[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 18-11803
Non-Argument Calendar

D.C. Docket No. 3:16-cv-01439-BJD-PDB

ANTHONY J. FERRIZZI,

Plaintiff-Appellant,

versus

RELIANCE STANDARD LIFE INSURANCE COMPANY,
a foreign corporation,

Defendant-Appellee.

Appeal from the United States District Court
for the Middle District of Florida

(November 7, 2019)

Before WILLIAM PRYOR, JILL PRYOR, and ANDERSON, Circuit Judges.

PER CURIAM:

Anthony Ferrizzi sued Reliance Standard Life Insurance Company ("Reliance") under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., after Reliance denied his claim for long-term disability benefits because of a pre-existing condition. Ferrizzi now appeals the district court's grant of Reliance's motion for summary judgment. Ferrizzi contends that the district court erred because Reliance's denial of his benefits claim was "arbitrary and capricious." Ferrizzi initially alleged several long-term disabilities in his claim for benefits, but the issue before this Court relates solely to the substance abuse/drug dependency claim arising from Ferrizzi's administrative appeal. Because we conclude that Reliance's denial was reasonable in light of the record, we affirm.

I. BACKGROUND

This appeal concerns a long-term disability plan sponsored and administered by Reliance and governed by ERISA. Reliance issued a policy to AutoNation Benefits Company, Inc., to provide long-term disability insurance to AutoNation employees. Ferrizzi began working as a service advisor at AutoNation Nissan in 2013.[1] Through his employment with AutoNation Nissan, Ferrizzi became insured under the Reliance long-term disability policy beginning on January 1, 2015.

[1] AutoNation Nissan is not a party to this suit.

Ferrizzi's last day at AutoNation Nissan was April 23, 2015. Ferrizzi then received short-term disability benefits from Reliance before applying for long-term disability benefits on November 2, 2015.[2] His long-term benefits claim application listed the date of loss as the day following the end of his employment: April 24, 2015. In response to the application question, "Why are you unable to work?" Ferrizzi answered, "Loss of mobility, memory loss, speech slurring, communica[tion] skills." In response to the application question, "What were your first symptoms?" he answered, "Head ach[e]s, seizures, right rotary cuff 3x, memory loss." In this initial application, Ferrizzi did not list substance abuse or drug dependency as a basis for his long-term disability benefits claim.

It is undisputed that Ferrizzi claimed long-term disability benefits within one year of his effective date of insurance. Reliance's policy dictates that, when, as here, individuals report a disability within the first year of the policy becoming effective, Reliance conducts a pre-existing condition investigation to determine whether the claimed disability was excluded from coverage under the policy's pre-existing condition language. Under the plan, "Benefits will not be paid for a Total Disability: (1) caused by; (2) contributed to by; or (3) resulting from; a Pre-existing Condition." The policy defined a "pre-existing" condition as follows:

[2] The short-term disability benefits were paid on the basis of disability resulting from: seizures, right shoulder pain, and depression.

> any Sickness or Injury for which the Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the six (6) months immediately prior to the Insured's effective date of insurance.

Reliance confirmed receipt of Ferrizzi's claim on November 11, 2015, and began its review of the medical records generated during the lookback period. Because Ferrizzi's plan began on January 1, 2015, the relevant six-month lookback period for Ferrizzi's policy was July 1, 2014, to December 31, 2014.

After reviewing Ferrizzi's medical records, Reliance denied Ferrizzi's claim for benefits because it determined that Ferrizzi's primary disabling condition was seizures/pseudoseizures, which qualified as a pre-existing condition based on Ferrizzi's medical records. Reliance informed Ferrizzi of the denial in a letter dated March 2, 2016.[3]

Ferrizzi timely appealed the denial of his benefits under Reliance's appeal procedures. In his appeal, Ferrizzi acknowledged that, "[d]uring the look back period (7/1/15-12/31/15 [sic]), [he] was treated for seizure/pseudoseizures." He asserted, however, that his long-term disability was really "the result of *substance*

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[3] The letter began by acknowledging the confusion about "what exactly happened at the date of loss to precipitate work stoppage" before ultimately concluding that Ferrizzi's "primary impairing condition was seizures/pseudoseizures" and "work stoppage on 4/24/15 was precipitated by seizures/pseudoseizures." Based on the medical records, Reliance determined that the seizures/pseudoseizures were a "pre-existing condition" because Ferrizzi "received medical treatment, consultation, care or services, or took prescribed drug or medicine during the period (July 1, 2014 to January 1, 2015)." Reliance also determined that, because Ferrizzi received treatment, consultation, care and services during the lookback period for the other conditions he claimed as disabilities, disability benefits were not payable for those conditions.

abuse/dependency following shoulder surgery and prescription of pain medication." Because, Ferrizzi argued, "*he received no treatment for opiate (drug) abuse/dependency*" during the lookback period, "*his long term disability . . . is not precluded by the Pre-Existing Condition exclusion.*"[4]

Reliance's appeal procedures allow every claimant to appeal a benefit claim denial, and it follows certain claim and appeal handling principles to "promote the neutral, unbiased and accurate adjudication of claims." The person conducting the appeal is not to be the same person or a subordinate of the same person who made the underlying decision. On appeal, "each claim is evaluated individually and without regard or deference to the original claim decision." Claim examiners and appeal reviewers (1) do not report to and are physically separate from the financial department, (2) are not compensated based on their decisions, (3) are evaluated on their promptness and accuracy but not on their decisions, and (4) must attend annual training on good-faith claim handling and the "International Claims Association Statement of Principles." If Reliance requests an independent doctor's opinion, it will ask an independent third-party vendor to identify one. Any doctor engaged to review a claim file "must be Board Certified and . . . maintain an active practice or be academically affiliated such that at least a portion of the medical

[4] Ferrizzi acknowledges that, "during the lookback period, Plaintiff was working productively, full-time while receiving treatment primarily for seizures, headaches and anxiety/depression."

professional's income is derived from a source unrelated to insurance examinations or file reviews."

The lengthy medical record that Reliance considered before it denied Ferrizzi's appeal encompassed a wide variety of sources and material. The evidence specifically relevant to its determination that Ferrizzi's substance abuse/drug dependency is a pre-existing condition that precludes benefits is as follows.

On November 25, 2014, Ferrizzi saw Dr. Minh Le, who wrote: "My assessment is 47-year-old male with alternation in mental status, potentially multifactorial, suspect based upon outpatient prescriptions, benzodiazepine, polypharmacy, underlying migraine disorder, and report of seizure disorder, on no controller medications potentially, due to withdrawal of benzodiazepines in the past."

On December 10, 2014, Ferrizzi was seen by the Shands Jacksonville Medical Center's Emergency Department ("ED"). The ED medical provider, Dr. Joel Mendez, documented the visit as follows:

> Mr. Ferrizzi is a 47 y/o WM presenting for an urgent visit, he has only been seen once prior. He called several days ago requesting an Rx for VALIUM even though it was made clear to him at his previous visit that we would not provide him controlled substances from this office due to admitted history of narcotic abuse and doctor-shopping behaviors evident in his E-FORSCE records. While waiting in the lobby, Mr. Ferrizzi fell forward out of his chair and hit his head on the wall. EMS was called to transport him to the ED. He denies blacking

> out, denies having a seizure. He reports that his PCP [primary care physician] declined to continue writing Rx for XANAX or HYDROCODONE and he has been without both for several weeks. He reports he has not been sleeping and has had a migraine for several days. While waiting for EM, he continues requesting an Rx for VALIUM or XANAX and asking that I speak with his PCP to try to convince him to continue prescribing the narcotics, which I reiterated that I would not do.
>
> On arrival to ED he was cleared by trauma bay and took an unlabeled pill turned out to be xanax in front of RN there.
>
> On arrival here patient immediately requesting narcotics, on c-collar complaining of neck pain. Denied syncope, cp, sob, headache, or any other symptoms.
>
> The history is provided by the patient.

A registered nurse at the ED also included this note about Ferrizzi's visit:

> 48 y.o male arrived to trauma bay, fully immobilized (c-collar and LBB) via JFRD s/p fall, possible syncope at the MD (psych) office in the towers. Pt GCS 15, + LOC, PERRL (3 bilaterally). . . . RN performing documentation, pt continues to sit up in bed, move collar and complain of neck pain and headache pain 8/10. Pt sat up in bed and took an unlabeled pill bottle out of his pocket and took, per pt, one pill. Pt would not tell RN what pill he took. RN consulted pharmacy and per pharmacy the pill is 2 mg PO Xanax. Pt stated he took pills for seizures. Pills were placed in a bottle and counted with pharmacy. 11 pills in bottle. Pt triaged to flex care.

Lastly, Dr. Mendez's "ED Re-Evaluation" note for the same December 10, 2014, visit documented Ferrizzi's state when leaving the ED:

> Patient arrives to ED after "fall" in outpt psych after being denied valium. Per notes, patient known for drug seeking behavour. Here immediately asking for narcotics and valium. Once being told he was going to get worked up with CT head and CT c spine and ekg, but no narcotics o[r] benzos will be provided patient became angry and

> agitated. Stating he was going to leave. Advi[s]ed him repeatedly that if he [leaves] without work up he could risk arrhythmia, cardiac abnormalities causing disability or death. Patient angrily walked out. He had full cap[a]city, was [alert & oriented] x 3, not intoxicated and understood. He left AMA [against medical advice] and refused to sign AMA paperwork.

The discharge record confirms that Ferrizzi left against medical advice.

From December 15, 2014, Ferrizzi visited a psychiatrist, Dr. Imtiaz Rasul. Ferrizzi told Dr. Rasul that his primary care physician had stopped his prescription for Xanax two weeks earlier. Dr. Rasul diagnosed him with major depressive disorder, anxiety disorder, panic disorder, nicotine dependence, seizure disorder, and migraines; Dr. Rasul also prescribed diazepam (generic Valium, a benzodiazepine drug).

On December 26, 2014, Ferrizzi had a follow up appointment with Dr. Rasul. Ferrizzi said he was feeling "great" after taking diazepam, and Dr. Rasul increased the dosage. Ferrizzi continued seeing Dr. Rasul after the lookback period concluded on January 1, 2015.

On September 23, 2016, Reliance informed Ferrizzi that it was obtaining an "independent physician" from a third-party vendor to review his appeal and the medical information in Ferrizzi's claim file. The review was conducted by Dr. Norman Miller, who has board certifications in neurology, psychiatry, addiction psychiatry, and forensic psychiatry. Dr. Miller reviewed Ferrizzi's file and issued an "Independent Peer Review" of the file to Reliance. Dr. Miller determined that

Ferrizzi's disability was a result of opioid and benzodiazepine use and dependence, and that he had "diagnoses of opioid dependence, anxiolytic dependence, depression, anxiety and pseudoseizures" during the lookback period. Dr. Miller's report also expressed the following medical opinion:

> Was the claimant's impairment(s) or alleged impairment(s) as of 04/24/2015 caused by, contributed to by, or did it result from a condition for which he received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for such condition, whether specifically diagnosed or not, during the period of 07/01/2014 to 01/01/2015?
>
> Yes. He was prescribed persistently regularly opioid medications, principally hydrocodone and Oxycodone and also, benzodiazepine medications or anxiolytics, principally Alprazolam and Lorazepam. These medications contribute to his alleged impairment as of 04/24/2015. Otherwise, I see no other medical conditions that would cause the alleged impairment of 04/24/2015. . . . As already explained, he was dependent and addicted to prescription opioid and benzodiazepines. It does not matter whether he took them as prescribed or not, they still had impairing effects on him. These medications induced depression and anxiety, pseudoseizures and pain.

Put simply, Dr. Miller concluded that Ferrizzi's substance abuse/drug dependence disability was a pre-existing condition during the lookback period.

After receiving Dr. Miller's report, Reliance upheld its decision to deny Ferrizzi's claim for long-term benefits based on the pre-existing condition exclusion. Noting that Ferrizzi now claimed "substance abuse/dependency [a]s the Sickness which caused Mr. Ferrizzi's Total Disability," Reliance relied heavily on Dr. Miller's report and concluded that

> Mr. Ferrizzi received consultation for substance abuse/dependency during the period July 1, 2014 to January, 2015, as evidenced by the explanation provided herein, including his emergency room visit during which he actively sought prescription medication, which he was denied. He also took prescribed drugs to which he was addicted during the period July 1, 2014 to January 1, 2015. As a result, his alleged Total Disability was caused by, contributed to by, or resulted from a Pre-existing Condition as defined.

In doing so, Reliance affirmed its original claim determination, resulting in a final denial of Ferrizzi's claim for long-term disability benefits.

Ferrizzi then filed this lawsuit on November 17, 2016. The parties both filed motions for summary judgment.

On February 12, 2018, the magistrate judge filed a Report and Recommendation recommending that the district court affirm "the decision denying the claim for benefits" and "enter judgment for Reliance Standard Life Insurance Company and against Anthony Ferrizzi." On March 28, 2018, the district court accepted the R&R, adopting it as the opinion of the court and overruling Ferrizzi's objections. The district court's order also denied Ferrizzi's motion for summary judgment and granted Reliance's motion for summary judgment. Ferrizzi timely appealed.

II. STANDARDS OF REVIEW

"We review de novo a district court's ruling affirming or reversing a plan administrator's ERISA benefits decision, applying the same legal standards that

governed the district court's decision." Blankenship v. Metro. Life Ins. Co., 644 F.3d 1350, 1354 (11th Cir. 2011).

Because ERISA itself does not set out a standard of review, this Court relies on the following six-step analysis to review an administrator's benefits decision:

> (1) Apply the de novo standard to determine whether the claim administrator's benefits-denial decision is "wrong" (i.e., the court disagrees with the administrator's decision); if it is not, then end the inquiry and affirm the decision.
>
> (2) If the administrator's decision in fact is "de novo wrong," then determine whether he was vested with discretion in reviewing claims; if not, end judicial inquiry and reverse the decision.
>
> (3) If the administrator's decision is "de novo wrong" and he was vested with discretion in reviewing claims, then determine whether "reasonable" grounds supported it (hence, review his decision under the more deferential arbitrary and capricious standard).
>
> (4) If no reasonable grounds exist, then end the inquiry and reverse the administrator's decision; if reasonable grounds do exist, then determine if he operated under a conflict of interest.
>
> (5) If there is no conflict, then end the inquiry and affirm the decision.
>
> (6) If there is a conflict, the conflict should merely be a factor for the court to take into account when determining whether an administrator's decision was arbitrary and capricious.

Id. at 1355 (citation omitted).

A "conflict of interest exists where the ERISA plan administrator both makes eligibility decisions and pays awarded benefits out of its own funds." Blankenship, 644 F.3d at 1355. Such is the case here. See Metro. Life Ins. Co. v.

Glenn, 554 U.S. 105, 120 (2008) ("The conflict of interest . . . is a common feature of ERISA plans.") (Roberts, C.J., concurring in part and concurring in the judgment).

Because the parties have briefed only the arbitrary and capricious issues involving steps three through six, and because the magistrate judge and the district court addressed only those issues, we will also pretermit the de novo review of steps one and two and begin with the "arbitrary and capricious" standard of steps three through six, considering the structural conflict as a factor. "Even where a conflict of interest exists, courts still 'owe deference' to the plan administrator's 'discretionary decision-making' as a whole. . . . [Our] basic analysis still centers on assessing whether a reasonable basis existed for the administrator's benefits decision." Blankenship, 644 F.3d at 1355 (internal citations omitted).

Distinct burdens of proof apply to this ERISA appeal. "[I]f the insurer claims that a specific policy exclusion applies to deny the insured benefits, the insurer generally must prove the exclusion prevents coverage." Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038, 1040 (11th Cir. 1998). But where, as here, there is a conflict of interest, "the burden remains on the plaintiff to show the decision was arbitrary; it is not the defendant's burden to prove its decision was not tainted by self-interest." Doyle, 542 F.3d at 1360.

III. DISCUSSION

This appeal requires us to decide whether Reliance's denial of benefits under the policy's pre-existing condition exclusion was arbitrary and capricious. "We first look to the plain and ordinary meaning of the policy terms to interpret the contract." Alexandra H. v. Oxford Health Ins. Inc. Freedom Access Plan, 833 F.3d 1299, 1307 (11th Cir. 2016). Under the Reliance policy, coverage is precluded for "Total Disability: (1) caused by; (2) contributed to by; or (3) resulting from a Pre-existing Condition," which is defined as

> any Sickness or Injury for which the Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the six (6) months immediately prior to the Insured's effective date of insurance.

We must determine if Reliance reasonably proved that Ferrizzi's substance abuse/drug dependency is such a pre-existing condition under the terms of the policy.

Ferrizzi insists that the pre-existing condition exclusion cannot apply because he was not diagnosed or treated for substance abuse/drug dependency during the lookback period. As noted in his appeal to Reliance, Ferrizzi does not dispute the existence of a substance abuse/drug dependency illness, but argues instead that he developed drug dependency in early 2015—*after* the lookback period. However, the policy's own definition of a "pre-existing condition" does not require a specific diagnosis or a specifically timed diagnosis of a condition for the

exclusion to apply. Under the policy, if Ferrizzi received "treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines" for "any Sickness or Injury" that caused, contributed to, or resulted in his "total disability" from substance abuse/drug dependence, then the policy excludes coverage. The Reliance policy exclusion does not require a formal diagnosis during the lookback period, and Ferrizzi's arguments to the contrary are unpersuasive.

Ferrizzi also argues that Reliance's independent reviewer failed to consider all the relevant evidence and focused only on a selective review of handpicked treatment notes, rendering Reliance's benefits decision arbitrary and capricious. We disagree. During the administrative appeal, Reliance conducted a comprehensive review of Ferrizzi's medical records. This second claim review was entirely separate from the initial review of his benefits claim and was supported by Dr. Miller's thorough "Independent Peer Review" of Ferrizzi's file. We find no evidence to suggest that Reliance—or Dr. Miller—failed to consider Ferrizzi's entire medical record.

Ultimately, we "owe deference to the plan administrator's discretionary decision-making as a whole. . . . [Our] basic analysis still centers on assessing whether a reasonable basis existed for the administrator's benefits decision." Blankenship, 644 F.3d at 1355 (internal citations omitted). If "we conclude that

there existed a reasonable basis to support the [administrator's] factual determination that, based on the administrative record examined in its entirety, [the insured] was not entitled to long-term disability benefits," then we will affirm Reliance's denial. Paramore v. Delta Air Lines, Inc., 129 F.3d 1446, 1452 (11th Cir. 1997) (upholding, under deferential review, the denial of benefits when plan administrator was required to evaluate conflicting medical reports about plaintiff's disability).

Here, Reliance determined that Ferrizzi "received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for a Sickness or Injury (i.e., opioid dependency) that caused, contributed to or resulted in his Total Disability." That determination deserves deference. Our independent review of Ferrizzi's medical records during the lookback period supports Reliance's conclusion that Ferrizzi had a pre-existing substance abuse/drug dependency condition. At the very least, Ferrizzi received "medical treatment" for substance abuse/drug dependency on at least one occasion during the lookback period: on December 10, 2014, when Dr. Mendez decided *not* to provide drugs when Ferrizzi presented with "drug seeking behavior."[5] The

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[5] During the same ED visit, Ferrizzi's actions, as documented by treatment notes, support a finding that he suffered from drug dependence/substance abuse during the lookback period. In the presence of a registered nurse, Ferrizzi brazenly "took an unlabeled pill bottle out of his pocket and took . . . one pill. [He] would not tell RN what pill he took," but it was later determined to be Xanax. After being denied narcotics, Ferrizzi became agitated and angry before leaving against medical advice and without signing the appropriate paperwork.

treatment notes from this one visit alone are sufficient to exclude coverage under the language of Reliance's policy.

But the December 10, 2014, record is not the only evidence supporting Reliance's decision. As a general matter, the medical records from the lookback period generally establish that Ferrizzi sought "consultation, care or services, . . . or took prescribed drugs or medicines" for his pre-existing condition of substance abuse/drug dependency. There is evidence that Ferrizzi filled numerous addictive medications and visited numerous hospitals and medical providers to obtain these medications. More specifically, three different entries from Ferrizzi's medical records from November and December 2014—indisputably within the six-month lookback period—document Ferrizzi's attempts to obtain prescriptions for benzodiazepines from three different doctors on at least three different occasions. Taken as a whole, Ferrizzi's medical records provide sufficient evidence to conclude that Ferrizzi suffered from substance abuse/drug dependency that equated to a "Sickness or Injury" under the Reliance policy during the lookback period. Because a reasonable basis existed to support Reliance's decision to deny benefits to Ferrizzi, we conclude that Reliance's decision thus was neither arbitrary nor capricious.

The only remaining issue our consideration is the structural conflict in this case. We must now consider whether Reliance's "conflict of interest tainted its

decision, thereby rendering its otherwise reasonable decision unreasonable." Doyle, 542 F.3d at 1360. As noted above, this so-called structural conflict is merely "a factor for the court to take into account when determining whether an administrator's decision was arbitrary and capricious." Blankenship, 644 F.3d at 1355. "Where a conflict exists and a court must reach step six, 'the burden remains on the plaintiff to show the decision was arbitrary.'" Id. (quoting Doyle, 542 F.3d at 1360).

The Supreme Court has acknowledged that the conflict-of-interest factor "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." Glenn, 554 U.S. at 117. This reasoning is particularly true in cases where the factor does not "act as a tiebreaker" or hold "case-specific importance." Id.

Here, Ferrizzi has failed to show that the structural conflict of interest present in this case rendered Reliance's decision unreasonable. Notably, Ferrizzi has not argued that Reliance failed to follow its own procedures in denying his claim. Reliance had stated procedures in place to "promote the neutral, unbiased and accurate adjudication of claims." When Ferrizzi asked for reconsideration of Reliance's initial denial, Reliance re-considered the evidence using an

independent, medically certified, third party medical reviewer. Under Reliance's established procedures, this appeal reviewer operated independently; did not report to the financial department; was physically separate from the financial department; and was not compensated based on the decision he reached. Absent evidence that Reliance failed to follow its stated procedures, we cannot say that the structural conflict had any impact on the reasonableness of Reliance's decision.

We conclude that Reliance's decision to deny Ferrizzi's claim under the pre-existing condition language of its policy was a reasonable decision supported by Ferrizzi's medical records, and the presence of a structural conflict has not rendered that decision unreasonable.

III. CONCLUSION

Like the plaintiff in Doyle, Ferrizzi had substantial medical and addiction problems, and neither party disputes that fact. But Reliance was vested with discretion to determine eligibility, and the courts owe deference to Reliance's determination so long as it was not arbitrary and capricious. Based on the record before us, we conclude that Reliance's denial of Ferrizzi's claim for benefits was not arbitrary and capricious or tainted by self-interest.

Thus, the district court properly granted summary judgment in favor of Reliance. Accordingly, the district court's order is

AFFIRMED.