# United States Court of Appeals for the Fifth Circuit

United States Court of Appeals
Fifth Circuit
**FILED**
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Lyle W. Cayce
Clerk

No. 21-20327

Lisa K. Bunner,

*Plaintiff—Appellant*,

*versus*

Dearborn National Life Insurance Company; Situs Group, L.L.C.; Employee Welfare Plan,

*Defendants—Appellees*.

Appeal from the United States District Court
for the Southern District of Texas
USDC 4:18-CV-1820

Before Dennis, Southwick, and Wilson, *Circuit Judges*.

Leslie H. Southwick, *Circuit Judge*:

Lisa Bunner appeals from the district court's denial of her claims for long-term disability benefits under an ERISA plan provided by her employer. We AFFIRM.

## FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of Lisa Bunner's denied claim for long-term disability benefits under an employer-provided disability plan covered by the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C.

§§ 1001–1461. The claim was denied because of the application of a pre-existing condition exclusion in the insurance contract. In August of 2015, Bunner discovered that she had a brain tumor. At the time, she suffered from numbness, tingling, and pain. She had the tumor removed in September 2015, and her symptoms desisted. Still, she was advised that radiation and chemotherapy would mitigate the risk of a recurrence. She received a form of radiation therapy as well as chemotherapy. In December 2015, while the radiation treatment was ongoing, Dr. Kyle R. Noll, Ph.D. evaluated Bunner and found she suffered from "isolated impairments in verbal learning and memory and poor initial encoding of visual information." Dr. Noll evaluated Bunner again on October 5, 2016 and noted impairments in learning and memory, and noted decline in attention, working memory, and left hand dexterity. Noll noted, though, that she "reportedly compensated well and maintained adequate daily functional capacities," including at work.

On October 11, 2016, Bunner was hired by Situs Group, a commercial real estate company. She believed then that she had managed to avoid any negative side effects from the radiation treatment. Though Bunner had little trouble performing her duties when she first began working for Situs, after a few months, she struggled to complete her work on time and began to experience various cognitive impairments.

Situs maintained an ERISA employee welfare benefit plan that provided long-term disability benefits to eligible current and former employees. The plan's insurance was provided by Dearborn National Life Insurance. Shortly after beginning her employment with Situs, Bunner attended a benefits meeting led by Situs's Benefits Coordinator, Kyndria Perkins. Perkins told participants that they could receive benefits regardless of pre-existing conditions and that they would not be questioned about their pre-existing conditions when the company was determining eligibility. An

unidentified Dearborn representative attended the same meeting and did not correct or otherwise qualify Perkins's representations.

Bunner decided to accept these benefits based on the meeting. To do so, she could either enroll as a new hire or wait for the Open Enrollment period. Initially, she planned to wait until the Open Enrollment because she had already purchased other medical insurance. When she reviewed the Open Enrollment form, though, she discovered language inconsistent with the representations made by Perkins. She questioned Perkins and Jolene Turner, Situs's recruiting coordinator. Both told her that if she enrolled as a new hire, she would not have to answer questions about her past medical history and would not be subject to the pre-existing condition exclusion. Consequently, Bunner enrolled as a new hire and signed up, among other things, for short-term disability ("STD") benefits. This enrollment automatically qualified Bunner for enrollment in Situs's long-term disability ("LTD") benefits plan.

Though Perkins and Turner had informed Bunner otherwise, her chosen STD plan explicitly excluded "any loss or Disability caused by, resulting from, arising out of or substantially contributed to, directly or indirectly, by . . . a Pre-existing Condition." A pre-existing condition was defined separately. The automatic LTD plan featured the same exclusion but with differently defined a pre-existing condition.

Bunner took a leave of absence effective March 10, 2017 and applied for STD benefits. She stated that her disability arose from her brain cancer and its treatment. She planned to return to work on August 28, 2017. Dearborn initially denied the claim for STD benefits, citing the exclusion in the policy. However, Situs requested that the exclusion be waived with respect to the STD benefits. Dearborn ultimately approved her STD

benefits, and Bunner was informed that she would receive them based on an exception to the pre-existing condition exclusion.

Soon after, Bunner met with a vocational counselor and expressed that she was concerned about her STD benefits ending. Bunner told the vocational counselor later that she had spoken to "her HR" and had been informed that she was "eligible" for LTD benefits but would be released from Situs if she did not return to work when her STD benefits terminated. Bunner informed Situs soon after that she would not be returning to work. Situs extended her STD benefits for the maximum duration, referred her claim to the LTD benefits department, and terminated her employment.

A Dearborn LTD claims examiner interviewed Bunner and informed her that she might be subject to the pre-existing condition exclusion. On September 25, 2017, Bunner's claim for LTD benefits was denied. After various exchanges with Situs, Bunner requested review of the denial of her claims on March 22, 2018. That request began a 45-day period in which Dearborn needed to review her claim. She argued for the first time that her disability arose from "cognitive impairments" rather than the treatment for her brain tumor. She also wrote a letter to Dearborn explaining the representations made to her at the benefits conference.

On May 1, 2018, Dearborn sent Bunner a letter informing her it had requested more medical records. It was extending its deadline by 45 days because it had not received and reviewed all of Bunner's medical records. Dearborn requested more medical records from Bunner twice more, but before its deadline and prior to any determination, Bunner filed suit against Dearborn and Situs on June 2, 2018, asserting, among other things, claims under Section 502(a)(1)(B) and Section 502(a)(3) of ERISA. *See* 29 U.S.C. § 1132(a)(1)(B), (3). Dearborn continued to request materials from Bunner and eventually denied her claim outright on August 14, 2018.

As to Bunner's suit, a magistrate judge determined that the case was prematurely filed. Still, because Bunner had not participated in the administrative review after she filed suit, the court suggested a remand so that both sides could more fully develop the record. Bunner objected, but the case was sent back to Dearborn and the litigation was stayed. On July 16, 2019, after review of Dr. Noll's October 5, 2016 evaluation, Dearborn again denied Bunner's claim. On September 4, 2019, the magistrate judge ordered Dearborn to consider new materials from Bunner. On October 4, 2019, Dearborn denied Bunner's claim once more, and on October 28, 2019, the magistrate judge lifted the stay.

Dearborn and Situs moved for summary judgment and Bunner moved for judgment. The magistrate judge considered the motions together, partly granting and partly denying Dearborn's motion and denying Bunner's motion. The district court adopted the magistrate judge's findings and conclusions, then held the equivalent of a bench trial on the lone remaining issue of ERISA estoppel. The district court determined that Bunner had not proven all the elements of an estoppel claim, denied her motion for judgment and the defendants' motion for attorneys' fees, and entered a final judgment dismissing the case with prejudice. Bunner timely appealed.

## DISCUSSION

Bunner raises at least eight points of error on appeal. We combine some of them in our discussion that follows.

### *A. Determinations about the administrative record*

Employee benefit plans are required to "provide adequate notice in writing" to beneficiaries whose claims have been denied and must "afford a reasonable opportunity" for a "full and fair review" of the denial. 29 U.S.C. § 1133. If a claimant requests the review, a plan administrator must provide a determination "not later than 60 days after receipt of the claimant's request

for review," unless "special circumstances" exist and require an extension, which is not to exceed an additional 60 days. 29 C.F.R. § 2560.503-1(i)(1)(i). In the disability context, the limit for an extension to issue a determination is 45 days. *Id.* at § 2560.503-1(i)(3)(i).

Bunner argues that the district court erred by allowing Dearborn more time to review Bunner's medical records and by closing the administrative record on a date beyond the statutorily mandated deadline. Dearborn responds that the plan administrator is vested with discretion to extend the initial deadline by 45 days, and that the extension beyond that extra 45 days still substantially complied with ERISA and was justified because of Bunner's premature filing of suit.

A plan administrator must substantially comply with ERISA procedures. *See Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 392 (5th Cir. 2006). Technical non-compliance is excused if the purposes of Section 1133 are fulfilled. *See id.* Those purposes include promoting resolution of the dispute at the administrative level and facilitating a meaningful dialogue between the plan administrator and the beneficiary. *See Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan*, 493 F.3d 533, 540 (5th Cir. 2007), *abrogated on other grounds by Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242 (2010).

We agree with the district court that Dearborn substantially complied with ERISA procedures and was entitled to extend the deadline to respond to Bunner's claim. Dearborn's May 1, 2018 letter notified Bunner of Dearborn's need for more time to review unreceived medical records to inform its decision about her claim. We discover no error in the magistrate judge's decision to toll the deadline when Bunner prematurely filed suit against Dearborn and Situs. The magistrate judge was working with a self-described "messy administrative record" due to the conduct of the parties,

and Dearborn was faced with continuing its administrative review as well as defending the premature suit brought by Bunner.

The court's decisions regarding the administrative record were consistent with ERISA's goal of encouraging the resolution of disputes at the administrative level and gave both sides the opportunity to supplement the record for fairer and fuller review by the plan administrator. Consequently, we also reject Bunner's argument that the district court improperly relied on portions of the administrative record developed after her proposed closure of the record.

*B. Summary judgment on Section 502(a)(1)(B) claims*

Bunner next argues that the district court erred by granting summary judgment to the Defendants on Bunner's claims under Section 502(a)(1)(B). She argues that the district court erred by applying the pre-existing condition exclusion and not determining that her disability resulted from visuo-construction and visuomotor integration deficits rather than from her pre-existing condition, namely the removal of the brain tumor and the subsequent complications from radiation. She further argues that the district court improperly rejected her argument that Dearborn and Situs waived their right to rely on the pre-existing benefit exclusion,

"We review a district court's grant of summary judgment in ERISA cases *de novo*, applying the same standards as the district court." *Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 250 (5th Cir. 2019). Summary judgment is merited when "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a).

We interpret the language of an ERISA plan in accordance with the federal common law, giving the language of the contract its "ordinary and generally accepted meaning." *See Green v. Life Ins. Co. of N. Am.*, 754 F.3d

324, 331 (5th Cir. 2014) (quotation marks and citation omitted). Only if the meaning is sufficiently ambiguous after applying the traditional rules of contract interpretation do we construe the language strictly in favor of the insured. *Wegner v. Standard Ins. Co.*, 129 F.3d 814, 818 (5th Cir. 1997).

The relevant plan unambiguously excluded coverage for "any loss or Disability caused by, resulting from, arising out of or substantially contributed to, directly or indirectly, by . . . a Pre-existing Condition." A pre-existing condition was defined, for purposes of LTD benefits, as one that

> was caused by, or results from a Sickness or Injury for which You received medical treatment, or advice was rendered, prescribed or recommended whether or not the Sickness was diagnosed at all or was misdiagnosed within 3 months prior to Your effective date; and . . . results in a Disability which begins in the first 12 months after Your effective date.

We agree with the district court that this exclusion bars Bunner's claim for benefits. First, Bunner's claim for disability arose on March 6, 2017, a date well within 12 months of her start date of October 11, 2016. Second, it is apparent from the record that Dr. Noll's October 5, 2016 treatment and evaluation of Bunner, rendered just weeks before her start date, revealed the very cognitive decline that continued its advance and further disabled her some months later. To accept Bunner's argument that her disability resulted from visuo-construction and visuomotor integration deficits rather than from the cumulative cognitive decline identified by Dr. Noll would require us to find, as the district court noted, that two separate events of cognitive decline occurred. This record does not support such a possibility.

Bunner argues alternatively that the defendants waived the pre-existing condition exclusion with respect to LTD benefits. "Waiver is the voluntary or intentional relinquishment of a known right." *Pitts By &*

*Through Pitts v. Am. Sec. Life Ins. Co.*, 931 F.2d 351, 357 (5th Cir. 1991) (emphasis removed). Unlike its close cousin estoppel, "*waiver* describes the act, or the consequences of the act, of one party only." *Id.* Our inquiry here, then, is focused on the defendants' acts.

There is no question that the defendants waived their right to assert the pre-existing condition exclusion as a defense to Bunner's claim for the initial, shorter term benefits. Indeed, Bunner received those benefits for their maximum duration. That waiver does not compel the conclusion that the defendants, based upon conversations about STD benefits, also intended to waive their right to enforce the exclusion when it came to Bunner's application for LTD benefits. The content of those conversations, exhaustively canvassed by the district court, almost solely concerned STD benefits. Any reference to LTD benefits in those communications indicated that the defendants were referring Bunner's claim to the LTD department for consideration, not that they were waiving their right to enforce the exclusion. Moreover, as the magistrate judge noted, the defendants were operating under the impression that Bunner was returning to work when her STD benefits ran out. The defendants did not waive their right to enforce the pre-existing condition exclusion as to the LTD benefits based on these conversations.

We are also unpersuaded by Bunner's attempt to expand the scope of our waiver analysis to include the defendants' statements made before Bunner signed up or made a claim for benefits. While the defendants may have made representations at the benefits conference that induced Bunner *to enroll in* the plan, this is not the equivalent of relinquishing a *known right* after Bunner agreed to a plan and then brought a claim for benefits. This impermissibly blurs the line between estoppel and waiver. Bunner's estoppel claims will be addressed in the following section.

*C. ERISA Estoppel*

Bunner next argues that the district court erred by rejecting her claim for ERISA estoppel.[1] She argues that the district court correctly found that the defendants made material misrepresentations upon which she reasonably and detrimentally relied but erred when it decided that she did not rely on them under extraordinary circumstances. The defendants argue, among other things, that Bunner failed to prove any of the requisite elements of ERISA estoppel and that the district court was correct only in its conclusion that Bunner failed to show extraordinary circumstances.

The district court held the equivalent of a bench trial when it considered Bunner's motion for judgment on the ERISA estoppel claim. *See North Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, 952 F.3d 708, 712 (5th Cir. 2020), *cert. denied*, 141 S. Ct. 1053 (2021). We thus review its conclusions of law *de novo* and its findings of fact for clear error. *Id.* at 713.

ERISA estoppel is a creature of the federal common law, and we review its application using the same standards as the district court. *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444 (5th Cir. 2005). To prevail on an ERISA estoppel claim, a plaintiff must demonstrate (1) a material misrepresentation, (2) upon which she "reasonably and detrimentally relied," (3) "under extraordinary circumstances." *See Talasek v. Nat'l Oilwell Varco, L.P.*, 16 F.4th 164, 168 (5th Cir. 2021). Because of the dearth of ERISA estoppel cases in this circuit, "we have often looked to our sister circuits for help in resolving these claims." *Id.*

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[1] Bunner also advances a claim of "quasi-estoppel" but admits that this circuit has never adopted that remedy in the ERISA context.

The district court concluded that while the first two elements were met based on the defendants' pre-enrollment misrepresentations, the third was not.[2] Because we agree that extraordinary circumstances were not shown, we do not quarrel with the court's first two conclusions and assume them *arguendo*.

This circuit has considered persuasive the Third Circuit's definition of "extraordinary circumstances." *See High v. E-Sys. Inc.*, 459 F.3d 573, 580 n.3 (5th Cir. 2006) (citing *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226 (3d Cir. 1994)). We examine that caselaw closely.

A panel of this court has aptly summarized that the Third Circuit requires circumstances in which there is "bad faith, fraud, or concealment, as well as possibly when a plaintiff repeatedly and diligently inquired about benefits and was repeatedly misled or when misrepresentations were made to an especially vulnerable plaintiff." *Cell Sci. Sys. Corp. v. La. Health Serv.*, 804 F. App'x 260, 266 (5th Cir. 2020) (quotation marks and citation omitted).

Bunner argues that she satisfies each of these categories of extraordinary circumstances. First, she states that she "repeatedly and diligently inquired about benefits" and the defendants failed to correct alleged misrepresentations. One Third Circuit opinion held that

[2] The district court exhaustively analyzed the communications between Bunner and the defendants *after* she had enrolled in the plan and concluded that the substance of those communications could not be considered material misrepresentations with respect to Bunner's claim for LTD benefits. At best, the communications show that (1) Dearborn waived the pre-existing condition exclusion for STD benefits after repeated conversations about those specific benefits and (2) that any claim for LTD benefits had to and would be processed separately. They lack the false or misleading qualities boasted by the original misrepresentations at the benefits conference or in the differing enrollment forms and cannot form the basis of an estoppel claim.

"affirmative misrepresentations . . . over an extended period of time" constitute extraordinary circumstances. *Pell v. E.I. DuPont de Nemours & Co. Inc.*, 539 F.3d 292, 304 (3d Cir. 2008). Other Third Circuit opinions conclude that the misrepresentations must be more than a few isolated falsities; there must be a "network of misrepresentations that arises over an extended course of dealing between parties." *Kurz v. Philadelphia Elec. Co.*, 96 F.3d 1544, 1553 (3d Cir. 1996) ("*Kurz II*"). We review some of the other opinions.

In one case, the plaintiff attended multiple seminars and "repeatedly contacted Plan representatives to inquire about coverage." *Smith v. Hartford Ins. Grp.*, 6 F.3d 131, 134 (3d Cir. 1993). He was told before and after the seminars that his wife's nursing care would be covered under a particular plan. *Id.* After no coverage was provided, he began calling the defendants and was told "[e]ach time . . . not to worry" and that the failure to pay was due to "administrative delays." *Id.* He also called the insurer's claim processors and was "assured . . . his wife's bills would be paid" and that any delays were merely due to a delay in obtaining his wife's medical records and the transition between two insurance plans. *Id.* The Third Circuit concluded that these events could constitute extraordinary circumstances. *Id.* at 142.

In another case, the plaintiff was "assured" by his manager and supervisor that his time spent working for another company, beginning on February 10, 1971, would be counted towards his pension. *Pell*, 539 F.3d at 298. He also received written assurances that this was the case. *Id.* When years later he received a communication indicating his time was not fully counted, he contacted the company's retirement counselor and was again assured that all his time would be counted, beginning on February 10, 1971, for purposes of his pension. *Id.* at 299. He made numerous inquiries and received several benefits estimates over ten more years, each time receiving assurances that his time would be counted beginning on February 10, 1971.

*Id.* When it was not counted properly, the plaintiff sued. *Id.* The court held that the defendant's "repeated affirmative misrepresentations, combined with Pell's diligence" amounted to extraordinary circumstances. *Id.* at 304–05.

In yet another case, a group of plaintiffs were told in meetings with retirement benefits counselors that no change was forthcoming to their company's retirement plan when in fact the company was considering increasing the pension for "employees with over 40 years of service who retired at age 65." *Kurz v. Philadelphia Elec. Co.*, 994 F.2d 136, 138 (3d Cir. 1993) ("*Kurz I*"). When some of those employees retired, they were not retroactively eligible for the increased pension and sued, claiming detrimental reliance on the misrepresentations at the benefits meetings. *See id.* Though the misrepresentations might be considered material, the Third Circuit rejected the plaintiffs' argument because there was "no conduct suggesting that [the employer] sought to profit at the expense of its employees, no showing of repeated misrepresentations over time, [and] no suggestion that plaintiffs [were] particularly vulnerable." *Kurz II*, 96 F.3d at 1553.

We are convinced that this case is more similar to *Kurz II* than it is to *Smith* or *Pell*. The actionable misrepresentations here occurred in a single month and were made by two individuals. None of the later conversations Bunner had with the defendants' representatives featured "affirmative misrepresentations" that Bunner would be covered for LTD benefits. The initial denial of STD benefits, coupled with approval due to an "exception" and subsequent conversations suggesting that LTD benefits were handled by another department, do not approach the consistent, affirmative misrepresentations that coverage was forthcoming held to be extraordinary circumstances in the aforementioned caselaw. The district court did not err in rejecting the argument based on repeated misrepresentations.

Bunner also argues that extraordinary circumstances are present because she was especially vulnerable due to her brain tumor and because she was unmarried and childless. She argues that the district court erred by measuring her disability when the misrepresentations were made rather than throughout the claims process. The Third Circuit law on a claimant's vulnerabilities was reasonably summarized as applying "only in instances of imminent and life threatening health emergencies to the plaintiff himself or to his family members." *Araujo v. Kraft Foods Glob., Inc.*, 387 F. App'x 212, 216 (3d Cir. 2010). It is undisputed that Bunner had recently undergone treatment for her brain tumor and had been evaluated in the same month that she began work for Situs. However, she asserted at the time that she did not think she had suffered any debilitating effects from the treatment and had no difficulty performing her duties for Situs. We cannot say that when she relied on Dearborn's representations that she was vulnerable in the way contemplated by the law.

We are not persuaded to the contrary by Bunner's reliance on *Curcio*, 33 F.3d at 238. There, the Third Circuit found extraordinary circumstances when the hospital employing a doctor misrepresented the amount of life insurance and supplemental accidental death and dismemberment ("AD & D") insurance available to its employees. *Id.* When the doctor was killed in an accident, the insurance company initially represented that full supplemental AD & D insurance was due to the decedent's wife. *Id.* The hospital confirmed and reassured the wife of this fact, but the insurance company later retracted its representation. *Id.* The hospital continued to support the wife's position, encouraging her to sue, offering her free legal services, and continuing to urge the insurance company to pay the supplemental insurance. *See id.* At some point, the hospital changed its stance and argued that the widow was due no supplemental insurance. *Id.*

Reviewing this "roller coaster," the Third Circuit concluded that the events were "demonstrative of extraordinary circumstances." *Id.*

The same cannot be said of the events in this case. *Curcio* bears little resemblance to Bunner's circumstances. As we have discussed, the conversations Bunner had with the defendants after the initial misrepresentations were made simply do not amount to the repeated affirmative misrepresentations, sufficient in other cases, to establish that she would be entitled to the LTD benefits.

Bunner finally argues that extraordinary circumstances are present because the defendants' conduct amounts to bad faith. She reasserts a number of acts by the defendants during the claims process that we have already held to be substantially compliant with ERISA procedures and those acts will be disregarded. To support a finding of bad faith for the litany of other acts she identifies, she cites *Ackerman v. Warnaco, Inc.*, 55 F.3d 117, 124–25 (3d Cir. 1995). There, the Third Circuit concluded that "a reasonable fact finder could infer" bad faith from a company's failure to distribute a handbook, hold scheduled meetings, or otherwise notify 169 employees of a substantial change to the company's termination allowance policy. *Id.* at 119, 125.

The facts of that case do not resemble the facts here. The handful of misrepresentations at the benefits conference and on the enrollment form, followed by numerous conversations between Bunner and the defendants about the availability of STD benefits with equivocal references to Bunner's eventual application for LTD benefits, do not equate to a large company arguably concealing a change to its entire employee termination policy. The district court, sitting as fact finder, carefully analyzed the record and concluded that the defendants' conduct amounted to little more than

"mistakes or oversights" and aggressive litigation of the action. We locate no reversible clear error in this finding.

*D. Injunctive relief*

Bunner argues that that the district court erred by granting summary judgment to the defendants on Bunner's Section 502(a)(3) request for an injunction requiring the production of recordings of all calls Dearborn had with other claimants. She raised this argument at the district court in a single footnote.

Section 1132(a)(3) allows suit "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3).

The magistrate judge rejected Bunner's request to compel production of records, finding that all relevant documents were in the record and that no injunction was needed to ensure a full and fair review. We cannot say that these determinations were error.

*E. Discovery decision*

Finally, Bunner argues that the district court erred by not permitting Bunner to conduct further discovery into the completeness of the record, the defendants' bad faith in following ERISA procedures, and whether other claimants in similar circumstances were treated differently than she was. We review a district court's discovery decisions for abuse of discretion. *See Green*, 754 F.3d at 329. "A district court abuses its broad discretion when its decision is based on an erroneous view of the law, but we will only vacate a court's judgment if it affected the substantial rights of the appellant." *Id.*

To support her argument, Bunner relies on *Crosby v. Louisiana Health Services & Indemnity Co.*, 647 F.3d 258 (5th Cir. 2011). In *Crosby*, we considered it an abuse of discretion when a district court construed one of our precedents as limiting the *admissible* evidence in an ERISA action to the administrative record, interpretative evidence about a plan, or medical evidence. *Id.* at 262–64 (citing *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287 (5th Cir. 1999) (en banc), *abrogated on other grounds by Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008)). We followed that holding, though, with "a few words of caution" about permitting expansive discovery in ERISA actions. *Id.* at 264. "[F]ull review of the motivations behind every plan administrator's discretionary decisions," we cautioned, "would seriously undermine ERISA's goal of resolving claims efficiently and inexpensively." *Id.* (quotation marks and citation omitted).

Here, neither the magistrate judge nor the district court appeared to consider itself limited by our precedents to certain categories of evidence. Indeed, the magistrate judge specifically noted that certain evidence, namely audio recordings that had already been provided to Bunner, would be relevant to her estoppel or waiver claims but need not be in the administrative record itself. Rather, the magistrate judge, after months of wrangling about the administrative record and the defendants' compliance with ERISA procedures, decided those issues were sufficiently resolved and that Bunner's arguments about the defendants' bad faith were nothing more than speculation. *See Crosby*, 647 F.3d at 264. We conclude that the magistrate judge and district court were doing little more than "guard[ing] against abusive discovery" and find no error. *See id.*

We AFFIRM the district court's grant of summary judgment and its subsequent ruling regarding estoppel under ERISA.