UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DIANE JONES,	:	3:00CV 1051 (WWE)
Plaintiff,	:	
	:	
v.	:	
	:	
UNUMPROVIDENT CORPORATION,	:	
Defendant	:	

RULING ON DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

This action arises from a dispute over non-payment of long-term disability benefits under a disability benefits plan ("Plan") established by the Urban league of Greater Hartford, Inc. ("Urban League"), and administered by the Paul Revere Life Insurance Company ("Paul Revere"), a disability insurer that subsequently became a subsidiary of UnumProvident Corporation ("Unum"). The Plan is regulated by the Employment Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001-1461.

Plaintiff asserts that Paul Revere wrongfully terminated the benefits she was receiving under the Plan, a violation of § 505(a)(1)(B) of ERISA, codified at 29 U.S.C. § 1132(a)(1)(B). Defendant asserts that there is ample evidence upon which to conclude that the plaintiff was no longer disabled under the terms of the Plan, and that Paul Revere's decision to terminate the plaintiff's Long Term Disability

("LTD") benefits was reasonable.

Pending before the Court is the defendant's motion for summary judgment (Doc. #14). For the reasons set forth below, the defendant's motion for summary judgment will be granted.

FACTS

The following facts are taken from the parties' moving papers and the administrative record. Due to the dearth of information in the plaintiff's complaint and Rule 9(c) statement, the facts were gleaned largely from the defendant's Local Rule 9(c) statement, as checked against the administrative record. The plaintiff, Diane Jones, is a former employee of the Urban League, where she was director of youth programs. The plaintiff was a participant in the Plan, which the Urban League established and maintained to provide disability benefits to its employees who participated in the Plan. The Urban League also offered LTD benefits to eligible participants, such LTD benefits being equal to 60% of the eligible participant's basic monthly earnings. The plaintiff was eligible to participate in the LTD benefits portion of the Plan, and did so.

The Plan

The Plan provides monthly LTD benefits to eligible participants who become disabled due to injury or sickness

while covered under the Plan. The Plan provides benefits for (1) total disability from any occupation; (2) total disability from the employee's own occupation; and (3) residual disability. As defined by the Plan, "totally disabled from the employee's own occupation or total disability from the employee's own occupation" means (1) because of injury or sickness, the employee cannot perform the important duties of his own occupation; and (2) the employee is under the regular care of a doctor; and (3) the employee does not work at all.

After 24 months of disability payments, there is a change in how total disability is defined, from an "own occupation" to an "any occupation" definition. As defined by the Plan, "totally disabled from any occupation, or total disability from any occupation" means (1) because of injury or sickness, the employee is completely prevented from engaging in any occupation for which he is or may become suited by education, training or experience; and (2) the employee is under the regular care of a doctor. Under the Plan, an individual is not entitled to benefits if he or she is working, but the Plan provides an exception for individuals who are working part-time for compensation that is less that 80% of the income they had earned at their employer.

The plaintiff was employed by the Urban League from

November 20, 1991, to September 29, 1996. In January of 1992, the plaintiff began working as a project counselor, and began working for a new program, National Urban League Incentive to Excel and Succeed ("NULITES"). In June of 1994, the plaintiff was appointed to the position of director of NULITES, and oversaw a staff of eight.

Plaintiff's Accident and Subsequent Treatment

On May 13, 1995, the plaintiff was involved in an automobile accident and sustained cervical injuries. In April, 1996, the plaintiff experienced increasing problems with her back, and was diagnosed as suffering from a herniated cervical disc and cervical spondylosis. She was unable to work for certain periods of time from April 15, 1996, through July 17, 1996. The plaintiff underwent cervical surgery, specifically an anterior cervical discectomy and spinal fusion on September 19, 1996. The plaintiff's treating physician was Dr. Paul Murray, an orthopedist located in Hartford, Connecticut. The actual cervical surgery was performed by Dr. Stephan Lange of Neurological Associates of Hartford. The plaintiff stopped working on or about August 23, 1996, due to migraine headaches, on the advice of her family physician, Dr. James Joseph, of Bloomfield, Connecticut.

On August 29, 1996, the Urban League terminated the

plaintiff from her job, effective September 29, 1996, due to funding reductions for its youth programs. Plaintiff asserts she was terminated because she was unable to perform her duties, but the record does not bear this out.

The plaintiff received short term disability ("STD") benefits as a result of her cervical injuries and subsequent surgery. After the plaintiff had exhausted her STD benefits and upon receipt of the plaintiff's medical information, Paul Revere approved the plaintiff's claim for long term benefits, with full benefits commencing on March 23, 1997.

In early 1997, several months after her employment with the Urban League had ended, the plaintiff began to complain of other physical ailments, including rotator cuff tendonitis, and generalized arthritis. In his medical reports, the attending physician, Dr. Murray, referred to a date of injury of December 15, 1996, the date of another motor vehicle accident in which the plaintiff had been involved. Medical records from Dr. Lange in January of 1997 also refer to a recent motor vehicle accident.

On September 26, 1997, Paul Revere sent out a field representative to speak to the plaintiff, and after the meeting, the representative questioned the extent of the plaintiff's disability and to what extent it prevented her

from performing her occupation. The representative's report occasioned Paul Revere to update its medical records and reports, and in doing so found that Dr. Murray had opined on July 21, 1997, that the plaintiff was no longer totally disabled from her job.

In February, 1998, Paul Revere sent the plaintiff's records to its medical consultant, Dr. Michael Theerman, who, upon consideration and review of the records, concluded that the plaintiff's cervical condition no longer precluded her from her occupational duties. The plaintiff was notified that Paul Revere intended to schedule an independent medical examination ("IME").

In April, 1998, the plaintiff underwent an IME conducted by Dr. Charles B. Kime, an orthopedist associated with Orthopedic Associates of Hartford. As a result of his review of the plaintiff's records and his examination, Dr. Kime concluded that the plaintiff had a permanent partial disability of 12% of the cervical spine, and had chronic lumbar strain. Dr. Kime found that the remainder of the plaintiff's pan-spinal pain complaints and pain behavior were non-diagnostic and not related to any ongoing disability. Dr. Kime opined that he would not restrict her activity in any way on the basis of her spinal diagnoses.

Based on Dr. Murray's reports, the IME conducted by Dr. Kime and the subsequent review by its medical consultant Dr. Theerman, Paul Revere informed the plaintiff by letter dated June 30, 1998, that the medical documentation indicated that she was not precluded from performing her occupation, and consequently, Paul Revere was terminating her LTD benefits. The plaintiff was informed of her right to appeal and was invited to submit any additional documentation relative to her claim. The plaintiff commenced an appeal to the decision of Paul Revere to terminate her LTD benefits.

The Plaintiff's Appeal and Defendant's Review Process

In support of her claim for continued benefits, and as part of the appeal process, the plaintiff submitted the notice of decision from the Social Security Administration ("SSA"). On June 10, 1998, the SSA found the plaintiff to be totally disabled based upon a back disorder, recurrent major depression and fibromyalgia. The SSA awarded the plaintiff disability benefits, which she continues to receive.

The SSA found that the plaintiff had the residual functional capacity to perform activities at the light level of exertion. Light work normally involves lifting, carrying, pushing or pulling not more than 20 pounds at a time. Light work involves standing and walking two thirds of the workday

or approximately six hours out of an eight-hour day. Sitting may occur intermittently during the remaining time. However, the SSA found the plaintiff's nonexertional impairment of major depression to significantly compromise her capacity to work.

The Paul Revere appeals examiner sent the plaintiff's SSA decision, findings and medical records to Paul Revere's medical consultant, Dr. Michael Theerman, for his review. Dr. Theerman opined that based on these records, the plaintiff was physically capable of light work, which meant she was physically capable of performing the duties of her position. Dr. Theerman noted that the plaintiff's psychiatric problems might be severe and thus the matter should be referred to Paul Revere's psychological department for its determination as to whether the condition was disabling. Paul Revere offered to consider the plaintiff's major depression as part of her claim upon her submission of medical documentation with regard to the depression. The plaintiff refused to submit any documentation concerning her depression, instead asserting that she was physically disabled from her duties as director as a result of her fibromyalgia.

Paul Revere performed another review in July, 1999, based on additional information submitted by plaintiff's attorney

regarding the fibromyalgia claims. The additional information was reviewed by an independent medical consultant retained by Paul Revere, Dr. Paul Martin, who was an experienced rheumatologist. Based on his review, Dr. Martin concluded that the plaintiff did not satisfy the criteria for fibromyalgia, nor did the records support the level of impairment claimed by the plaintiff as a result of her claimed fibromyalgia. Paul Revere then contacted the plaintiff's attorney to request additional information regarding the plaintiff's fibromyalgia claim.

In June, 1998, the plaintiff was referred by Dr. James Joseph, her family physician, to neurologist Dr. David S. Silvers for a second opinion. Dr. Silvers stated that he could not find any objective abnormalities on the plaintiff's neurological examination, and instead questioned whether many of her symptoms may be secondary to her mood disorder. Dr. Flavio Romanul, another neurologist who examined the plaintiff at the request of her doctors, stated after the examination of the plaintiff in July, 1998, that she could return to the office in two months.

Upon receipt of the updated medical records, Paul Revere sent the records to Dr. Martin for his review. Dr. Martin once again opined that the documentation failed to support a

physical condition that would impair the plaintiff from performing the duties of her own occupation or that of any occupation.

The plaintiff did not submit any documentation of evidence of a psychiatric condition for review on appeal. Consequently, on September 18, 1999, Paul Revere denied the plaintiff's appeal with regard to its termination of benefits, giving rise to this litigation.

DISCUSSION

The defendant argues in support of its motion for summary judgment that the deferential standard of "arbitrary and capricious" should apply in this case, and that its denial of LTD benefits to the plaintiff under the Plan was not arbitrary and capricious. The plaintiff argues that a *de novo* standard of review should apply, and that genuine issues of material fact exist to preclude summary judgment.

Standard of Review for Summary Judgment

A motion for summary judgment will be granted where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to judgment as a matter of law. Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). "Only when reasonable minds could not differ as to the import of the evidence is summary judgment proper." Bryant v.

Maffucci, 923 F. 2d 979, 982 (2d Cir.), cert. denied, 502 U.S. 849 (1991).

The burden is on the moving party to demonstrate the absence of any material factual issue genuinely in dispute. American International Group, Inc. v. London American International Corp., 664 F. 2d 348, 351 (2d Cir. 1981). In determining whether a genuine factual issue exists, the court must resolve all ambiguities and draw all reasonable inferences against the moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). If a nonmoving party has failed to make a sufficient showing on an essential element of his case with respect to which he has the burden of proof, then summary judgment is appropriate. Celotex Corp., 477 U.S. at 323. If the nonmoving party submits evidence which is "merely colorable," legally sufficient opposition to the motion for summary judgment is not met. Anderson, 477 U.S. at 249.

The standard of review to be applied in a denial of an ERISA claim was considered by the Supreme Court in the seminal case of Firestone Tire and Rubber v. Bruch, 489 U.S. 101 (1989). In that case, the Court ruled that consistent with established principles of trust law, a denial of benefits challenged under 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. Id. at 115. To determine what standard to apply to the plaintiff's challenge of a denial of benefits, a "court must determine whether the Plan confers discretionary authority on the Plan's Administrator ... When an employee benefit plan grants a plan fiduciary discretionary authority to construe the terms of the plan, the court may reverse only if the fiduciary's decision was arbitrary and capricious." Kocsis v. Standard Ins. Co., 142 F.Supp.2d 241, 251 (D.Conn. 2001). Stated another way in the statute itself, in order for an arbitrary and capricious standard to apply to an ERISA Plan fiduciary's determination of eligibility for benefits under said Plan, expression of a clear intent in the Plan to vest the fiduciary with discretionary authority is necessary; any ambiguities in the plan must be construed against the fiduciary and in favor of the party seeking judicial review. 29 U.S.C. §§ 1001 *et seq*. "Where the plan reserves such discretionary authority, denials are subject to the more deferential arbitrary and capricious standard, and may be overturned only if the decision is without reason, unsupported by substantial evidence or erroneous as a matter of law ... The plan administrator bears

the burden of proving that the arbitrary and capricious standard of review applies, since the party claiming deferential review should prove the predicate that justifies it." Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 249 (2d Cir. 1999).

Courts look to the plain language of the policy to determine whether an ERISA plan confers discretionary authority on the plan administrator. In Kinstler, the Second Circuit recognized that "magic words such as discretion and deference may not be absolutely necessary to avoid a *de novo* standard of review. At the same time, we have noted that the use of such words is certainly helpful in deciding the issue. When we have deemed the arbitrary and capricious standard applicable, the policy language reserving discretion has been clear." Id. at 251.

This Court faces the necessity of making a decision based upon ambiguous wording in the defendant's Plan. ERISA case law abounds where the courts have to decide along a continuum whether the wording of a plan proves discretionary authority on the part of the plan administrator, i.e., when the language is sufficient, and when it is insufficient. The Second Circuit granted *de novo* review where the policy language read as follows: "We will pay a Monthly Benefit if an Insured: ...

(4) submits satisfactory proof of Total Disability to us." Kinstler, 181 F.3d at 251. Conversely, in Kocsis, the court concluded that the defendant had carried its burden of proving that the plan at issue reserved discretion to the plan's administrator to determine eligibility for benefits when the language in that plan read as follows: "[The defendant] reserves to itself full and exclusive authority to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy ... and [the defendant] reserves to itself the right to determine: a. Your eligibility for insurance; b. Your entitlement to benefits; c. The amount of benefits payable to you; d. the sufficiency and the amount of information we may reasonably require to determine a., b., or c., above." 142 F.Supp.2d at 251. The court found, based on Second Circuit precedent, that the language was sufficient, albeit without the use of the word "discretion" or "discretionary," to trigger the application of the arbitrary and capricious standard.

Based on the guidelines delineated by case law in the Second Circuit, and as evidenced by the two examples given above, this Court concludes that the language in the Plan administered by Paul Revere is sufficient to trigger the

arbitrary and capricious standard of review. The plaintiff cautions against reading separate provisions of the Plan together, and claims that none of the provisions relate to the discretion of the plan administrator to determine unilaterally that the claimant was not medically disabled. This Court disagrees. To summarize, the Plan sets forth a specific definition of total disability, as outlined above. The Plan gives the administrator the right to require additional written proof to verify the continuance of any disability, and the Plan requires that evidence of insurability must be based on medical information that is acceptable to Paul Revere, the Plan administrator. Paul Revere asserts that read together, these provisions create the functional equivalent of discretionary authority. This Court concurs with Paul Revere, and finds discretionary authority of the Plan administrator.

The next step is to decide whether the denial of benefits by Paul Revere was without reason, unsupported by substantial evidence, or erroneous as a matter of law, the standard set forth in Kinstler. "Under this deferential standard, the court is not free to substitute its own judgment for that of the Plan's administrator as if it were considering the issue of eligibility anew. Thus the court may not upset a reasonable interpretation by the administrator. Furthermore,

a district court's review under the arbitrary and capricious standard is limited to the administrative record." Kocsis, 142 F.Supp.2d at 252.

The plaintiff also points to the SSA's finding of total disability as proof of her disability under the Plan. The definition of "disability" which controls a decision by the SSA is not binding on a Plan Administrator under ERISA. Kocsis, 142 F.Supp. at 255. In addition to the plaintiff's medical information, the SSA considered the plaintiff's residual functional capacity, age, education, and previous work experience to determine if the plaintiff could perform other work in the economy. The SSA found the plaintiff to be 43 years old, with a high school education, and having acquired skills which are not transferable to other work the claimant can perform, this in spite of the record showing the plaintiff having seventeen years of schooling, which the defendant states as comprising an education level of six credits short of a master's degree in education. The Court adheres to the finding in Kocsis that Paul Revere is not bound by the decision of the SSA.

The Court concludes that the plaintiff has failed to present a genuine issue of material fact as to whether Paul Revere's review of the plaintiff's claim, and subsequent

denial of benefits, was arbitrary and capricious. Paul Revere based its decision on the opinions of its own medical professionals, opinions of the plaintiff's own physicians, plus the opinions of those physicians to whom the plaintiff's physicians referred her for second opinions. Paul Revere considered the findings of the SSA, and offered to consider the plaintiff's psychiatric claims as a basis for paying disability benefits. The plaintiff refused to provide the necessary documentation and materials for Paul Revere's psychological department to consider.

The administrative record bears this out, indicating that Paul Revere conducted a thorough review of the medical records of the plaintiff, the opinions of all the plaintiff's treating physicians, including the second opinions sought by her treating physicians, the findings of the SSA, and the opinions of the independent physicians who examined the plaintiff. The Court does not find Paul Revere's denial of benefits to the plaintiff devoid of reason, unsupported by substantial evidence, nor erroneous as a matter of law, and therefore, not arbitrary and capricious.

CONCLUSION

For the reasons stated above, the defendant's motion for summary judgment [Doc.# 14] is GRANTED. The Clerk is directed

to enter judgment for the defendant on the plaintiff's claims and close the case.

SO ORDERED this 22nd day of January, 2002, at Bridgeport, Connecticut.

_____/s/_____
WARREN W. EGINTON, Senior U.S. District Judge