FILED
United States Court of Appeals
Tenth Circuit

June 14, 2023

Christopher M. Wolpert
Clerk of Court

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

AUDREY M. EASTER,

Plaintiff - Appellant,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY,

Defendant - Appellee.

No. 21-4106
(D.C. No. 2:19-CV-00612-HCN)
(D. Utah)

ORDER AND JUDGMENT*

Before **HOLMES**, Chief Judge, **PHILLIPS**, and **CARSON**, Circuit Judges.

Audrey Easter, a former social worker at Intermountain Health Care, Inc., submitted a claim for long-term disability benefits under a Group Long-Term Disability Benefit Plan (the "Plan"), which was insured by Hartford Life and Accident Insurance Company ("Hartford"). After her long-term disability ("LTD") claim was denied, Ms. Easter brought this Employee Retirement Income Security Act (ERISA) suit seeking review of Hartford's decision. Specifically, Ms. Easter alleged that Hartford's denial of her disability claim was not adequately supported by the

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* This order and judgment is not binding precedent, except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

evidence. Furthermore, she claimed that Hartford's decision was procedurally flawed and therefore was not entitled to any deference by the district court.

The district court rejected Ms. Easter's arguments, determined that the denial of coverage was not arbitrary and capricious, and granted summary judgment to Hartford. Ms. Easter now appeals from the district court's judgment. Exercising jurisdiction under 28 U.S.C. § 1291, we **affirm**.

I

Intermountain Health Care, Inc. ("IHC") established the Group Long-Term Disability Benefit Plan for employees of the company. Hartford was the claim administrator for the determination of LTD claims under the Plan. The Plan delegated to Hartford the "full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy." Aplee.'s Supp. App. at 43 (Intermountain Health Care Employee Benefit Plan).

To be eligible for benefits, the Plan required a claimant to submit proof of loss showing that she was disabled under the Plan's terms and conditions. *See id.* at 27–28. As relevant here, the Plan defined disability as "mean[ing] You are prevented from performing one or more of the Essential Duties of . . . Your Occupation." *Id.* at 30. The Plan defined "Your Occupation" as the occupation "as it is recognized in the general workplace." *Id.* at 33.

A

Ms. Easter, a former social worker at IHC, submitted a claim for LTD benefits under the Plan. In connection with her claim for benefits, Ms. Easter submitted

Attending Physician's Statements from two of her treating physicians—Certified Physician's Assistant ("PA-C") Megan Sandy and Advanced Practice Registered Nurse ("APRN") Megan Jones. *See* Aplt.'s App. at 94–95 (Megan Sandy's Attending Physician's Statement, dated Apr. 21, 2016); *id.* at 294–95 (Megan Jones's Attending Physician's Statement, dated Aug. 31, 2016). The statements identified Chronic Fatigue Syndrome ("CFS"), obstructive sleep apnea, and hypersomnia as the relevant disabling physical conditions.

On November 17, 2016, Hartford sent a letter to APRN Jones seeking clarification of the "level of activity [her] patient [was] able to reliably and consistently perform." *Id.* at 286–87 (Hartford's Form Letter, dated Nov. 17, 2016). On November 21, 2016, APRN Jones responded to the form letter by indicating that Ms. Easter was capable of performing sedentary and light activity. *See id.* at 287. Then, on November 22, 2016, Hartford spoke with APRN Jones by telephone. When Hartford informed APRN Jones that Ms. Easter had not worked since March 20, 2016, APRN Jones stated that she "was not aware that [Ms. Easter] had been [out of work] this long and made a comment—you would hope/think she would have improved by now." Aplee.'s Supp. App. at 68 (Hartford's Summary Detail Report, filed Aug. 10, 2020).

On December 7, 2016, Hartford issued a letter denying Ms. Easter's claim for LTD benefits. *See* Aplt.'s App. at 252–57 (Hartford's Initial Claim Determination Letter, dated Dec. 7, 2016). Hartford first identified the specific documents that it relied upon in rendering its decision—which included PA-C Sandy's Attending

Physician's Statement and medical records. *See id.* at 254. Then, the letter catalogued some of the medical information contained in Ms. Easter's file, which showed, among other things, that Ms. Easter had "received treatment for depression, chronic fatigue syndrome and anxiety by Megan Sandy." *Id.* at 255. After outlining the evidence, Hartford determined that Ms. Easter's psychiatric conditions fell within the scope of the Plan's pre-existing condition limitation. *See id.* at 256. As such, Hartford denied Ms. Easter's LTD claim for her psychiatric conditions.

Hartford then separately evaluated Ms. Easter's physical conditions. As provided by the Plan, Hartford stated that for Ms. Easter "[t]o meet the definition of Disability . . . for the physical conditions [her] medical provider outlined, [she] must be unable to perform the Essential Duties of [her] Occupation throughout and beyond the Elimination Period." *Id.* Hartford noted that Ms. Easter's occupation was "considered a sedentary level occupation." *Id.* Hartford then stated that it had "reviewed the medical information for [Ms. Easter's] physical conditions including hypersomnia and obstructive sleep apnea." *Id.* Hartford further noted that it had "received a response from Megan Jones APRN confirming [Ms. Easter] [was] able to perform a sedentary and light level occupation." *Id.* Thus, Hartford concluded that "[b]ased on [Ms. Easter's] restrictions provided by Megan Jones APRN as well as the combination of all the medical information in [her] file, [Ms. Easter was] able to perform all of the physical demands of [her] Occupation." *Id.* Accordingly, Hartford denied the LTD claim relating to Ms. Easter's physical conditions.

B

Ms. Easter submitted an appeal letter on January 2, 2017. *See id.* at 280–83 (Ms. Easter's Appeal Letter, dated Jan. 2, 2017). In the letter, Ms. Easter agreed that she "was receiving treatment for [her] Depressive Disorder, Anxiety Disorder and Panic Attacks" during the period subject to the pre-existing condition limitation. *Id.* at 280. Accordingly, Ms. Easter appealed only the initial claim decision regarding "the 'primary condition' for [her] claim" which she identified as CFS "and the other disability conditions . . . listed in the denial letter (specifically hypersomnia and obstructive sleep apnea)." *Id.*

Hartford referred Ms. Easter's file to an outside vendor for an independent physician peer review. *See* Aplee.'s Supp. App. at 119–20 (Hartford's Medical Consultant Referral Form, dated Jan. 24, 2017). The peer review was assigned to Dr. Allen Blavias, who was Board certified in Sleep Medicine, Pulmonary Medicine, and Critical Care Medicine. In evaluating Ms. Easter's claim, Dr. Blavias reviewed the "entire 512 page medical file" and spoke with Ms. Easter's primary health care providers—APRN Jones and PA-C Sandy. Aplt.'s App. at 271–79 (Dr. Blavias's Medical File Review, dated Feb. 7, 2017).

When speaking to Dr. Blavias, APRN Jones "acknowledged that Ms. Easter's symptoms of excessive daytime sleepiness appeared to be out of proportion to the degree of obstructive sleep apnea." *Id.* at 273. APRN Jones also "felt that the primary cause of Ms. Easter's severe fatigue was likely her mental health issues, rather than a sleep disorder." *Id.* For her part, PA-C Sandy remained "confident" in

the diagnosis of CFS, but like APRN Jones, "acknowledged that the sleep disorders and other medical issues [did] not seem adequate to explain [Ms. Easter's] reported symptoms." *Id.* at 274.

Based on his independent review, Dr. Blavias concluded that:

> CFS is typically only diagnosed after other causes of fatigue have been eliminated. In this case, Ms. Easter appears to have ongoing significant psychiatric issues including severe depression and anxiety, which may also cause similar symptoms as CFS. As I am not an expert in these areas, I cannot opine as to the degree that they may be causing impairment. She has a diagnosis of mild obstructive sleep apnea with mild hypersomnia. It is unlikely that these are significantly contributing to her complaints and would not be expected to cause significant impairments in function.

Id. at 277.

Hartford reviewed Dr. Blavias's peer-review report and decided to schedule a neuropsychological evaluation to determine if Ms. Easter's "reported cognitive complaints are the result of" CFS. Aplee.'s Supp. App. at 58. Hartford again referred the file to an outside vendor to conduct the evaluation. Dr. Kevin Duff, who is Board certified in Clinical Neuropsychology, performed the independent evaluation of Ms. Easter. Dr. Duff found that:

> [Ms. Easter's] self-reported somatic symptoms . . . were significantly higher than levels reported by patients in pain clinics (higher than >99.9% of these individuals), and significantly higher than those suspected of malingering (higher than 97% of these individuals). She endorsed significantly greater fatigue . . . than healthy controls (>99.9%) and patients with diagnosed sleep disorders (>99.9%). She also endorsed more daytime sleepiness . . . than patients with diagnosed narcolepsy (79%), sleep apnea (92%), and insomnia (99%). Her report on a scale of

> personality and psychopathology . . . suggested exaggeration of symptoms . . . .

Aplt.'s App. at 263 (Dr. Duff's Neuropsychological Evaluation, dated Mar. 17, 2017).

Stated otherwise, Dr. Duff found that Ms. Easter's symptoms were "more likely than not to be exaggerated." *Id.* at 265. As such, Dr. Duff concluded that "there was no clear evidence to suggest that Ms. Easter would have issues with endurance at work." *Id.* at 266.

On March 24, 2017, Hartford issued its appeal determination. *See id.* at 244–50 (Hartford's Appeal Determination Letter, dated Mar. 24, 2017). Hartford stated that it had "considered not only the medical information provided[,] but [also] information you provided [to] us, as well as the opinion of your treatment providers, review by the independent physician and the neuropsychological evaluation results along with provisions" of the Plan. *Id.* at 249. Ultimately, Hartford concluded that "the evidence does not support that you suffer from [a] physical condition, such as chronic fatigue syndrome, OSA etc. of such severity to warrant any restrictions/limitations on your activities. . . . As such, the denial of your claim for LTD benefits was appropriate and the claim remains closed." *Id.*

C

Ms. Easter proceeded to file the instant suit on September 11, 2019. *See id.* at 11–16 (Am. Compl., filed Sept. 11, 2019). She alleged that Hartford wrongfully denied her claim for disability benefits in violation of 29 U.S.C. § 1132(a).

On cross-motions for summary judgment, the district court held that Hartford's determination of Ms. Easter's disability claim was procedurally proper and supported by substantial evidence. *See id.* at 217–25 (Mem. Decision and Order Granting Def.'s Mot. for Summ. J. and Den. Pl.'s Mot. for Summ. J., filed Aug. 20, 2021). More specifically, the district court declined to apply the "procedural[-]irregularity" exception to the present matter and reviewed Hartford's decision under the deferential arbitrary-and-capricious standard. *Id.* at 219. Under that standard, the district court concluded that Hartford's "decision to deny [Ms. Easter] benefits was reasonable and not arbitrary and capricious." *Id.* at 225. Accordingly, the district court granted Hartford's Motion for Summary Judgment and denied Ms. Easter's motion. This appeal followed.

II

Ms. Easter appeals from the district court's judgment, claiming that the court "erred in determining the standard of review in this case." Aplt.'s Opening Br. at 1. Specifically, she asserts that Hartford's decision was procedurally flawed and should not have been entitled to any deference by the district court. *See id.* at 26–33. Alternatively, Ms. Easter contends that—even absent any procedural irregularities—the district court erred in concluding that Hartford's decision was supported by substantial evidence. *See id.* at 33–42.

Hartford argues that no procedural irregularity occurred in its initial claim determination or appeal process "that would warrant changing the [arbitrary and capricious] standard of review." Aplee.'s Resp. Br. at 14. Hartford further contends

that the "administrative record establishes that [it] conducted a thorough and objective analysis of [Ms.] Easter's LTD claim based on CFS and sleep disorders." *Id.* at 54. Through its review, Hartford alleges that it "reasonably concluded that the evidence did not support the existence of functional impairments due to CFS and sleep disorders severe enough to prevent [Ms.] Easter from working." *Id.*

After carefully considering the administrative record and the briefs, we first hold that there were no procedural irregularities in Hartford's review process that call for an alteration of the standard of review. Accordingly, operating under the deferential arbitrary-and-capricious standard, we conclude that Hartford's initial claim determination and appeal decision were reasonable and supported by substantial evidence.

III

"When the district court grants a motion for summary judgment, our review is de novo, and we apply the same standards as the district court." *Adamson v. Unum Life Ins. Co. of Am.*, 455 F.3d 1209, 1212 (10th Cir. 2006) (citation omitted). "Where, as here, the parties in an ERISA case both moved for summary judgment and stipulated that no trial is necessary, 'summary judgment is merely a vehicle for deciding the case; the factual determination of eligibility for benefits is decided solely on the administrative record, and the non-moving party is not entitled to the usual inferences in its favor.'" *LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan*, 605 F.3d 789, 796 (10th Cir. 2010).

IV

Ms. Easter contends that the district court erred in applying a deferential standard of review to Hartford's decision and should have instead reviewed the decision de novo. *See* Aplt.'s Opening Br. at 26–33. Although Ms. Easter acknowledges that the Plan delegates discretionary authority to Hartford, she nonetheless contends that the district court erred in failing to consider "whether the procedural irregularities claimed by [Ms.] Easter occurred, and if so, whether they warranted a reduction in deference to Hartford's decisions." *Id.* at 27.

Specifically, she asserts that "substantial procedural irregularities occurred within Hartford's decisions on her claim, including: (1) Hartford's initial denial failed to address [Ms.] Easter's primary disabling condition of CFS; (2) Hartford did not inform [Ms.] Easter of additional information it required to determine her claim; (3) Hartford's initial denial did not address the evidence provided by [Ms.] Easter's primary care provider, PA-C Sandy, or [Ms.] Easter's self-reported evidence of her work limitations; [and] (4) Hartford provided no opportunity for [Ms.] Easter or her medical providers to respond to its medical reviews on appeal." *Id.* Furthermore, Ms. Easter claims that the district court improperly disregarded the fact that Hartford "holds a 'dual role' conflict of interest by both determining and paying benefit claims," which should have warranted a further reduction in deference to Hartford's decisions. *Id.* (quoting *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 108 (2008)).

Unsurprisingly, Hartford disagrees. First, Hartford argues that Ms. Easter "fail[s] to acknowledge that this Court has changed the deferential standard of review to the *de novo* standard of review only for 'procedural irregularities' arising from claim administrators either never issuing a decision or issuing a substantially late appeal decision." Aplee.'s Resp. Br. at 14. Hartford notes that "[n]one of the alleged 'procedural irregularities' on which [Ms.] Easter relies fall within this narrow exception." *Id.* Furthermore, Hartford claims that—even if the procedural irregularity doctrine could extend to other scenarios—"[n]o 'procedural irregularity' exists" in its initial claim determination or appeal review "that would warrant changing the standard of review." *Id.* Finally, Hartford contends that we "should give no weight to [its] dual role capacity," as it "took many active steps to reduce potential bias and to promote accuracy." *Id.* at 15–16.

While Hartford is correct that we have never extended the procedural-irregularity exception beyond two limited scenarios—*viz.*, where a claim administrator either did not issue a decision or issued a substantially late appeal decision—we need not decide whether the exception could extend to other scenarios. Even assuming *arguendo* that the procedural-irregularity exception covers other instances of non-compliance, we conclude that there is no procedural irregularity here that calls for an alteration of the standard of review. Furthermore, we give no weight to Hartford's dual role capacity as a basis for altering the standard of review. Accordingly, we review Hartford's denial of benefits under an arbitrary-and-

capricious standard and determine that the district court did not err in concluding that Hartford's appeal decision was supported by substantial evidence.

A

"We review *de novo* the 'district court's determination of the proper standard to apply in its review of an ERISA plan administrator's decision . . . .'" *Rasenack ex rel. Tribolet v. AIG Life Ins. Co.*, 585 F.3d 1311, 1315 (10th Cir. 2009) (omission in original) (quoting *DeGrado v. Jefferson Pilot Fin. Ins. Co.*, 451 F.3d 1161, 1167 (10th Cir. 2006)).

"'[A] denial of benefits' covered by 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.'" *LaAsmar*, 605 F.3d at 796 (alteration in original) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). "If the benefit plan gives the administrator such discretion, then, absent procedural irregularities, the denial of benefits is reviewed under an arbitrary and capricious standard." *Kellogg v. Metro. Life Ins. Co.*, 549 F.3d 818, 825 (10th Cir. 2008). "Under this arbitrary-and-capricious standard, our 'review is limited to determining whether the interpretation of the plan was reasonable and made in good faith.'" *LaAsmar*, 605 F.3d at 796 (quoting *Kellogg*, 549 F.3d at 825–26).

The presence of procedural irregularities may "require us to apply the same de novo review that would be required if discretion was not vested in [the plan administrator]." *Id.* Specifically, we have stated that "de novo review may be

appropriate if the benefit-determination process did not substantially comply with ERISA regulations." *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1152 (10th Cir. 2009); *see also Mary D. v. Anthem Blue Cross Blue Shield*, 778 F. App'x 580, 588 (10th Cir. 2019) (unpublished) ("But even where the plan affords such discretionary authority to the fiduciary or administrator, deferential review isn't guaranteed: in the face of procedural irregularities in the administrative review process, a district court will instead review the benefits denial de novo.").

To date, "we have applied de novo review in situations where an administrative appeal was 'deemed denied' because the plan administrator 'made no decision to which a court may defer,' and where the plan administrator failed in a timely manner to resolve a claim or appeal." *M.K. v. Visa Cigna Network POS Plan*, 628 F. App'x 585, 591 (10th Cir. 2015) (unpublished) (first quoting *Finley v. Hewlett-Packard Co. Emp. Benefits Org. Income Prot. Plan*, 379 F.3d 1168, 1173 (10th Cir. 2004); then citing *Rasenack*, 585 F.3d at 1317; and then citing *LaAsmar*, 605 F.3d at 797). As noted *supra*, for purposes of resolving this appeal, we assume *arguendo* that the procedural-irregularity exception covers other instances of non-compliance. We then proceed to address Ms. Easter's allegations of procedural irregularity and conclude that there is no procedural irregularity here that calls for an alteration of the standard of review.

B

1

Ms. Easter first claims that, with one exception, "Hartford's initial denial letter does not discuss [Ms.] Easter's CFS at all." Aplt.'s Opening Br. at 33. Instead, she alleges that "Hartford's initial decision refers vaguely to [her] 'physical impairments,' which may or may not include her CFS." *Id.* As such, she contends "[t]he failure of Hartford's initial denial to address [her] CFS . . . violated the requirement under 29 CFR § 2560.503-1(g)(1) that the 'adverse decision [be] set forth in a manner calculated to be understood by the claimant.'" Aplt.'s Opening Br. at 34.

Hartford responds by claiming that it had considered Ms. Easter's CFS diagnosis when denying her LTD claim. *See* Aplee.'s Resp. Br. at 21. Specifically, Hartford contends that in the initial claim determination letter, it "stated that it had reviewed all documents in the file 'as a whole' and listed some of the reviewed documents"—including "[PA-C] Sandy's medical records, which referenced the diagnosis of CFS." *Id.* at 22. As such, Hartford asserts that its review "encompassed CFS and underscored its consideration of [Ms.] Easter's complaints of fatigue." *Id.* Furthermore, Hartford claims that it "very clearly stated the grounds for its determination," such that Ms. Easter should have "fully understood the grounds on which Hartford had based its denial of the LTD claim." *Id.* at 22–23. We agree.

Ms. Easter is correct that the initial claim determination letter does not expressly list CFS as one of the physical conditions supporting her LTD claim.

Instead, the letter provides that Hartford "reviewed the medical information for [Ms. Easter's] physical conditions *including hypersomnia and obstructive sleep apnea*." Aplt.'s App. at 256 (emphasis added). However, despite this omission, when the initial claim determination letter is viewed as a whole, it is clear that Hartford reviewed Ms. Easter's CFS diagnosis when denying her LTD claim.

As a starting point, the plain terms of the letter indicate that Hartford considered Ms. Easter's CFS in its initial denial. Specifically, in discussing the medical information in Ms. Easter's file, the letter provides: "The medical information . . . showed [Ms. Easter] received treatment for depression, *chronic fatigue syndrome* and anxiety by Megan Sandy." *Id.* at 255. Furthermore, the letter expressly notes that Hartford reviewed, among other things, PA-C Sandy's Attending Physician's Statement and medical records. *See id.* at 254–55. PA-C Sandy's Attending Physician's Statement—which Hartford relied upon and expressly referenced to support its initial claim determination—listed CFS as Ms. Easter's primary disabling condition. *See id.* at 94–95. Thus, when Hartford stated that it "reviewed all of the medical information in [Ms. Easter's] file to decide if [she] met the definition of Disability," that review necessarily encompassed Ms. Easter's CFS diagnosis. *Id.* at 256.

Furthermore, contrary to Ms. Easter's assertions, Hartford clearly provided its rationale for denying her LTD claim. Specifically, Hartford noted that Ms. Easter's occupation was "considered a sedentary level occupation," and APRN Jones indicated that Ms. Easter was "able to perform a sedentary and light level

occupation." *Id.* Based on the information "provided by Megan Jones APRN as well as the combination of all the medical information in [Ms. Easter's] file," Hartford concluded that Ms. Easter was "able to perform all of the physical demands of [her] Occupation." *Id.* Accordingly, Hartford concluded that it "must deny [Ms. Easter's] claim for LTD benefits." *Id.*

Regardless of the merits of Ms. Easter's disagreement with Hartford's conclusion, this reasoned and detailed explanation is more than sufficient to satisfy ERISA's procedural requirements. *See, e.g.*, *Liebel v. Aetna Life Ins. Co.*, 595 F. App'x 755, 764 (10th Cir. 2014) (unpublished) ("The physicians reviewing [the medical records] for functional impairment did not have to specifically refer to this reported symptom to demonstrate that they considered it insufficient to support [Plaintiff's] disability claim."); *see also Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003) (holding that ERISA does not "impose a heightened burden of explanation on administrators when they reject" a claimant's evidence). In particular, Hartford's adverse decision was "set forth[] in a manner calculated to be understood by [Ms. Easter]" and provided the "specific reason . . . for the adverse determination." 29 CFR § 2560.503-1(g)(1).

2

Next, Ms. Easter asserts that "Hartford failed to inform [her] of additional information needed to determine her claim." Aplt.'s Reply Br. at 13 (capitalization omitted). Specifically, Ms. Easter contends that "29 CFR § 2560.503-1(g)(1)(iii) required that Hartford's initial denial letter notify [her] of 'any additional material or

information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.'" *Id.* Ms. Easter claims that Hartford failed to comply with this provision (1) by failing to inform her of any concerns that it had with "the credibility" of her evidence and (2) by failing to obtain "independent medical reviews at the initial stage of the claims process." *Id.* at 14. We are unpersuaded.

Hartford did not base its denial of Ms. Easter's LTD claim on her failure to produce a particular piece of evidence or for failing to comply with a specific procedural requirement. Stated another way, Hartford did not need any additional information from Ms. Easter to determine the merits of her claim. Instead, Hartford assessed Ms. Easter's evidence, found it unconvincing—based in part on the statements of *Ms. Easter's own physician*—and provided a detailed rationale for its decision. *See* Aplt.'s App. at 252–57. Indeed, Hartford's rationale in the initial claim determination letter did not rest, in any part, on Ms. Easter's failure to produce additional material. *See id.*

Furthermore, ERISA contains no requirement that a plan administrator refer a claim for an independent medical review before issuing an initial claim determination. And Ms. Easter provides no authority supporting such a position. As such, we see no basis for imposing such a requirement on Hartford. *See Williams v. Hartford Life & Acc. Ins. Co.*, No. 2:11-cv-00637, 2013 WL 1336228, at *7 (D. Utah Mar. 29, 2013) ("[Plaintiff] does not cite any authority for the proposition that a denial of disability benefits without a file review by an independent physician—much

less a medical examination—is arbitrary and capricious."); *cf. Menge v. AT&T, Inc.*, 595 F. App'x 811, 815 (10th Cir. 2014) (unpublished) ("[A] plan administrator may reasonably rely on the opinions of its own doctors who have reviewed the claimant's medical file but not consulted with the claimant's treating physicians."); *M.K.*, 628 F. App'x at 597 ("[W]e conclude that CIGNA's reviewing physicians acted reasonably and in good faith in reviewing the information provided by [plaintiff].").

Accordingly, we conclude that Hartford fully complied with 29 CFR § 2560.503-1(g)(1)(iii).

3

Third, Ms. Easter claims that Hartford "fail[ed] to respond to the evidence provided by [Ms.] Easter and her treating physicians" at the initial stage of the claims process. Aplt.'s Opening Br. at 29. In particular, Ms. Easter takes issue with the fact that Hartford allegedly disregarded PA-C Sandy's opinions when rendering its initial claim determination. Instead, Hartford allegedly "concluded that [Ms.] Easter had the ability to perform 'sedentary' or 'light' duty work based solely upon APRN Jones' responses to a form letter that asked whether [Ms.] Easter could perform various manual tasks." *Id.* at 33–34. That is, Ms. Easter contends that neither Hartford nor the district court could "identify any specific information, other than the form letter, supporting Hartford's initial denial." *Id.* at 36.

Hartford argues that "the administrative record documents that [it] reviewed all [of the] evidence in arriving at its claim determination." Aplee.'s Resp. Br. at 24. Specifically, in the initial claim determination letter, "Hartford both confirmed its

review of all documents and listed expressly the many medical records that it had reviewed." *Id.* at 25. Hartford contends that the "ERISA regulations did not require [it] to provide a further summary of the reviewed medical records in its claim determination letter." *Id.* We believe Hartford has the better of the argument.

Ms. Easter is correct that Hartford relied, in part, on APRN Jones's responses to the form letter in arriving at its initial claim determination. However, we believe it was entirely appropriate for Hartford to do so, especially given that those responses came from Ms. Easter's own treating physician. Indeed, in that form letter, APRN Jones indicated that Ms. Easter was capable of performing "sedentary" activity, which included an occupation that "[r]equires mainly sitting, walking/standing for brief periods and frequent handling, finger [sic] and extending arms at desk level." Aplt.'s App. at 286. Furthermore, APRN Jones even believed that Ms. Easter was capable of performing "light" activity (i.e., a higher designation of difficulty), which included an occupation that "[r]equires walking or standing to a significant degree, or sitting most of the time [with] pushing/pulling of arm or leg controls." *Id.*

Thus, given APRN Jones's opinion, it was reasonable for Hartford to rely on the form letter to conclude that Ms. Easter's CFS diagnosis did not prevent her from performing a "sedentary" occupation. In other words, given that Ms. Easter's role was "considered a sedentary level occupation," and "Megan Jones APRN confirm[ed] [she was] able to perform a sedentary and light level occupation," Hartford could reasonably rely on APRN Jones's opinion to "deny [Ms. Easter's] claim for LTD benefits." *Id.* at 256.

Furthermore, Hartford—in its initial claim determination letter—specifically noted that it had reviewed PA-C Sandy's Physician's Statement and medical records. *See id.* at 254–55. Thus, contrary to Ms. Easter's assertions, Hartford did "not arbitrarily refuse to credit" the opinions of Ms. Easter's other treating physician. *Nord*, 538 U.S. at 834; *see also Blair v. Alcatel-Lucent Long Term Disability Plan*, 688 F. App'x 568, 576 (10th Cir. 2017) (unpublished) ("[W]hile an administrator 'may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician,' ERISA does not require an administrator to defer to a treating physician." (quoting *Nord*, 538 U.S. at 823)). And although Hartford did not delve into much detail regarding PA-C Sandy's opinions, it was not required to do so under ERISA. Indeed, the Supreme Court has held 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 administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Nord*, 538 U.S. at 834; *see also Eugene S. v. Horizon Blue Cross Blue Shield of N.J.*, 663 F.3d 1124, 1135 (10th Cir. 2011). As such, to the extent the medical reports conflicted, Hartford was not required to provide an explanation of why it credited APRN Jones's opinion—*viz.*, her reliable medical evidence—over PA-C Sandy's opinion. Accordingly, we see no procedural irregularity that demands an alteration of the standard of review.

4

a

Fourth, Ms. Easter contends that she was entitled to respond to Hartford's medical reports in her administrative appeal. *See* Aplt.'s Opening Br. at 30–33. Specifically, Ms. Easter claims that "Hartford's denial of [her] administrative appeal relie[d] heavily upon the medical reports it obtained from Dr. Blavias and Dr. Duff." *Id.* at 31. Ms. Easter further notes that she and her medical providers "were given no opportunity to respond to such medical reports." *Id.* She claims that Hartford's failure to provide her an opportunity to respond to the medical reports violated our decision in *Metzger v. UNUM Life Insurance Co. of America*, 476 F.3d 1161, 1166–67 (10th Cir. 2007), which, in her view, "requires that a claimant be provided an opportunity to respond where the administrator relies upon evidence that is not already known to the claimant, or which contains new factual information." Aplt.'s Opening Br. at 32.

Hartford believes Ms. Easter "has misconstrued *Metzger*." Aplee.'s Resp. Br. at 29. Specifically, Hartford asserts that in *Metzger*, we "held that the ERISA regulations in effect at the time . . . did not require the disclosure of reviewers' reports obtained during an appeal before the issuance of the final appeal decision." *Id.* at 31. Furthermore, Hartford contends that—even if Ms. Easter's reading of *Metzger* were correct—neither Dr. Blavias's nor Dr. Duff's medical reports can be considered "new evidence." *Id.* at 32. As such, Hartford believes it had no obligation to provide Ms. Easter with an opportunity to respond. Alternatively,

Hartford claims that even if it were required to provide Ms. Easter with an opportunity to respond, its failure to do so did not cause material prejudice warranting an alteration of the standard of review. *See id.* at 35. More specifically, Hartford claims that allowing Ms. Easter "to submit rebuttals of the reports of Dr. Blavias and Dr. Duff would neither [have altered] Hartford's determination nor serve[d] any purpose." *Id.* We conclude that Hartford prevails in this dispute.

For the purposes of this appeal, we assume, without deciding, a plan administrator's reliance on appeal on new factual information or evidence could require a claimant to be provided an opportunity to respond to the new material. We further assume that Dr. Blavias's and Dr. Duff's reports constituted "new evidence," thereby requiring Hartford to provide Ms. Easter with an opportunity to respond. Even so, we conclude that Hartford substantially complied with ERISA regulations and the result of the appeal would not have been different had such an opportunity to respond been provided. Accordingly, we see no reason to alter the standard of review. *See Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 634 (10th Cir. 2003) ("Courts have . . . been willing to overlook administrators' failure to meet certain procedural requirements when the administrator has substantially complied with the regulations and the process as a whole fulfills the broader purposes of ERISA and its accompanying regulations."); *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 895 (10th Cir. 1988) ("Not every procedural defect will upset the decision of plan representatives."). We turn to explicate the reasoning underlying these conclusions.

b

In a cogent, nonprecedential decision, *Forrester v. Metropolitan Life Insurance Co.*, 232 F. App'x 758 (10th Cir. 2007) (unpublished), a panel of our court was presented with an argument that is very similar to the one Ms. Easter asserts here. Specifically, the plaintiff argued that—before the plan administrator decided her administrative appeal—she should have been provided the opportunity to rebut the medical reports of three independent physicians who reviewed the evidence submitted in her initial claim determination. *See id.* at 760. In rejecting the plaintiff's claim, we noted that "the reports at issue basically just review[ed] the record as supplemented by additional evidence submitted on [the plaintiff's] behalf." *Id.* Furthermore, while we acknowledged that the medical reports also mentioned two telephone calls the physicians initiated with the plaintiff's medical providers, we concluded that the disclosure of "the substance of these telephone conversations in light of the rest of the record . . . would not have altered the administrative disposition under review and 'no purpose would be served by a [remand for] further, but procedurally correct, review of [the plaintiff's] claims' under the Plan." *Id.* at 761 (first alteration in original) (quoting *Sage*, 845 F.2d at 895). As such, the panel concluded:

> We need not decide whether conversations with a claimant's own providers (to whom she obviously had direct access) fall within the exception to *Metzger*'s non-disclosure rule, as any omission in this respect did not cause material prejudice and, absent that, substantial compliance with

ERISA full and fair review requirements is sufficient.

Id. at 760.

We are persuaded by the logic of *Forrester* and believe it applies here. Like in *Forrester*, Dr. Blavias initiated telephone calls with Ms. Easter's medical providers. In those calls, both PA-C Sandy and APRN Jones expressed some skepticism regarding Ms. Easter's inability to work. Similarly, Dr. Duff's medical report included findings of symptom exaggeration by Ms. Easter. However, these allegedly new findings were consistent with other evidence already in the administrative record that raised questions about the credibility of Ms. Easter's reported symptoms. For example, as discussed *supra*, APRN Jones had already indicated that Ms. Easter was capable of sedentary and light activity. *See* Aplt.'s App. at 286–87.

Furthermore, APRN Jones had previously spoken to Hartford by telephone regarding Ms. Easter's CFS, and expressed some surprise that Ms. Easter's symptoms had not yet improved. *See* Aplee.'s Supp. App. at 68. Indeed, Hartford's very reason for denying Ms. Easter's LTD claim was that it was unconvinced Ms. Easter's symptoms actually precluded her from working—i.e., that she likely was exaggerating the severity of her symptoms. In justifying its conclusion, Hartford cited APRN Jones's responses to the form letter, which called Ms. Easter's reported symptoms into question. It is implausible then for Ms. Easter to claim that she was unaware of Hartford's skepticism towards the severity of her CFS diagnosis, and that she needed an opportunity to rebut these cumulative findings—*viz.*, the medical reports—on appeal.

As such, we conclude "the substance of these telephone conversations" and Dr. Duff's findings of symptom exaggeration did not "alter[] the administrative disposition under review." *Forrester*, 232 F. App'x at 761. And the remainder of the physicians' reports merely "review[ed] the record as supplemented by additional evidence submitted on [Ms. Easter's] behalf." *Id.* at 760. Accordingly, we conclude that Hartford's alleged procedural defect did not cause material prejudice, and that Hartford otherwise fully and fairly complied with relevant ERISA regulations.

C

Finally, Ms. Easter contends that the district court improperly disregarded Hartford's "dual role" conflict of interest. *See* Aplt.'s Opening Br. at 29–30. Specifically, she notes that "Hartford acted as both the claims adjudicator and payor, and thus was under a 'dual role' conflict of interest in this case." *Id.* at 30. Ms. Easter claims that the district court should have taken this conflict into account, "by reducing its deference to Hartford's decision to the extent that [was] required by the degree of the conflict." *Id.* Although Ms. Easter acknowledges that Hartford presented evidence showing that it had taken steps to reduce potential bias and promote accuracy, she claims that Hartford's evidence "was impermissibly vague and was not based upon personal knowledge." *Id.* As such, she concludes the evidence "should have been excluded as inadmissible." *Id.*

Hartford contends that it presented evidence describing the steps it took "to reduce the possibility of bias affecting its determinations." Aplee.'s Resp. Br. at 37. Furthermore, Hartford notes that Ms. Easter has "not cite[d] any evidence to dispute

Hartford's discussion of its many active steps to eliminate bias"; instead, she solely "relies on objections that Hartford's interrogatory response was 'impermissibly vague and was not based upon personal knowledge.'" *Id.* Hartford asserts that Ms. Easter's objections in that regard are groundless, as the interrogatory response was sufficiently detailed, and a Hartford representative properly verified the response. *See id.* We agree with Hartford.

"Where the plan administrator is 'operat[ing] under a conflict of interest, . . . that conflict' may be weighed 'as a factor in determining whether the plan administrator's actions were arbitrary and capricious.'" *Foster v. PPG Indus., Inc.*, 693 F.3d 1226, 1232 (10th Cir. 2012) (alteration and omission in original) (quoting *Charter Canyon Treatment Ctr. v. Pool Co.*, 153 F.3d 1132, 1135 (10th Cir. 1998)). "A plan administrator acting in a dual role, i.e., both evaluating and paying claims, has such a conflict of interest." *Id.* However, a conflict "should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits." *Glenn*, 554 U.S. at 117.

Here, Hartford's interrogatory response makes clear that it took significant steps to reduce potential bias and to promote accuracy. For example, Hartford states that it has "'walled off' claims personnel from the company's finance department" and "compensates members of the claims department and appeals unit in accordance

with the terms of their individual employment with Hartford based on the quality, accuracy, and timeliness of their claim investigations and decisions." Aplt.'s App. at 183–84 (Hartford's Resps. to Ms. Easter's Interrogs., dated Feb. 20, 2020). Furthermore, Hartford provides a detailed explanation of how it achieves these ends—which dispels Ms. Easter's "vagueness concerns." *See id.*

As relevant here, Hartford also mitigated the potential for undue influence of the "dual role" capacity by retaining two independent specialists, Dr. Blavias and Dr. Duff. *See Holcomb v. Unum Life Ins. Co. Am.*, 578 F.3d 1187, 1193 (10th Cir. 2009) ("[The plan administrator] took steps to reduce its inherent bias by hiring two independent physicians . . . . We therefore give the conflict-of-interest factor limited weight in evaluating whether [the plan administrator] abused its discretion."); *Liebel*, 595 F. App'x at 762 ("[W]e give a conflict 'limited weight in evaluating whether [a plan administrator] abused its discretion' when it 'did not rely solely on . . . its own on-site physicians and nurses' but 'took steps to reduce its inherent bias by hiring . . . independent physicians' to assess the claimant's alleged disability." (omissions and second alteration in original) (quoting *Holcomb*, 578 F.3d at 1193)). Ms. Easter fails to show how these remedial steps are insufficient to quell her concerns.

Moreover, Ms. Easter's personal knowledge objection is meritless. Federal Rule of Evidence 602 provides that "[a] witness may testify to a matter only if evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter." FED. R. EVID. 602. Despite Rule 602's personal knowledge mandate, "it 'does not require that the witness'[s] knowledge be positive

or rise to the level of absolute certainty. Evidence is inadmissible . . . only if in the proper exercise of the trial court's discretion it finds that the witness could not have actually perceived or observed that which he testifies to.'" *United States v. Sinclair*, 109 F.3d 1527, 1536 (10th Cir. 1997) (omission in original) (quoting *M.B.A.F.B. Fed. Credit Union v. Cumis Ins. Soc., Inc.*, 681 F.2d 930, 932 (4th Cir. 1982)).

Here, an Appeals Specialist for Hartford (i.e., a Hartford representative) verified the accuracy of the relevant interrogatory responses and attested that she was "familiar" with the contents of the responses and that the "factual averments" in the responses were "true and correct to the best of [her] knowledge, information, and belief, and based on [her] review of available documents." Aplt.'s App. at 185. Thus, based on the representative's "review of available documents" and attestation as to the accuracy of the "factual averments" of the responses, it seems readily apparent that she (as Hartford's representative) actually could have perceived—in satisfaction of Rule 602—the factual information supporting Hartford's interrogatory responses. As such, we conclude that the interrogatory responses were properly admitted.

***

In sum, for the foregoing reasons, we conclude that Ms. Easter's allegations of procedural irregularity are meritless. Accordingly, the arbitrary-and-capricious standard remains the operative one and controls our review of Ms. Easter's substantive challenges to Hartford's decisions. We address those substantive challenges *infra*.

IV

Ms. Easter contends that, even absent any procedural irregularities, "the district court erred in holding that Hartford's decision is supported by sufficient evidence." Aplt.'s Opening Br. at 33 (capitalization omitted). Indeed, she claims that neither Hartford's initial denial nor its appeal decision was supported by substantial evidence. *See id.* at 33–42. More specifically, Ms. Easter asserts "there is no evidence in the record which supports a denial of [her] claim of disability based upon CFS." *Id.* at 43.

Hartford believes that Ms. Easter's "attacks on [its] determinations are groundless." Aplee.'s Resp. Br. at 38. First, Hartford contends that it "based its [initial] claim determination on a thorough and reasonable investigation of [Ms.] Easter's LTD claim." *Id.* at 39 (bold and capitalization omitted). Hartford also claims that it "based its appeal determination on a full and a fair review of [Ms.] Easter's appeal." *Id.* at 41 (bold and capitalization omitted). We agree. More specifically, under the deferential arbitrary-and-capricious standard, we conclude that Hartford's initial claim determination and appeal decision were reasonable and supported by substantial evidence.

A

"Where the plan gives the administrator discretionary authority . . . 'we employ a deferential standard of review, asking only whether the denial of benefits was arbitrary and capricious.'" *LaAsmar*, 605 F.3d at 796 (quoting *Weber v. GE Grp. Life Assurance Co.*, 541 F.3d 1002, 1010 (10th Cir. 2008)). "Under this

arbitrary-and-capricious standard, our 'review is limited to determining whether the interpretation of the plan was reasonable and made in good faith.'" *Id.* (quoting *Kellogg*, 549 F.3d at 825–26). "We will uphold the decision of the plan administrator 'so long as it is predicated on a reasoned basis,' and 'there is no requirement that the basis relied upon be the only logical one or even the superlative one.'" *Eugene S.*, 663 F.3d at 1134 (quoting *Adamson*, 455 F.3d at 1212). "The reviewing court 'need only assure that the administrator's decision fall[s] somewhere on a continuum of reasonableness—even if on the low end.'" *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999) (alteration in original) (quoting *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999)). "Indicia of arbitrary and capricious decisions include lack of substantial evidence, mistake of law, bad faith, and conflict of interest by the fiduciary." *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1282 (10th Cir. 2002).

Substantial evidence is "evidence that a reasonable mind might accept as adequate to support the conclusion reached by the decision-maker." *Graham v. Hartford Life & Acc. Ins. Co.*, 589 F.3d 1345, 1358 (10th Cir. 2009) (quoting *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 382 (10th Cir. 1992)). "Substantial evidence requires more than a scintilla but less than a preponderance." *Id.* (quoting *Sandoval*, 967 F.2d at 382). "Substantiality of the evidence is based upon the record as a whole." *Caldwell*, 287 F.3d at 1282.

B

1

First, Ms. Easter contends that the district court "erred in holding that Hartford's initial denial was supported by substantial evidence." Aplt.'s Opening Br. at 36. Specifically, she claims that, in upholding Hartford's initial determination, the district court placed too much weight on APRN Jones's responses to Hartford's form letter, and otherwise identified no other evidence supporting Hartford's decision. *See id.* Furthermore, she claims that Hartford simply made a "vague reference to all of the evidence in the file" to support its initial determination. *Id.*

Hartford claims that it "did not limit its review to [APRN] Jones'[s] submissions and medical records"; instead, it "obtained and reviewed medical records from all of [Ms.] Easter's health care providers." Aplee.'s Resp. Br. at 40. Hartford further contends that it "listed the medical records [that it] reviewed in the determination letter." *Id.* As such, Hartford asserts that its "documentation of its claim review and the determination letter showed that" it considered all the relevant medical information in rejecting Ms. Easter's LTD claim. *Id.* at 41. We conclude that Hartford has the better of the argument.

First, as discussed *supra*, Hartford's reliance on the form letter was entirely appropriate. APRN Jones was one of two medical providers who submitted an Attending Physician's Statement supporting Ms. Easter's disability claim. *See* Aplt.'s App. at 294–95. Thus, it was reasonable for Hartford to follow up with APRN Jones to seek clarification of her opinions regarding Ms. Easter's level of

functionality, and to rely on her responses when rendering its decision. In the form letter, APRN Jones informed Hartford that she believed Ms. Easter could perform sedentary and light activity—thereby calling the severity of Ms. Easter's symptoms into question. *See id.* at 286–87. Accordingly, we do not believe it was improper for Hartford to rely on the form letter to conclude that Ms. Easter's CFS diagnosis did not prevent her from performing a "sedentary" occupation. *See id.* at 256.

Furthermore, contrary to Ms. Easter's assertion, Hartford did not vaguely refer "to all of the evidence in the file." Instead, it specifically cited the evidence on which it relied in rejecting Ms. Easter's claim, which included medical records and statements from multiple physicians. *See id.* at 254–55. Indeed, the letter discussed many of the findings made in those reports, and extensively catalogued the prior diagnoses and treatments Ms. Easter had received over the years. *See id.* at 255–56. Finally, the initial claim determination letter provided a detailed rationale for denying Ms. Easter's LTD claim. *See id.* at 256.

Given all of this, we cannot say that there was insufficient evidence "that a reasonable mind might accept as adequate to support the conclusion reached by the decision-maker." *Graham*, 589 F.3d at 1358 (quoting *Sandoval*, 967 F.2d at 382). In other words, we conclude that the district court did not err in holding that Hartford's initial denial was supported by substantial evidence.

2

Ms. Easter also asserts that "Hartford's appeal decision was not supported by substantial evidence." Aplt.'s Opening Br. at 36 (capitalization omitted).

Specifically, Ms. Easter claims that "Hartford's appeal decision relies exclusively upon the medical reports provided by Dr. Blavias and Dr. Duff, including Dr. Blavias'[s] summary of conversations that he had with [Ms.] Easter's treating physicians." *Id.* at 37. However, she argues that "Dr. Blavias'[s] and Dr. Duff's reports do not provide substantial evidence to support the denial of [her] claim." *Id.*

Hartford claims that Dr. Blavias's peer-review report, Dr. Duff's neuropsychological evaluation, "as well as the other evidence in the administrative [record] constituted substantial evidence on which Hartford could reasonably" rely in deciding that Ms. Easter's "self-reported impairments were not credible." Aplee.'s Resp. Br. at 48. Specifically, Hartford notes that "Dr. Blavias had found that the evidence did not support a disability due to obstructive sleep apnea or hypersomnia." *Id.* And "Dr. Duff had tested [Ms.] Easter to evaluate the existence of a cognitive impairment due to CFS and found evidence of extreme symptom exaggeration." *Id.* Thus, Hartford contends that the weight of the evidence did not "support a physical condition of such severity that would preclude [Ms. Easter] from performing full time work activities." *Id.* We agree.

In addressing Ms. Easter's diagnoses of CFS, obstructive sleep apnea, and hypersomnia, Dr. Blavias conducted an exhaustive review of Ms. Easter's medical records. *See* Aplt.'s App. at 271–77. Dr. Blavias found that Ms. Easter had "mild obstructive sleep apnea with mild hypersomnia," and concluded that "[i]t [was] unlikely that these [were] significantly contributing to her complaints and would not be expected to cause significant impairment in function." *Id.* at 277. Instead, Dr.

Blavias noted that Ms. Easter's complaints of fatigue and cognitive deficits "may be caused by [CFS] and/or psychiatric illness," and stated that the role of psychiatric illness was outside of his area of expertise. *Id.* at 278.

Dr. Blavias also spoke with Ms. Easter's medical providers—*viz.*, APRN Jones and PA-C Sandy. APRN Jones told Dr. Blavias that Ms. Easter's "symptoms of excessive daytime sleepiness appeared to be out of proportion to the degree of obstructive sleep apnea." *Id.* at 273. APRN Jones also "felt that the primary cause of Ms. Easter's severe fatigue was likely her mental health issues, rather than a sleep disorder." *Id.* PA-C Sandy similarly "acknowledged that the sleep disorders and other medical issues [did] not seem adequate to explain [Ms. Easter's] reported symptoms." *Id.* at 274. Thus, although Dr. Blavias was unable to make a final determination regarding Ms. Easter's CFS, his peer-review report—which included the summary of conversations he had with Ms. Easter's treating physicians—cast significant doubt on the severity of Ms. Easter's reported symptoms.

Hartford then reviewed Dr. Blavias's peer-review report and determined that he had not fully resolved the issue concerning cognitive deficits related to CFS. Consequently, Hartford—out of an abundance of caution—referred the claim to Dr. Duff for a neuropsychological evaluation to clarify if Ms. Easter's reported cognitive complaints were the result of CFS.

Dr. Duff's testing revealed that Ms. Easter was likely exaggerating the severity of her symptoms. More specifically, Dr. Duff found that Ms. Easter's self-reported symptoms of fatigue and sleepiness were greater than 99.9% of persons with sleep

disorders, daytime sleepiness, narcolepsy, sleep apnea, and narcolepsy. *See id.* at 263. Indeed, Dr. Duff noted that most of Ms. Easter's "cognitive scores were within normal limits" despite Ms. Easter "endors[ing] more cognitive complaints than 99% of the normative group." *Id.* at 266. As such, Dr. Duff determined that "there was no clear evidence to suggest that Ms. Easter would have issues with endurance at work." *Id.* Accordingly, Dr. Duff's evaluation was consistent with APRN Jones's and PA-C Sandy's concerns that Ms. Easter's self-reported symptoms were out of proportion to her CFS and sleep disorders.

Based on the findings in the two medical reports, and other evidence in the administrative record (e.g., APRN Jones's responses to the form letter), Hartford could reasonably conclude that the weight of the evidence did not support Ms. Easter's LTD claim. Stated another way, Hartford's appeal decision was "predicated on a reasonable basis" and supported by substantial evidence. *Eugene S.*, 663 F.3d at 1134 (quoting *Adamson*, 455 F.3d at 1212). As such, we conclude that the district court did not err in concluding that Hartford's appeal decision was supported by substantial evidence.[1]

[1] Ms. Easter also claims that Hartford "misapplied its pre-existing condition exclusion to exclude consideration of any mental impairment that [Ms.] Easter may have suffered as a result of her CFS flare up." Aplt.'s Opening Br. at 36 n.19. However, Hartford did—in fact—consider Ms. Easter's evidence regarding the existence of a cognitive impairment due to CFS in its appeal review. Indeed, that was the very reason Hartford scheduled the neuropsychological evaluation—*viz.*, to determine if the "reported cognitive complaints are the result of [CFS]." Aplee.'s Supp. App. at 58. Thus, contrary to Ms. Easter's contention, Hartford did not exclude consideration of any mental impairment that Ms. Easter may have allegedly suffered as a result of CFS.

V

For the foregoing reasons, we **AFFIRM** the district court's judgment.

Entered for the Court

Jerome A. Holmes
Chief Judge