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

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| **DONNA S. McCBRIDE,** | : | **CIVIL ACTION** |
| | : | |
| **Plaintiff,** | : | |
| | : | |
| **v.** | : | |
| | : | |
| **CONTINENTAL CASUALTY COMPANY and COMMONWEALTH SAVINGS BANK'S LONG TERM DISABILITY PLAN** | : | |
| | : | |
| **Defendants.** | : | **NO. 97-4625** |

**M E M O R A N D U M**

**Reed, J.** **May 11, 1999**

Plaintiff Donna S. McBride ("McBride") brought this suit as a result of being denied long term disability benefits. The cause of action arises under the Employee Retirement Insurance Security Act of 1974, 29 U.S.C. § 1001, et seq., as amended ("ERISA"). Presently before the Court are the cross motions for summary judgment of McBride (Document No. 35) and defendants Continental Casualty Company ("Continental") (Document No. 32) and Commonwealth Savings Bank's Long Term Disability Plan ("CSB") (Document No. 33). Also before the Court is the petition of Continental for leave to file the affidavit of Charles H. Meacham (Document No. 38). Jurisdiction is proper pursuant to 28 U.S.C. § 1331. For the reasons set forth below, both motions for summary judgment will be denied and the motion for leave to file the affidavit will be granted.

## I. Background

McBride worked for Continental Savings Bank from September 10, 1984 until her

termination which was effective March 3, 1995. At the time of her termination, McBride was a Senior Vice President. CSB provided long term disability insurance to its employees under its Long Term Disability Plan ("Plan"), which was funded by an insurance policy issued by Continental to CSB. CSB's Plan, which includes the Long Term Disability Insurance Policy ("Disability Policy") issued by Continental, constitutes a defined employee benefit plan within the meaning of ERISA, and McBride was a participant in the Plan and Disability Policy that is a component of the Plan. CSB is the plan sponsor and the plan administrator.

The Plan affords monthly long term disability benefits to CSB employees who meet its eligibility requirements. Only active, full-time employees are eligible for insurance. It is uncontested that after March 3, 1995, McBride was ineligible for benefits under the Disability Policy. To qualify for long term disability benefits, a claimant must complete a ninety (90) day elimination period, during which the claimant is continuously unable to perform his or her duties.

Under the Disability Policy, coverage is provided to eligible employees who have a "Total Disability." Total Disability is defined in the Policy as:

> . . . the Insured Employee, because of Injury or Sickness is:
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> (1) continuously unable to perform the substantial and material duties of his regular occupation;
> (2) under the regular care of a licensed physician other than himself; and
> (3) not gainfully employed in any occupation for which he is or becomes qualified by education, training, or experience.

"Sickness" is defined as "sickness or disease causing loss which begins while the Insured Employee's coverage is in force." (Defendant Continental Casualty Company's Exhibits to Motion for Summary Judgment ("Def. Exhibits"), Exh. A).

On November 10, 1994, due to emotional distress, McBride took a medical leave of

absence from CSB. On November 15, 1994, McBride submitted a letter from Victoria P. Neely, Ph. D., stating that she was "distraught" and suffering from anxiety and stress, and advising McBride to take a medical leave of absence from CSB. On December 7, 1994, Neely submitted an Attending Physicians Statement to McBride CSB. (Def. Exhibits, Exh. B at 118). In response to the question "[i]f still disabled, when should patient be able to return to work?" Neely answered January 5, 1995. In November of 1994, Neely also referred McBride to B. Kenneth Nelson, M.D., for treatment. Nelson prescribed Paxil, Nortriptyline and Hydroxyzine.

On December 29, 1994, McBride wrote a letter to CSB informing them that she intended to return to work on January 5, 1995 as stated in the medical certification of Neely. McBride, however, was informed by CSB that because her attorney was negotiating the terms and conditions of her termination it would not be in the best interest of either McBride or the CSB if she returned to work. McBride did not return to work. Pursuant to a severance agreement, McBride was terminated effective March 3, 1995.

McBride received short term disability benefits from November of 1994 through March of 1995. She continued to see Neely through March of 1995. In March, McBride was referred back to her regular therapist, Joyce Maxner, M.S.W., when Maxner returned to the area following a six-month relocation to Florida.

On March 1, 1996, in a letter to CSB, McBride applied for long term disability benefits under the Plan. In connection with her disability claim, Neely submitted a Physician's's Statement dated June 6, 1996. (Plaintiff's Memorandum of Law in Support of Her Motion for Summary Judgment ("Plt. Mem."), Exh. 9). In her June statement, Neely stated that McBride was suffering from a clinical disability, with a diagnosis of "Marked emotional distress with the

predominant manifestation being a combination of depression and anxiety" pursuant to Code 309.28 of the Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition ("DSM-IV"). Neely also stated that the McBride's initial prognosis (recovery and return to work date) as defined at the time was "dependant upon McBride's ability to incorporate stress management and cognitive problem solving skills into her work setting" as well as changes in her work setting.

McBride has since seen a number of doctors all of whom are consistent in their findings that McBride is mentally ill. Lindley M. Winston, M.D., a psychiatrist, submitted a Physician's statement dated May 30, 1996, in which he stated that McBride was mentally ill, suffering from Delusional Disorder, Code 297.1 of the DSM-IV, and that the onset of her current episode most likely began in December of 1994. (Plt. Mem., Exh. 11). Carl M. Sonder, M.D., submitted a Attending Physician's Statement in which he stated that McBride suffers from Bipolar Disorder. Also, in a letter to Continental dated September 30, 1996, based upon a review of McBride's past medical records, interviews with McBride and family members, as well as the natural evolution of major mood disturbances such as Bipolar Disorder, Sonder opined that McBride's condition emerged prior to 1994. Sonder further opined that the impairments associated with her condition escalated over a period of time until she became totally disabled in November of 1994. It is his opinion that McBride has remained disabled since that time.

On October 2, 1996, Neely submitted a letter clarifying her initial projected return date of January 5, 1995. (Plt. Mem., Exh. 19). Neely explained that her prognosis was qualified with a statement indicating that it was dependant on her ability to "incorporate stress management and cognitive problem solving skills into her work setting." Neely states that because the conditions

were not met, any projected return date was necessarily voided. Furthermore, she states that she never defined a subsequent return date and "experienced Ms. McBride to be disabled throughout the time I worked with her." (Id.).

Subsequent to her termination, McBride's condition deteriorated, eventually necessitating psychiatric hospitalization at the Institute of the Pennsylvania Hospital on April 4, 1996. McBride was re-hospitalized on June 16, 1998, and discharged on June 26, 1998 at her own insistence. At that time, Daniel Gruener, M.D., recommended electroconvulsive therapy ("ECT"). McBride has since undergone ECT treatment. (Plt. Mem., Exh. 16).

McBride's claim for long term disability and subsequent appeal were both denied because claims representative and appeal committee concluded that McBride's condition did not prevent her from engaging in the material and substantial duties of her own occupation when the ninety day elimination period ended. (Plt. Exh. 18 & 24). It appears undisputed that McBride was under the regular care of a licensed physician and was not gainfully employed in any occupation for which she is or became qualified by education, training or experience.

**II. Legal Standard**

Under Federal Rule of Civil Procedure 56(c), summary judgment may be granted when, "after considering the record evidence in the light most favorable to the nonmoving party, no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law." Turner v. Schering-Plough Corp., 901 F.2d 335, 340 (3d Cir. 1990). For a dispute to be "genuine," the evidence must be such that a reasonable jury could return a verdict for the nonmoving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). If the moving

party establishes the absence of a genuine issue of material fact, the burden shifts to the non-moving party to "do more than simply show that there is some metaphysical doubt as to the material facts." Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586 (1986). The non-moving party may not rely merely upon bare assertions, conclusory allegations, or suspicions. Fireman's Ins. Co. of Newark v. DuFresne, 676 F.2d 965, 969 (3d Cir. 1982). The applicable standards by which the Court must decide a motion for summary judgment do not change when the parties file cross-motions for summary judgment. Appelmans v. City of Philadelphia, 826 F.2d 214, 216 (3d Cir. 1987); Manufacturers Life Ins. Co. v. Dougherty, 986 F. Supp. 928, 931 (E.D. Pa. 1997). Each motion must be considered separately and each side must 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., 32 F. Supp.2d 211, 213 (E.D. Pa. 1998).

**III. Discussion**

As a preliminary matter, the Court must determine the correct standard of review. ERISA does not specify a standard of review that courts should use to evaluate the denial of benefits by a plan administrator. The United States Supreme Court, however, has held that "a denial of benefits challenged under [ERISA] is to be reviewed under a *de novo* standard, unless the benefit plan gives the administrator authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). *De novo* review of plan administrators' factual determinations, as well as their interpretations of plan language, "is appropriate if the plan does not grant the plan administrator discretion to make those determinations." Mitchell v. Eastman Kodak Co., 113

F.3d 433, 438 (3d Cir. 1997). If the plan does grant such authority to the plan administrators, their benefit determinations are reviewed under an arbitrary and capricious, or an abuse of discretion standard. Abnathya v. Hoffman-La Roche, Inc., 2 F.3d 40, 45 (3d Cir. 1993).

Whether a plan confers discretionary powers upon the plan administrator depends upon the terms of the plan. Luby v. Teamsters Health, Welfare and Pension Trust Funds, 944 F.2d 1176, 1180 (3d Cir. 1991). Discretionary powers may be either expressly granted or implied by a plan's terms. Id. To determine whether a plan implicitly grants discretionary authority, the Court must interpret the plan as a whole and "in light of all the circumstances." Id. If the terms of the ERISA plan are ambiguous, however, "the interpretation most favorable to the insured will be adopted." Heasley v. Belden & Blake Corp., 2 F.3d 1249, 1257 (3d Cir. 1993). This rule is consistent with ERISA's goal to "promote the interest of employees and their beneficiaries in employment benefit plans." Firestone, 489 U.S. at 113; Heasley, 2 F.3d at 1257.

To support its argument that the disability plan grants the plan administrator discretion, defendants point to a provision in the plan requiring "due written proof of loss."[1] Defendant argues that the modifier "due" means that the proof submitted to the plan administrator must be adequate, thus demonstrating that the plan administrator must be satisfied

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[1]The relevant provisions state:

> **WRITTEN PROOF OF LOSS.** Written proof of loss must be furnished to Us within the 90 days after the end of a period for which We are liable. If it is not possible to give the proof within 90 days, the claim is not affected if the proof is given as soon as reasonably possible. Unless the Insured Employee is legally incapacitated, written proof must be given within 1 year of the time it is otherwise due.
>
> **TIME OF PAYMENT OF CLAIM**. Benefits will be paid monthly immediately after We receive due written proof of loss.

that the claimant is entitled to compensation under the plan.[2] See Patterson v. Caterpillar, Inc., 70 F.3d 503, 505 (7th Cir. 1995); Caldwell v. Life Ins. Co. of North America, 959 F. Supp. 1361, 1365 (D. Kan. 1997). I disagree. Cannon v. CNA, 1998 WL 310663, at *2-3 & n.3 (E.D. Pa. June 11, 1998). I find it significant that the reference to "due" proof upon which Continental is relying is included in the section explaining that claims will be paid upon receipt of "due" proof and not in the preceding section which describes the claimant's duty to provide information to support his or her claim. There is no requirement of "satisfactory proof," "due proof" or anything similar in the section explaining what information a claimant must submit to support a claim of disability.[3] The policy only requires that "written proof" be "furnished to Us . . . ." Simply requiring written proof is not a grant of discretion to the plan administrator. Chido v. Unum Life Ins. Co of America, 1998 WL 743596, at *2 (E.D. Pa. Oct. 6, 1998).

Thus, I am not persuaded that the language contained in these documents is sufficient to apply the deferential "arbitrary and capricious" standard of review. Based on my review of the related documents, including the Plan, there is no language, express or implied, that

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[2]In further support of their position, Defendants argue that the Court of Appeals for the Third Circuit, in a recent unpublished slip opinion, held that a requirement of "satisfactory proof" was an implicit grant of discretion. See Pinto v. Reliance Standard Life Ins. Co., No. 97-5297, slip op. at 7 (3d Cir. May 28, 1998) (attached at Def. Exhibits, Exh. J). First, although an unpublished slip opinion is persuasive authority, it is not binding. See Internal Operating Procedure 5.8. Second, in Pinto neither party disputed that the policy included the discretion necessary to invoke the "arbitrary or capricious" standard. Third, Pinto can be easily distinguished because the policy language is not the same. See Pinto, No. 97-5297, slip op. at 7.

[3]The section describing the claimant's duty to provide information to support his or her claim does, however, use the same word, stating that, barring incapacity, the required written proof must be submitted "within 1 year of the time it is otherwise due." Read in context, the Court understands the word "due" in the section describing when claims will be paid to mean that claims will be paid when the administrator receives the information required to support the claim that is owed under the terms of the Plan, i.e., written proof.

At best, Continental's interpretation presents an ambiguity. Accordingly, "the interpretation most favorable to the insured will be adopted." Heasley, 2 F.3d at 1257.

refers to any discretionary power of the plan administrator to determine disputes arising from a beneficiary's claim of disability on a case-by-case basis. See Luby, 944 F.2d at 1181; Cannon 1998 WL 310663, at *3. Therefore, I conclude that a *de novo* standard of review is appropriate.

Upon a review of the entire record before the Court, I find that there are material facts in dispute as to whether McBride was totally disabled during the elimination period. Thus, considering the evidence in the light most favorable to McBride, Continental and CSB are not entitled to summary judgment. However, there is at least some evidence that McBride was able to, or at least willing to return to work during the elimination period.[4] Thus, viewing the evidence in the light most favorable to the defendants, a reasonable fact finder could conclude that McBride was not totally disabled during the entire elimination period. Because the defendants have presented sufficient evidence to create a genuine issue of fact, I conclude that McBride is not entitled to summary judgment.

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[4]Defendants' argument that the terms of McBride's severance agreement somehow implies that she is not or was not disabled lacks merit. First, the terms were negotiated and are a product of the various interest and priorities of both parties. Second, the agreement itself contains a statement that McBride is disabled, invalidating any inference that can be drawn from the document that she is not.

Defendants similarly draw an inference that McBride was not disabled from a change in the number of times McBride visited Neely per month. Such an inference is too tenuous to support a decision to deny benefits. The realities of managed care often cause patients to see a doctor less frequently than they would otherwise choose to, especially in the area of mental health. More importantly, however, any such inference is negated by Neely's explicit statement that McBride was totally disabled during the time she treated her--from November of 1994 through March of 1995. (Plt. Exh. 19).

Additionally, defendants' argument that the policy does not provide benefits for illnesses caused by "environmental factors" is specious and contrary to the terms of the policy. The policy covers total disability because of "injury or sickness" and sickness is defined as "sickness or disease causing loss which begins while the Insured Employee's coverage is in force." (Def. Exhibits, Exh. A). Here, the sickness is a mental illness. The fact that work related stressors may have contributed or triggered McBride's mental disorder is beside the point. On this record, trying to discern whether any disputes with co-workers contributed to McBride's mental disorder or whether her mental disorder caused her to have problems with her co-workers (after years of amicable relations) is a matter of sheer speculation. (See Def. Exhibit, Exh. G). The pertinent issue is whether her mental disorder precluded her from performing the substantial and material duties of her occupation.

## IV. Conclusion

Based upon the foregoing analysis, both motions for summary judgment will be denied. The motion for leave to file the affidavit of Charles H. Meacham will be granted.[5] An appropriate Order follows.

[5]McBride argues that the submission of the affidavit is untimely and prejudicial. Although the submission is slightly out of time, plaintiff has failed to show any prejudice. The Court understands that Mr. Meacham is not a treating physician and has not spoken with any of McBride's physicians. His "understanding" of McBride's disability will therefore be weighed accordingly. More importantly, the affidavit does not contain any information previously unknown to McBride and the contents of the affidavit will not change the result here.

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| **Defendants.** | : | **NO. 97-4625** |

**O R D E R**

**AND NOW** this 11th day of May 1999, upon consideration of cross motions for summary judgment of plaintiff Donna S. McBride (Document No. 35) and defendants Continental Casualty Company ("Continental") (Document No. 32) and Commonwealth Savings Bank's Long Term Disability Plan ("CSB") (Document No. 33), and the supporting memoranda, pleadings, exhibits and affidavits submitted by the parties, having found that there are genuine issues of material fact and that neither the defendants nor the plaintiff is entitled to judgment as a matter of law, and for the reasons set forth in the foregoing memorandum, it is hereby **ORDERED** that the motions are **DENIED**.

**IT IS FURTHER ORDERED** that the request for leave to file the affidavit of Charles H. Meacham (Document No. 38) is **GRANTED**.

**IT IS FURTHER ORDERED** that the parties shall submit a joint report to the Court no later than **June 14, 1999** as to the status of settlement. If the parties need the assistance of the Court in facilitating settlement negotiations, the report shall so indicate. By said date, plaintiff

shall contact the Deputy Clerk to arrange a date for a final scheduling conference.

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**LOWELL A. REED, JR., J.**