UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 07-11839-GAO

BRETT S. LOUIS
Plaintiff

v.

GENWORTH LIFE AND HEALTH INSURANCE COMPANY and DOOR SYSTEMS, INC., LONG TERM DISABILITY PLAN,
Defendants.

OPINION AND ORDER
September 30, 2008

O'TOOLE, D.J.

I. Background

The plaintiff, Brett S. Louis, seeks to recover long term disability ("LTD") benefits under a LTD policy (the "Policy") provided by Genworth Life and Health Insurance Company ("Genworth") under the Door Systems, Inc., Long Term Disability Plan (the "Plan"). Louis brings this claim under section 502 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). He also seeks to recover attorneys' fees, costs and interest pursuant to 29 U.S.C. § 1132(g). At issue is whether the Policy's pre-existing conditions provision excludes Louis' claim from coverage.

The Policy states that benefits will not be paid "[f]or any Period of Disability which is caused by, contributed to by, or results from a Pre-existing Condition." (Record for Judicial Review at 19 [hereinafter Record].) "Pre-existing Condition" is defined by the Plan as:

> A Sickness or Injury for which you, during the Treatment Free Period … before the effective date of your insurance under the policy:
>
> 1. Received medical care, treatment or consultation, diagnosis or diagnostic tests; or
> 2. Took any drugs, medicine or medication prescribed or recommended by a Physician.
>
> An Injury or Sickness may be a Pre-Existing Condition regardless of whether it was diagnosed prior to the effective date of your insurance.

(Id. at 9.) The effective date of the Policy was February 1, 2005. (Id. at 2.) The Policy states that the "Treatment Free Period" is the three month period prior to the effective date (from November 1, 2004 through January 31, 2005). (Id. at 5.)

On November 20, 2005, while attending his son's wedding, Louis fell on a hotel bathroom floor, struck his head, and sustained a traumatic brain injury. Louis submitted a claim for LTD benefits under the Policy, stating that he is totally disabled and unable to work in any occupation as a result of this injury. At that time, he had been insured for less than one year and his claim was therefore subject to the pre-existing conditions exclusion.[1] Genworth denied Louis' claim for LTD benefits initially and after an appeal because it found that his disability was caused by, contributed to by, or resulted from a pre-existing condition. During the Treatment Free Period, Louis had been treated for dystonia[2] (later be diagnosed as Stiff Man Syndrome[3]) which had resulted in episodes

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[1] The "Pre-Existing Limitation Period" is the twelve months after the effective date of the policy. (R. at 5.)

[2] Dystonia is "[a] state of abnormal (either hypo- or hyper-) tonicity in any of the tissues." Stedman's Medical Dictionary 536 (26th ed. 1995).

[3] Stiff Man Syndrom, or Stiff Person Syndrome, is "a rare disease of the nervous system. Progressively severe muscles stiffness typically develops in the spine and lower extremities …. Most patients experience painful episodic muscle spasms that are triggered by sudden stimuli." Johns Hopkins | Neurology & Neurosurgery : Stiff Person Syndrome, http://www.hopkinsneuro.org/disease.cfm/condition/Stiff_Person_Syndrome (last visited September 25, 2008).

where his muscles would contract, become rigid, and lead him to fall down. Louis argues that his fall that led to his brain injury occurred because he slipped on a wet floor, and not because of any pre-existing condition.

II. Standard of Review

The parties dispute whether Genworth was granted discretionary authority to determine eligibility for benefits, thereby triggering the arbitrary and capricious or abuse of discretion standard of review. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan, et al, 402 F.3d 67, 74 (1st Cir. 2005). Louis makes several arguments in support of his contention that a de novo standard of review should apply, none of which are persuasive.

Louis first argues that the Supreme Court's statement in Firestone that "a denial of benefits challenged under § 1132(a)(1)(B) must be reviewed under a *de novo* standard unless the benefit plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits," 489 U.S. at 115, was only dictum not binding on this Court. This argument was made with the express recognition that it was contrary to First Circuit law, but in the hope that the Supreme Court's then-anticipated decision in Metropolitan Life Insurance Company v. Glenn, -- U.S. -- , 128 S.Ct. 2343 (2008), would hold that the conflict of interest present when a plan administrator or fiduciary also has the discretion to determine eligibility for benefits requires a standard of review more favorable to a claimant than the "arbitrary and capricious" standard. In Glenn, the Court held that a conflict of interest should be taken into account as a factor in evaluating whether a plan fiduciary's denial of a claim was arbitrary and capricious, but it also stated that its decision in this respect did not change the standard of review from a deferential one to de novo. Id. at 2350.

Aside from this more general argument, Louis advances several other reasons why a de novo standard should be applied. He contends that the language which purports to grant Genworth discretion to determine claims is not sufficient to do so because it is not contained within the insurance policy. The document he points to as omitting any grant of discretion is the Group Long Term Disability Certificate. (R. at 2–30.) The discretionary-granting language is contained in another document entitled "End of Insurance Certificate." (Id. at 31–33.) It states:

> GE Group Life Assurance Company is a fiduciary, as that term is used in ERISA and the regulations which interpret ERISA, with respect to insurance policies under which you, and if applicable, your dependents are insured. In this capacity, we are charged with the obligation, and possess discretionary authority to make claim, eligibility and other administrative determinations regarding those policies, and to interpret the meaning of their terms and language.
>
> GE Group Life Assurance Company, as Claims Fiduciary, shall have the sole and exclusive discretion and authority to carry out all actions involving claims procedures explained in the Policy. The Claims Fiduciary shall have the sole and exclusive discretion and power to grant and/or deny any and all claims for benefits, and construe any and all issues relating to eligibility for benefits.

(Id. at 33.) Having drawn a distinction between the two certificates, Louis relies on Schwartz v. Prudential Ins. Co. of Am., 450 F.3d 697, 699 (7th Cir. 2006), where the discretion-granting language was contained only in a summary plan description. The Seventh Circuit ruled that because the summary plan description was a separate document required by ERISA to summarize the plan accurately in a manner that could be understood by the average participant, it could not grant discretion without being "an unnegotiated enlargement of the administrator's authority," so that to hold that discretion was granted therein would constitute "allowing the tail to wag the dog." Id. at 700.

However, in this case the End of Insurance Certificate is part of the insurance policy, as is the Group Long Term Disability Certificate. The latter states that it "contains the terms of the Group

Policy that affect your insurance. This Group Certificate is *part* of the Group Policy." (R. at 2) (emphasis added). It does not constitute the *entire* Policy, however, and therefore the absence of discretion-granting language therein is of no consequence. (See id.) Unlike the summary plan description in Schwarz, the discretion-granting document here is not one that summarizes, and therefore is clearly distinct from, the insurance policy, but instead one that provides additional details of the Policy. See 450 F.3d at 700; (R. at 33.) The End of Insurance Certificate begins by stating "[i]f your Employer's benefit plans are subject to the requirements of [ERISA], the following provisions apply…" and lists various terms specifically related to ERISA, including language granting discretion to Genworth as a fiduciary. (See R. at 32.)

Louis further contends that the grant of discretion to Genworth was not accomplished because the Plan Administrator failed to grant discretion to itself first before granting that discretion to a fiduciary. The Plan does not name the Plan Administrator and therefore Door Systems, Inc., as the Plan Sponsor, is the Plan Administrator by default. See 29 U.S.C. § 1002 (16) ("The term 'administrator' means—(I) the person specifically so designated by the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor…."). Louis contends that the plan instrument had first to grant discretion to Door Systems, Inc., before it could be granted to Genworth.

A plan instrument "may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan." 29 U.S.C. § 1105(c)(1). Louis relies on Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 584 (1st Cir. 1993), to suggest that discretion was not properly granted to Genworth. In Rodriguez-Abreu, the plan instrument did not

grant discretion to the Plan Administrator (who denied the claim) but instead granted it "the Named Fiduciaries or their delegates." Id. Because "the Named Fiduciaries did not expressly delegate their discretionary authority to the Plan Administrator," the First Circuit held that a de novo standard of review applied. Id. The problem in Rodriguez-Abreu was not with the first grant of discretion (to the Named Fiduciaries), but rather that there had been no second delegation of that discretion from the Named Fiduciaries to the Plan Administrator that had actually decided the claim. See id. Only one grant of discretion is attempted here—to Genworth, the fiduciary that decided Louis' claim—and Louis' argument provides no reason why that grant was not successful.

Louis also argues that Genworth failed to exercise its discretion in a timely manner, and therefore should be stripped of discretion. The First Circuit has declined to decide whether a failure to render a timely decision entitles a claimant to de novo review, or whether a plan's substantial compliance with ERISA can save it from that consequence. See Bard v. Boston Shipping Ass'n, 471 F.3d 229, 236 (1st Cir. 2006). In Bard, the claimant had filed suit on a "deemed exhausted" basis because the plan had yet to resolve his benefits claim. Id. at 235. The court noted that "[c]ases from other circuits, all governed by the old ERISA regulations [containing a similar "deemed denied" provision], have held that a de novo standard of review may be proper in deemed denial cases—though some of these cases have also examined whether there has been 'substantial compliance' with ERISA and/or the plan's terms." Id. at 236. However, the court expressly did not reach the "invitation to join those circuits holding that a plan's ERISA violations will strip it of the

deference its decisions otherwise enjoy," id. at 230, and decided the case on another basis.[4] Bard provides no basis for stripping the defendants of the deferential standard of review.

Because Genworth was granted discretionary authority to determine benefits eligibility, the arbitrary and capricious or abuse of discretion standard is the proper one by which to review Genworth's denial of Louis' claim. See Wright, 402 F.3d at 74. Under that standard, the decision to deny benefits is upheld if it was "reasoned and supported by substantial evidence." Gannon v. Metro. Life Ins. Co., 360 F.3d 211, 213 (1st Cir. 2004). "Evidence is substantial if it is reasonably sufficient to support a conclusion. . .." Id. A court may not substitute its own judgment for that of the decision maker. Terry v. Bayer Corp., 145 F.3d 28, 40 (1st Cir. 1998).

As noted earlier, the Supreme Court recently held that a conflict of interest exists when a plan administrator or fiduciary both evaluates claims for benefits and pays benefits claims. Glenn, 128 S.Ct. at 2348. Because Genworth is both the payor of benefits and evaluator of claims, such a conflict of interest exists here. However, mere existence of the conflict does not change the standard of review, which continues to be deferential. See id. at 2350. It is rather "one factor among many that a reviewing judge must take into account." Id.

A court's review in the ERISA context is typically based only on the administrative record, and "the district court sits more as an appellate tribunal than as a trial court…." Leahy v. Raytheon Co., 315 F.3d 11, 18 (1st Cir. 2002). Summary judgment is the proper vehicle by which to evaluate the reasonableness of the administrative determination in light of that record, but "the non-moving

[4] The court explicitly stated its holding: "when a plan with material ambiguous terms violates ERISA in a manner that BSA-ILA [the benefits plan] did, and a claimant's application is prejudiced by these violations through his reliance on a reasonable interpretation that the plan does not ultimately adopt, we will bar the plan from using the claimant's reliance against him." Bard, 471 F.3d at 237.

party is not entitled to the usual inferences in its favor." Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 517 (1st Cir. 2005).

III. Choice of Law

Louis argues that New York law applies. New York disability insurance law would be favorable to Louis, as Genworth could only rely on the pre-existing conditions exclusion to avoid paying benefits for twelve months. See Benesowitz v. Metro. Life Ins. Co., 514 F.3d 174, 175–76 (2d Cir. 2007) (insurers may toll benefits pursuant to a pre-existing conditions exclusion during the first twelve months of coverage, but cannot impose an absolute bar to coverage). However, the Policy clearly states "State of Issue: Rhode Island," and that it "is governed by the laws of the State of Issue shown above which is the state of issue of the group policy." (R. at 2.) Louis argues that New York law should nevertheless be applied because the "W-2 Service Agreement" between Genworth and Door Systems, Inc. states that it is governed by New York law. (See id. at 340–41.) This agreement does not purport to be part of the Policy, and is explicitly limited to the preparation of W-2 forms. (See id.) I agree with the defendants that the Policy is not governed by New York law. Because no other issues in the case depend on what state's insurance law governs the Policy, a more involved choice of law analysis is not necessary.

IV. Review for Abuse of Discretion

After reviewing the Record and the submissions of the parties, I conclude that Genworth's denial of Louis' claim for LTD benefits under the Policy was not an abuse of its discretion.

A. Genworth's Conclusion that Dystonia is a "Sickness"

Louis argues that dystonia is a movement disorder and not a "Sickness," which is defined under the Policy as "Disease or illness, Mental Illness, Substance Abuse or pregnancy." (See R. at 10.) The Policy does not define "Disease or illness." (See R. at 2–33.) A "disease" is "[a]n interruption, cessation, or disorder of body functions, systems, or organs," Stedman's Medical Dictionary 492 (26th ed. 1995), or as "a condition of the living animal … or of one of its parts that impairs the performance of a vital function." Webster's New Collegiate Dictionary 324 (1979). A movement disorder such as dystonia can be considered a "Disease" under the Policy.

Furthermore, this argument ignores the fact that Louis' condition was ultimately diagnosed as Stiff Man Syndrome, which is explicitly defined as a disease. See *supra* note 3. To the extent the name given the condition might be thought to matter, the Policy states that "[a]n Injury or Sickness may be a Pre-Existing Condition regardless of whether it was diagnosed prior to the effective date of your insurance," and therefore a contemporaneous specific diagnosis is not required. (See R. at 9.)

Genworth therefore did not abuse its discretion by considering Louis' condition to be a "Sickness."

B. Genworth's Conclusion that Louis had a Pre-existing Condition

Louis argues that his brain injury, the basis for his disability, does not constitute a pre-existing condition. (See Pl.'s Mem. in Supp. of his Mot. for J. on the R. 20.) He is right, but his point misreads the language of the Policy: the disability for which benefits may be paid does not *itself* have to be the pre-existing condition for the exclusion to be effective. (See R. at 9, 19.) Rather, there is

an exclusion from coverage for a disability that is "caused by, contributed to by, or results from a Pre-existing Condition…." (Id. at 19.) The condition that causes, contributes to, or results in the disability qualifies as a "Pre-existing Condition" if it is "[a] Sickness or Injury for which you, during the Treatment Free Period …." received medical treatment or took medication. (Id. at 9.)

The Record establishes that during the three month "Treatment Free Period" prior to the Policy's effective date, Louis was treated for dystonia and prescribed Klonopin and Mirapex by Dr. Nutan Sharma. (R. at 715–16.) Although his condition was later diagnosed as Stiff Man Syndrome (see id. at 224–25), it was essentially the same condition that had previously been described as dystonia, albeit more seriously developed. (Pl.'s Rule 56.1 Statement ¶ 12.)

After the Treatment Free Period, and during the time leading up to the brain injury, Louis continued to be treated for his condition, which the reports indicate was worsening (See id. at 718–24.) In particular, Dr. Sharma's reports from these visits note that Louis had "multiple falls at home," (id. at 719) and on November 11, 2005 (nine days prior to the accident) that "[s]ince his last visit, Mr. Louis has had a couple of falls," one of which was described as "an episode in which the entire body goes rigid and he falls without the ability to use any self-preservation/self-righting reflexes." (Id. at 723.) Genworth did not abuse its discretion by concluding that Louis had a pre-existing condition as defined under the Policy. Accordingly, if Louis' disability was caused by, contributed to by, or resulted from his condition, it would be excluded from coverage.

C. Genworth's Conclusion that the Pre-existing Condition Caused, Contributed to, and Resulted in his Disability

Louis makes two arguments related to causation in support of his contention that Genworth abused its discretion by denying his disability claim. The first addresses the Policy's definition of causation as "caused by, contributed to by, or results from." (See R. at 19.) The second argues that Genworth abused its discretion by relying on unreliable evidence to reach its conclusion as to causation.

1. Defining Causation

Louis argues that an average person would not be able to discern what is excluded from coverage under the pre-existing condition exclusion. Insurance contract "terms must be given their plain meanings, meanings which comport with interpretations given by the average person." Wickman v. Northwestern Nat'l Ins. Co., 908 F.2d 1077, 1084 (1st Cir. 1990). In Louis' view, the phrase "caused by, contributed to by, or results from," is ambiguous because it is unclear whether it means the causation or contribution must have been (1) in whole or in part; (2) directly or indirectly; or (3) a substantial contributing factor but not the sole cause, or a consequence of. (Pl.'s Mem. in Supp. of his Mot. for J. on the R. 24.) Accordingly, Louis argues that a layman's interpretation should prevail which would give this phrase a more limited scope.[5]

[5]Louis urges the application of *contra proferentum* to construe the ambiguous definition against the insurer. See Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264, 268 (1st Cir. 1994). That, doctrine, however, may only be applied under a de novo standard of review. Stamp v. Metro. Life Ins. Co., 531 F.3d 84, 93 (1st Cir. 2008).

Louis cites Vickers v. Boston Mut. Life Ins. Co., 135 F.3d 179, 180 (1st Cir. 1998), in which the insured died in a car crash after suffering a heart attack. The heart-attack was non-fatal, and therefore the injuries sustained in the accident were the medical cause of death. Id. The insurance policy stated that benefits would be paid "for loss from bodily injuries: a) caused by an accident … and b) which, directly and from no other causes, resulted in a covered loss." Id. Although the heart attack was both a cause in fact and a proximate cause of the death, the court stated that "[t]his is no answer when we are interpreting the word 'cause' in a layman's insurance policy," and held for the insured. See id. at 181–82.

If the language used in Louis' policy included only "caused by" and "resulted from," Vickers might be more helpful to Louis, as causation in the law is a bit of a term of art from which a layman's understanding of causation might diverge. In any event, the use of "contributed to" suffices to make the breadth of the exclusion clear to a layman. In Vickers, the court noted that "[s]urely Vickers' family thinks of him as having been killed in an automobile accident." Id. at 180. Rephrasing this point, it might be said that Vickers' family thought of his death as being *caused by* an automobile accident. See id. Similarly, Louis thinks of his disability as being *caused by* a fall in which he struck his head. But, if his condition played any role in his fall, it would also be consistent with a layman's understanding to say that his condition *contributed to* his disability.

Put another way, the problem in Vickers was not the meaning of the language, but that the language did not adequately convey the intended meaning to the policy holder. See id. at 181–82. The plain meaning of the language circumscribed less territory than the technical legal meaning. See id. Here, the inclusion of the words "contributed to by" solves that problem. (See R. at 19.)

2. Genworth's Reliance on Statements in the Record as to Causation

Louis also argues that Genworth's conclusion that his pre-existing dystonia or Stiff Man Syndrome caused, or contributed to, his actual fall was not based on reliable evidence, specifically statements in medical records that Louis' fall was reportedly caused by a dystonic episode.

First, to the extent this objection is that the statements relied upon were hearsay, it is not well taken. Genworth was not required to disregard information contained in Louis' claims file unless the information would be admissible in a formal civil trial. Karr v. Nat'l Asbestos Workers Pension Fund, 150 F.3d 812, 814 (7th Cir. 1998) (Posner, C.J.) ("A pension or welfare fund trustee or administrator is not a court. It is not bound by the rules of evidence.")

Louis' greater point is that Genworth improperly rejected his contention that he slipped on a wet floor on the basis of statements that were not reliable. The Record contains multiple statements from different sources that (1) attribute Louis' fall to a dystonic episode as well as alcohol intake, and (2) fail to make any mention of a wet floor. The sources of these statements include an Ambulance Service report of November 20, 2005, stating that Louis' wife said that "his Dystonia acted up and he was unable to catch himself [and] he struck his head and fell to the floor," (R. at 507), as well as several other medical records from the emergency room, (see id. at 500, 505), and from subsequent medical visits, all to that effect. (See id. at 239, 465, 472, 475, 534, 537, 663.) In a declaration dated November 16, 2006, Louis' wife explained that when Louis had entered the men's room she "stood inside the door to watch him," and "saw Brett walk from a stall to the sink. He fell forward and hit is head on the sink …. Then he fell backwards striking the back of his head on a marble floor." (Id. at 297.) There was no mention of a wet floor. (See id.)

On March 12, 2007, Genworth communicated to Louis a preliminary determination of his appeal, stating its conclusion that Louis' disability was "caused by, contributed to, or resulted from" his pre-existing condition. (Id. at 213.) Genworth noted that it would keep Louis' file open for thirty days so that Louis could submit further information if necessary. (See id.) It was not until after receiving this preliminary denial of Louis' appeal that evidence was put forth regarding a wet floor. In a supplemental declaration dated April 12, 2007, Louis' wife stated that "[m]y pants legs had become wet as the pants had absorbed water from the bathroom floor when I knelt down to assist my husband immediately after his fall." (Id. at 146.) Louis also submitted a declaration dated April 13, 2007, stating that "[o]n Sunday, November 20, 2005, I fell in the bathroom in the public men's room … and hit my head on the sink and the marble floor, solely because the floor was wet with water and was slippery." (Id. at 151.) The Record also contains a declaration from Dennis Handy, dated April 5, 2007, stating that he was in the men's room at the time of the accident and had noticed that the floor was wet. (Id. at 160.)

In Genworth's letter communicating its final denial of Louis' appeal, it noted that Handy's declaration "is not inconsistent with the other information provided to us, except that he did not actually witness Mr. Louis' fall." (Id. at 135.) As to Louis' wife's declaration, Genworth noted that she was a nurse and had been the original source of the statements in some of the medical reports attributing Louis' fall to dystonia. (Id.) It also noted that neither her previous declaration nor any of the medical reports that contain information provided by her made any mention of a wet floor. (Id. at 135–36.) Similarly, Genworth explained that Louis' more recent declaration was the first time he attributed his fall to a wet floor, and noted in particular that Louis had filled out one disability claim form only weeks after the fall on December 12, 2005, and a second on March 17, 2006, describing

how he had fallen without any reference to a wet floor. (Id. at 136.) Genworth determined that these newer statements "do not negate a final determination and conclusion that Mr. Louis' fall which caused his current condition can reasonably be found to have been 'caused by, contributed to by, (and) result from a Pre-existing condition' coverage for which is specifically excluded. . .." (Id. at 139.)

Genworth's decision was reasonably supported by the evidence in the Record, which contains numerous statements attributing Louis' fall to his pre-existing condition and not to a slip on a wet floor. There was no reason for Genworth to find that these reports were unreliable and disregard them. Indeed, even if the Federal Rules of Evidence did apply, there is an exception from the usual exclusion of hearsay for "[s]tatements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment." Fed. R. Evid. 803(4). It was reasonable for Genworth to give greater weight to the more contemporaneous reports, including those made for the purpose of diagnosis or treatment, attributing Louis' fall to dystonia and describing the fall without any reference to a wet floor than to the much later statements asserting for the first time (following a preliminary letter of denial) that the wet floor caused the fall. On a deferential standard of review it is not for a court to conduct its own independent re-weighing of the evidence.[6] Cf. Orndorf, 404 F.3d at 518 ("[D]e novo review generally consists of the court's independent weighing of the facts and opinions in [the] record….").

[6] Furthermore, of these more recent statements, only Louis himself stated that the wet floor actually caused the fall. Even assuming that Louis had slipped on the wet floor, if his pre-existing condition prevented him catching himself or otherwise stopping or mitigating his fall, that condition could be said to have "contributed to" his disability.

Genworth's decision to deny Louis' claim as excluded from coverage by the pre-existing conditions provision was "reasonable and supported by substantial evidence," not arbitrary, capricious, or an abuse of discretion, and therefore must be upheld. See Glista v. Unum Life Ins. Co. of Am., 378 F.3d 113, 125 (1st Cir. 2004).

V. Conclusion

For the foregoing reasons, the defendants' motion for summary judgment (dkt. no. 9) is GRANTED and the plaintiff's motion for summary judgment (dkt. no 12) is DENIED. Judgment shall enter for the defendants.

It is SO ORDERED.

/s/ George A. O'Toole, Jr.
United States District Judge