

**UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT**

SHIRLEY O. FOUGHT,
Plaintiff-Appellant,

v.

UNUM LIFE INSURANCE
COMPANY OF AMERICA,

Defendant-Appellee.

No. 02-2176

ORDER
Filed August 13, 2004

Before **TACHA**, Chief Judge, **McKAY**, and **HENRY**, Circuit Judges.

This matter is before the court on appellee's Petition For Rehearing and Suggestion for Rehearing En Banc. The request for panel rehearing is granted. The per curiam opinion filed on February 6, 2004 is vacated, and the attached revised opinion is substituted in its place.

In light of the substantial revisions made by the panel, however, we will suspend local rule 40.3, which prohibits successive rehearing petitions. *See Fed. R. App. P. 2* (giving court of appeals discretion, for good cause, to "suspend any

provision of [the] rules”); 10th Cir. R. 2.1 (providing court discretion to suspend the local rules).

Entered for the Court
PATRICK FISHER, Clerk of Court

by:
Deputy Clerk

FILED
United States Court of Appeals
Tenth Circuit

AUG 13 2004

PATRICK FISHER
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No. 02-2176

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO
(D.C. NO. CIV-01-124)

Robert P. Warburton (Ray M. Vargas, II, with him on the briefs), Sheehan,
Sheehan & Stelzner, P.A., Albuquerque, New Mexico, for Plaintiff-Appellant.

Kathryn D. Lucero (Kerri L. Peck, with her on the brief), Foster, Johnson,
McDonald, Lucero, Koinis, LLP, Albuquerque, New Mexico, for Defendant-
Appellee.

Before **TACHA, McKAY** , and **HENRY** , Circuit Judges.

PER CURIAM .

Shirley O. Fought challenges the decision by UNUM's claims administrator to deny long-term disability benefits under her employer's group disability plan. A severe staph infection that followed elective heart surgery hospitalized and disabled Ms. Fought. UNUM's plan administrator denied coverage by concluding that Ms. Fought suffered from a pre-existing coronary artery condition that "caused," "contributed to," or "resulted" in Ms. Fought's disability, citing language in the plan. After exhausting the company's internal appeals process, Ms. Fought brought a civil suit under 29 U.S.C. § 1132(a)(1)(B), alleging that she was entitled to disability benefits under the plan. UNUM admitted to a conflict of interest, as both payor and administrator of the plan. The magistrate judge denied discovery regarding the extent of UNUM's conflict of interest. The district court then granted summary judgment in favor of UNUM.

Exercising jurisdiction under 28 U.S.C. § 1291, we hold that the district court did not apply the appropriate standard of review when it considered the plan administrator's denial of benefits to Ms. Fought. Applying the correct standard of review, we reverse the grant of summary judgment in favor of UNUM and remand to the district court for further proceedings.

I. BACKGROUND

A. Undisputed Facts

On May 18, 1998, Ms. Fought enrolled in her employer's group long-term disability plan, which was issued by UNUM with an effective date of June 1, 1998. The policy, under a provision entitled "What disabilities are not covered under your plan?" states: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition." Aple's Supp. App. at 341-42.

The policy does not define the terms "caused by, contributed to by, or resulting from." The policy provides the following details regarding a pre-existing condition:

You have a pre-existing condition when you apply for coverage when you first become eligible if:

- you received medical treatment, consultation, care or services including diagnostic measure or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

Id. at 342.

Prior to her enrollment in the plan, Ms. Fought had been diagnosed and treated for coronary artery disease. In August 1998, approximately three months after her enrollment in the plan, Ms. Fought underwent angioplasty. On March 8, 1999, she was admitted for unstable angina syndrome, and on March 15, 1999, she underwent an elective coronary artery revascularization surgery. During surgery, the doctors discovered that Ms. Fought's sternum was narrow and osteoporotic, requiring a special procedure to close the surgical wound. Her doctors noted that "her postoperative course was anticipated to be quite challenging[,] given the concerns about the wound." *Aplt's App.* at 79. She was discharged six days after surgery on March 22, 1999. "At the time of [her] discharge, there [was] no evidence of infection," and "her wounds were healing well." *Id.* at 83; 166.

Three weeks later, the incision from Ms. Fought's wound became "dehiscid," or split open. On April 8, 1999, she was readmitted for care of her dehiscid sternal wound and a possible infection. *Aple's Supp. App.* at 97.

At this time, her wound cultures tested positive for a "few" *Klebsiella pneumoniae* bacteria. She was placed on antibiotics and given intensive wound care to prevent infection. After a hospital stay of five days, and a "dramatic improvement in the appearance of the wound," she was sent to a skilled nursing facility. *Aplt's App.* at 85. At the time, the "wound appearance looked

satisfactory.” *Id.* at 85. She was discharged from the facility on April 19, 1999.

On May 7, 1999, Ms. Fought complained of right-side chest pain. She was readmitted to the hospital on May 11, 1999, with a white blood cell count of 12,000 and a low grade fever. Two exposed sternal wires were detected. Her sternal wound and blood cultures were positive for both *Klebsiella pneumonia* and methicillin-resistant *Staphylococcus aureus* in the sternal wound and methicillin-resistant *Staphylococcus aureus* in the blood stream. *Id.* at 139.

Ms. Fought was placed in the Intensive Care Unit. Over the next two months, she underwent various operative procedures, was intubated, and received hemodynamic monitoring, nutritional support, and sedation. One surgery involved extensive sternal wound reconstruction and required Ms. Fought to be placed on a ventilator. She was discharged on July 15, 1999, when she was transferred to another facility for intensive wound care.

On September 13, 1999, UNUM denied coverage under the long-term disability plan, having determined that Ms. Fought’s pre-existing condition “caused, contributed to, or resulted in the condition(s) for which [she was] claiming disability.” *Aplt’s App.* at 33-34 (Letter to Ms. Fought from Anne Dionne, Disability Benefit Specialist, dated Sept. 13, 1999). Ms. Fought submitted a formal request to have her claim reopened, *see id.* at 143 (Letter from Ms. Fought to Ann Dionne, dated Oct. 19, 1999), as well as letters from three

doctors certifying that the staph infection was neither a pre-existing condition nor related to her pre-existing coronary artery disease. *Id.* at 156 (Note from Dr. Robert T. Ferraro, dated Oct. 19, 1999) (“[T]he staph infection which is the basis for multiple wounds on chest is not related to coronary artery disease. *This is a separate, unrelated diagnosis without preceding history.*”) (emphasis added); *id.* at 154 (Note from Dr. Robert Dubroff, dated Oct. 22, 1999) (“[Ms.] Fought is totally disabled due to her heart condition. *The staph infection was not a pre-existing condition.*”) (emphasis added); *id.* at 155 (Note from Dr. Neil T. Chen, undated) (“[Ms.] Fought’s chest & abdominal wounds/infection is [sic] not a preexisting condition.”) (emphasis in original).

UNUM’s medical department reviewed Dr. Ferraro’s letter,¹ but the

¹ The letter from UNUM does not mention the other doctors’ letters, saying only that “Dr. Ferraro’s note was reviewed by our medical department.” Aplt’s App. at 147. Apparently, the other two doctors’ letters were faxed to UNUM on October 25, 1999, the very day that UNUM sent Ms. Fought the letter confirming its denial of disability benefits. *See id.* at 146. “Plan administrators, of course, may not arbitrarily refuse to credit a claimant’s reliable evidence, including the opinions of a treating physician.” *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1972 (2003). We note that UNUM’s subsequent review, *see* Aplt’s App. at 150, appeared to include consideration of Ms. Fought’s additional doctors’ notes.

We also note that the parties do not argue that the plan administrator misallocated the weight it gave to the treating physician’s opinion, so the admonishments of *Black & Decker* do not apply. *See Black & Decker*, 123 S. Ct. at 1972 (“[W]e hold [that] courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant’s physician; nor may courts impose on plan administrators a discrete burden of explanation
(continued...)”) (continued...)

company declined to reverse its previous decision, stating that although “the staph infection itself was not present during the pre-existing condition period (3/1/98-5/31/98), it was the result of surgery that was performed for a cardiac condition that was present, diagnosed and treated during that time frame.” *Id.* at 147-48 (Letter to Ms. Fought from Anne Dionne, dated Oct. 25, 1999).

Ms. Fought then retained legal counsel, who contacted UNUM’s Long-Term Disability Quality Review Section, and informed the company that Ms. Fought was appealing the denial of coverage. *See id.* at 159. After a review, UNUM again denied coverage, stating that “the staph infection was the result of surgery performed for a cardiac condition that was caused by, contributed to by, or resulted from the cardiac condition that was present, diagnosed and treated during the pre-existing period.” *Id.* at 150 (Letter from John J. Schifano, Senior Benefit Analyst, dated Dec. 2, 1999).

Finally, Ms. Fought contacted the New Mexico Public Relations Commission, which corresponded with UNUM concerning Ms. Fought’s situation. Responding to the state agency’s inquiry, UNUM explained that the staph infection was the result of coronary bypass surgery, which was performed to treat her pre-existing condition. “She would not have had to have the surgery, later

¹(...continued)
when they credit reliable evidence that conflicts with a treating physician’s evaluation.”).

developing an infection, if she did not have the cardiac conditions which were present and treated for during the pre-existing period.” *Id.* at 158 (Letter from Theresa-Ann Uminga, Senior Complaints Specialist, to James A. Chavez, Ms. Fought’s Attorney, dated Feb. 11, 2000).

B. Procedural History

In August 2001, Ms. Fought filed suit in federal district court alleging UNUM violated 29 U.S.C. § 1132 in denying her claim for benefits. UNUM admitted that it operated under a conflict of interest, *id.* at 12 (Memorandum Opinion and Order Granting Defendant’s Motion for Summary Judgment, filed May 31, 2002), because it both administers claims and is the payor of those claims. Ms. Fought requested discovery to allow inquiry into the extent of UNUM’s conflict of interest. The magistrate judge denied this request.

UNUM moved for summary judgment. The district court, acknowledging the conflict of interest, proceeded to interpret the contract language “caused by, contributed to by, or resulting from” as meaning “related to” and “foreseeable complication of” a pre-existing condition. The district court ruled that the “staph infection [was] related to the coronary artery disease as a foreseeable complication of treatment.” *Aplt’s App.* at 14. On that basis, the district court granted UNUM’s motion for summary judgment, concluding that UNUM’s

decisions to deny Ms. Fought long-term disability benefits were not arbitrary or capricious, and ordered Ms. Fought to pay UNUM's costs.

Ms. Fought now appeals.

II. ANALYSIS

UNUM's long-term disability plan is governed by the Employee Retirement and Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citations and internal quotation marks omitted); *see also* 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans.").

In seeking coverage under her long-term disability benefit plan, Ms. Fought advances three arguments. First, she argues that the district court erred by using the wrong standard of review when it reviewed UNUM's decision. Second, she argues that UNUM's denial of benefits was, in any event, an unreasonable interpretation under the plan. Finally, she argues that the district court failed to consider UNUM's obligation to draft plan provisions in a manner calculated to be

understood by the average plan participant.

We begin with the appropriate standard of review, discussing (1) the current state of the Tenth Circuit's "sliding scale" standard of review, (2) the application of the sliding scale standard of review in conflict of interest cases, (3) the application of a reduced deference standard in this case.

We then combine our analysis of Ms. Fought's second and third arguments. Given our standard of review, we first analyze whether the plan administrator's construction of the plan language is a reasonable one. In so doing, we consider (a) the plan's pre-existing exclusion clause, (b) the role of causation in interpreting the pre-existing exclusion clause, (c) the Department of Labor's regulations and a published example regarding pre-existing conditions, (d) relevant circuit and district court case law involving similar questions, and (e) whether clearer exclusionary language may have been available to UNUM. Finally, we examine whether, given the record evidence and our reduced deference standard of review, UNUM's application of the pre-existing condition exclusion was supported by substantial evidence.

A. The Standard of Review

"Summary judgment orders are reviewed de novo, using the same standards as applied by the district court." *Pitman v. Blue Cross & Blue Shield of Okla*, 217

F.3d 1291, 1295 (10th Cir. 2000). Accordingly, like the district court, we must review UNUM's decision to deny benefits to Ms. Fought, and we must determine the appropriate standard to be applied.

The Supreme Court provided important guidance regarding the standard of review in ERISA benefits cases in *Firestone*, 489 U.S. at 113-15. The Court noted that deference to expert administrators is grounded in the most fundamental premises of trust law. If a disinterested party exercising discretionary powers has looked at evidence and rendered a decision, it is not only reasonable but a wise conservation of judicial resources not to have judges replicate the administrator's work. *See id.*

Recognizing that parties to a contract can agree to vest discretionary authority in an administrator, the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) [ERISA] is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. There is no dispute that here the plan expressly gives UNUM, as plan administrator, the discretion to determine whether to deny a claimant insurance benefits under the plan. *Aplt's. App.* at 31. Therefore, because the plan grants UNUM discretion, "[a] court reviewing a challenge to a denial of employee benefits . . . applies an 'arbitrary and capricious' standard to a plan

administrator's actions." *Charter Canyon Treatment Ctr. v. Pool Co.*, 153 F.3d 1132, 1135 (10th Cir. 1998). "[O]ur review is limited to determining whether [the plan administrator's] interpretation was reasonable and made in good faith." *Hickman v. GEM Ins. Co.*, 299 F.3d 1208, 1213 (10th Cir. 2002). "[A]ssuming full and expansive discretion has been conferred, then the plan administrator's interpretation of ambiguous plan provision should be judged as follows: (a) as a result of reasoned and principled process (b) consistent with any prior interpretations by the plan administrator (c) reasonable in light of any external standards and (d) consistent with the purposes of the plan." Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U.L. REV. 1083, 1135, 1172 (2001) (hereinafter, Kennedy, *Judicial Standard*) (summarizing and recommending the Fourth Circuit's current set of reasonableness factors). Finally, in reviewing a plan administrator's decision under the arbitrary and capricious standard, "the federal courts are limited to the 'administrative record' – the materials compiled by the administrator in the course of making his decision." *Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1201 (10th Cir. 2002).

The possibility of an administrator operating under a conflict of interest, however, changes the analysis. *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1282 (10th Cir. 2002) ("Indicia of arbitrary and capricious decisions

include . . . conflict of interest by the fiduciary.”). Thus, “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a ‘facto[r]’ in determining whether there is an abuse of discretion.” *Firestone*, 489 U.S. at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).² “The rationale for this approach is clear. A conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries.” *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990); *see also Pitman*, 217 F.3d at 1296 (“[W]hen an insurance company serves as ERISA fiduciary . . . , it is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to plan participants.”) (quoting *Brown*, 898 F.2d at 1561).

Following *Firestone*, the various circuit courts attempted to put the Court’s instructions into practice. “Since *Firestone*, all of the circuit courts agree that a conflict of interest triggers a less deferential standard of review. The courts,

² We continue to treat the terms “arbitrary and capricious” and “abuse of discretion” as interchangeable in this context. *See Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 n.1 (10th Cir. 1996) (“Some circuit courts have recently distinguished between these two standards and have concluded that the abuse of discretion standard is more appropriate. Most courts, however, have held that this is a distinction without a difference. We agree and adhere to the arbitrary and capricious standard of review.”) (internal citations and quotation marks omitted).