IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF UTAH

CENTRAL DIVISION

HETHYR TOMAN,

Plaintiff,

v.

GOLDMAN, SACHS & COMPANY MEDICAL PLAN,

Defendant.

MEMORANDUM DECISION AND ORDER

Case No. 2:02CV 1184 DAK

This matter is before the court on (1) Defendant's Motion for Summary Judgment, (2) Plaintiff's Motion for Summary Judgment, and (3) Plaintiff's Motion to Strike Portions of the Declaration of Shanna Jensen. A hearing on the motions was held on March 26, 2004. At the hearing, plaintiff, Hethyr Toman, was represented by Brian S. King. Defendant, Goldman, Sachs & Company Medical Plan (the "Plan"), was represented by Scott A. Hagen of Ray, Quinney & Nebeker. Before the hearing, the court considered carefully the memoranda and other materials submitted by the parties. Since taking the matter under advisement, the court has further considered the law and facts relating to these motions. Now being fully advised, the court renders the following Memorandum Decision and Order.

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I. CROSS-MOTIONS FOR SUMMARY JUDGMENT

A. Background

The Plan is an employee benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et. seq.* The Plan's sponsor and administrator is Goldman, Sachs & Co. The Plan is administered on behalf of Goldman, Sachs & Co. by UnitedHealthcare. Plaintiff is a participant in the Plan and has filed this lawsuit seeking benefits under 29 U.S.C. § 1132. Both parties' motions for summary judgmcnt deal with the same issue–whether the Plan properly denied plaintiff's claim for benefits.

In December of 2001, plaintiff's oral surgeon, Dr. Dennis DeDecker, wrote UnitedHealthcare to obtain pre-authorization to perform surgery upon the plaintiff. Dr. DeDecker's letter stated, in part:

> Hethyr Toman suffers from a musculoskeletal defect resulting in decreased jaw function and ability to masticate food properly. In effect, the patient is a masticatory cripple.
>
> The above planned treatment will be necessary in order to correct the patient's skeletal defect. This is considered a functional correction and is not cosmetic.

In addition, Dr. DeDecker diagnosis of the plaintiff included "impairment of normal chewing" and "alteration of normal speech."

After receiving Dr. DeDecker's letter, UnitedHealthcare reviewed the request for pre-authorization and indicated on its internal medical review form that the plaintiff "has 100% coverage if deemed medically necessary" but recommended that the claim be denied. On January 8, 2002, UnitedHealthcare sent a letter denying coverage because "[t]he requested dental services are not

eligible for benefit coverage per the terms of the medical benefit plan."

Plaintiff appealed the Plan's denial of coverage and went ahead with her surgery scheduled for February 13, 2002 even though her appeal was still pending. In support of her administrative appeal, the plaintiff submitted additional materials to UnitedHealthcare consisting primarily of letters describing the plaintiff's condition written by the plaintiff and her medical care providers as well as impression moldings of her teeth. After receiving the additional materials, UnitedHealthcare requested and received medical records from the plaintiff's primary physician, Dr. Alex Tessnow. On March 1, 2002, UnitedHealthcare sent another letter denying coverage under the Plan and stating as its reason:

> Medical records from Dr. Tessnow show that referral to oral surgery was to remedy malocclusion. No symptoms of difficulty eating or speaking were noted. Orthognathic surgery for malocclusion is not a covered benefit without demonstration of a functional impairment.

The plaintiff once again appealed and received a final denial letter on April 8, 2002 stating that the Plan had determined that the previous denial should be upheld.

The plaintiff incurred $33,934.88 in medical bills as a result of the surgery. After the Plan's final denial of benefits, the plaintiff was required to use credit cards to pay her medical providers in order to avoid collection proceedings and to protect her credit rating. At the time these motions were filed, the plaintiff was continuing to make payments, with interest, on the credit card balances.

THE PLAN'S LANGUAGE

Under the "**Medical Benefits**" portion of the Plan Document it states, in relevant part:

> **Oral Surgery and Dental Services**
>
> - Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.
> - The following services and supplies are covered only if needed because of accidental injury to natural teeth:
>   - Oral surgery.
>   - Full or partial dentures.
>   - Fixed bridge work.
>   - Prompt repair to natural teeth.
>   - Crowns.
>
> . . . .
>
> **Reconstructive Surgery**
>
> - Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
>   - Birth defect.
>   - Sickness.
>   - Surgery to treat a Sickness or accidental injury.
>   - Accidental injury
> - Reconstructive breast surgery following a necessary mastectomy.
> - Reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to Sickness or accidental injury.
> - Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a Covered Person may suffer psychological consequences or

> socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.
>
> Notify United HealthCare Insurance Company for Non-Network benefits 5 business days before receiving services. By notifying United HealthCare Insurance Company, United HealthCare Insurance Company can verify that the service is a reconstructive procedure rather than a cosmetic one.

Under the "**General Exclusions and Limitations**" portion of the Plan Document it states, in relevant part:

> This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:
>
> . . . .
>
> - Surgical correction or other treatment of malocclusion.[1]
>
> . . . .
>
> - Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak. See **Medical Benefits** for limited coverage of oral surgery and dental services.

UnitedHealthcare also utilized internal medical guidelines to determine whether the plaintiff's surgery was a covered benefit under the Plan. Generally speaking, the guidelines provide

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[1] "Malocclusion is an abnormal alignment of the upper and lower jaws that prevents the teeth from meeting properly." THE MERCK MANUAL § 8, ch. 114 (2d home ed.).

coverage for oral surgery when there is a medically documented functional impairment, as opposed to cosmetic impairments that are not covered. The Plan did not rely upon the exclusion provisions as the basis for its denial, but rather, evaluated plaintiff's claim under the Medical Benefits section of the policy and the guidelines to determine whether it was medically necessary. The Plan now argues that its evaluation of the plaintiff's claim for functional impairment/medical necessity was a "mistake" and that it should have denied the claim under the exclusion provisions of the Plan Document.

B. Discussion

1. Standard of Review

District courts review a denial of benefits challenged under ERISA "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." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The Plan in this case grants such discretion and therefore an arbitrary and capricious standard of review would normally be applied.[2] However, this case presents a unique issue in that the Plan did not assert or rely upon the exclusion provisions as the basis for its denial

[2] The Plan Document states "[t]he Plan Administrator has the discretion to construe and interpret the terms of this Plan and the authority and responsibility to make factual determinations." (Plan Document p. 62) The Plan Document also states that "Goldman, Sachs & Co. has entered into an arrangement with United Health Care Service Corp. (called 'the Company') which provides for the Company to process benefit claims and provide certain other services under the Plan" (Plan Document p. 3) and that "[t]he Plan is administered on behalf of the Plan Administrator by the Company [United Healthcare]." (Plan Document p. 61). A plan administrator may delegate its discretionary authority to a third-party administrator. *See Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 630 (10th Cir. 2003).

during the administrative proceedings. Instead, the Plan denied plaintiff's claim based upon an alleged failure to demonstrate a functional impairment. The Plan now argues that a determination of medical necessity/functional impairment is not necessary and seeks to invoke, for the first time, the exclusionary language of the Plan Document as the basis for denying coverage.

When applying an arbitrary and capricious standard of review, new arguments should generally not be considered. *See Nance v. Sun Life Assurance Co. of Canada*, 294 F.3d 1263, 1269 (10th Cir. 2002) ("In determining whether the plan administrator's decision was arbitrary and capricious, the district court generally may consider only the arguments and evidence before the administrator at the time it made that decision.") (quoting *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992)); *Lund v. UNUM Life Ins. of America*, 19 F. Supp. 2d 1254, 1259 (D. Utah 1998) ("When the arbitrary and capricious standard applies, judicial review is confined to the arguments and evidence presented to the plan administrator at the time of its decision.").

ERISA requires the Plan to provide the plaintiff "adequate notice in writing" when there has been a denial "setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1). One of the purposes for such a requirement is to allow the plaintiff an opportunity to marshal the appropriate evidence necessary to contest the denial of benefits during the administrative appeal process. The only specific reason provided by the Plan in writing for its denial of plaintiff's claim was the lack of a functional impairment. The plaintiff would be at an enormous disadvantage if the court were to allow, under an arbitrary and capacious standard of review, the Plan to rely upon post-hoc rationalizations for its denial of benefits

that were never communicated to the plaintiff during the administrative process.

Apparently realizing the inherent problems associated with allowing the Plan to invoke a new argument for denial of benefits (i.e. the exclusion provisions) while at the same time granting deference to the Plan's decision under an arbitrary and capricious standard of review, counsel for the Plan conceded at the hearing that if the court were to consider the exclusion provisions then it would have to apply a *de novo* standard of review. The Plan relied upon cases from the Second, Seventh, and Eighth Circuits to argue at the hearing that the court should apply a *de novo* standard of review and consider the exclusion provisions of the Plan Document even though the exclusion provisions were not relied upon as the basis of the Plan's denial in the administrative proceedings. *See Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653, 660 (8th Cir. 1992); *Weber v. Saint Louis University*, 6 F.3d 558, 560 (8th Cir. 1993); *Matuszak v. Torrington Co.*, 927 F.2d 320, 323 (7th Cir. 1991); *Juliano v. The Health Maintenance Organization of New Jersey, Inc.*, 22 F.3d 279, 287-88 (2d Cir. 2000). The Plan argues that the practical effect of prohibiting the Plan from relying upon policy provisions it failed to invoke at the administrative level would be to allow for the Plan Document to be modified by oral or written misrepresentations—a result prohibited by ERISA.

The issue of whether an ERISA plan can waive its right to rely upon the exclusion provisions in a plan by failing to assert the provisions during the administrative process has not been directly addressed by the Tenth Circuit. Other circuits addressing similar issues have reached varying results. *See Lauder v. First UNUM Life Ins. Co.*, 284 F.3d 375, 381 (2d Cir. 2002) (recognizing that circuits have reached opposite conclusions when deciding whether the doctrine of waiver applies to an ERISA claim). In *Lauder*, the Second Circuit determined that a case-specific analysis was necessary

to determine whether an ERISA plan waived an unasserted defense and held that under the facts before it the insurer had waived the defense of lack of disability because it chose not to pursue the defense during the administrative proceedings. *Id.* at 380-82.

The court does not need to resolve the issue of whether the Plan's failure to assert the exclusion provisions as a basis for its denial during the administrative process prohibits it from relying upon the exclusion provisions as a defense in the district court proceeding because it would not change the outcome of this case. Whether the court applies an arbitrary and capricious standard of review under which it cannot consider the exclusion provisions or applies a *de novo* standard of review and considers the exclusion provisions, the court reaches the same result. Accordingly, the court will analyze this case under both the arbitrary and capricious standard of review and *de novo* standard of review.

2. Arbitrary and Capricious

In determining whether the Plan's decision is arbitrary and capricious, the court looks to factors such as whether there is a lack of substantial evidence, mistake of law, bad faith, or conflict of interest by the fiduciary. *See Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380 n. 4 (10th Cir. 2002). "'The Administrator['s] decision need not be the only logical one nor even the best one. It need only be sufficiently supported by facts within [the administrator's] knowledge to counter a claim of that it was arbitrary or capricious.' The decision will be upheld unless it is 'not grounded on any reasonable basis.'" *Kimber v. Thiokol*, 196 F.3d 1092, 1098 (10th Cir. 1999) (citations omitted). "Substantial evidence is 'such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the [decisionmaker].'" *Caldwell v. Life Ins. Co. of North America*, 287 F.3d 1276, 1282 (10th Cir. 2002) (quoting *Sandoval*, 967 F.2d at 382) (alteration in

original). "Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Fought v. UNUM Life Ins. Co. of America*, 357 F.3d 1173, 1178 n. 1 (10th Cir. 2004) (quoting *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 123 S.Ct. 1965, 1972 (2003)).

As previously discussed, under an arbitrary and capricious standard of review, the court will not consider any new evidence or arguments. The only issue is whether it was arbitrary and capricious for the Plan to deny plaintiff's claim based upon lack of functional impairment. The Plan's statement in its denial letter that the plaintiff had failed to demonstrate a functional impairment and that "no symptoms of difficulty eating or speaking were noted" completely disregards the substantial and uncontradicted evidence documenting the plaintiff's difficulty with eating, chewing, headaches, and overall pain resulting from her condition. The Plan relies exclusively upon the failure of Dr. Tessnow to expressly mention functional impairments such as difficulty eating or speaking in two pages of his progress notes as the basis for its denial.[3] Without explanation, the Plan gives no weight to the diagnosis and findings of Dr. DeDecker—the specialist to whom Dr. Tessnow referred the plaintiff for evaluation. Moreover, the Plan never conducted an independent medical evaluation to determine whether Dr. DeDecker's conclusions were incorrect. As such, there is no evidence in the administrative record to contradict Dr. DeDecker's diagnosis. The administrative record is replete with evidence of the plaintiff's functional impairments and

[3] The Plan's briefs repeatedly refer to the fact that Dr. Tessnow's progress notes indicate "jaw pain ø headaches" in an attempt to discredit the numerous other references in the administrative record to plaintiff's headaches. Dr. Tessnow's indication of no headaches appears to be an anomaly and is contradicted by Dr. Tessnow's March 27, 2002 letter discussing the plaintiff's migraine headaches associated with her jaw condition. Regardless, the court's decision would remain the same even if there was no evidence in the administrative record of plaintiff's headaches.

devoid of any evidence to support a finding that the surgery was being performed for cosmetic reasons. In sum, there is no evidence in the administrative record upon which a reasonable mind could accept as adequate to support the Plan's determination that the plaintiff's condition was not a functional impairment. Accordingly, the court holds that the Plan's denial of coverage for plaintiff's surgery was arbitrary and capricious.

3. De Novo

Under *de novo* review, the court will consider the exclusion provisions of the policy but will give no deference to the Plan's interpretation or factual findings.[4] The plaintiff carries the burden of showing a covered loss, but the defendant carries the burden of demonstrating facts that bring the loss under an exclusionary clause of the Plan. *See Blair v. Metropolitan Life Ins. Co.*, 974 F.2d 1219, 1221 (10th Cir. 1992). "Under ERISA, an insurer bears the burden to prove facts supporting an exclusion of coverage. Federal courts treat insurer claims of policy exclusions as affirmative defenses." *Fought,* 357 F.3d at 1185 (10th Cir. 2004) (internal citations omitted). Moreover, "[e]xclusions must be interpreted narrowly." *Id.* at 1189.

As previously discussed under the court's arbitrary and capricious analysis, the court finds that the plaintiff met her burden of demonstrating a covered loss under the Medical Benefits section of the Plan Document. The court finds that the plaintiff suffered from a musculoskeletal defect causing functional impairments such as decreased jaw function, inability to masticate certain foods properly, and migraine headaches. As discussed in Dr. Peter Paulos' January 10, 2002 letter, the plaintiff's abnormality is a "congenital deformity," and therefore qualifies as a birth defect under the

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[4] The court does not decide the issue of whether, under a *de novo* review, the Plan waived its right to assert the exclusion provisions because it does not change the court's conclusion.

Plan Document language. The plaintiff's skeletal defect also caused her to be diagnosed with class III malocclusion. The court notes that under UnitedHealthcare's guidelines, both skeletal deformities and class III malocclusion are identified as diagnoses that can be associated with functional impairments and therefore covered under the Plan.

The court finds that the Plan has failed to meet its burden to demonstrate facts that would bring the plaintiff's surgery under the exclusion provisions of the Plan Document. Reading the Plan Document as a whole and interpreting the exclusions narrowly demonstrates that the Plan Document provides coverage for certain limited forms of oral surgery. This is evident by the fact that even under the Plan Document language excluding coverage for "any treatment to improve the ability to chew or speak" the next sentence states "See **Medical Benefits** for limited coverage of oral surgery and dental services." The language of the Plan Document clearly indicates that certain types of oral surgery are covered under the Plan. The court's interpretation of the Plan Document is consistent with UnitedHealthcare's guidelines that state "[t]he primary consideration is to establish the presence of a functional deficit that causes a medical (as contrasted with dental) impairment, due to skeletal malformation or anomaly fo the maxilla and or mandible, and as opposed to cosmetic intervention." Under a *de novo* review, the court holds that the plaintiff is entitled to coverage under the Plan for her surgery.

C. Attorney Fees

Under ERISA, an award of attorney fees and costs is discretionary. 29 U.S.C. § 1132(g)(1).

> In deciding whether to exercise its discretion and award fees, a district court should consider the following nonexclusive list of factors: (1) the degree of the offending party's culpability or bad faith; (2) the degree of the ability of the offending party to satisfy an award of attorney fees; (3) whether or not an award of attorney fees against

> the offending party would deter other persons acting under similar circumstances; (4) the amount of the benefit conferred on members of the plan as a whole; and (5) the relative merits of the parties' positions.

Deboard v. Sunshine Mining & Refining Co., 208 F.3d 1228, 1244 (10th Cir. 2000).

In weighing the above factors, the court determines that an award of attorney fees and costs is not appropriate in this case. First, even though the court found that the Plan erred in denying plaintiff's claim, there is not enough evidence to support a finding of bad faith or culpability sufficient to support an award of attorney fees. Second, this lawsuit was brought for individual relief only, and therefore does not benefit members of the Plan as a whole. Third, it is not clear that an award of attorney fees in this case would deter the Plan from improperly denying future claims. The facts and circumstances of this case are unique, and not likely to be frequently repeated. Fourth, while the court believes the merits of the case favor the plaintiff, this case raises unique issues of law and fact that the Plan was justified in litigating. Finally, even though the Plan has the ability to satisfy an award of attorney fees, by itself, that is not enough to justify an award of attorney fees. Therefore, plaintiff's request for attorney fees and costs pursuant to 29 U.S.C. §1132(g)(1) is denied.

D. Prejudgment Interest

An award of prejudgment interest is proper in an ERISA case "when it serves to compensate the injured party and its award is otherwise equitable." *Allison v. Bank One-Denver*, 289 F.3d 1223, 1243 (10th Cir. 2002). The court has discretion is determining the appropriate interest rate. *See Caldwell*, 287 F.3d at 1287 (the calculation of prejudgment interest "rests firmly within the sound discretion of the trial court.").

The court finds that an award of prejudgment interest in this case is both equitable and necessary to fully and fairly compensate the plaintiff. Plaintiff was required to use credit cards in

order to pay the medical expenses she incurred and continues to make payments and accrue interest on the credit card debt. Even though the court is not required to incorporate the state's statutory interest rate, the court believes adoption of Utah's statutory prejudgment interest rate is appropriate in this case in order to adequately compensate the plaintiff. *See Allison*, 289 F.3d at 1244 ("the district court did not abuse its discretion in awarding prejudgment interest at the Colorado statutory rate of 8 percent."). Accordingly, the court awards plaintiff prejudgment interest at Utah's statutory prejudgment interest rate of ten percent (10%) from April 15, 2002 to the date of the entry of judgment in this matter. *See* Utah Code Ann. § 15-1-1(2).

II. PLAINTIFF'S MOTION TO STRIKE PORTIONS OF THE DECLARATION OF SHANNA JENSEN

Plaintiff moved to strike paragraphs 3,4,5,6,8,9, and 12 of Shanna Jensen's declaration. The court has not relied upon Ms. Jensen's declaration to the extent it expresses an opinion as to whether plaintiff's surgery was a covered benefit under the Plan or to the extent Ms. Jensen speculates as to the reasoning of other persons that reviewed the plaintiff's claim on behalf of the Plan. Plaintiff's Motion to Strike Portions of the Declaration of Shanna Jensen is therefore moot.

III. CONCLUSION

For the foregoing reasons, IT IS HEREBY ORDERED that: (1) Defendant's Motion for Summary Judgment is DENIED; (2) Plaintiff's Motion for Summary Judgment is GRANTED; (3) Plaintiff's Motion to Strike Portions of the Declaration of Shanna Jensen is MOOT. The Clerk of the Court is directed to enter judgment for the Plaintiff in the amount of $33,934.88 plus prejudgment interest at the rate of ten (10) percent from April 15, 2002 to the date of the entry of

judgment in this case. Plaintiff's request for attorney fees and costs pursuant to 29 U.S.C. §1132(g)(1) is denied.

DATED this 8th day of April, 2004.

BY THE COURT:

DALE A. KIMBALL
United States District Judge

jmr

United States District Court
for the
District of Utah
April 9, 2004

* * CERTIFICATE OF SERVICE OF CLERK * *

Re: 2:02-cv-01184

True and correct copies of the attached were either mailed, faxed or e-mailed by the clerk to the following:

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