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ERISA's Outer Limits—The Admissibility of Extrinsic Evidence in Denied Claims for Plan Benefits

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Cue music. Scene: Federal district court, Anywhere, USA. A young lawyer, Steve Jones, represents Sophie Smith, who lost her husband in a motorcycle accident. She has filed suit because Defiant Insurance has denied her claim for Accidental Death benefits. According to Defiant, Sophie's claim fails because Mr. Smith's use of the prescription drug, Coumadin, an oral anticoagulant, was a contributing factor to his death.¹ Mr. Jones stands at the lectern and says, "The plaintiff calls Dr. Joe Johnson, an independent medi-

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cal expert.” Defiant’s lawyer, Joe Dokes, objects. He argues Dr. Joe Johnson’s testimony cannot be admitted into evidence because Dr. Joe Johnson’s evidence was not part of the administrative record. Judge Albright, presiding over this ERISA trial, asks the lawyers to approach the bench. Judge Albright asks, “Can I consider extrinsic evidence in this ERISA dispute?” Judge Albright states it is her understanding that, for the most part, if the record before the ERISA plan administrator is complete, then no new evidence will be considered by a reviewing court.² The answer to Judge Albright’s question turns on where the question is asked. In some circuits, extrinsic evidence is usually allowed, in others sometimes allowed, and in still others, never allowed.

Just as medieval alchemists poured their energies into discovering a formula that would change lead into gold, so too do modern ERISA plaintiffs’ lawyers spend prodigious amounts of time and energy seeking to convert their clients’ denied benefit claims, based on barren administrative records, into something more substantial. The ERISA plaintiffs’ lawyers in these cases can only achieve success if they can introduce extrinsic evidence at trial that was not part of the administrative record. It turns out that under ERISA, the success of a plaintiff’s sorcery depends upon the requirements of pleading and proof in the circuit in which the extrinsic evidence is presented.

Legal Background

Plaintiffs like Sophie Smith who seek ERISA-regulated plan benefits often attempt to introduce evidence to a court which they did not earlier present to the employee benefit plan’s administrator. Standing in the way of the introduction of extrinsic evidence is the ERISA statute’s requirement that participants exhaust the plan’s claims review procedure before filing suit.³ The ERISA statute states:

In accordance with regulations of the Secretary, every employee benefit plan shall:

1. 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 matter calculated to be understood by the participant; and
2. Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full, fair review by the appropriate named fiduciary of the decision denying the claim.⁴

The *Amato* Court explained that ERISA Section 503 was:

apparently intended by Congress to help reduce the number of frivolous lawsuits under ERISA; to provide the consistent treatment

of claims for benefits; to provide a non-adversarial method of claim settlement; and to minimize the cost of claim settlement for all concerned.⁵

Whether or not a plaintiff like Sophie Smith can introduce extrinsic evidence at trial largely depends on whether or not the ERISA plan in dispute contains the “magic words.”

Twenty-two years ago, the Supreme Court tried to answer the following question: “Under what circumstances should a court reviewing a denied claim for employee benefits substitute its own judgment for that of the ERISA plan administrator?” In *Firestone Tire & Rubber Co. v. Bruch*,⁶ the Supreme Court found that absent special plan language, a plan administrator’s interpretation of an employee benefit plan’s terms would be subject to “Judge Judy” review (called “*de novo*” review because the court gives no presumption of correctness to a plan administrator’s decision to grant or deny a claim for benefits). In other words, like Judge Judy on TV, the reviewing court will make the call based on the record developed before the plan administrator as to whether the participant is entitled to ERISA plan benefits. However, if the plan contains certain “magic words,” then the court would not second-guess a plan administrator’s decision.

The Consequences of ERISA’s Magic Words

ERISA’s “magic words” are simple: The plan must state that the administrator has been given the discretionary power to construe the plan’s terms and to determine who is eligible for benefits.⁷ According to the *Firestone* court, if the ERISA plan contains the “magic words,” then a reviewing court will defer to the administrator’s decision under the “abuse of discretion” standard of review.⁸ If the plaintiff can show the administrator operates under a conflict of interest in a case arising under the abuse of discretion standard, then a reviewing court may consider additional evidence showing whether the conflict biased the ultimate decision.⁹

The US Supreme Court stated in *Firestone* that a plan grants discretion if the administrator has the “power to construe disputed or doubtful terms.”¹⁰ *If a plan administrator’s decisions are subject to the abuse of discretion standard of review, then the scope of admissible evidence will be limited to the administrative record.*¹¹

The US Supreme Court explained in *Firestone* that:

The terms of trusts created by written instruments are “determined by the provisions of the instrument as interpreted in light of all the circumstances and such other evidence of the intention of the settlor with respect to the trust as is not inadmissible.”¹²

Following *Firestone*, the federal circuit courts of appeals have consistently ruled that, absent a showing of conflicted decision-making, a federal court reviewing a denied claim for ERISA benefits under the “arbitrary and capricious” standard of review can only consider the evidence submitted to the plan administrator.¹³

ERISA benefit denial cases typically are adjudicated on the record compiled before the plan administrator. Because full blown discovery would reconfigure that record and distort judicial review, courts have permitted only modest, specifically targeted discovery in such cases. See, *Liston v. UNUM Corp. Officers Severance Plan*, 330 F.3d 19, 23 (1st Cir. 2003) (noting that “some very good reason is needed to overcome the strong presumption that the record on review is limited to the record before the administrator.”

In some cases, a good reason has been found to exist when a party makes a colorable claim of bias. See *id.* Targeted discovery addressed to such an issue may shed new light on the motivation behind the plan administrator’s decision without expanding the panoply of materials on which that decision was based.

The majority opinion in *Glenn* fairly can be read as contemplated some discovery on the issue of whether a structural conflict has morphed into an actual conflict. See, e.g., *Glenn*, 128 S.Ct. at 2351.¹⁴

The “Federal Common Law” of Judicial Review

Congress intended courts “to develop a federal common law of rights and obligations under ERISA-regulated plans.”¹⁵ Justice Sandra Day O’Connor, writing for a unanimous Court, explained that federal courts should look to the principles of trust law, in which “courts construe terms in trust agreements without deferring to either party’s interpretation.”¹⁶ The *Firestone* court reasoned that the standard of review under ERISA should protect beneficiaries at least as much as state contract law protected them prior to ERISA’s enactment.¹⁷ The federal circuits have, however, split over the appropriate evidentiary scope of *de novo* review in ERISA cases involving denied benefit claims.

Circuit-by-Circuit Analysis of the Introduction of Additional Evidence Under a De Novo Standard of Review

The Supreme Court in *Firestone* said that *de novo* review was the default standard if an ERISA plan did not contain the

“magic words.” In response, the circuit courts of appeal have split as to whether or not they should limit the scope of review under the *de novo* standard to evidence presented to the plan administrator.

Four separate rules have emerged:

1. Per se rules limiting the evidence a court can consider to the evidence presented to the plan administrator;
2. A rule allowing claimants to introduce “missing” evidence to a reviewing court;
3. Multi-factor discretionary rules for admitting additional evidence; and
4. A per se rule allowing plaintiffs to introduce any new evidence.

The First and Second Circuits—Extrinsic Evidence on *De Novo* Review Is Limited to Showing Procedural Irregularities or a Biased Decision

The First Circuit has adopted the rule in *Orndorf v. Paul Revere Life Ins. Co.*:

De novo review generally consists of the court’s independent weighing of the facts and opinions in that record to determine whether the claimant has met his burden of showing he is disabled within the meaning of the policy. While the court does not ignore the facts in the record ... the court grants no deference to administrator’s opinions or conclusions based on these facts.¹⁸

Jacob Orndorf had worked as a perfusionist, a person who operates a heart-lung machine, for Jersey Shore Cardiac Associates. Orndorf worked for Jersey Shore for three years until he became a drug addict. He applied for and was granted long-term disability benefits in 1995. He was told that the drug addiction benefit would continue until June 26, 2000. In 1998, Orndorf informed the insurance company that he claimed a continuation of his disability payments beyond June 2000, based on his purported back problem. The insurance company ultimately determined that Orndorf was not disabled due to his back problem.

The key question on appeal was whether Orndorf could introduce evidence outside of the administrative record regarding the question of whether he was disabled. Because the Paul Revere policy did not contain the “magic words,” the district court reviewed Orndorf’s claim under the *de novo* standard of review.

The First Circuit rejected Orndorf's request to admit additional evidence, explaining that there was no dispute about what the plan's terms meant:

Thus, there is no occasion to consider the use of outside evidence to assist the court in interpreting the plan language. ...

The decision to which judicial review is addressed is the final ERISA administrative decision. It would offend interests in finality and exhaustion of administrative procedures required by ERISA to shift the focus from that decision to a moving target by presenting extra-administrative record evidence going to the substance of the decision. ... There is no claim Orndorf was denied an opportunity to present evidence to the administrator. Here, the plaintiff had ample time to collect records and had two administrative appeals reviews of his claims by Revere. Even if the new evidence directly concerned the question of his disability before the final administrative decision, it was inadmissible.

Furthermore, the final administrative decision acts as a temporal cut off point. ...

As this court noted in *Liston*, the focus of judicial review, under the arbitrary and capricious standard, is ordinarily on the record made before the administrator and at least some very good reason is needed to overcome that preference. ...

Where the challenge is not to the merits of the decision to deny benefits, but to the procedure used to reach the decision, outside evidence may be of relevance. For example, evidence outside the administrative record might be relevant to a claim of personal bias by a plan administrator or of prejudicial procedural irregularity in the ERISA administrative review procedure.¹⁹

In the First Circuit, a plaintiff's ability to augment the administrative record is quite limited.

Following the Supreme Court's decision in *Glenn*, the First Circuit explained:

ERISA benefit-denial cases typically are adjudicated on the record compiled before the plan administrator. Because full-blown discovery would reconfigure that record and distort judicial review, courts have permitted only modest, specifically targeted discovery in such cases. See *Liston v. Unum Corp. Officer Sev. Plan*, 330 F.3d 19, 23 (1st Cir. 2003) (noting that "some very good reason is needed to overcome the strong presumption that the record on review is limited to the record before the administrator").

In some cases, a good reason has been found to exist when a party makes a colorable claim of bias. *See id.* Targeted discovery addressed to such an issue may shed new light on the motivation behind the plan administrator's decision without expanding the panoply of materials on which that decision was based.²⁰

The rule in the Second Circuit is the same as in the First Circuit. For example, consider the case of *Locher v. UNUM Life Ins. Co. of America*.²¹ Mary Ann Locher went to work for a New York law firm even though she had chronic fatigue syndrome (CFS). Locher did not tell the law firm that she had CFS or the reason for her many "excessive" unscheduled absences for medical appointments occurring during the workday. Approximately one year after she began to work for the law firm, she resigned without informing them that she was leaving because of her CFS. Several months later, her attending physician filed a claim for long-term disability benefits with UNUM, indicating Ms. Locher had been disabled on the date of her resignation. The long-term disability plan did not accord the administrator with the "discretionary authority to determine eligibility for benefits or to construe the terms of the plan."²² Accordingly, the administrator's denial of Ms. Locher's claim was reviewed by the trial court *de novo*.²³ After a three-day trial, the district court awarded Locher with benefits and attorney fees. UNUM appealed. The district court permitted Locher to have an expert testify for her at trial as well as a coworker as a fact witness. The district court found that it had good cause for admitting evidence outside the administrative record and permitted this additional evidence.

The Second Circuit affirmed, explaining:

upon *de novo* review, even purely factual interpretation cases may provide a district court with good cause to exercise its discretion to admit evidence not available at the administrative level if the administrator was not disinterested and, in this situation, the district court may assume an active role in order to ensure a comprehensive and impartial review of the case.²⁴

Good cause may exist not merely because the claims reviewer and claims payer are the same entity, but also because the procedures employed in arriving at the claim determination were flawed. The Second Circuit indicated it had also found "good cause" for consulting evidence outside the administrative record where an insurer's claimed reason for denying a claim was not stated in its notices to the claimant:

Where sufficient procedures for initial or appellate review of a claim are lacking, there exist greater opportunities for conflicts

of interests to be exacerbated and, in such a case, the fairness of the ERISA appeals process cannot be established using only the record before the administrator. In such circumstances ... the district court may assume an active role in order to ensure a comprehensive and impartial review of the case.²⁵

The Second Circuit permits ERISA plaintiffs to introduce new evidence at trial which supports the plaintiff's interpretation of plan terms.²⁶ According to the Second Circuit, it is for the court to determine the appropriate interpretation of plan terms; hence, the plaintiff's interpretation is just as valid as the plan administrator's.²⁷ While the D.C. Circuit has not addressed the *de novo* evidence issue, a district court, in *Doe v. MAMSI Life and Health Co.*,²⁸ followed the First and Second Circuit precedent in permitting limited discovery to complete the administrative record.

The Third Circuit's "Missing Evidence" Approach

Under the *de novo* standard in the Third Circuit, the plaintiff is not entitled to unlimited discovery. Such a result would run counter to the ERISA public policy favoring an efficient adjudication of benefits claims. "[I]f the record on review is sufficiently developed, the district court may, in its discretion, merely conduct a *de novo* review of the record of the administrator's decision, making its own independent benefit determination."²⁹ The fact that a *de novo* standard of review applies does not "require that a district court conduct a *de novo* evidentiary hearing or full trial *de novo* in making a determination between ERISA claimants."³⁰ In *Scheider v. Life Insurance Co. of North America*,³¹ the court granted the defendant's motion to limit the court's consideration of the plaintiff's claim for benefits to the administrative record. The court found that the administrative record was "sufficiently developed to allow the court to make a *de novo* review of the administrator's decision."³² For example, the plaintiff had "been given the opportunity to provide the administrator with any and all documents supporting his position" and had "been examined by numerous physicians at both his and defendant's request."³³

For example, in the seminal Third Circuit decision in *Luby*, the question presented was what evidence, if any, a reviewing court may consider under a *de novo* standard of review. Francis Luby had died. His beneficiary was entitled to a \$20,000 lump-sum death benefit. The problem was that when Francis Luby died, there were two beneficiary cards on file. The first card, signed by Luby in 1968, designated his wife as his beneficiary. The second beneficiary card, filed in 1987, designated his girlfriend.³⁴ At the bench trial, the district court examined a number of documents signed by Luby that were not before the plan administrator. Based upon a comparison of these other documents, the district court

found that Luby had signed the original beneficiary card in 1968, but did not sign the 1987 beneficiary card.³⁵ In affirming the trial judge's decision to make these handwriting comparisons, the Third Circuit explained:

Our decision does not require that a district court conduct a *de novo* evidentiary hearing or full trial *de novo* in making a determination between ERISA claimants. If the record on review is sufficiently developed, the district court may, in its discretion, merely conduct a *de novo* review of the record of the administrator's decision, making its own independent benefit determination.

Admitting evidence not considered by the plan administrator is crucial in cases such as this, where there is no evidentiary record to review. Here, the Fund determined that Golosky [the girlfriend] was the proper beneficiary merely by noting that she was named on the most recent benefit card in Francis Luby's file. The Fund does not authenticate members' signatures on benefit cards either when the cards are filed or when benefits are paid. There was simply no evidentiary record for the district court to review for Mrs. Luby's claim that the most recent beneficiary card was not signed by Francis Luby and was therefore invalid.³⁶

The Fourth and Tenth Circuits—The Multi-Factor Test

The seminal case dealing with whether extrinsic evidence can be admitted at the trial court when considering a denied benefit claim under the *de novo* standard is *Quesinberry v. Life Insurance Co. of North America*.³⁷ The Fourth Circuit explained:

In summary, we conclude that courts conducting *de novo* review of ERISA benefits claims should review only the evidentiary record that was presented to the plan administrator or trustee except where the district court finds that additional evidence is necessary for resolution of the benefit claim. Exceptional circumstances that may warrant an exercise of the court's discretion to allow additional evidence include the following: claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not

have presented in the administrative process. We do not intimate, however, that the introduction of new evidence is required in such cases. A district court may well conclude that the case can be properly resolved on the administrative record without the need to put the parties to additional delay and expense.

This list of factors is not exhaustive but is merely a guide for district courts faced with motions to introduce evidence not presented to the plan administrator. In determining whether to grant such a motion, the district court should address why the evidence proffered was not submitted to the plan administrator.³⁸

The Fifth and Sixth Circuits Do Not Permit the Introduction of Extrinsic Evidence

Both the Fifth and Sixth Circuits prohibit ERISA participants from introducing evidence at trial that was not presented to the plan administrator. The Sixth Circuit reasoned, in *Perry v. Simplicity Engineering*,³⁹ that certain hospital records and expert vocational testimony were inadmissible because the participant had not presented this evidence to the plan administrator.⁴⁰ Federal courts are not to “function as substitute plan administrators.”⁴¹ The “primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes inexpensively and expeditiously.”⁴² Allowing extrinsic evidence into the trial court record would “seriously impair” this goal.⁴³

The Sixth Circuit’s decision in *Wilkins v. Baptist Health Care System, Inc.*, 150 F.3d 609, 615 (6th Cir. 1998) limiting evidence to the administrative record is typical.

Wilkins asserts that the district court erred in failing to consider an affidavit of Dr. Vanarthos, describing his impressions of the February 11, 1994 MRI. This argument is meritless. Although the district court reviewed the decision of the Plan Administrator *de novo*, the district court was confined to the record that was before the plan administrator. *See Perry v. Simplicity Engineering*, 900 F.2d 963, 966 (6th Cir. 1990); *see also Rowan*, 119 F.3d at 437. LINA made its final decision denying Wilkins’s claim for benefits on May 4, 1995. The Vanarthos affidavit is dated June 20, 1995. Therefore, the affidavit was not included in the record upon which LINA based its decision; accordingly, it also was not part of the district court’s consideration of Wilkins’s claim. We thus conclude that the district court did not err in excluding from its review of Wilkins’s claim evidence that was not part of the administrative record.

The Fifth Circuit has adopted the same rule and the same rationale.⁴⁴ An ERISA plan administrator is better positioned than a trial

court to find facts in connection with a dispute for ERISA plan benefits. In *Vega v. National Life Insurance Services, Inc.*,⁴⁵ the Fifth Circuit explained:

There is no justifiable basis for placing the burden solely on the administrator to generate evidence relevant to deciding the claim, which may or may not be available to it, or which may be more readily available to the claimant. If the claimant has relevant information in his control, it is not only inappropriate but inefficient to require the administrator to obtain that information in the absence of the claimant's active cooperation.

In the Seventh and Eleventh Circuits, All Extrinsic Evidence Is Admissible

In the Seventh Circuit, *de novo* review requires the court to make an independent decision about the merits of the participant's claim, rather than an independent review.⁴⁶ To make a determination on the merits of the participant's claim, discovery is essential.⁴⁷ A trial court is to weigh all of the medical evidence and, if the paper record contains a material dispute, a trial must be conducted.⁴⁸

Judge Easterbrook explained:

Firestone holds that “*de novo* review” is the norm in litigation under ERISA. Cases such as this show that “*de novo* review” is a misleading phrase. The law Latin could be replaced by an English word, such as “independent.” And the word “review” simply has to go. For what *Firestone* requires is not “review” of any kind; it is an independent *decision* rather than “review” that *Firestone* contemplates. The Court repeatedly wrote that litigation under ERISA by plan participants seeking benefits should be conducted just like contract litigation, for the plan and any insurance policy are contracts. 489 U.S. at 112-13, 109 S.Ct. 948. In a contract suit the judge does not “review” either party's decision. Instead the court takes evidence (if there is a dispute about a material fact) and makes an independent decision about how the language of the contract applies to those facts.⁴⁹

The rule in the Eleventh Circuit is to the same effect, “in this Circuit, a district court conducting a *de novo* review of an Administrator's benefits determination is not limited to the facts available to the Administrator at the time of the determination.”⁵⁰ In *Kirwan*, the Eleventh Circuit considered additional evidence such as medical records, expert medical testimony, and Social Security Administration records. This evidence showed that the claimant developed her disability while covered by her employer's disability plan, and precluded summary judgment in favor of Marriott.⁵¹

The Eighth and Ninth Circuits Permit Extrinsic Evidence upon a Showing of Good Cause

Where the claimant has failed to present evidence to the administrator despite multiple opportunities to do so during the claim review process, the claimant's evidence will be excluded at trial.⁵² A similar rule pertains in the Ninth Circuit "although a district court generally may consider only evidence contained in the administrative record, an exception exists when the court reviews a plan administrator's decision *de novo*."⁵³ Thus, in the Ninth Circuit, a trial court has discretion to consider extrinsic evidence when necessary to adequately review the denial of a participant's claim if good cause is shown:

A district court may, in its discretion, consider new evidence that was not before the plan administrator "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision." *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 943-44 (9th Cir. 1995). "Evidence that meets this standard need not satisfy the strict rules for the admissibility of evidence in a civil trial, and may be considered so long as it is relevant, probative, and bears a satisfactory indicia of reliability." *Tremain v. Bell Industries, Inc.*, 196 F.3d 970, 978 (9th Cir. 1999). "[E]xceptional circumstances where introduction of evidence beyond the administrative record could be considered" include (1) "claims that require consideration of complex medical questions or issues regarding the credibility of medical experts;" and (2) "instances where the payor and the administrator are the same entity and the court is concerned about impartiality." *Opeta v. Northwest Airlines Pension Plan for Contract Employees*, 484 F.3d 1211, 1217 (9th Cir. 2007) (citing *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1027 (4th Cir. 1993)).⁵⁴

Conclusion

Whether our young lawyer, Steve Jones, can introduce the testimony of the independent medical expert will turn on whether his trial is in Chicago, Illinois (where that testimony will be admitted), or in Cleveland, Ohio (where the testimony will not be admitted). Following the US Supreme Court's decision in *Glenn*, the courts seem generally disposed to allow some discovery into whether an ERISA plan fiduciary's structural conflict of interest biased the decision that was taken. That said, a true conflict among the circuits exists as to

whether extrinsic evidence can be considered when reviewing a denial of a claim for ERISA-regulated employee benefits under the *de novo* standard. This area of ERISA litigation continues to evolve. While a complete summary of all decisions in the area of *de novo* review and extrinsic evidence is beyond the scope of this article, the author hopes this brief summary may be of some assistance.

Notes

1. In *Vierra v. Life Ins. Co. of North America*, 642 F.3d 407, 414 (3d Cir. 2011), the court considered these same facts and ruled that testimony of plaintiff's independent medical expert was admissible, and reversed the grant of summary judgment to the defendant.
2. *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090 (9th Cir. 1999).
3. *Amato v. Bernard*, 618 F.2d 559 (9th Cir. 1980).
4. 29 U.S.C. § 1133.
5. *Id.* at 567.
6. 489 U.S. 101 (1989).
7. *Id.* at 115; *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006).
8. *Firestone*, 489 U.S. at 115.
9. *Id.*
10. 489 U.S. at 111; *see also Kearney*, 175 F.3d at 1089.
11. Emphasis supplied unless otherwise indicated; *id.* at 1090; *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995) (compiling cases).
12. 489 U.S. at 112. (quoting Restatement (Second) of Trusts § 4, comment d (1959)).
13. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).
14. *Denmark v. Liberty Life Assurance Co. of Boston*, 566 F.3d 1, 10 (1st Cir. 2009).
15. *Firestone*, 489 U.S. at 110.
16. *Id.* at 112.
17. *Id.* at 113–114.
18. *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 518 (1st Cir. 2005).
19. 404 F.3d at 519–520.
20. *Denmark v. Liberty Life Assur. Co. of Boston*, 566 F.3d 1, 10 (1st Cir. 2009).
21. 389 F.3d 288 (2004).
22. *Id.* at 293.
23. *Id.*
24. *Id.* at 294 (internal quotations omitted).
25. *Id.* at 296.
26. *Masella v. Blue Cross & Blue Shield, Inc.*, 936 F.2d 98, 105–106 (2d Cir. 1991).
27. *Id.* at 104.
28. 448 F. Supp. 2d 179, 184 (D. Ct. DC 2006).
29. *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1185

- (3d Cir. 1991).
30. 448 F. Supp. 2d 179, 184 (D. Ct. DC 2006).
31. 820 F. Supp. 191, 193 (D.N.J. 1993).
32. *Id.* at 193.
33. *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1185 (3d Cir. 1991).
34. *Id.* at 1179.
35. *Id.* at 1183.
36. *Id.* at 1185.
37. 987 F.2d 1017 (4th Cir. 1993).
38. *Id.* at 1026–1027. The Tenth Circuit adopted the Quesinberry approach in *Hall v. UNUM Life Ins. Co. of America*, 300 F.3d 1197, 1202 (10th Cir. 2002).
39. 900 F.2d 963 (6th Cir. 1990).
40. *Id.* at 965–966.
41. *Id.* at 966.
42. *Id.* at 967.
43. *Id.*
44. *Pierra v. Conn. Gen. Life Ins. Co.*, 932 F.2d 1552, 1559 (5th Cir. 1990).
45. 188 F.3d 287, 298 (5th Cir. 1999).
46. *Krolnik v. Prudential Ins. Co. of Am.*, 570 F.3d 841 (7th Cir. 2009).
47. *Id.*
48. *Id.* at 844.
49. 570 F.3d at 843.
50. *Kirwan v. Marriott Corp.*, 10 F.3d 784, 789 (11th Cir. 1994).
51. *Id.* at 790.
52. *Davidson v. Prudential Ins. Co. of Am.*, 953 F.2d 1093, 1095 (8th Cir. 1992) (discussing factors relevant to a showing of good cause).
53. *Beattie v. Prudential Ins. Co. of Am.*, 313 F. App'x. 46 (9th Cir. 2009).
54. *Velikanov v. Union Sec. Ins. Co.*, 626 F. Supp. 2d 1039, 1047 (C.D. Cal. 2009).

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