IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

ADRIANA STARITA, Plaintiff, v. NYCARE HEALTH PLANS, INC., CLAIMS SERVICE INTERNATIONAL, INC., and PENNSYLVANIA SAVINGS BANK, Defendants.	:	CIVIL ACTION NO. 98-5375

MEMORANDUM

R.F. KELLY, J. MARCH 28, 2000

Before this Court is the Motion by Defendants, NYLCare Health Plans, Inc. ("NYLCare"), Claims Service International, Inc. ("CSI"), and Pennsylvania Savings Bank ("PSB"), for Summary Judgment and, in the alternative, Motion in Limine to Preclude Admission of Evidence Outside the Claims File. Plaintiff Adriana Starita has responded with a Cross Motion for Summary Judgment and, in the alternative, Motion to Determine Standard of Judicial Review. For the following reasons, Defendants' Motion for Summary Judgment will be granted, and Plaintiff's Cross Motion for Summary Judgment will be denied.

BACKGROUND

This action arises from a claim by Plaintiff for long-term disability benefits under the provisions of an employee welfare benefit plan established by her employer, PSB, and governed by the Employee Retirement Income Security Act, 29

U.S.C. § 1001, et seq. ("ERISA").[1] Plaintiff was approved for payment of long-term disability benefits, effective October 10, 1994, arising from an auto accident occurring on August 10, 1994.

On November 21, 1996, NYLCare notified Plaintiff that further benefits would be suspended pending review of continuing eligibility for benefits. On December 26, 1996, NYLCare notified Plaintiff that further benefits would be denied because the policy required that the insured be disabled from "any occupation" rather than just her "own occupation" in order to continue to be eligible to receive benefits. Plaintiff filed an administrative appeal.

On May 19, 1997, the Honorable Timothy C. Pace issued a decision finding that Plaintiff has been under a disability as defined by the Social Security Act and Regulations promulgated thereunder since August 10, 1994, and awarded Plaintiff disability insurance benefits. On May 23, 1997, a copy of Judge Pace's decision was forwarded to NYLCare with a renewed request for reinstatement of benefits. NYLCare acknowledged receipt of the favorable Social Security decision; however, on July 9, 1997,

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[1] PSB was Plaintiff's employer and purchased a policy from New York Life Insurance Company pursuant to which eligible employees could receive long-term disability benefits; PSB processed enrollments and paid premiums, but was not involved at all in the claims decision. NYLCare succeeded New York Life Insurance Company regarding obligations under the contract and made the claims decisions under the policy with respect to the Plaintiff. CSI provided claims review services to NYLCare.

the insurance company affirmed its denial of benefits to Plaintiff based on information documenting her ability to do sedentary work in another occupation that will accommodate her restrictions and limitations, and requested additional medical documentation to support Plaintiff's claim. Subsequently, Plaintiff filed the instant lawsuit.

STANDARD OF REVIEW FOR SUMMARY JUDGMENT

"Summary judgment is appropriate when, after considering the evidence in the light most favorable to the nonmoving party, no genuine issue of material fact remains in dispute and `the moving party is entitled to judgment as a matter of law.'" Hines v. Consolidated Rail Corp., 926 F.2d 262, 267 (3d Cir. 1991) (citations omitted). "The inquiry is whether the evidence presents a sufficient disagreement to require submission to the jury or whether it is so one sided that one party must, as a matter of law, prevail over the other." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249 (1986). The moving party carries the initial burden of demonstrating the absence of any genuine issues of material fact.[2] Big Apple BMW, Inc. v. BMW of North America, Inc., 974 F.2d 1358, 1362 (3d Cir. 1992), cert. denied,

[2] "A fact is material if it could affect the outcome of the suit after applying the substantive law. Further, a dispute over a material fact must be 'genuine,' i.e., the evidence must be such 'that a reasonable jury could return a verdict in favor of the non-moving party.'" Compton v. Nat'l League of Professional Baseball Clubs, 995 F. Supp. 554, 561 n.14 (E.D. Pa.) (citations omitted), aff'd, 172 F.3d 40 (3d Cir. 1998).

507 U.S. 912 (1993). Once the moving party has produced evidence in support of summary judgment, the nonmovant must go beyond the allegations set forth in its pleadings and counter with evidence that demonstrates there is a genuine issue of fact for trial. Id. at 1362-63. Summary judgment must be granted "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). "When there are cross-motions, each motion must be considered separately, and each side must still establish a lack of genuine issues of material fact and that it is entitled to judgment as a matter of law." Nolen v. Paul Revere Life Ins. Co., 32 F. Supp.2d 211, 213 (E.D. Pa. 1998).

DISCUSSION

Defendants begin by asking this Court to apply the arbitrary and capricious standard rather than de novo in reviewing the denial of Plaintiff's claim for further benefits.[3] Both parties recognize that such fact-based determinations by an ERISA plan administrator are to be reviewed de novo unless the plan specifically grants the plan administrator discretion to

[3] Under an "arbitrary and capricious" standard, a court can set aside a judgment only if it was unreasonable, and not merely incorrect, which is the question for the court when review is plenary (de novo). Herzberger v. Standard Ins. Co., ___ F.3d ___, 2000 WL 202653, *1 (7th Cir. Feb 23, 2000).

make those determinations.[4] See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Mitchell v. Easman Kodak Co., 113 F.3d 433, 438 (3d Cir. 1997). According to Defendants, however, the policy's requirement of the submission of "proof of total disability" vests the Insurance Company with discretionary authority to determine eligibility of benefits and construe the terms of the policy. More specifically, the policy contains the following provision:

> When **proof is received** by the Insurance Company that an insured employee is totally disabled as the result of sickness or injury and requires the regular attendance of a legally qualified physician, the Insurance Company will pay a monthly benefit to the insured employee after completion of the elimination period. This monthly benefit will be paid as long as total disability continues provided that **proof of continued total disability** is submitted, at the insured employee's expense, to the Insurance Company upon request.

(Defs.' Mem. of Law in Supp. of Summ. J., Ex. 3 at 10 (emphasis added)). Defendants contend that other federal courts have held that language similar to the above grants an administrator discretion in making benefits determinations. (Defs.' Summ. J. Mem at 8) (citing Patterson v. Caterpillar, Inc., 70 F.3d 503,

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[4] Discretionary powers may be implied as well as express. Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176, 1180 (3d Cir. 1991). While Firestone does not condition a court's finding of discretion on a particular verbal formula, the primary focus of such a determination, under Firestone, is on plan language. Heasley v. Belden & Blake Corp., 2 F.3d 1249, 1256 (3d Cir. 1993).

505 (7th Cir. 1995) and Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 379 (7th Cir. 1994)).

Recently, however, the Seventh Circuit case law relied upon by Defendants has been called into doubt by that appellate court's latest opinion on the precise issue at hand. In Herzberger v. Standard Ins. Co., ___ F.3d ___, 2000 WL 202653 (7th Cir. Feb. 23, 2000), the Seventh Circuit Court of Appeals decided whether a plan administrator was given a power of discretionary judgment from language in plan documents stating that benefits shall be paid when the plan administrator upon proof (or satisfactory proof) determines that the applicant is entitled to the benefits. In that case, the plaintiff sought disability benefits for chronic fatigue syndrome and the plan administrator determined that the plaintiff's real problem was a mental disorder, for which the plan placed a tight lid on the amount of disability benefits payable. The plan document provided that the administrator would pay the benefit "upon receipt of satisfactory written proof" that the plaintiff has become disabled. In concluding that the above language, standing alone with nothing to qualify or amplify it, does not take the plan out of the default rule entitling the disappointed applicant to plenary review, the Seventh Circuit reasoned as follows:

> We hold that the mere fact that a plan requires a determination of eligibility or entitlement by the administrator, or requires proof or satisfactory proof of the

> applicant's claim, or requires both a determination and proof (or satisfactory proof), does not give the employee adequate notice that the plan administrator is to make a judgment largely insulated from judicial review by reason of being discretionary. Obviously a plan will not – could not, consistent with its fiduciary obligation to the other participants – pay benefits without first making a determination that the applicant was entitled to them. The statement of this truism in the plan document implies nothing one way or the other about the scope of judicial review of his determination, any more than our statement that a district court "determined" this or that telegraphs the scope of our judicial review of that determination. That the plan administrator will not pay benefits until he receives satisfactory proof of entitlement likewise states the obvious, echoing standard language in insurance contracts not thought to confer any discretionary powers on the insurer. . . . When an automobile insurance policy provides that the insurer will not pay for collision damage save upon submission of proof of that damage, all it is saying is that it will not pay upon the insured's say-so; it will require proof. There is no reason to interpret an ERISA plan differently.

Id. at *4 (citations omitted).

Other federal appellate courts have similarly ruled that the de novo standard of review applies when a plan merely requires that proof of disability be submitted to the insurance company. Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 252 (2d Cir. 1999) ("[T]he word `satisfactory,' whether in the phrase `satisfactory proof' or the phrase `proof satisfactory to [the decision-maker]' is an inadequate way to

convey the idea that a plan administrator has discretion."); Haley v. Paul Revere Life Ins. Co., 77 F.3d 84, 89 (4th Cir. 1996) (concluding that plan language giving insurance company right to require additional written proof to verify continuance of disability did not grant discretionary authority to deny benefits); Brown v. Seitz Foods, Inc. Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998) (holding that language requiring proof of loss does not trigger the deferential ERISA standard of review); Bounds v. Bell Atlantic Enters. Flexible Long-Term Disability Plan, 32 F.3d 337, 339 (8th Cir. 1994) (concluding that the deferential standard is not triggered by an insurance policy's proof-of-loss provision unless it expresses an intent to confer discretion); Kearney v. Standard Ins. Co. 175 F.3d 1084, 1089-90 (9th Cir. 1998) (concluding that district court properly applied de novo review where language in plan required satisfactory written proof of disability), cert. denied, 120 S. Ct. 398 (1999); but see Perez v. Aetna Life Ins. Co., 150 F.3d 550, 555-58 (6th Cir. 1998) (concluding that insurance company has discretion after interpreting plan language providing "right to require as part of the proof of claim satisfactory evidence" to mean that the evidence must be satisfactory to the insurance company).

In addition, two recent federal district court opinions have recognized that conferring discretionary authority on a plan

administrator based on plan language that merely requires proof of a claim would effectively conflict with the Supreme Court's ruling in Firestone. See Neurological Resources v. Anthem Ins. Co., 61 F. Supp.2d 840 (S.D. Ind. 1999); MacMillan v. Provident Mut. Life Ins. Co., 32 F. Supp.2d 600 (W.D.N.Y. 1999). In this regard, the court in Neurological Resources observed the following:

> Employee benefit plans are ultimately contracts and are often the subject of collective bargaining, as in this case. The standard of review -- i.e., the extent of the plan administrator's discretion to deny benefits to employees and their families -- can be a subject of collective bargaining. If the courts were to deem language merely requiring "proof" of a claim as sufficient to confer discretion on an administrator, it would appear that the only way for negotiators to assure de novo review would be to include language explicitly disclaiming discretionary power. That approach would effectively reverse the presumption adopted by the Supreme Court in Firestone. Parties and their lawyers who draft ERISA plans are entitled to clear guidance on the often critical question of the standard of review. It is easy to write explicit language satisfying the Firestone exception for grants of discretionary power. Searching for implicit grants of such authority creates a serious risk that courts, and parties, will get lost in what the Second Circuit accurately described as "semantic swamps" in this debate. See Kinstler, 181 F.3d at 252.

Neurological Resources, 61 F. Supp.2d at 850; see also MacMillan, 32 F. Supp.2d at 613 (recognizing that cases allowing proof-of-claim requirements to confer discretion upon the administrator

comes close to wholesale importation of arbitrary and capricious standard into ERISA, which the Supreme Court found unwarranted).

Here, the plan in the instant action requires only the submission of "proof" with no modifier. In such cases, where there is no indication that the insurance company has discretion to decide whether it considers the proof submitted to be satisfactory, other federal courts have held that a de novo standard of review is appropriate. MacMillan, 32 F. Supp.2d at 613; Grady v. Paul Revere Life Ins. Co., 10 F. Supp.2d 100, 110 (D.R.I. 1998) (policy provisions requiring claimants to submit proof of claim, proof of loss, and written proof of entitlement, as well as provisions providing defendant with right to request additional information and to order an independent medical examination are insufficient under Firestone); cf. Landau v. Reliance Standard Life Ins. Co., No. CIV. A. 98-903, 1999 WL 46585 (E.D. Pa. Jan. 13, 1999) (policy language providing for payment of benefit if insured submits satisfactory proof of total disability grants discretion to insurance company to make benefits determinations).

However, Defendants have pointed to additional language within a general provision of the policy which Defendants contend grants discretion to NYLCare under the terms of the policy. That provision states the following:

> EXAMINATION: The Insurance Company, at its own expense has the right to have a claimant

> examined:
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> (1) Physically;
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> (2) Psychologically; and
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> (3) Psychiatrically;
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> **to determine the existence of any total disability which is the basis for a claim**.
> This right may be used:
>
> (1) As often as it is reasonably required;
>
> (2) While a claim is pending.

(Defs.' Mem. In Supp. of Summ. J., Ex. 3 at 25 (emphasis added)).

In Newcomb v. Standard Ins. Co., 187 F.3d 1004 (9th Cir. 1999), the defendant insurance company argued that similar language of a provision within a disability benefits policy conferred adequate discretion so as to subject the denial of benefits to an abuse of discretion review. In that case, the provision stated that a claimant must submit "written authorization for STANDARD to obtain the records and information needed to determine [the claimant's] eligibility for LTD BENEFITS." The Ninth Circuit was not persuaded by the word "determine," however, and held that the de novo standard of review applied:

> Standard relies on two cases to support its argument that the words "to determine" are dispositive of the standard of review. First in Eley v. Boeing Co., 945 F.2d 276, 278 n.2 (9th Cir. 1991), the court held that the language "[t]he Company shall determine the eligibility of a person for benefits under the plan," sufficiently conferred

> discretion so as to make abuse of discretion the appropriate standard of review. Second in Bogue v. Ampex Corp., 976 F.2d 1319, 1324 (9th Cir. 1992), the court reviewed a Plan Administrator's decision to deny benefits for an abuse of discretion due to the language "[t]he determination . . . will be made by Allied-Signal upon consideration of whether the new position . . . has responsibilities similar to those of your current position.
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> These two cases are clearly distinguishable from this case. As was pointed out in Kearney, the court in Bogue found "that an administrator had discretion only where discretion was `unambiguously retained' by the administrator." Kearney, 175 F.3d at 1090 (citing Bogue, 976 F.2d at 1325). Discretion was not "unambiguously retained" in this case. Merely using the word "determine" in the policy does not insure that the denial of benefits will be reviewed for abuse of discretion. The word determine in this case was used in a provision which functioned to inform the claimant that he had to provide Standard with authorization to obtain records. The primary function of this provision is not to confer discretion. We are, therefore, not persuaded that this use of the word "determine" confers the appropriate discretion, and hold that the correct standard of review is de novo.

Id. at 1006.

As the Ninth Circuit was able to set apart Newcomb from its earlier cases, the instant action is similarly distinguishable. In this case, the "determine" language in the benefits policy appears in a general provision which mainly functioned to inform the claimant that the Insurance Company has the right to subject her to a medical examination, not to confer discretion. Cf. Garcia v. Fortis Benefits Ins. Co., No. CIV. A.

99-826, 2000 WL 92340, *6 (E.D. Pa. Jan. 24, 2000) (court applied arbitrary and capricious standard of review where plan explicitly declared that insurance company "shall have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.").

Thus, as Plaintiff points out, the policy provisions are, at best, ambiguous as to any implied grant of discretionary authority. (Pl.'s Opp'n Brief at 17.) In cases where such ambiguities exist, the Third Circuit has applied the principle of contra proferentem. See Heasley, 2 F.3d at 1257-58 (affirming the district court's choice of the de novo standard of review). Contra proferentem derives from recognition that insurers should be expected to set forth clear limitations on liability in their policies and, if they fail to do so, they should not be allowed to take advantage of resulting ambiguities that could have been prevented with greater diligence. Heasley, 2 F.3d at 1257 (citing Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 540 (9th Cir.), cert. denied, 498 U.S. 1013 (1990)). Application of the doctrine of contra proferentem in this case compels the conclusion that a grant of discretionary authority is neither expressly given nor clearly implied and, thus, a de novo standard

of review shall be applied.[5]

DE NOVO REVIEW

Defendants contend that even under the de novo standard of review, Defendants are entitled to summary judgment.[6] Defendants argue that "the administrative record in this case is of such strength that this Court, independently reviewing the record, should find as NYLCare did, and terminate Plaintiff's disability benefits." (Defs.' Mem. in Supp. of Summ. J. at 34.)

Defendants set forth the following factual record in support of their position that the review process related to Plaintiff's claim in this action was correct:

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[5] It is worth noting that an inherent conflict exists in this case based on NYLCare's dual role as plan administrator and payor. See Rizzo v. Paul Revere Ins. Group, 925 F. Supp. 302, 308-09 (D.N.J. 1996) (finding that insurance company's dual role as policy claims administrator and as the issuing insurance company created "hobgoblin of self-interest"), aff'd, 111 F.3d 127 (3d Cir. 1997); see also Nolen, 32 F. Supp.2d at 216 (inherent conflict of interest exists when insurance company acts as insurer and claims administrator, resulting in application of heightened arbitrary and capricious standard of review). Thus, even if this Court concluded that an arbitrary and capricious standard of review was applicable, heightened scrutiny would be warranted. Rizzo, 925 F. Supp. at 309-10 (de novo review of plan administrator's decision occurs where insurance company has significant conflict of interest, and if administrator's decision is wrong, but reasonable, court then determines whether decision was tainted by self-interest).

[6] Because this Court has concluded that a de novo standard of review applies to the case at hand, Defendants' contention that only the claims file may be reviewed in order to determine whether the arbitrary and capricious standard was violated is moot. See Luby, 944 F.2d at 1184-85 (when conducting de novo review, court is not limited to evidence before administrator).

On August 10, 1994, Plaintiff was injured in a car accident. (Pl.'s Compl. at ¶ 9.) After her 60-day elimination period, Plaintiff submitted an application for long-term disability benefits in October, 1994. (Defs.' Summ. J. Mem., Ex. 7.) In her application, Plaintiff listed her work experience, which included jobs as assistant manager supervising 6 employees from June of 1976 to January of 1988, manager of 19 employees from January, 1988, to June, 1992, and manager of 3 employees from November, 1992, to present.

Also in Plaintiff's application was a statement, dated October, 28, 1994, from Dr. Paul Sedacca, Plaintiff's primary treating physician. Id. Dr. Seddaca diagnosed Plaintiff's injuries as "acute traumatic cervical, shoulder, lumbar, [right] knee & ankle sprain/strain" and rated her at a "Class 5" level of physical impairment, meaning she was "incapable of minimum (sedentary) activity." Id. Dr. Sedacca further stated that Plaintiff was not a suitable candidate for occupational rehabilitation for her occupation, or any other occupation, and that her current profession could not be modified to allow for her injuries related to the August 10, 1994 incident. Id. After reviewing Plaintiff's application and interviewing her, Defendant NYLCare notified Plaintiff that her disability claim had been approved and had commenced on October 10, 1994.

Then, in January and March of 1995, Dr. Sedacca again

stated that Plaintiff's physical condition precluded her ability to work and perform usual household chores. (Defs.' Summ. J. Mem., Exs. 11 and 12.) Shortly thereafter, Plaintiff was examined by Dr. Leonard Bruno, at the request of Dr. Sedacca, for a neurological evaluation on March 13, 1995. (Defs.' Summ. J. Mem., Exs. 13.) Dr. Bruno concluded that Plaintiff's condition is "self-limited does not require operation, will respond to conservative treatment and that she should be treated with anti-inflammatory medications, physical therapy and perhaps some disc decompression." Id.

On March 30, 1995, Plaintiff's initial application for Social Security Disability benefits was denied based upon the finding that she could continue in her past job as a bank teller. (Defs.' Summ. J. Mem., Ex. 14.) Subsequently, on June 11, 1995, Plaintiff's request for reconsideration of the March 30, 1995 denial of Social Security Disability benefits was also denied. (Defs.' Summ. J. Mem., Ex. 15.) Despite Plaintiff's denial of Social Security Disability benefits, she continued to receive her monthly disability check from Defendant NYLCare.

On December 11, 1995, Dr. Sedacca issued a report that Plaintiff's "[p]rognosis for complete recovery in this case must be listed as guarded primarily based on the nature and severity as well as permanency of the aforementioned injury . . . ." (Defs. Summ. J. Mem., Ex. 16.) Accordingly, Dr. Sedacca provided

Defendant CSI with a report, dated February 14, 1996, stating that Plaintiff should be "restricted from all duties" related to her occupation. (Defs. Summ. J. Mem., Ex. 17.)

During this time, CSI arranged for Plaintiff to be independently examined by Dr Mario Arena, an orthopedic surgeon. In February 12, 1996 report, Dr Arena found that Plaintiff's prognosis was very good and that he believed Ms. Starita had recovered completely from injuries sustained from her motor vehicle accident. (Defs. Summ. J. Mem., Ex. 18.) Moreover, Dr. Arena concluded that Plaintiff had no physical restrictions resulting from the car accident and that she could perform all her normal job duties as branch manager of PSB without restriction. Id.

When CSI asked Dr. Sedacca to comment on Dr. Arena's February 12, 1998 evaluation of Plaintiff, Dr. Sedacca issued handwritten comments stating that "the report I have re: MRI lumbar differs from Dr. Arena's re: (+) disc herniation L4-5" and "pt is capable of sedentary work." (Defs. Summ. J. Mem., Ex. 19.) Then, on May 29, 1996, CSI obtained an on-site physician's evaluation of Plaintiff's medical records and the May 7, 1996 comments by Dr. Sedacca related to Plaintiff's working ability which concluded that Plaintiff has "sedentary work capability where she could change position as needed." (Defs. Summ. J. Mem., Ex. 21.)

On June 24, 1996, CSI sent Plaintiff a letter informing her that, as of October 10, 1996, the definition of total disability changes to "an injury or sickness which . . . (2) prevents the insured employee from doing each of the main duties of any occupation. Any occupation is one that the insured employee's training, education, or experience will reasonably allow." (Defs. Summ. J. Mem., Ex. 22.) The letter also explained that CSI was reviewing Plaintiff's current disability status to determine her eligibility for continued benefits beyond 10/10/96 and that medical information provided indicated that Plaintiff was "able to work in a sedentary occupation that would allow [her] to sit & stand alternatively as needed" and asked Plaintiff to respond as to whether she agreed with this assessment. Id. Ms. Starita did not respond to this inquiry.

On August 9, 1996, CSI obtained the report of a vocational consultant as to Plaintiff's capability to perform occupations other than those she had undertaken in the past, based on her training, education, or experience. (Defs. Summ. J. Mem., Ex. 25.) The vocational consultant concluded that Plaintiff was capable of performing sedentary work in numerous occupations, including the following: loan officer; loan review analyst (financial); research or administrative assistant; guidance counselor; certification and selection specialist; educational consultant; manager; and counselor. Id.

On September 11, 1996, CSI notified Plaintiff that "[b]ased on the medical information in the file and your vocational and work history, it does not appear you will be eligible for benefits beyond 24 months, or October 10, 1996." (Defs. Summ. J. Mem., Ex. 24.) However, before terminating Plaintiff's disability benefits, CSI sent another letter to Dr. Sedacca, on September 17, 1996, asking for his opinion as to whether Plaintiff has the "work capacity" to perform in a "sedentary occupation." (Defs. Summ. J. Mem., Ex. 25.) Dr. Sedacca responded by letter, dated October 22, 1996, stating that Plaintiff's injuries "cause her chronic impairment of a multiple nature; however by definition she would be capable to try very sedentary type work. I would need actual job descriptions to review." Id. CSI then forwarded Dr. Sedacca a list of job descriptions on October 30, 1996, and requested that he review them and advise as to whether Plaintiff was able to perform the occupations. (Defs. Summ. J. Mem., Ex. 26.) After reviewing the occupations -- which included loan officer, loan review analyst, research or administrative assistant, guidance counselor, certification selection specialist, education consultant, educational specialist, and manager/counselor -- Dr. Sedacca replied that "they seem to all meet the criteria for the "sedentary work" category. Therefore, they are all approved based on her injuries outlined previously." Id.

In light of the above, NYLCare terminated Plaintiff's disability benefits by letter dated December 26, 1996. (Defs. Summ. J. Mem., Ex. 27.) Following her termination of disability benefits, Plaintiff, by and through her counsel, requested that said termination be reviewed. On May 16, 1997, CSI stated that they would investigate further upon Plaintiff providing them with sufficient medical information to reopen the claim, including her Social Security Status. (Defs. Summ. J. Mem., Ex. 30.)

On May 23, 1997, Plaintiff's counsel forwarded CSI a favorable decision awarding Plaintiff Social Security Disability Benefits and requested that the termination of Plaintiff's benefits be reconsidered. (Defs. Summ. J. Mem., Ex. 31.) CSI agreed to review Plaintiff's claim. (Defs. Summ. J. Mem., Ex. 32.)

On June 20, 1997, an on-site medical assessment by CSI of Plaintiff's claim was completed by Dr. Stephen Z. Hull. (Defs. Summ. J. Mem., Ex. 33.) After reviewing the entire claims file related to Plaintiff's claim, Dr. Hull concluded as follows:

> I feel we continue to have a preponderance of medical documentation supporting sedentary work capacity and only second hand opinion without supporting documentation that the claimant does not have capacity. I think you can feel comfortable sustaining a denial based on medical information submitted by the claimant and her lawyer to date.

Id.

On July 9, 1997, NYLCare notified Plaintiff that the

favorable Social Security award had been considered, but the decision to terminate her disability benefits had been upheld based on the evidence demonstrating Plaintiff's ability to perform sedentary work. (Defs.' Summ. J. Mem., Ex. 34.)

Plaintiff contends that the following issues of fact preclude the entry of summary judgment: (1) Defendants misunderstood Plaintiff's vocational background, (2) Defendants' "in-house" vocational "work-up" was predicated upon an error of fact, (3) Defendants in-house vocational work-up failed to demonstrate either competence or objectivity, (4) Defendants' medical evaluation failed to address the central issue of disability, (5) Defendants misconstrued the work restrictions issued by Plaintiff's treating physician, and (6) the medical and vocational evidence offered by the parties conflict with Defendants' decisions.

First, Plaintiff points out that Defendants have misconstrued her responses to the Educational Background form as indicating that she possessed a bachelor's degree. Thus, Plaintiff argues that Defendants' in-house vocational "work-up" was predicated upon an error of fact and cannot be relied on by this Court to approve Defendants' denial of benefits. In addition, Plaintiff asserts that seven of the nine listed occupations in Defendants' in-house vocational assessment are beyond Plaintiff's actual educational background and employment

background by virtue of Plaintiff's lack of college degree. (Pl.'s Summ. J. Opp'n Brief at 27-28.) Plaintiff adds that there is no indication anywhere in Defendants' in-house vocational assessment that the individual performing the assessment was qualified to do so. Id.

Defendants reply that there is no dispute that Plaintiff was a highly skilled professional who worked extensively in the banking industry for more than eighteen years, and that two of the vocational assessments by NYLCare are within the range of Plaintiff's capabilities. Defendants also argue that it was not improper for NYLCare to rely on its own vocational expert, despite the position of Plaintiff's vocational expert.

Nevertheless, Plaintiff contends that the vocational evidence is in conflict. Plaintiff explains that his vocational expert, Mr. William Hausch, is the same vocational expert selected by the Social Security Administration to testify at Plaintiff's Social Security Hearing. Mr. Hausch's professional opinion regarding Plaintiff's disability status has remained the same since March 5, 1997 – four months prior to Defendant's last denial of benefits notice on July 9, 1997 -- that Plaintiff was and is not employable. Mr. Hausch's opinion was forwarded to Defendants on May 23, 1997, prior to the last denial of benefits notice of July 9, 1997. Plaintiff points out that there was no

additional vocational investigation taken by Defendants following their receipt of this conflicting vocational information from the Social Security Decision/Award and prior to the last denial.

However, Defendants have taken the position that NYLCare had no obligation to consider the Social Security determination.[7] See Pokol v. E.I. Du Pont De Nemours & Co., 963 F. Supp. 1361, 1379-80 (D.N.J. 1997) ("[I]t is not inherently contradictory to permit an individual to recover benefits pursuant to the Social Security Act while being denied benefits pursuant to a private ERISA benefit plan."). That being said, Defendants highlight Dr. Hull's report in which he comments that the definition of disability applied by the Social Security administrative law judge is not the same as under the ERISA plan and that review of the judge's ruling suggests that the judge was not in possession of any documentation from Dr. Sedacca indicating his opinion that the claimant had sedentary work capacity.

In this regard, Plaintiff has set forth the deposition testimony of Dr. Sedacca regarding Plaintiff's work restrictions. At his deposition, Dr. Sedacca clarified his intent to convey the

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[7] Although the approval of disability benefits by the Social Security Administration is not dispositive on the issue of whether a claimant satisfies the requirement for disability under an ERISA-covered plan, this Court may consider the Social Security Administration's determination of disability in reviewing NYLCare's denial of benefits. Whatley v. CNA Ins. Cos., 189 F.3d 1310, 1314 n.8 (11th Cir. 1999).

opinion that Plaintiff "would be capable to try very sedentary type work." Dr. Sedacca described "very sedentary work" to include Plaintiff's need to change positions based on her sensation of pain. Dr. Sedacca estimated this limitation based on an eight-hour work day at four to six rest periods, spanning 10-15 minutes per rest period. (Pl.'s Opp'n Mem., Ex. D, Sedacca Dep., dated 11/2/99, at 38-39, 42-43.)

Furthermore, with respect to his review of the global job descriptions provided to him by CSI, Dr. Sedacca explained his comment that "they seem to all meet the criteria for the `sedentary work' category" and, therefore, "they are all approved based on [Ms. Starita's] injuries outlined previously." In this regard, Dr. Sedacca testified that he did not intend to give a vocational opinion with respect to approval of any of those job descriptions, and, without the specific requirements of lifting or bending or how many rest periods would be involved in each of those job descriptions that were given to him, Dr. Sedacca could not definitively state whether the job descriptions met the criteria for the sedentary work category. (Pl.'s Summ. J. Opp'n Mem., Ex. D, Sedacca Dep., dated 11/2/99, at 47-48.) Thus, Plaintiff submits that "defendants are attempting to read too broadly the narrow and limited work capability opinions actually held by Dr. Sedacca." (Pl.'s Opp'n Brief at 34.)

Defendants reply that NYLCare, in terminating

Plaintiff's benefits, was merely enforcing the terms of the policy after reviewing all available medical information. And while Plaintiff characterizes Defendants' inability to ascertain clarification of Dr. Sedacca's opinions as part of Defendants' misconstruction and misinterpretation of the medical evidence before them, Defendants point out that NYLCare's July 9, 1997 letter to Plaintiff's counsel invited Plaintiff to provide additional medical information after identifying the basis for the denial of benefits. See Wahl v. First Unum Life Ins. Co., Civ. A. No. 93-4813, 1994 WL 57214, * 3 (E.D. Pa. Feb. 17, 1994) ("[D]enial letter must specifically identify at least some of the information that a claimant must submit in order to perfect his claim.").

In Thomas v. Kemper Nat'l Ins. Cos., 984 F. Supp. 885 (E.D. Pa. 1997), an employee benefits plan participant brought a state court breach of contract action seeking disability benefits from her employer. After the case was removed to federal court, the participant amended her complaint to include a cause of action under ERISA. The employer then filed a motion for summary judgment. The district court granted the employer's motion for summary judgment based on the employer's contention that the plaintiff failed to exhaust her administrative remedies. In doing so, Judge Joyner reasoned as follows:

> ERISA does not, by its terms, mandate exhaustion of these required administrative

> remedies prior to instituting suits for denial of benefits. However, in an effort to promote the goals intended by Congress when the Act was drafted, the exhaustion doctrine is generally applied to such cases before plaintiffs are allowed to sue under ERISA. . . . Thus, unless the claim alleges a statutory violation rather than a mere denial of benefits under an ERISA plan or it can be shown that exhaustion of administrative remedies would prove futile or the remedy inadequate, exhaustion of remedies is a pre-requisite to maintaining an action for denial of benefits under ERISA.

Id. at 890 (citations omitted).

The record in Thomas clearly showed: (1) that the plaintiff was aware of the plan's requirement for medical verification of continuing disability, (2) that plaintiff's counsel was notified that the decision to terminate plaintiff's benefits was made because no medical certification of continuing disability had been provided, and (3) that the manager of defendants' employee claims department invited the plaintiff to provide any additional information which may affect the decision and explained the procedure for obtaining review of the decision. Id. Because the court found that the plaintiff made no request for review of the decision terminating plaintiff's disability benefits, and that neither plaintiff nor her counsel ever attempted to provide defendants with any additional information, as requested, the court concluded that the plaintiff did not exhaust the administrative remedies available to her and that she was, therefore precluded for pursuing the ERISA action. Id. at

891.

In the instant action, NYLCare's July 9, 1997 denial letter addressed to counsel for Plaintiff included the following:

> We feel we have a preponderance of medical documentation supporting sedentary work capacity and only second hand opinions without supporting documentation that the claimant does not have work capacity. Therefore, we are requesting that you provide us with additional supporting medical documentation including the following:
>
> – All of Dr. Sedacca's office notes
> – Dr. Giam Petro's office notes and credentials
> – Dr. Valentino Ciullo's office notes
> – Dr. Alfred Iezzi's office notes
> – Dr. Barbara Browne's EMG/NCV report and office notes
>
> Once reviewed, we will ask Dr. Sedacca if this information would alter his opinion that the claimant had sedentary work capacity as of October 10, 1996.

(Defs.' Summ. J. Mem., Ex. 34.)

Defendants contend, and Plaintiff does not dispute, that Plaintiff's counsel did not respond to the July 9, 1997 letter. Instead, after more than fifteen months had passed, Plaintiff filed the Complaint commencing the present action on or about October 9, 1998. (Defs.' Summ. J. Mem., Ex. 1.) The Complaint does contain a section entitled "Exhaustion of Administrative Remedies." Id. at ¶¶ 9-15. In that section of the Complaint, Plaintiff alleges that she timely requested administrative review after Defendants denied further benefits on

December 26, 1996; however, with respect to Defendants' letter, dated July 9, 1997, Plaintiff merely states that Defendants affirmed their decision to deny further benefits and that all administrative remedies provided under the policy have been exhausted, despite Defendants' request for additional information. Id. at ¶¶ 12-15. In addition, Plaintiff has not alleged a specific statutory violation other than a denial of benefits under an ERISA plan. Id. at ¶¶ 17-19. Under these circumstances, this Court concludes that, despite the appearance of genuine issues of material fact with regard to the vocational evidence and the work restrictions issued by Plaintiff's treating physician, Plaintiff has not exhausted her administrative remedies, and, thus, is precluded from pursuing this ERISA action. Thomas, 984 F. Supp. at 890-91.

Based on the above, Defendants' Motion for Summary Judgment is granted, and Plaintiff's Cross Motion for Summary Judgment is denied.

ADRIANA STARITA, Plaintiff, v. NYCARE HEALTH PLANS, INC., CLAIMS SERVICE INTERNATIONAL, INC., and PENNSYLVANIA SAVINGS BANK, Defendants.	:	CIVIL ACTION NO. 98-5375

ORDER

AND NOW, this 28th day of March, 2000, upon consideration of the Motion by Defendants, NYLCare Health Plans, Inc., Claims Service International, Inc., and Pennsylvania Savings Bank, for Summary Judgment and, in the alternative, Motion in Limine to Preclude Admission of Evidence Outside the Claims File, and Plaintiff Adriana Starita's Cross Motion for Summary Judgment and, in the alternative, Motion to Determine Standard of Judicial Review, it is hereby ORDERED that Defendants' Motion for Summary Judgment is GRANTED and Plaintiff's Cross Motion for Summary Judgment is DENIED. The parties' motions in the alternative are DENIED as moot.

BY THE COURT:

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ROBERT F. KELLY, J.