating under a conflict of interest remains arbitrary and capricious with a significantly diminished degree of deference. Although [e]ven a conflicted fiduciary should receive deference when it demonstrates that it is exercising discretion among choices which reasonably may be considered to be in the interest of the participants and beneficiaries, the burden shifts to the fiduciary to prove that is interpretation of plan provisions committed to its discretion was not tainted by self-interest. *Adams v. Thiokol Corp.,* 231 F.3d 837, 842 (11th Cir. 2000) (citing *Brown v. Blue Cross Blue Shield of Alabama, Inc.,* 898 F.2d 1556, 1568 (11th Cir. 1990)). If the fiduciary succeeds in proving this burden, the opposing party 'may still succeed if the action is arbitrary and capricious by other measures.' *Adams,* 231 F.3d at 842.

to the administrative record known to the administrator when the decision to deny the LTD benefits was made. *Jett v. Blue Cross and Blue Shield of Alabama, Inc.,* 890 F.2d 1137, 1139 (11th Cir. 1989). Only after the *de novo* review and the Court determines that the administrator is wrong, does it then look for a conflict of interest. *HCA Health Servs. of Georgia, Inc.,* 240 F.3d at 993.

If the Court determines that the administrator's decision was wrong, the Court must then decide whether the claimant has proposed a reasonable interpretation of the plan. *Lee v. Blue Cross Blue Shield of Alabama,* 10 F.3d 1547, 1550 (11th Cir. 1994). Assuming the claimant's interpretation is reasonable, the Court then turns to whether or not the administrator's wrong interpretation of the plan is nonetheless reasonable. *HCA Health Servs. of Georgia,* 240 F.3d at 994. A plan administrator's wrong but reasonable interpretation of the plan is entitled to deference, even in light of the claimant's reasonable interpretation, unless the administrator suffers from a conflict of interest. Id. The Plaintiff's reasonable interpretation does not trump the administrator's wrong interpretation. Id. The principles governing the administrator's decision are similar to the principles of trust law which state that the administrator's interpretation will not be disturbed if it is reasonable. *Firestone Tire and Rubber Co.,* 489 U.S. at 110-111.

The first step for the Court in an ERISA action is to conduct a *de novo* review of the administrative record to determine if the administrator's decision was right or wrong. *Williams v Bellsouth Telecommunications, Inc.,* 373 F.3d 1132, 1138 (11th Cir. 2005); *HCA Health Servs. of Georgia,* 240 F.3d at 993. The Court will review *de novo* MetLife's initial decision to discontinue the Plaintiff's LTD benefits. If after a *de novo* review of the administrative record, the Court determines that the administrator was wrong, the Court will review whether or not the arbitrary and capricious standard or the heighten arbitrary and capricious standard should be used. *Williams,* 373 F.3d at 1138.

DISCUSSION

The Plaintiff argues she is entitled to benefits under the terms of the policy as a Class I employee due to her disability which she claims began in May 2002. She further argues that MetLife is prohibited from raising the preexisting condition exclusion as a defense because it was not raised in its denial letter and/or in the alternative MetLife erred in denying her benefits because it erroneously determined her date of hire. MetLife states that Plaintiff has no legal coverage under the Plan because her coverage became effective on February 4, 2002, after she became ill. MetLife further argues the Plaintiff's claim was untimely filed, or in the alternative, the case should be remanded to MetLife for a formal determination of the Plaintiff's administrative appeal.

(1) Administrative Exhaustion

First, the Court will address MetLife's alternative request for remand since that determination will affect whether or not the case is remanded or a decision is reached on the record. MetLife argues the case should be remanded because the Plaintiff's appeal file was misplaced and no final determination was ever made. "It is well-established law in this circuit that plaintiffs in ERISA cases must normally exhaust available administrative remedies under their ERISA-governed plans before they may bring suit in federal court." *HCA Health Services of Georgia, Inc. v. Employers Health Insurance Company,* 240 F.3d 982, 992 (11th Cir. 2001) (citing *Springer v. Wal- Mart Associates Group Health Plan,* 908 F.2d 897, 899 (11th Cir. 1990)).

In this instance, the Plaintiff complied with the administrative procedures and filed her appeal within 180 days of receiving MetLife's letter denying her claim. (LTD: 71). MetLife acknowledges there were multiple communications between MetLife and the Plaintiff regarding the denial of her claim and further acknowledges the Plaintiff filed a formal appeal via counsel on May 20, 2005. However, MetLife lost the Plaintiff's file and never completed its appeal review.

It is undisputed, the Plaintiff and MetLife were engaged in the appeals process. The Plaintiff entered into negotiations with MetLife and in good faith filed her appeal within the 180 day time limit outlined in the Plan. MetLife then had 45 days after the appeal

was formally filed to file a response. (LTD: 71-72). MetLife's failure to provide a timely review and answer to the Plaintiff's appeal is an implicit denial of her appeal. *See HCA Health Services of Georgia,* 240 F.3d at 992 (finding the insurer issued an implicit denial of the plaintiff's appeal by not making a determination on the plaintiff's appeal within the allotted [45] day time frame). Therefore, the Court will not recommend that the case be remanded to MetLife for a formal determination of the Plaintiff's administrative appeal but will instead proceed with examining the issues on summary judgment.

(2) Whether the Plaintiff Complied with the Policy's Notice Requirement and Qualified for Benefits as a Class I Employee in May 2012

The Plaintiff argues that she was disabled in May of 2002 when she could no longer practice medicine and was reassigned as a bilingual health educator by the Family Health Centers. The Defendant states the Plaintiff was disabled in April of 2003 when she could no longer work. The Defendant argues that Family Health dropped its plan with the Defendant on March 31, 2003, when it ceased paying premiums. Therefore, the Defendant argues the Plaintiff was not covered by the plan on her designated disability date.

The Defendant also argues the Plaintiff's claim for disability based upon her classification as a Class I employee in May of 2002 is invalid because the claim would then violate the Policy's notice requirements.

Under the terms of the Policy, the Plaintiff had to notify the Defendant of her disability within thirty (30) days of the date of disability. (BMA: 19). The Policy reads in pertinent part:

> [t]he Insured must send written notice of claim to BMA within 30 days of the date Disability starts. If the Insured cannot send notice within this time, BMA must be notified as soon as it is reasonably possible to do so.
>
> BMA will send claim forms to the insured within 15 days after the notice of claim is received. These forms must be completed and sent to BMA If the insured does not receive the forms within 15 days after written notice of claim is sent, the Insured can send a written proof of claim to BMA.
>
> The time limit for a claim is no later than 90 days after the end of the Elimination Period. If the proof of claim is not filed within this time limit, the claim may be denied. If it was not reasonably possible to furnish this proof within the time limit, BMA will not reduce or deny the claim. But, BMA shall have no liability when proof is furnished later than one year from the time proof is otherwise required, except in the absence of legal capacity of the claimant.

(BMA: 19)

In this instance, the Plaintiff states she became disabled in May of 2002, however, she did not notify the Defendant of her disability until March 15, 2004, which was almost two (2) years after she claimed the onset of her disability. Under the terms of the Policy, the Plaintiff was required to provide notice to the Defendant "within 30 days of the date Disability starts" or by June of 2002. The Plaintiff actually claimed the onset of disability as May 16, 2002, therefore, her notice was due on June 15, 2002. Thus, the proof of claim would be due by November 11, 2002. The November 11, 2002, date is derived by adding the 90 day Elimination Period to the date of disability and then adding the 90 day deadline requiring that the proof of claim be submitted within 90 days of the end of the elimination period.[3] Finally, the Policy limitation on liability required the Plaintiff to file some claim by at least November 11, 2003. The Plaintiff did not file for disability until March 15, 2004. (BMA: 19). Thus, the Plaintiff's claim would be time barred because she failed to file her claim within the time restrictions included in the Policy. *See* Leit v. Revlon, 85 F. Supp. 2d 1293, 1297 (S.D. Fla. 1999) (holding "[p]articipant's claim for benefits under ERISA-covered long term disability plan was time-barred under plan, where participant failed to comply with plan's requirements that notice of claim be given within 30 days of date that disability starts and to provide proof of claim within 270 days following discovery of disability.").

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[3] May 16, 2002 + 90 day Elimination Period + 90 day proof of claim deadline = November 11, 2002.

The Plaintiff asserts the notice clause may not be argued by the Defendant because the notice exemption was not set forth in its denial letter and that the Defendant did not suffer any prejudice from the late notification. However, in a recent decision, the Eleventh Circuit held that it was not error for the district court to specifically consider and examine post-hoc explanations provided by the insurer in ERISA cases. *Tippitt v. Reliance Standard Life Insurance, Co.,* 2008 WL 1875968 * 3 (11th Cir. April 29, 2008).

The Plaintiff also argues that the presumption of prejudice to the Defendant does not apply to this action because there is no proof the Defendant was prejudiced by the late notice. Florida law provides that prejudice to the insurer is presumed "when a policy makes a compliance with a written notice provision a condition precedent to the insurer's liability." *Tiedtke v. Fidelity & Casualty Co. of New York,* 222 So. 2d 206, 208 (Fla. 1969). While the Plaintiff argues it believes the Defendant would not have acted upon the application if it had been presented in a timely fashion, mere conclusory speculations about how the Defendant would have acted are insufficient to overcome the presumed prejudice under Florida law.

The Plaintiff further argues that written notification was not part of the Policy and therefore, *Tiedke,* does not apply. The Plaintiff's argument lacks merit. As noted above, the Policy required 30 days written notice within the commencement date of claimed disability. (BMA: 19). The Policy further

states that failure to provide some notice within a year of the onset of the disability would relieve the Insurer of any liability under the Policy's terms. Consequently, the decision from *Tiedke* applies and therefore, the Court respectfully recommends the Plaintiff's claim should be denied.

(3) Whether the Defendant is Prohibited from Raising a Preexisting Condition Defense

The Plaintiff argues that MetLife is precluded from raising the preexistence clause as a defense to her claim because MetLife did not include the preexisting exclusion in its letter denying her benefits. MetLife states the Plaintiff was not covered under the plan until February 1, 2002, therefore, she would not be covered for any long term consequences she suffered due to a grand mal brain seizure she had on December 2, 2001.

The Plaintiff's argument that only the information contained in the letter issued by MetLife denying her benefits lacks merit. Courts have held that under *de novo* review the Plan Administrator may argue policy provisions that were not listed in the denial letter. *Farley v. Benefit Trust Life Insurance, Co.*, 979 F. 2d 653, 660 (8th Cir. 1992). In this case, the Court should first review the Plan Administrator's decision *de novo* to make an initial determination if the Administrator was right or wrong. *Williams,* 373 F.3d at 1138; *HCA Health Servs. of Georgia,* 240 F.3d at 993. Both Parties agree that a *de novo* review is appropriate in this instance.

Although the Plaintiff argues that ERISA claimants are entitled to timely and specific explanations of benefit denials, and may not be sandbagged by post-hoc justifications of plan decisions, it is not error for the district court to consider them. *Tippitt,* 2008 WL 1875968 at *3 (holding that it was not error for the district court to specifically consider and examine post hoc explanations). In *Farley,* the Eighth Circuit held that to allow the insurer to only argue the information included in the letter of denial and not the terms and conditions of the policy as a whole would in effect permit the oral modification of the benefit plan covered under ERISA. 979 F. 2d at 660. Such an action would conflict with the intent of the statute and with the case law governing ERISA review. *Id.* Furthermore, the Eleventh Circuit's recent ruling in *Tippitt* clearly established that a district court can in fact consider an administrator's post-hoc explanations for denying coverage. 2008 WL 1875968 at * 3. The district court may choose not to accord self-severing post hoc explanations much weight, but it is not error for the district court to consider them. *Id.* If the Court were to review only the language of the denial letter and no other provisions of the Policy, the effect would be to create coverage where no coverage existed. *See Doe v. Cigna Life Insurance Co. of New York,* 304 F. Supp. 2d 477, 496-497 (W.D. N.Y. 2004) (holding the doctrine of waiver is inapplicable where the issue is the existence or nonexistence of coverage).

Therefore, the Court must consider whether or not the Defendant's preexisting condition argument is

valid. However, before considering the preexisting condition clause, the Court must first determine if the Defendant used the proper date of hire in making its determination that the Plaintiff's condition was excluded under the preexisting condition clause.

(4) Whether MetLife Erred in Determining the Plaintiff's Date of Hire

Under the terms of the LTD policy, the Plaintiff had to be actively at work for Family Health for at least thirty (30) hours per week and complete a sixty (60) day waiting period from the date of hire before she would be eligible for LTD coverage under the subject policy. (BMA: 32). The Plaintiff argues that her date of hire was September 25, 2001, because that was the date she signed the Professional Services Agreement (PSA) with Family Health Centers of Southwest Florida (Family Health) and that she was actively at work at least thirty (30) hours per week. The Defendant states the date of hire was November 5, 2001, the Plaintiff actually began working at Family Health on November 6, 2001 and she actually became eligible for coverage on February 4, 2002.

On September 23, 2001, Family Health sent the Plaintiff a letter that clearly stated the Plaintiff would be required to enter into a PSA prior to her employment. (STD: 11). The PSA clearly stated that the time the agreement was to begin was November 5, 2001, and continue until November 4, 2003. (LTD: 23). The Plaintiff signed the agreement and, therefore, acknowledged at that time she would begin working

for Family Health on November 5, 2001, and not September 25, 2001. In addition to the PSA, the Plaintiff also signed a letter of intent on September 23, 2001, which stated "Dr. Claib will be employed to practice as a Family Practice Physician primarily at the Lehigh Medical Clinic on behalf of Family Health Centers of Southwest Florida, Inc. beginning on or about November 5, 2001. (STD: 11). It is clear, the Plaintiff understood and agreed that she would begin her employment with Family Health on or about November 5, 2001, when she signed the letter of intent. Therefore, it is recommended the date to be considered as the Plaintiff's date of hire should be November 5, 2001.

(5) Whether the Plaintiff's Condition was Properly Excluded Under the Preexisting Condition Clause

The Policy's preexisting condition clause states:

> [a] disability which begins during the first 12 months of coverage, which is caused by, contributed to by, or results from a Preexisting Condition will not be covered unless the insured has received no Treatment for the condition for 6 consecutive months after the insured's Effective Date.
>
> Preexisting Conditions means a Sickness or Injury for which the Insured received Treatment within 3 months prior to the Insured's Effective Date.

(BMA: 19).

The Plaintiff also argues that she met the terms of coverage under the Policy because she was at work for at least thirty (30) hours per week from the time she signed the PSA in September. However, the Plaintiff was employed with another company from September 25, 2001, until she began working for the Defendants on November 5, 2001. The Policy required the Plaintiff to be employed by Family Health and working at least thirty (30) hours a week for a period of sixty (60) days before LTD coverage would be effective. (BMA: 32). The Policy language clearly states the "person must be Actively at Work at the Policyholder's place of business at least 30 hours each week." (BMA: 32). This view is further supported by the employee handbook which states "as a regular full time employee of Family Health Centers, you may be eligible to participate in a number of employee benefit programs." (LTD: 56)(emphasis added). Included in the benefits program discussed in the employee handbook are the LTD benefits at issue in this case. (LTD: 57).

Under the policy's terms and conditions, the coverage would then begin as follows:

> [t]he person's coverage or any change in benefits due to change in class begins the first date all requirements for coverage are met if that date is the first day of a Policy Month. If all requirements are met after the first day of the Policy Month, the Effective Date will be the first day of the following Policy Month.

> Coverage may be delayed if the insured is not Actively at Work on the date coverage would otherwise have been effective.

(BMA: 11). Therefore, had the Plaintiff been actively at work from November 5, 2001 through January 5, 2002, she would have been eligible for coverage on January 5, 2002. However, because she did not return to work until February 4, 2002, her coverage was not effective until that date. The Plaintiff suffered a grand mal seizure on December 2, 2001, prior to her effective date. Under the terms of the Policy, the Plaintiff was not eligible for coverage until she actually returned to work on February 3, 2002. Therefore, it is respectfully recommended the Plan Administrator correctly determined the Plaintiff was not covered under the preexisting condition exclusion contained in the policy.

Conclusion

The Court respectfully recommends the Plaintiff is time barred from bringing her claim because she failed to comply with the Policy's notice requirements. The Court further respectfully recommends that the Plaintiff was not eligible for LTD coverage until sixty (60) days from her hire date which began on November 5, 2001. Thus, the period of eligibility would have begun on January 5, 2002, but due to her absence after she suffered a grand mal brain seizure, eligibility began on February 4, 2002.

As such, it is respectfully recommended that the Plaintiff was not covered under the preexisting condition clause contained in the policy.

Accordingly, it is now

RESPECTFULLY RECOMMENDED:

(1) The Defendants Business Men's Assurance Company of America, and Metropolitan Life Insurance Company's Motion for Summary Judgment (Doc. #29) should be GRANTED.

(2) The Plaintiff Beatriz Martinez-Claib, M.D.'s Motion for Summary Judgment (Doc. # 31) should be DENIED.

Failure to file written objections to the proposed findings and recommendations contained in this report within ten (10) days from the date of its filing shall bar an aggrieved party from attacking the factual findings on appeal.

Respectfully recommended at Fort Myers, Florida, this 9th day of September, 2008.

s/ Sheri Polster Chappell

United States Magistrate Judge

APPENDIX D: Eleventh Circuit Order denying petition for rehearing, February 26, 2013

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 08-16781

D.C. Docket No. 06-00479-CV-FTM-99-SPC

BEATRIZ MARTINEZ-CLAIB, M.D.,
Plaintiff-Appellant,

versus

BUSINESS MEN'S ASSURANCE COMPANY OF AMERICA,
METROPOLITAN LIFE INSURANCE COMPANY,
Defendants-Appellees

On Appeal from the United States District Court
For the Middle District of Florida

Before EDMONDSON, BLACK and SILER,[*] Circuit Judges

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[*] Honorable Eugene E. Siler, Jr., United States Circuit Judge for the Sixth Circuit, sitting by designation.

PER CURIAM:

The petition(s) for rehearing filed by Appellant is DENIED.

ENTERED FOR THE COURT:

J.L. Edmondson, United States Circuit Judge

APPENDIX E: Excerpt from MetLife disability policy re denial explanation requirements

If BMA denies the claim, in whole or in part, the claimant will receive a written notification setting forth:

The specific reason or reasons for the denial;

Specific reference to pertinent Plan or Policy provision(s) on which the denial is based;

A description of any additional material or information necessary to perfect the claim for appeal, and an explanation of why such material or information is necessary; and

Appropriate information as to the steps to be taken if the claimant wishes to appeal BMA's determination, including the claimant's right to review pertinent Plan documents.

APPENDIX F: MetLife's November 23, 2004 Claim Denial Letter

Dear Mrs. Martinez-Claib;

We have completed our review of your Long Term Disability claim and have concluded that you are not eligible to receive Long Term Disability benefits.

In order to be eligible for Long Term Disability (LTD) benefits, you must have a qualifying period of disability.

According to our records, your date of hire was November 6, 2001. Under the Family Health Ctrs Long Term Disability (LTD) plan, 'a person must complete a waiting period of 60 days from the date of hire. If all requirements are met after the first day of the month, the effective day will be the first day of the following month." Your 60 day waiting period was completed January 5, 2002. Since this was after the first of the month, your LTD coverage would not be effective until the following month, February 1, 2002.

However, your plan also states "Coverage may be delayed if the Insured is not Actively at Work on the date coverage would otherwise have been effective." Since you were not actively at work, December 1, 2001 through February 2, 2002, your LTD coverage was effective the date you returned to active work, February 3, 2002.

The Family Health Ctrs cancelled their Long Term Disability Plan with MetLife effective March 31, 2003. Since your last day of work was April 8, 2003, the Long Term Disability plan from MetLife was no longer in effect.

Therefore, based on all available information we have, there is no qualifying period of disability under the Long Term Disability Plan with MetLife and you are not eligible to receive benefits under this Plan.

You may appeal this decision by sending a written request for appeal to MetLife Disability, PO Box 14592, Lexington KY 40511-4592 within 180 days after you receive this denial letter. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate for us to give your appeal proper consideration. Upon request, MetLife will provide you with a copy of the documents, records, or other information we have that are relevant to your claim and identify any medical or vocational expert(s) whose advice was obtained in connection with your claim.

MetLife will evaluate all the information and advise you of our determination of your appeal within 45 days after we receive your written request for appeal. If there are special circumstances requiring additional time to complete our review, we may take up to an additional 45 days, but only after notifying you of the special circumstances in writing. In the

event your appeal is denied in whole or in part, you will have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

Sincerely,

Tracy Laing

Sr. Case Management Specialist

APPENDIX G: Excerpts from arguments presented in district and circuit courts by Dr. Martinez-Claib regarding contractual denial-explanation requirement

District Court:

Plaintiff's Objections to Second Report and Recommendation, September 23, 2008:

Dr. Martinez-Claib has argued previously that "because ERISA and its enabling regulations require that a claimant be provided with the specific reasons for a claim denial at the time a claim is denied, a plan administrator or insurer is not allowed to argue new reasons once the claim is in litigation." BMC Opposition at 2; *see also* BMC Motion at 15-18. Consequently, she argued, MetLife could not invoke either the PEC exclusion or the notice of claim deadline. BMC Motion at 15-18; BMC Opposition at 1-4. The R&R, however, concluded "it was not error for the district court to specifically consider and examine post-hoc explanations provided by the insurer," citing *Tippitt v. Reliance Standard Life Ins. Co.,* 276 Fed.Appx. 912 (11th Cir. 2008). R&R at 9. That conclusion, despite *Tippitt's* determination, is erroneous, if only because MetLife was *contractually* required to provide specific reasons and policy provisions when it denied the claim.

* * *

Therefore, when it denied the claim, MetLife was contractually bound to provide "the specific reason or

reasons for the denial," and cite to specific policy provisions.

Eleventh Circuit:

Appellant's Opening Brief, January 20, 2009:

The BMA policy provided in pertinent part:

* * *

Therefore, in addition to statutory and regulatory requirements to that effect, MetLife was contractually bound in this case to provide specific reasons, and cite to specific policy provisions, at the time the denial was conveyed. Thus, to allow MetLife to bring in new rationales now would effect precisely what the R&R sought to avoid: it would "permit oral modification of [an] employee welfare plan[ ] governed by ERISA." *See* R&R, Doc. 53, pg.10; *Farley v. Benefit Trust Life Ins. Co.,* 979 F.2d 653, 660 (8th Cir. 2002). That is, it would unduly relieve MetLife of its contractual obligation to provide specific reasons at the proper time. That, in turn, would contravene ERISA itself, which provides that MetLife, as an ERISA fiduciary, was obligated to discharge its duties with respect to the plan "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with ERISA." *Yochum v. Barnett Banks, Inc. Severance Pay Plan,* 234 F.3d 541, 545 (11th Cir. 2000) (quoting 29 USC §1104(a)(1)(D)).

Appellant's Reply Brief, April 17, 2009:

As Dr. Martinez-Claib argued previously, ERISA and its enabling regulations are not the only sources of a denial explanation requirement here. The insurance policy MetLife was administering itself contained a like requirement, and excusing MetLife from that requirement would violate the written terms of the policy no less than precluding *post hoc* rationales would.