UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
ABINGDON DIVISION

AUDREY JUNE COMPTON,	)	
	)	
Plaintiff,	)	Case No. 1:01CV00113
	)	
v.	)	**OPINION**
	)	
TRIGON BLUE CROSS BLUE SHIELD,	)	By: James P. Jones
	)	United States District Judge
Defendant.	)	

Nicholas Compton, Compton & Compton, P.C., Lebanon, Virginia, for Plaintiff; John B. Nicholson, Trigon Insurance Company, Richmond, Virginia, for Defendant.

In this ERISA case, I find that the decision of the benefit plan administrator denying the plaintiff's claim for air ambulance service is supported by a plain reading of the plan and cannot be overturned.

I

The plaintiff, Audrey June Compton, was insured under a group health insurance policy issued by the defendant, Trigon Blue Cross Blue Shield ("Trigon") to Modern Chevrolet Sales, Inc., her husband's employer. The BlueCare Group Policy ("Policy")

contains the terms of the health insurance benefit plan. In addition, Trigon distributed a summary plan description ("Summary") of the benefits covered under the Policy.

The plaintiff was born with a heart condition and has had a series of related problems since 1988, including an interruption of the aortic arch, an aortic aneurysm, aortic regurgitation and a mild stroke.

In 1999, Hartzell V. Schaff, M.D., treated the plaintiff at the Mayo Clinic in Rochester, Minnesota. Dr. Schaff performed surgery to repair the plaintiff's heart, including aortic valve replacement and aortic replacement with bypass to the descending aorta. According to Dr. Schaff, the plaintiff "suffered complications from the surgery that caused weakness in her arms and some difficulty in maintaining her balance." (July 13, 1999 Letter to Def.).

Based on these complications, Dr. Schaff concluded that it was necessary for the plaintiff to be transported from the Mayo Clinic to her home by an air ambulance. Dr. Schaff reasoned that commercial air travel or land travel would be too difficult for the plaintiff to tolerate.

On July 14, 1999, the plaintiff was flown by private jet from Minnesota to Tri-Cities Regional Airport in Bristol, Tennessee, which is close to the plaintiff's home in Rosedale, Virginia. The plaintiff has filed an affidavit from her daughter, Deane Bostic, that states she obtained prior approval from Trigon that the air ambulance was

covered by the plaintiff's insurance. In turn, Trigon has submitted an affidavit of its custodian of records, stating that Trigon's records do not contain any pre-approval for this service.

The air ambulance flight cost $4900. Trigon determined that the charge was not covered under the Policy and refused to pay. Linda Sedillo, a supervisor for Trigon, conducted a review of the plaintiff's case, including referral of the facts to physicians for medical review and corresponded frequently with Dr. Schaff, the plaintiff and her counsel. The plaintiff requested that Trigon review its determination, but after reconsideration, Trigon again denied coverage for the flight.

Thereafter, the plaintiff filed a motion for declaratory judgment in the Circuit Court of Russell County, Virginia. Trigon removed the case to this court on the ground of federal question jurisdiction because the health plan in this case is governed by the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.A. §§ 1001-1461 (West 1999 & Supp. 2001). *See* 28 U.S.C.A. § 1331 (West 1993).

Pursuant to the scheduling order, Trigon filed a copy of its administrative record and the parties are deemed to have filed cross motions for summary judgment. They have briefed the issues and the case is now ripe for decision.[1]

II

It is undisputed that the Policy grants Trigon the discretion to determine benefit eligibility. (*See* Policy at 26.) Accordingly, under ERISA, a reviewing court must apply a deferential standard of review, in which the fiduciary's decision will not be disturbed if reasonable, even if the court would have come to a different conclusion. *See Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). The court's review is limited to the material that was before the plan administrator at the time the decision was made. *See Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 788 (4th Cir. 1995).

In determining the reasonableness of a fiduciary's discretionary decision, the court may consider, inter alia, the following factors:

> (1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the plan and

[1] I will dispense with oral argument because the facts and legal contentions are adequately presented in the materials before the court and argument would not aid the decisional process.

> with earlier interpretations of the plan; (5) whether the decision making process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have.

Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, 201 F.3d 335, 342-43 (4th Cir. 2000).

Trigon argues that under a proper interpretation of the Policy, the air ambulance service here was not covered, even if it had been medically necessary in the plaintiff's case. On the other hand, the plaintiff argues that the relevant language, particularly of the Summary, allows payment of this expense. The plaintiff also asserts that her physician was of the opinion that her travel in this fashion was medically required and that his judgment should prevail.

Under ERISA, the court must interpret the benefit plan documents in accord with the ordinary insurance contract principle that where the language is ambiguous, it must be construed in accordance with the reasonable expectations of the insured. *See Tester v. Reliance Standard Life Ins. Co.*, 228 F.3d 372, 375 (4th Cir. 2000).

The Policy provides in regard to ambulance service as follows:

> Professional ambulance services are covered when used locally to or from a Covered Facility or Provider's office. The following three conditions must also be met:

1. the trip to the facility or office must be to the nearest one having services adequate to treat the Covered Person's condition;

2. the services received in that facility must be the nearest one having services adequate to treat the Covered Person's condition;

3. if the Company requests it, the attending Provider explains why the Covered Person could not have been transported in a private car or by any other less costly means.

(Policy at 18).

The Summary provides as follows on this subject:

> Professional ambulance services are covered when used locally to or from a hospital for bed patient care or for emergency outpatient care. Transportation must be to the nearest hospital (or skilled nursing home) with facilities adequate to treat your condition, including trips:
>
> - Between hospitals
> - From a hospital to a skilled nursing facility
> - From a hospital or skilled nursing facility to your home
>
> Payments are limited to $3,000 in covered ground ambulance services during a calendar year.

(Summary at 13.)

In the Fourth Circuit, if there is a conflict between and the summary plan description and the benefit plan itself, the plan controls unless the plan participant relied on the summary or was prejudiced by it. *See Martin v. Blue Cross & Blue Shield of Va., Inc.*, 115 F.3d 1201, 1204 (4th Cir. 1997) (citing *Hendricks v. Central Reserve Life Ins. Co.*, 39 F.3d 507, 511 (4th Cir.1994)).

While there is no evidence that the plaintiff relied on the Summary in the instance, it does not appear to make any difference, since the Policy and the Summary are not in conflict in any meaningful sense on the crucial question. Both the Policy and the Summary provide that the transportation must be in relation to the nearest hospital with facilities or services "adequate to treat [the covered person's] condition."

No evidence exists in the record that the Mayo Clinic in Rochester, Minnesota, was the nearest hospital to Rosedale, Virginia, that had adequate facilities or services to treat the plaintiff. Thus, the air ambulance service is not covered, regardless of whether it was medically necessary.

The plaintiff argues that ambulance service to her home under the Summary is a separate service and is not limited by any of the other provisions in the section. This construction is untenable. The Summary may not reasonably be construed as covering ambulance service from any hospital to the plaintiff's home.

The plaintiff also contends that Trigon acknowledged that the Mayo Clinic was the nearest hospital when it paid for the plaintiff's surgery. However, neither the Summary nor the Policy contain any such local requirement for in-patient treatment.

The administrative record does contain a brief statement from a representative of Trigon that the plaintiff had been referred from the University of Virginia hospital to the Mayo Clinic for elective surgery, but nothing in that statement or in the remainder of the record shows that the Mayo Clinic was the nearest hospital adequate to treat the plaintiff's condition.

Finally, the plaintiff asserts that Trigon pre-approved this claim. The plaintiff submitted an affidavit from her daughter, Deane Bostic, to that effect. However, the administrative record does not contain evidence of any pre-approval. The administrative record does include a memorandum of a phone call between C. Hines, a Trigon representative, and the plaintiff's daughter on July 13, 1999. This memorandum includes a statement by Trigon's representative to the plaintiff's daughter that ambulance service was only covered to the nearest facility that could provide services that the Mayo Clinic could not.

The daughter's affidavit does not specify when she received pre-approval or the name or position of the Trigon representative that authorized pre-approval. Under the discretionary review standard, I hold that it was not unreasonable for Trigon to

conclude that the air ambulance service was not pre-approved. Even if it were proper to include this affidavit in my review, it is too vague to overcome the lack of any evidence in the administrative record of pre-approval for these charges.

Assuming that Trigon has a conflict of interest in this case as both insurer and benefits administrator, Trigon's determination was reasoned and principled. Therefore, in accordance with the applicable *Booth* factors, I hold that Trigon's determination that the plaintiff's air ambulance service was not covered under her health insurance policy is unassailable.

IV

For the foregoing reasons, summary judgment will be granted in favor of Trigon. A separate judgment consistent with this opinion is being entered herewith.

DATED: December 27, 2001

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United States District Judge