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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

A. DOUGLAS MURCH,

Plaintiff,

v.

THE PRUDENTIAL WELFARE BENEFIT
PLAN, an ERISA Plan, and AETNA LIFE
INSURANCE COMPANY,

Defendants.

No. CO5-0992P

ORDER ON THE PARTIES'
CROSS-MOTIONS FOR SUMMARY
JUDGMENT AND PARTIAL
SUMMARY JUDGMENT

This matter comes before the Court on the parties' cross-motions for summary judgment and partial summary judgment (Dkt. Nos. 8 and 14). Plaintiff A. Douglas Murch is attempting to recover home-health-care benefits allegedly owed him under the Prudential Welfare Benefit Plan ("the Plan"), an ERISA health-insurance plan administered by Defendant Aetna Life Insurance Co. ("Aetna"). Both parties moved for summary judgment regarding the standard of review, Plan coverage of home health care, and whether the Plaintiff must exhaust administrative remedies for claims after March 20, 2004.

The Court DENIES Defendant's motions in totality. (1) The Court GRANTS Plaintiff's motion to have the claims reviewed de novo. The Plan documents fail to properly delegate discretionary authority to Aetna. (2) The Court DENIES Defendant's motion to deny coverage for February 8-July 17, 2004. Aetna's interpretation of the plan was substantively and procedurally unreasonable. Plaintiff is deemed to have exhausted administrative remedies for claims through July 17, 2004, and the Court REMANDS these claims to Aetna so the company may undertake a proper

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2 2 review. (3) The Court DENIES Defendant's motion to deny consideration of Plaintiff's claims
3 3 beyond July 17, 2004. Although Plaintiff did not submit a claim for this period, Plaintiff has
4 4 demonstrated that doing so would have been futile. Aetna must undertake a review of Plaintiff's
5 5 home health care after July 17, 2004, reading the SPED as covering home health care that is not

6 6 strictly custodial.

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8 8 **Background**

9 9 Mr. Douglas Murch suffered a life-threatening stroke on December 14, 2003. He was
10 10 discharged from the hospital on February 7, 2004. Mr. Murch is covered by a self-funded welfare
11 11 benefit plan (the Prudential Welfare Benefits Plan ["the Plan"]), which is governed by the Employee
12 12 Retirement Income Security Act of 1974 ("ERISA," 29 U.S.C. § 1001 et seq.) and administered by
13 13 Aetna under an Administrative Services Only ("AZO") agreement between Aetna and Prudential. As
14 14 required under ERISA, the benefit plan has a Plan document (in this case, the Prudential Welfare
15 15 Benefits Plan document) and a Summary Plan Document ("SPED," here, the Retiree Benefits
16 16 Handbook), which enumerates the benefits under the Plan.

17 17 When Mr. Murch was discharged from the hospital, Dr. Lombard, one of his treating
18 18 physicians, wrote a home-health certification and plan of care. Dr. Lombard stated: "[Mr. Murch]
19 19 will require a home health aid. . . . These services are medically necessary to allow him to function at
20 20 home. Without these home-based services, Mr. MURCH's residual deficits would require him to be
21 21 hospitalized/institutionalized in order to be cared for safely and properly." (Dkt. 9, Ex. D,
22 22 Attachment 7 at 63). Mr. Murch's wife, Mary Murch, allegedly suffers from severe rheumatoid
23 23 arthritis.

24 24 The Murches employed round-the-clock home-health-care aides after Mr. Murch returned
25 25 home. The aides' work involved both activities that required medical training and activities that did
26 26 not. The aides took Mr. Murch's vital signs; ensured his physical safety until he was able to walk on

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2 2 his own; helped him dress, bathe, and transfer from bed to wheelchair; took care of his sling; installed
3 3 and removed compression gloves and stockings; did light housekeeping; and sometimes simply kept
4 4 Mr. Murch company.

5 5 **B. The benefit claims process.** On June 27, 2004, the Murches submitted to Aetna claims
6 6 for round-the-clock health care for February 8-March 20, 2004. On August 26, a nurse in Clinician
7 7 Claim Review (“CCR”) recommended to the CCR medical director that Aetna cover four hours per
8 8 day for February 8 through June 4 and deny coverage for the other twenty hours per day as “primarily
9 9 custodial.” Although no claims had yet been made for services after March 20, the nurse
10 10 recommended that charges beyond June 5 be denied as “custodial.” (AR Vol. 1 of 4 at AET 673-74).
11 11 On September 2, 2004, Aetna orally informed the Murches that it would deny twenty of the twenty-
12 12 four hours claimed per day through June 5, 2004, as “primarily custodial.”

13 13 The Murches appealed Aetna’s denial on September 15, 2004. On October 13, 2004, Aetna
14 14 denied the appeal. On December 3, 2004, the Murches filed a claim for benefits for the period March
15 15 21 through July 17, 2004. The Murches, having not received a determination on this second claim
16 16 more than four months after it was submitted, hired an attorney, who wrote to Aetna on April 25,
17 17 2005. Aetna responded with a copy of the denial of the appeal from the first claim. The Murches did
18 18 not submit a claim for benefits beyond July 17, 2004.

19 19
20 20 **Legal Analysis**

21 21 Resolving this dispute requires answering four questions: (1) Do the parties dispute material
22 22 issues of fact; is summary judgment appropriate in this case? (2) What standard of review should the
23 23 Court use in reviewing Aetna’s claims resolution—abuse of discretion or de novo? (3) Was home
24 24 health care of the kind paid for by the Murches after Mr. Murch left the hospital covered under the
25 25 plan, given a plain reading of the SPED? (4) Which benefit claims should the Court consider, and
26 26 should coverage be considered for the period after July 17, 2004, for which the Murches did not

1 1
2 2 submit a claim?

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4 4 **A. Summary judgment**

5 5 Summary judgment is not warranted if a material issue of fact exists for trial. Warren v. City
6 6 of Carlsbad, 58 F.3d 439, 441 (9th Cir. 1995), cert. denied, 516 U.S. 1171 (1996). The underlying
7 7 facts are viewed in the light most favorable to the party opposing the motion. Matsushita Elec. Indus.
8 8 Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986). "Summary judgment will not lie if . . . the
9 9 evidence is such that a reasonable jury could return a verdict for the nonmoving party." Anderson v.
10 10 Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). The party moving for summary judgment has the
11 11 burden to show initially the absence of a genuine issue concerning any material fact. Adickes v. S. H.
12 12 Kress & Co., 398 U.S. 144, 159 (1970). However, once the moving party has met its initial burden,
13 13 the burden shifts to the nonmoving party to establish the existence of an issue of fact regarding an
14 14 element essential to that party's case, and on which that party will bear the burden of proof at trial.
15 15 Celotex Corp. v. Catrett, 477 U.S. 317, 323-24 (1986). To discharge this burden, the nonmoving
16 16 party cannot rely on its pleadings, but instead must have evidence showing that there is a genuine
17 17 issue for trial. Id. at 324.

18 18 In this case, the parties do not dispute material issues of fact. Before the Court are the
19 19 relevant Plan documents and an extensive administrative record chronicling Mr. Murch's home health
20 20 care after his hospital release. Because the factual record is undisputed, summary judgment is
21 21 appropriate.

22 22 **B. Standard of review**

23 23 ERISA does not expressly designate a standard of review for courts to apply when
24 24 adjudicating benefit disputes. The Supreme Court has held that "a denial of benefits challenged
25 25 [under ERISA] is to be reviewed under a de novo standard unless the benefit plan gives the
26 26 administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe
the terms of the plan." Firestone Tire & Rubber v. Bruch, 489 U.S. 101, 115 (1989). In this case,

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2 2 the Court must determine whether Aetna had discretionary authority that was properly delegated.

3 3 What is considered a permissible grant of discretionary authority varies among jurisdictions.
4 4 The Ninth Circuit has specified that proper discretionary authority must be expressly granted by the
5 5 plan's language and not follow merely from a decision maker's *exercise* of discretion: "[U]nless plan

6 6 documents unambiguously say in sum or substance that the Plan Administrator or fiduciary has
7 7 authority, power, or discretion to determine eligibility or to construe the terms of the Plan, the
8 8 standard of review will be de novo." Sandy v. Reliance Standard Life Ins. Co., 222 F.3d 1202, 1207
9 9 (9th Cir. 2000).

10 10 In this case, Prudential violated its own procedure, as outlined in the Plan documents, when it
11 11 granted discretionary authority to Aetna. The Plan document specifies that the "Administrative
12 12 Committee shall be . . . the 'plan administrator,' as defined in Section 3(16)(A) of ERISA . . . and
13 13 shall have responsibility, and full and absolute discretion and authority to control . . . [the]
14 14 administration of the Plan. . . ." (AR Vol. 4 of 4 at AET 2221-22, filed in paper form only). The
15 15 Plan document gives the Administrative Committee authority to delegate responsibility to a "Third
16 16 Party Administrator." Id. The AZO names Aetna as the plan administrator and gives Aetna
17 17 "discretionary authority to determine entitlement to Plan benefits." (Dkt. 9, Ex. B at 16). However,
18 18 the AZO is a contract between Prudential and Aetna; the Administrative Committee is not a signee.
19 19 Because Prudential did not follow its own process for appointing a third-party administrator,
20 20 Prudential did not properly delegate discretionary authority to Aetna. Mr. Murch's claims should be
21 21 reviewed de novo.

22 22 ~~Although the Court finds that Mr. Murch's claims merit de novo review because of a failure~~
23 23 ~~to properly delegate discretionary authority on the part of Prudential, the Court notes that it reaches~~
24 24 ~~the same result regarding the reasonableness of Aetna's review of Mr. Murch's claims, even when~~
25 25 ~~employing the abuse of discretion standard. Assuming, for the sake of argument, that Defendant~~
26 26 ~~Aetna is correct that discretionary authority was correctly delegated and the Court should review the~~

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2 2 MUCH claims under the abuse of discretion standard, the Court still reaches the conclusion that
3 3 Aetna's review of Plaintiff's health-care claims was substantively and procedurally unreasonable. The
4 4 reasoning the Court relies on to support this result is set forth in the following section.

5 5 **C. Plain-language analysis of the Retiree Benefits Handbook (i.e., the SPED)**

6 6 Whether the standard of review is de novo or abuse-of-discretion, the Court must determine
7 7 whether Aetna reasonably interpreted the terms of the Plan. The doctrine of reasonable expectations
8 8 applies as a principle of federal common law controlling interpretation of insurance contracts
9 9 governed by ERISA. Winters v. Costco Wholesale Corp., 49 F.3d 550, 554 (9th Cir. 1995). An
10 10 ERISA contract should be interpreted "in an ordinary and popular sense as would a [person] of
11 11 average intelligence and experience." Deegan v. Continental Cas. Co., 167 F.3d 502 (9th Cir. 1999).
12 12 Further, ERISA plan coverage is intended to be liberally construed in order to protect the interests of
13 13 beneficiaries ("coverage [is intended to] . . . be construed liberally to provide the maximum degree of
14 14 protection to working men and women covered by private retirement programs"). 1 ERISA Leg.
15 15 History 604, S. Rep No. 93-127, 93d Cong., 1st Sess. 18 (1973), reprinted in 1974 US Code Cong.
16 16 & Admin. News 4838, 4854.

17 17 In this case, the "contract" is the SPED, the primary source of information for beneficiaries.
18 18 ERISA requires the SPED to be a straightforward, nontechnical explanation of what the plan is, how
19 19 it works, and what benefits are available. It must be "written in a manner calculated to be understood
20 20 by the average plan participant." ERISA § 102(a).

21 21 Aetna's interpretation of the SPED does not square with the reasonable expectations of an
22 22 insured. A plain-language reading of the main text of the SPED (i.e., excluding the glossary) leaves
23 23 one with the impression that home health care of the type that was given Mr. MUCH is covered.
24 24 Glossary definitions in that document, however, contradict or leave unresolved the issue of whether
25 25 and what kind of home health care is covered. The relevant language from the front of the SPED is
26 26 as follows:

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Home Health Care: The programs cover care provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed if home care were not available. In order to be eligible for Home Health Care, a doctor must create a written plan of care within 15 days of the start of Home Health Care services, and Home Health Care services must be preceded by at least one day of Hospital confinement. . . . Care that is strictly custodial (such as bathing and toileting) is not covered. . . . (Dkt. 9, Ex. C, Attachment 3 at 14-15)

Other Covered Services: . . . Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practicing Nurse and required for treatment of an acute illness or injury. The program does not cover nursing care when it includes *only* Custodial Care (such as bathing and toileting). . . . (Id. at 15, italics in original)

What the Retiree Medical Programs Do Not Cover: . . . Charges for services or supplies . . . that are not Necessary or are not appropriately provided for the care of a diagnosed sickness or injury. . . . (Id. at 17)

Other Services: Home Health Care. 100% [covered]; no Deductible; 1 day prior hospitalization required. . . . (Id. at 34).

Glossary definitions undermine the conclusion that home health care of the type paid for by the Murches is covered:

Home Health Care: Home Health Care . . . usually begins after a person has been an Inpatient in the Hospital. . . . The need for such care must be confirmed in writing by a doctor, and it must be established that the Home Health Care is taking the place of an Inpatient stay in a Hospital. . . . Custodial Care—care provided to help a person in the activities of daily living, such as dressing, bathing or toileting—is not covered under Home Health Care. . . . (Dkt. 9, Ex. C, Attachment 4 at 43; note the omission of “only” or “strictly” custodial care not being covered).

Medically Necessary: A Medically Necessary service, confinement or supply is one that is prescribed by a licensed physician for the diagnosis or treatment of a sickness or injury, and is generally accepted and in use by the medical community for the condition being treated or diagnosed. However, the fact that a physician prescribes a service, confinement or supply for a covered individual does not ensure that it will be considered an Eligible Expense under the Retiree Medical Program. The health care carrier will make the final decision as to what is Medically Necessary. . . . (Id. at 45).

Necessary: A service or supply furnished by a particular Provider is Necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved. To be appropriate, the service or supply must: Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person’s overall health condition. . . . In no event will the following services or supplies be considered to be Necessary: Those that do not require the technical skills of a medical, a mental health or a dental professional; those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care Provider or health

1 1 care facility. . . .

2 2
3 3 (Id. at 46-47).

4 4 Reviewing Aetna's interpretation either de novo or under an abuse-of-discretion standard, the
5 5 ~~Court overturns Aetna's interpretation of the benefits plan, finding that the language of the SPED is~~

6 6 inconsistent with Aetna's interpretation. In a closely analogous case, Saltarelli v. Bob Baker Group
7 7 Medical Trust, 35 F.3d 382, 385 (9th Cir. 1994), a benefits exclusion was found not in the main body of
8 8 the SPED but only in the Definitions chapter and required a "coordinated reading" of separate definitions.
9 9 ~~Id. at 385. The court considered the exclusion "not conspicuous to attract the attention of a reasonable~~
10 10 ~~layman" and held the exclusion unenforceable, adopting the doctrine of reasonable expectations. Id.~~

11 11 Here, the language in the front of the SPED allows coverage for the type of health care paid for
12 12 by the Murches. The language of the text as a whole, however, is self-contradictory. This is not an
13 13 ERISA contract involving "two reasonable and fair interpretations" (Babikian v. Paul Revere Life Ins.
14 14 Co., 63 F.3d 837 (9th Cir. 1995)); the contract is poorly written. Aetna's interpretation therefore must
15 15 be seen as unreasonable. See Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability
16 16 Income Plan, 85 F.3d 455, 458 (9th Cir. 1996) (an administrator's interpretation of an ERISA plan that
17 17 conflicts with the plain language of the plan is unreasonable).

18 18 The Murches reasonably read the SPED as covering home care if it was authorized by a doctor
19 19 following a hospital stay, was not strictly custodial but involved some custodial care, and was necessary.
20 20 Because Mary MUCH is allegedly physically unable to transfer her husband from a wheelchair to a bath
21 21 chair or a toilet, the Murches did not consider the care to be "mainly for [her] personal comfort or
22 22 convenience." ~~Letters from Drs. Lombard and Jordan support the view that the care was necessary (see~~
23 23 ~~Dkt. 9, Ex. D, Attachment 7 at 63-65).~~

24 24 Aetna's conclusion—that the Plan clearly excludes coverage for home health care that includes
25 25 both care that requires medical training and care that does not—is contrary to the plain language of the
26 26 text in the main part of the handbook. The text twice emphasizes that only care that is *strictly* or *only*

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2 2 “custodial” is not covered. The glossary definition of “home health care” contradicts the text in the front
3 3 of the handbook on this point (in the glossary, custodial care is not modified by “strictly”). Aetna argues
4 4 that readers are told that capitalized terms appear in the glossary (Dkt. 9, Ex. C, Attachment 2 at 14).
~~5 5 However, a definitive denial of coverage for custodial care appears only in the definition of “necessary.”~~

6 6 a term that does not come up in the description of home health care coverage in the front of the
7 7 handbook. A beneficiary’s reasonable expectation would be that home health care that is not strictly
8 8 custodial is covered.

9 9 ~~The company also argues that necessary care could have been confined to a four-hour period.~~
10 10 The cumulative time required to perform the duties might have required fewer than four hours per day,
11 11 but the need for medical expertise was sporadic. In the months after Mr. Murch’s stroke, care givers
12 12 assisted Mr. MUCH throughout the day and night. An entry in late May shows that he was still using
13 13 a wheelchair and required assistance during the night with transferring, walking, turning or positioning,
14 14 and “treatments.” (AR Vol. 2 of 4 at AET 0931). Mrs. MUCH was reportedly unable to assist her
15 15 husband with these tasks.

16 16 Determining that a claim determination is unreasonable in turn affects the requirement that
17 17 Plaintiff exhaust administrative remedies.

18 18 **D. Requirement that plaintiff exhaust administrative remedies**

19 19 A claimant ordinarily must exhaust administrative remedies before filing suit under ERISA.
20 20 Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980). Exhaustion will be required only when it is required
21 21 by the particular plan involved. Nelson v. EG&G Energy Measurements Group, Inc., 37 F.3d 1384 (9th
22 22 Cir. 1994). ~~There are exceptions to the general rule that review procedures must be exhausted. For~~
23 23 example, unreasonableness—either substantive or procedural—on the part of a plan fiduciary can relieve
24 24 the claimant of having to exhaust review procedures. A finding that pursuing a claim would be futile also
25 25 can trigger an exception to the exhaustion rule.

26 26 **1. ERISA’s procedural requirements.** ERISA sets forth minimum requirements for claims

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2 2 procedures. Every plan must provide a claimant with “a reasonable opportunity to appeal an adverse
3 3 benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full
4 4 and fair review of the claim and the adverse benefit determination.” 2 ERISA § 503, 9 CFR § 2560.503-

5 5 ~~1(h)(1). “Full and fair review” means, inter alia, providing the claimant with an opportunity to submit~~
6 6 information relevant to the claim and a review process that takes into account the information submitted.
7 7 29 CFR § 2560.503-1(h)(2). When a claimant appeals a denial of benefits, the review must not defer to
8 8 the initial decision and must be conducted by an appropriate named fiduciary who is neither the individual
9 9 who made the initial determination nor one of her subordinates. 29 CFR § 2560.503-1(h)(3)(ii). If the
10 10 initial determination was made on the basis of a medical judgment (for example, a judgment that a
11 11 treatment was not medically necessary), the fiduciary must consult with a health care professional who
12 12 has experience in the relevant medical field.

13 13 The SPED in this case explicitly requires claimants to exhaust plan remedies before filing suit:
14 14 “You . . . must follow the claims and appeals procedures outlined below before taking action in any other
15 15 forum regarding a claim under The Prudential Welfare Benefits Plan” (Dkt. 9, Ex. C, Attachment 4 at
16 16 22). The Plan’s full claims procedure runs as follows: Once a beneficiary files a claim, Aetna has a
17 17 maximum of 30 days to provide a “Notice of Adverse Benefit Determination” (Id. at 24). The beneficiary
18 18 may then file an appeal, to which Aetna has 30 or 60 days to respond, depending on the type of appeal.
19 19 If the decision is still adverse, the beneficiary is deemed to have exhausted the plan remedies and may file
20 20 suit within one year of the final determination of the appeal (Id. at 27-29). Here, exhaustion is required
21 21 by the Plan. Unless an exception applies, Plaintiff would have to follow the full claims procedure before
22 22 filing suit for denied benefits.

23 23 **2. Exceptions to exhaustion requirement.**

24 24 **a. Unreasonable claims procedure.** A court may decline to require exhaustion where the claims
25 25 procedure is procedurally and/or substantively unreasonable 29 CFR § 2560.503-1(k)(2)(ii). As discussed
26 26 above, Aetna’s claims procedure was substantively flawed; its interpretation of the SPED was

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unreasonable. The company's claims procedure was procedurally flawed as well. An example of a deficiency that would give rise to a claim of procedural default is failure to comply with time limits for rendering a decision. Gilbertson v. Allied Signal, 328 F.3d 625 (10th Cir. 2003).

ERISA regulations regarding time limits for responding to beneficiaries' claims and appeals

establish the "outer boundaries of reasonableness." Rodolff v. Provident Life & Accident Ins. Co., 256 F. Supp. 2d 1137, 1142 (D. Cal. 2003). In Rodolff, the court deemed a claims-resolution process that missed ERISA time limits to be to be unreasonable and granted de novo review. Id. at 1142-43. Under 29 C.F.R. § 2560.503-1(f)(2)(iii)(B), the claims administrator must respond to a "post-services" claim within 30 days.

As outlined in the Background section above, Plaintiff submitted two claims for home health care.

The first was submitted on June 27, 2004, for care from February 8 through March 20, 2004. Aetna missed the window to respond to this claim by more than a month when it responded on September 2, 2004.

Plaintiff made a second claim, on December 3, 2004, for care during the period March 30-July 17, 2004. Plaintiff alleges, and the record supports, that Aetna mistakenly processed this claim as a duplicate appeal of the denial of the first claim. Defendant claims that the second claim amounted to a reiteration of previous arguments and evidence; however, Aetna was still obliged to respond to the claim and consider additional materials submitted in its support. A "full and fair review" means taking into account all information submitted by the claimant. 29 CFR § 2560.503-1(h)(2). Plaintiff's attorney sent a letter to Aetna on April 25, 2005, more than four months after the second claim was submitted. Aetna responded with a letter concerning the dates of the first claim.

Because Aetna's claims-review procedure—which missed the requisite response deadlines by more than a month in the case of the first claim and by more than four months in the case of the second claim—was substantively and procedurally unreasonable, Plaintiff is deemed to have exhausted administrative procedures for purposes of these two claims. Defendant's motions to deny coverage for

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2 2 the period February 8-July 17, 2004, are denied. The claims are REMANDED to Aetna for proper
3 3 review.

4 4 **b. Futile claims procedure.** Plaintiff argues that he did not submit a third claim because doing
5 5 so would have been futile. Futility must be clearly demonstrated; “bare assertions of futility are

6 6 insufficient to bring a claim within the futility exception.” Diaz v. United Agric. Employee Welfare
7 7 Benefit Plan & Trust, 50 F.3d 1478, 1485 (9th Cir. 1995). A district court’s review is limited to the
8 8 administrative record. Winters v. Costco Wholesale Corp., 49 F.3d 550 (9th Cir. 1995).

9 9 Here, Aetna’s claims administrators made an internal decision, when the Murches had submitted
10 10 claims only for the period through March 20, 2004, that claims after June 5, 2004, would be denied as
11 11 “custodial.” Dkt., Ex. D at 3-4. Furthermore, four months after Aetna was supposed to have made a
12 12 benefits determination regarding Plaintiff’s second claim, Aetna still had not responded. Plaintiff has
13 13 sufficiently demonstrated futility in the case of claims submitted after July 17, 2004. The Court remands
14 14 consideration of claims after July 17, 2004, to Aetna.

15 15 **3. Remedies.** Usually, a claimant whose plan fiduciary fails to comply with ERISA’s procedural
16 16 requirements is not entitled to an award of denied benefits. McKenzie v. General Tel. Co. of Cal., 41
17 17 F.3d 1310, 1315 (9th Cir. 1994), cert. denied, 514 U.S. 1066 (1995). Courts commonly remedy a
18 18 violation of claims procedures by remanding the claim with instructions to the plan fiduciary to undertake
19 19 a proper review. Following McKenzie, the Court REMANDS the claims for reconsideration and
20 20 instructs Aetna to read the SPED as covering home health care that is not strictly custodial.

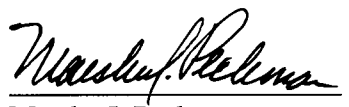
21 21
22 22 **Conclusion**

23 23 For these reasons, the Court DENIES Defendant’s motions in totality. (1) The Court GRANTS
24 24 Plaintiff’s motion to have the claims reviewed de novo. The Plan documents fail to properly delegate
25 25 discretionary authority to Aetna. However, analyzing Aetna’s handling of the MUCH claims under both
26 26 a de novo standard and an abuse of discretion standard, the Court reaches the same outcome as to all

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other issue in this litigation. (2) The Court DENIES Defendant's motion to deny coverage for February 8-July 17, 2004. Aetna's interpretation of the plan was substantively and procedurally unreasonable. Plaintiff is deemed to have exhausted administrative remedies for claims through July 17, 2004, and the Court REMANDS these claims to Aetna so the company may undertake a proper review. (3) The Court DENIES Defendant's motion to deny consideration of Plaintiff's claims beyond July 17, 2004. Although Plaintiff did not submit a claim for this period, Plaintiff has demonstrated that doing so would have been futile. Aetna must undertake a review of Plaintiff's home health care after July 17, 2004, reading the SPED as covering home health care that is not strictly custodial.

The Clerk is directed to send copies of this order to all counsel of record.
Dated this 23rd day of May, 2006.


Marsha J. Pechman
United States District Judge

