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REPORT OF THE SUBCOMMITTEE ON
BENEFIT CLAIMS

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II. Claims Procedures

B. Reasonable Claims Procedures

Bond v. Twin Cities Carpenters Pension Fund, 307 F.3d 704; 29 EB Cases 1001 (8th Cir. 2002): A retired union carpenter brought action against a pension fund for reimbursement of costs associated with determining his benefit eligibility. The plan required its participants to first seek a benefit determination through the plan's board of trustees. If not satisfied with the determination, then the participant's sole remedy was to submit to binding arbitration. The plan directed participants to bear half the costs of arbitration, unless the arbitrator alters this presumption in his or her decision. The district court granted judgment for the fund; the circuit court reversed and remanded. Following the regulations in effect in 1999 when the participant filed his claim, the court held that the plan unduly inhibits the pursuit of ERISA claims, and thus is not in accord with ERISA's statutory and regulatory framework. Guided by a Department of Labor opinion letter, the court found that when a plan requires a participant to submit to arbitration, cost-splitting contravenes the reasonableness standard set forth in 29 C.F.R. §2560.503-1(b). The court noted that the new amendments to the regulations confirmed this finding.

Chapman v. ChoiceCare Long Island Term Disability Plan, 28 F.3d 506, 27 EB Cases 2505 (2nd Cir. 2002): Plaintiff was employed as a recovery specialist. Her last day of employment was in mid January 1995. Plaintiff claimed to no longer be able to work as result of a mental disability. In November of 1996, Plaintiff applied for, and was denied LTD benefits based on failure to timely apply. In a letter to plaintiff's counsel dated January 29, 1997, the insurance company cited the policy's proof of claim provision, which states that proof must be given "no later than 90 days after the end of the elimination period" or "as soon [thereafter] as reasonably possible." The "elimination period" is defined in the policy to be a period of 90 days in which no benefit is payable. Although the policy says nothing about what qualifies as "reasonably possible," the letter denying benefits explains that proof will not be considered if submitted later than one year after the deadline. Plaintiff appealed the denial and was denied again. The Plan required Plaintiff to apply for benefits within 90 days of the close of the elimination period, or as soon as was "reasonably possible." The policy defined the elimination period as 90 days after no benefit is payable. Further, the Plan required that any appeal be made within 60 days of the adverse determination. The court did not reach the issue of the denial of the appeal, as that was remanded to the District Court for a determination if the deadline was even applicable. (It was never mentioned in the policy, the SPD, or the denial letter.) The court went on to conclude that the 60-day deadline may have been equitably tolled due to the brevity of the delay and the nature of Plaintiff's mental condition.

Dunnigan v. Metropolitan Life Insurance Co., 277 F.3d 223; 27 EB Cases 1257 (2nd Cir. 2002): Insurance company denied application for long term disability benefits approximately 125 days after request. The insurance company denied the appeal approximately 165 days later and stated that no other appeals were allowed. In addition, the insurance company did not inform the plaintiff of any special circumstances requiring extension of the time period to make a decision. After hiring a lawyer, plaintiff made additional appeals. Inexplicably, the insurance company reversed its prior denials and granted retroactive benefits without interest. The court found, absent a good cause shown for justifying the longer period, it is arguable that the time period specified in the regulations for making determinations defines the duration of the reasonable period during which the Plan is not chargeable with an interest obligation. The court noted the Supreme Court's ruling in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 144, 105 S.Ct. 3085, 87 L.,Ed.2d 96 (1985) that an untimely decision does not give the beneficiary an entitlement to

consequential damages is not inconsistent with the use of the period specified in the regulations as the measure of reasonable delay or with a ruling that unexcused delay can give rise to an obligation to pay interest.

Gruber v. UNUM Life Ins. Co. of America, 195 F. Supp. 2d 711 (D. Md. 2002): This enforced the plan's period of limitation for filing an appeal because the claimant was afforded an opportunity for a full and fair review. Claimant's disability benefits were terminated because she received workers compensation and social security benefits. She also reached the two-year limit on benefits for a mental disability. The appeal was filed months after the expiration of the 60-day period under the plan and applicable version of 29 CFR 2560.503-1(g)(3). Plaintiff argued that this tardiness should be excused due to her attorney's hospitalization, the inadequacy of the denial letter under the DOL Claims Procedure and the futility of filing an appeal. The court found the letter denying the appeal was adequate and rejected the remaining two reasons for tolling the period of limitation.

Sanfilippo v. Provident Life and Casualty Insurance Co., 178 F. Supp. 2d 450, 27 EB Cases 1732 (S.D.N.Y. 2002): This enforced a 60-day period to appeal the denial of a disability claim which was clearly defined in the SPD. The 60-day period also complied with the then effective DOL Claims procedure at 29 CFR 2560.503-1(h)(2)(I). Claimant had no acceptable reason for her tardy appeal and could not show exhaustion of the administrative procedure would have been futile.

C. Adequate Notice of Claim Denial

Caldwell v. Life Insurance Company of North America, 287 F.3d 1276; 27 EB Cases 2511 (10th Cir. 2002): Insurer denied a long term disability claim on the grounds that the participant did not meet the "own occupation" definition. By implication, but without any explanation, the plan also denied the claim on the basis that the participant did not meet the "any occupation" definition in the plan. The district court found in favor of the participant on the "own occupation" definition, but upheld the implied denial under the "any occupation" definition. The Circuit concluded the district court erred in reaching the merits of the "any occupation" claim, holding that ERISA Section 1133(1) requires that a claims administrator provide adequate notice to any participant whose claim has been denied, "setting forth the specific reasons for such denial. ..." 29 U.S.C. §1133(1). No such reasons appeared in the denial letter and the court remanded to the district court to remand to the Plan Administrator for a full and fair review.

Flint v. ABB, Inc., 2002 WL 31465644 (S.D. FL 2002): Participant in a LTD plan whose benefits were terminated and later reinstated brought an action to recover accrued interest on reinstated benefits. Plaintiff was disabled as a result of an automobile accident and began drawing LTD benefits. Approximately three years later, the Plan notified Plaintiff that he was no longer totally disabled and would not be receiving any further benefits. The court found that the letter advising Plaintiff of the termination of benefits contained sufficient explanation as to comply with ERISA. Specifically, the letter outlined the reasons for the termination of benefits made reference to the particular Plan provision used to terminate benefits, and advised Plaintiff of how to perfect an appeal, and the timelines in which he could do so.

Olive v. American Express Long Term Disability Benefit Plan, 183 F. Supp. 2d 1191; 27 EB Cases 2020 (S.D. CA 2002): Plaintiff underwent abdominal surgery and was away from work as a result of a disability. MetLife contacted Plaintiff and explained that she was now eligible to apply for LTD benefits. An application for benefits and instructions on how to enroll were included with the correspondence. Plaintiff completed and returned the application. The application was denied. She requested, and was granted, a medical review. Plaintiff was sent a letter advising her that the

application for benefits had been denied, the decision was final and would remain in effect. The letter sets forth the information used in making the determination and advises Plaintiff of the availability of a review process. However, it does not set forth what additional information should be provided, provide definitions of terms used, or give an explanation of the objective information required to determine medical necessity. As a result, the court concluded that it failed to provide Plaintiff with adequate notice as it does not indicate whether the claim is medically or procedurally deficient or offer any indication as to what additional information is needed to complete the claim. Since the Plan only provided for one level of review, the insufficient notice warranted application of the *de novo* review standard.

Hickman v. Gem Ins. Co., Inc., 299 F.3d 1028, (10th Cir. 2002): Complainants alleged the insurance company did not comply with Section 503 or the claims procedure regulation when it denied their appeals of health benefit claims concerning the calculation of usual and customary fees. Claimants maintained the written denial of the claims did not contain sufficiently specific reasons, references to the plan, information about perfecting the claims or steps to be taken for further review. The district court and the Tenth Circuit ruled that a deficient denial notice does not necessarily result in a substantive remedy. There was no substantive harm in this matter because the method of calculating usual and customary fees was neither ambiguous nor contrary to the contract.

D. Full and Fair Review and Access to Pertinent Documents

Johannssen et. al., v. District 1 – Pacific Coast District, Meba Pension Plan, 292 F.3d 159, 27 EB Cases 2838 (4th Cir. 2002): Plaintiffs were denied prior pension credit, despite a 1992 amendment that granted such pension credit. The employer/sponsor was a union whose prior leaders were convicted of election fraud and embezzlement. Plaintiffs were political allies of the incarcerated union officials. The new union leadership refused to recognize the validity of the 1992 amendment. The Fourth Circuit determined claimants had not received a full and fair review, affirmed the district court’s use of the *de novo* standard and ruled the 1992 amendment granting prior pension credit was valid.

Bond v. Twin Cities Carpenters Pension Fund, 307 F.3d 704, 29 EB Cases 1001 (8th Cir. 2002): A requirement that a claimant split the cost of an arbitrator to appeal an adverse claim decision under a pension plan was struck down by the Eighth Circuit as a violation of the full and fair review provision of Section 503. The claim was governed by the former claims procedure, and the Court found that the cost-splitting requirement violated both the former and the amended regulation. The court noted that the amended DOL claims procedure specifically bars a requirement that a claimant pay fees related to an appeal. 29 C.F.R. 2560.503-1(b)(3).

Moffett v. Halliburton Energy Services, Inc., 291 F.3d 1227, 28 EB Cases 1824 (10th Cir. 2002): The court denied plaintiff’s claim for improperly withholding information where the claimant’s request for information was vague and did not specifically identify the information allegedly withheld.

Caldwell v. Life Insurance Co. of North America, 287 F.3^d 1276, 27 EB Cases 2511 (10th Cir. 2002): The Tenth Circuit ruled that the administrator inappropriately relied on the disability determinations of the state workers compensation agency and social security and concluded that plaintiff was disabled from performing his “own occupation.” The Court of Appeals reversed the district court and referred to the administrator for a more thorough determination as to whether the plaintiff was unable to perform “any occupation”. The question whether a vocational expert was required for a full and fair review was also referred to the administrator with instructions that the court would examine the need for vocational experts on a case by case basis.

American Medical Association v. United Healthcare Corp., 2002 U.S. Dist. LEXIS 20309 (S.D.N.Y. 2002): This involves another decision in a case brought by out-of-network physicians who requested information about the insurer's usual, customary, and reasonable ("UCR") fees. The 2002 decision dismissed the Section 503 claim against the Plan Administrator because the duty to provide a full and fair review pertains only to the plan - not the Plan Administrator. The court also dismissed requests for Section 502(c) penalties against the administrator where individual claimants failed to submit written requests for information as required in Section 104(b)(4). The court, however, declined to dismiss the Section 502(c) claims of those individuals who submitted written requests because it was too early in the proceeding to determine whether claimants had a right to UCR information under Section 104(b)(4).

Reedstrom v. NOVA Chemicals, 2002 U.S. Dist. LEXIS 22513 (S.D. Okl.): The court rejected claimants' action for severance benefits, despite a deficient administrative record that did not contain a written denial of benefits. The employer distributed downsizing guidelines, which provided, in part, that severance benefits would not be paid if an employee left before the end of the year. Claimant resigned before the deadline and only received verbal communications denying his request for severance benefits. The court did not cite the claims procedure regulation, but ruled that a *de novo* review was appropriate because claimant, in the absence of a written record, did not receive a full and fair review pursuant to Section 503. There was also a financial conflict of interest. Under *de novo* review, claimant was not eligible for severance benefits because he resigned before the deadline in the employer's written guidelines.

Carney v. IBEW Local Union 98 Pension Fund, 28 EB Cases, 2272 (E.D. Pa. 2002): The court held that the plan could not apply new amendments retroactively or rely on defenses not raised during the administrative review. The administrator's physician certified claimant as permanently and totally disabled, which qualified claimant for benefits under existing plan language. The plan then was amended to require eligibility for social security disability benefits, and the claim was denied on the basis on the new amendment. Claimant requested the Trust Agreement, minutes of trustee meetings and actuarial reports. The trust agreement and the minutes were delivered after the 30-day grace period, but the actuarial reports were never delivered. The administrator raised defenses before the court that were not raised during the administrative review, e.g., inadequate medical conclusions and suspicion that claimant was working. The court rejected these new defenses as post hoc rationalizations and awarded plaintiff a disability pension. The request for penalties under Section 502(c) was denied because complainant had his pension and there was no prejudice or bad faith.

Leung v. Skidmore, Owings & Merrill, 213 F. Supp. 2d 1097, (N.D. Cal. 2002): The court held that Section 104 only pertains to the "latest" information regarding the operation of the plan and not outdated documents. Plaintiff was the surviving spouse of an employee who was terminated after his receipt of long-term disability benefits. The employee died a few years later and the spouse requested information about the employer's present and past life insurance plans. She never received documents concerning old policies. The court dismissed her subsequent claim for penalties under Section 502(c) ruling that Section 104 only pertains to the "latest" information.

Sentara Virginia Beach General Hospital v. Le Beau, 182 F. Supp. 518 (E.D. Va. 2002): The employer cancelled its health insurance policy and failed to inform the hospitalized employee of the cancellation. The surviving spouse unsuccessfully requested documents about the insurance policy from the insurance carrier and filed an action. The insurance carrier argued that it was not the administrator and therefore was not obliged to produce documents pursuant to Section 104. The court denied summary judgment and held that, as a matter of law, it could not rule out the possibility the insurance carrier was Plan Administrator.

Suozzo v. Bergreen, 28 EB Cases 1916 (S.D.N.Y. 2002): A secretary alleged that the employer refused to provide requested copies of amendments to the pension plan, as well as other pertinent documents. The court ruled complainant did not have standing to maintain an action for failure to disclose information to third parties.

Colarusso v. Transcapital Fiscal Systems, Inc. Top Hat Value Added Plan, 2002 U.S. Dist. LEXIS 19865 (D.N.J. 2002): This case confirmed that a request for information pursuant to Sections 104(b)(4) and 105(a) must be in writing, but an oral request is sufficient to trigger a duty to provide a summary plan description under Section 104(b)(1). Complainant had a split dollar life insurance and supplemental retirement plan through his employer. When the plan was terminated, Section 104(b)(1) mandated issuance of an amended summary plan description within 210 days of the end of the plan year. Claimant's oral request for an amended summary plan description, however, triggered a duty to provide it within 30 days pursuant to Sections 104(b)(1) and 502(c). The court ruled that the administrator's misrepresentations and delay constituted bad faith and justified penalties. The administrator was assessed Section 502(c) penalties at a rate of \$50.00 per day, which totaled \$46,400.00, plus interest.

Sunderline v. First Reliance Standard Life Insurance Co., 2002 U.S. Dist. LEXIS 22646 (W.D.N.Y. 2002): Plaintiff's long-term disability benefits were terminated when she returned to work on a part-time basis. She contested this decision and requested a summary plan description from the insurer. The insurer referred her to the employer/administrator who sent her the insurance policy. The court ruled that the insurance policy did not meet the requirements for a summary plan description under Section 102 and assessed a penalty of \$17,000. The court also ruled the insurer had no contractual obligation to indemnify the employer for the penalty.

Alves v. Harvard Pilgrim Health Care, Inc., 204 F. Supp. 2d 198, 28 EB Cases 1799 (D. Mass. 2002): The court ruled that ERISA does not require a summary plan description to provide cost sharing information, and such information need not be volunteered in the absence of a request pursuant to Section 104 or 105.

Smith v. Champion International Corp., 220 F. Supp. 2d 124, 28 EB Cases 2846 (D. Conn. 2002): The employer, Champion, entered into an agreement with a cost control company, CORE, to reduce claims under its long-term disability plan. After plaintiffs' long-term disability benefits were terminated, they brought a Section 503 class action against CORE alleging failure to grant a full and fair review of their claims. The case was dismissed because CORE was not a fiduciary and only made recommendations. Champion retained the role of administrator and fiduciary.

DeLeon v. Bristol-Myers Squibb Co. Long Term Disability Plan, 203 F. Supp. 2d 1181 (D. Or. 2002): This case also involved CORE. Bristol-Myers' agreement with CORE made CORE an ERISA fiduciary under the disability benefit plan. CORE denied the plaintiff's disability appeal, sent some information in response to plaintiff's written request, and referred plaintiff to the employer for the remainder of the information. The court ruled that CORE abused its discretion by ignoring the opinions of the treating physicians and crediting the opinion of its physician who never examined complainant. In assessing penalties against CORE, the court observed that Section 503(2) does not create a right to receive documents until the claim has been denied. CORE was penalized \$100 per day for the first 14 days and \$50 per day for the following 51 days.

Combe v. La Madeleine, Inc., 2002, U.S. Dist. LEXIS 21602 (E.D. La. 2002): The administrator of a health plan pre-certified plaintiff's corrective surgery as "medically necessary", but warned that the pre-certification did not guarantee payment. After a \$119,626.90 surgery, the administrator paid only \$8,158.05. Later, the administrator characterized the surgery as TMJ-related,

which had a lifetime benefit of only \$1,000. The administrator filed a cross-claim for \$7,158.05 and filed a motion for summary judgment. The court denied the motion for summary judgment and ruled the administrator had abused its discretion. The claimant had not received a full and fair review because it was unreasonable to characterize claimant's complex jaw surgery as TMJ.

Tholke v. Unisys Corp., 2002 U.S. Dist. LEXIS 6658 (S.D.N.Y. 2002): The court held the administrator abused its discretion and remanded the disability claim to the administrator for a full and fair review. There were medical and job-related inconsistencies in the record that no member of the administrative review panel questioned. A full and fair review of an appeal must involve more than rubber stamping an initial report.

Tilton v. United Health Care of Louisiana, Inc., 2002 U.S. Dist. LEXIS 16875 (E.D. La. 2002): An OBGYN corrected a number of the patient's problems during one surgery. He billed \$11,355.00. The insurance company made two payments of \$1,400.00 and \$691.25. The OBGYN contested the payment, which was reviewed by a claims processing employee, and the insurance company's internist. They denied the appeal on grounds the OBGYN received the usual and customary fee for one surgery. The court ruled that the administrative appeals process had not been exhausted and remanded the case to the administrator. The court admonished the administrator, stating that a full and fair review would require a thorough analysis of the claim and the involvement of an OBGYN.

Bahnaman et. al. v. Lucent Technologies, Inc., 219 F. Supp. 2d 921, 27 EB Cases 2860 (N.D. Ill. 2002): The court granted the administrator's motion for summary judgment on plaintiff's pension benefit claims. The court found plaintiff received a full and fair review under 29 CFR 2560.503-1(h)(2). Although the same person drafted both rejection letters, the court found there were different decision-makers.

Thompson v. Life Insurance Co. of North America, 27 EB Cases 1874 (10th Cir. 2002) (*unpublished*): The Circuit rejected an "actively at work" defense because it was not raised during the administrative review. The court also found the pre-existing condition defense was not a reasonable defense because the pre-existing condition was cardiovascular and the disability was due to pulmonary disease.

Cox v. Reliance Standard Life Insurance Co., 28 EB Cases 2750 (4th Cir. 2002) (*unpublished*): After a fight with his wife, the deceased broke into his locked house. In response to a report of a possible burglary, the police entered deceased's bedroom. The deceased pointed a gun at the police, who shot and killed him. The administrator of the life insurance policy refused to pay the death benefit alleging the deceased was killed while engaging in a felony, i.e., assaulting police officers. The district court and the Fourth Circuit held the administrator had not given the claim a full and fair review. The court found that no reasonable administrator could conclude that the deceased knew the men in his bedroom were police officers.

Browning v. A.T. Massey Coal Co. Employees' Comprehensive Benefit Plan, 28 EB Cases 1533 (S.D. W. Va. 2002) (*unpublished*): A coal miner's disability claim was denied 361 days after it was filed. Claimant appealed and submitted a written request for a copy of his job description, which was never received. During the lawsuit, it was disclosed that the administrator's physician was given a supervisor's job description rather than the claimant's. The court struck the administrator's "self-serving" evidence as untimely under the pre-trial order and awarded the disability pension, finding an abuse of discretion. The court denied Section 502(c) penalties because the requested job description was not a "formal legal document used to set up or manage the plan" under Section 104(b)(4). No penalties were awarded for non-compliance with the time requirements

of the claims procedure regulations. The court held that penalties are not authorized for an administrator's late response.

Hackett v. Xerox Corp. Long Term Disability Income Plan, 2003 U.S. App. LEXIS 264 (7th Cir. 2003): The Seventh Circuit reinstated plaintiff's benefits because he did not receive "full and fair review" of the plan's decision to terminate his long-term disability benefits. The physicians' reports on which the plan relied conflicted with numerous prior reports and provided no basis for the plan's change in position. The court found that the plan had failed to comply with the ERISA obligation to provide "specific reasons" for benefit denials. The court recognized that the plan administrator was free to initiate a new review of Hackett's eligibility for benefits once benefits were reinstated and to terminate Hackett's benefits if he were found not to be disabled upon a full and fair review of his claim.

E. Remedies for Procedural Violations

Hickman v. Gem Ins. Co., Inc., 299 F.3d 1028, 28 EB Cases 2867 (10th Cir. 2002): Complainants maintained the written denial of the claims did not contain sufficiently specific reasons, references to the plan, information about perfecting the claims or steps to be taken for further review. The Circuit ruled that a deficient denial notice does not necessarily result in a substantive remedy.

Watson v. Deaconess Waltham Hospital, 298 F.3d 102, 28 EB Cases 1993 (1st Cir. 2002): The participant claimed employer violated its fiduciary obligation by not informing him of the existence of the LTD plan or giving him the proper plan documents when he was eligible for the plan, and by not mentioning the loss of LTD eligibility when he made the change to part-time employment in March 1996. He brought suit under 1132 (a)(3) for equitable relief. The Court found that the employer did not actively conceal its policy and there were no allegations that it regularly failed to comply with notice requirements. The employer held an annual "benefit fair," scheduled for the open enrollment period, which all of the benefits carriers attended in order to answer employees' questions. Further, new employees, including the plaintiff, regularly received a checklist of benefits for which they were eligible. The Court found that technical violations of ERISA's notice provisions generally did not give rise to substantive remedies outside § 1132(c) unless there were some exceptional circumstances, such as bad faith, active concealment, or fraud.

Tillery v. Hoffman Enclosures, Inc., 280 F.3d 1192, 27 EB Cases 1789 (8th Cir. 2002): Plaintiff claimed entitlement to benefits based on the alleged failure of a fiduciary to provide (1) a summary plan description (SPD), (2) timely notice of the denial of benefits, and (3) notice of appeal rights. With regard to the SPD, the Court found plaintiff failed to explain how such an oversight affected their substantive rights or the decision of the Plan Administrator. Absent evidence to the contrary, any failure to provide the SPD was harmless. With regard to the failure to provide timely notice of the denial or their appeal rights, the Court found that the plaintiff failed to present any evidence demonstrating how lack of timely notice caused any substantive harm. Essentially, the Court concluded the decision had been the product of a thorough analysis by the claims administrator; therefore, no substantive harm could be shown.

Shaw v. The McFarland Clinic, 2002 U.S. Dist. LEXIS 19832 (S.D. Iowa 2002): Plaintiff was Iowa's last polio victim, and she brought suit against her employer's ERISA medical plan for reconstructive surgery of a deformed calf. The plan denied coverage, but in so doing failed to comply with ERISA's procedural guidelines governing claims procedures. The first denial letter failed to reference any specific plan provisions, stating only that the surgery would be considered cosmetic and not covered by the plan. It offered a phone number for questions or to submit additional

information, but did not describe what materials might be necessary or why such information might be necessary. It also failed to inform the plaintiff that she had a right to review of her claim and how to go about seeking that review. Plaintiff's appeal to the administrator similarly resulted in a letter that contained no explanation of why the denial was affirmed, or what the employee's rights were. The court found the procedural violations were blatant and untenable and also found that the claim could not be reviewed impartially. The Court used these violations as a basis for refusing to remand the claim back to the administrator, for denying the plan's motion for summary judgment, granting plaintiff's motion for summary judgment, and awarding plaintiff damages.

Spanos v. TJX Cos., 220 F. Supp. 2d 67 (D. Mass. 2002): Employee's ERISA claim for disability was remanded to employee benefits committee since employee's first appeal was decided by the wrong entity-- the appeals committee of the insurer, rather than by the employee benefits committee of the employer.

III. Judicial Enforcement

B. Exhaustion of Claims Review Procedure

Harrow v. Prudential Ins. Co. of Amer., 279 F.3d 244, 27 EB Cases 1481 (3rd Cir. 2002): The beneficiary of an employee benefit plan brought class action against the plan's health insurer under ERISA after the insurer was denied coverage for anti-impotence drug, asserting both wrongful denial of benefits and breach of fiduciary duty. The district court granted summary judgment for the insurer and the beneficiary's administratrix appealed. The Court of Appeals held that (1) the futility exception to the administrative exhaustion requirement did not apply given the beneficiary's minimal inquiry to insurer, and (2) the exhaustion requirement applied to putative breach of fiduciary duty claim that was really disguised challenge to benefits denial. The Court determined that the futility exception was inapplicable here, finding that, at the time the beneficiary filed suit, it was unclear and uncertain whether the insurer would automatically bar coverage.

The Court of Appeals next addressed the exhaustion issue. The beneficiary claimed that exhaustion should not apply because she was asserting statutory rights under § 404 of ERISA. The Court stated that "[p]laintiff's cannot circumvent the exhaustion requirement by artfully pleading benefit claims as breach of fiduciary claims." When the facts alleged do not present a breach of fiduciary duty claim that is independent of a claim for benefits, the exhaustion doctrine still applies. According to the Court, "[a] claim for breach of fiduciary duty is actually a claim for benefits where the resolution of the claim rests upon the interpretation and application of an ERISA-regulated plan rather than upon an interpretation and application of ERISA." The Court of Appeals agreed that plaintiff was actually challenging a denial of benefits, not conduct amounting to a statutory breach of fiduciary duty. Thus, summary judgment was appropriate, as plaintiff failed to exhaust administrative remedies.

Zhou v. Guardian Life Ins. Co. of Amer., 295 F.3d 677, 28 EB Cases 2776 (7th Cir. 2002): A chiropractor, to whom patient had assigned the right to receive payment under health insurance plan sued Plan Administrator, seeking to recover payment of benefits and alleging violation of the disclosure and reporting requirements of ERISA. Chiropractor's claims were partially denied by the Plan Administrator of patient's health plan. The district court dismissed, and the chiropractor appealed. The Court noted the chiropractor admitted that he did not exhaust his administrative remedies and pursue further administrative appeals of the partial denial of his claim. The Court dismissed the chiropractor's claims of futility, stating that for a party to come within the futility exception to the exhaustion requirement, a party must show that he is certain his claim will be denied on appeal, not merely that he doubts that an appeal will result in a different decision. The Court

noted that, save for bald allegations and conclusory statements, the Chiropractor offered no facts that would lead the court to find that it was a certainty that a further administrative appeal would result in a denial of his claim. When a party has proffered no facts indicating that the review procedure that he initiated will not work, the futility exception does not apply.

D'Amico v. CBS Corporation, 297 F.3d 287, 28 EB Cases 1656 (3rd Cir. 2002): Plaintiffs were a class of former employees of CBS (formerly known as Westinghouse) and participants in the Westinghouse Pension Plan. Plaintiffs claimed that CBS's failure to provide vesting after partial terminations constituted a breach of its fiduciary duty under section 404(a)(1)(A) and (D) of ERISA. The complaint requested damages and declaratory relief to remedy these alleged violations. It also alleged that exhaustion would be futile. Although the plan provided a procedure for presenting claims for benefits, none of the plaintiff's attempted to exhaust this plan remedy before bringing suit.

The Third Circuit recognized the possibility of waiving exhaustion in cases where statutory rights stem from the fiduciary duties set forth in section 404 of ERISA. The exhaustion requirement for these section 404 claims arises from the fact that some of the duties established by section 404 are synonymous with a claim to enforce the terms of a benefit plan. Thus, the Third Circuit still requires exhaustion in cases where the alleged statutory violation -- a breach of fiduciary duty under section 404 -- is actually a claim based on denial of benefits under the terms of a plan. Exhaustion requirements for fiduciary allegations brought under section 404, therefore, hinge on whether the allegations amount to a claim for plan benefits.

The Court held that the plaintiff's were required to exhaust plan remedies because their fiduciary allegations, which were based on CBS's failure to comply with a vesting and partial termination provision in its plan, amounted to a claim for plan benefits under Harrow. The Court also found that the plaintiff's had failed to meet their burden of establishing plan remedies were futile.

Norris v. Citibank, N.A. Disability Plan, 308 F.3d 880 (8th Cir. 2002): Plaintiff experienced severe back pain as the result of a herniated disc. Her pain forced her to take disability, and prevented her from working for her employer on a full-time basis. Two years later, the employer advised plaintiff in a letter that, due to a lack of sufficient clinical information, her period of disability could not be recertified. The letter also advised plaintiff that she could submit a written request for reconsideration within 60 days. Less than 60 days later, the plaintiff sent the Plan Administrator a handwritten letter labeled "Appeal." The court concluded that plaintiff satisfied the plan's exhaustion requirement when she submitted her handwritten "Appeal."

Kilkenny v. Guy C. Long, Inc., 288 F.3d 116, 28 EB Cases 1749 (3rd Cir. 2002): A dispute arose between rival labor unions and an employer over the proper assignment of work, and the employer's obligation to make contributions to a benefit fund. Plaintiffs, aggrieved benefit fund union trustees, filed suit for an accounting and recovery of contributions allegedly due their fund for work performed by a rival union. The district court dismissed for lack of standing.

The Court of Appeals found that, under ERISA, internal administrative remedies -- like the mandated arbitration procedures at hand -- had to be exhausted prior to bringing suit in federal court. The trust agreements in this case mandated arbitration in the event of deadlock. Moreover, the gravamen of the union trustees' suit was the proper interpretation of a collective bargaining agreement requiring arbitration of matters involving "plan administration." Thus, the union trustees were required to exhaust administrative remedies. Further, the Court found that the union trustees could not demonstrate a "clear and positive" showing of futility excusing exhaustion of administrative remedies. The union trustees were not authorized under the trust agreements to bring

suit without either receiving the approval of a majority of the trustees or employing the arbitration procedures. The union trustees instituted suit on their own without majority approval and refused to arbitrate a deadlocked motion over their authority to sue for allegedly delinquent funds. Accordingly, the court concluded that the union trustees lacked standing to sue.

Chapman v. Long Island Care Disability Plan, 288 F.3d 506, 27 EB Cases 2505 (2nd Cir. 2002): Plaintiff insured claimed that she was mentally disabled. Her claim for disability benefits under Defendant disability plan was denied as untimely filed, as was her request for administrative review. She initiated suit in district court against the plan for judicial review of that decision. The district court granted summary judgment to the plan and dismissed the insured's complaint.

On review, the Court of Appeals rejected the plan's argument that it was not a proper defendant. A plan was a proper defendant in an action to recover benefits under section 502(a)(1)(b) of ERISA. Also, the Court found that the untimeliness defense, having been asserted in the review letter, was properly preserved and could not be said to have been waived. As to the untimeliness of the appeal, the insured conceded the lateness of her administrative appeal, but contended that the error should be excused on grounds of equitable tolling. The Court declined to rule in the question of whether equitable tolling applied to time limits that were specified in plan provisions. However, the Court found that if the district court reached the equitable tolling argument, the proof proffered by claimant's counsel was sufficient to warrant an evidentiary hearing on the question of whether the insured's mental illness impaired counsel's efforts to file a timely request for review. Also, the Court determined that the district court had to determine, on remand, whether the time limit in the plan was enforceable given that such limitation was not mentioned in either the policy or the summary plan description.

Watts v. Bellsouth Telecommunications, Inc., 2003 WL 23394 (11th Cir. Jan 3, 2003): the Eleventh Circuit noted that it has held a number of times that a claimant's failure to exhaust the administrative remedies that an ERISA plan provides for challenging the denial of a benefits claim ordinarily bars her from pursuing that claim in court. The Court had never, however, decided the issue presented in the instant case, which is whether that bar should apply when the claimant's failure to exhaust her administrative remedies is the result of language in the summary plan description she reasonably interpreted as meaning she could go straight to court with her claim. The Court concluded the "failure to exhaust her administrative remedies bar" should not apply under these circumstances.

IV. Judicial Standard of Review

C. Power Granting Language

Helm v. Sun Life Assurance of Canada, Inc., 2002 WL 726487 (9th Cir. Apr. 24, 2002) (unpublished): Here, the Policy provides that long-term disability benefits will be paid upon Sun Life's receipt of "written proof," and "[t]he proof, which must be satisfactory to us, is to be given to us at our Office." The Policy also states that proof in connection with the terms or benefits of the Policy may be required, and "[i]f proof is required, we must be provided with such evidence satisfactory to us as we may reasonably require under the circumstances. Held: the Policy in the instant case unambiguously provides that the Plan Administrator has the discretion to grant or deny claims.

Jebian v. Hewlett-Packard Company, 310 F.3d 1173, 1177 (9th Cir. 2002): The plan explicitly grants discretion to decide appeals from denials of claims for benefits to the Plan Administrator. The pertinent language reads: "The Claims Administrator shall have the

discretionary authority to construe the language of the plan and make the decision on review on behalf of the Organization.”

The Ninth Circuit held: “The question before us, of first impression in this circuit, is whether a Plan Administrator’s decision, otherwise within the administrator’s discretion, can be accorded judicial deference when the purported final, discretionary decision is not made until after the claim is, according to both the terms of the plan and Department of Labor (DOL) regulations, already automatically deemed denied on review. We conclude that where, according to plan and regulatory language, a claim is “deemed ... denied” on review after the expiration of a given time period, there is no opportunity for the exercise of discretion and the denial is reviewed *de novo*.”

Fritcher v. Health Care Service Corporation, 301 F.3d 811, 816-7 (7th Cir. 2002): The phrase “in the reasonable judgment of the Claim Administrator” did not rise to the level articulated by the *Herzberger* court to rebut the presumption of plenary review. The phrase “reasonable judgment of ... medical[] necess[ity]” does not signal subjective discretion. In fact, it implies some process of ratiocination will be used before benefits will be paid. The words “reasonable judgment” do not serve as adequate notice to the participant and his family that the administrator’s judgment will be insulated from judicial review, particularly after *Herzberger*.

Hoover v. Provident Life And Acc. Ins. Co., 290 F.3d 801, 808 (6th Cir. 2002): The policies do not expressly state that the administrator has discretion over the determination of residual benefits, nor is there language requiring “satisfactory” proof of a disability. Instead, the policies permit Provident only to require proof to determine financial loss. Even if we were to assume that this language vested discretion in Provident, it would apply only to proof of lost income. The language relied on by Provident in no way equals a grant of discretion in determining whether Hoover suffers from a medical condition rendering her unable to work. Further, the Court rejected the idea that Provident reserved itself discretion by providing that it may require physical examinations at its own expense. The policies do not provide any discretion in the review of these examinations, nor do they require that the results of the examinations provide adequate evidence that the insured is disabled.

Gallagher v. Reliance Standard Life Ins. Co., 305 F.3d 264, 269-70 (4th Cir. 2002): The Plan contained the following language: “We will pay a Monthly Benefit if the Insured ... submits satisfactory proof of Total Disability to us.” The Court held that the language of the Plan did not grant Reliance discretionary authority. A grant of discretion must be clear. An insured employee reading this language would most likely interpret “to us” as an indication of where to submit the proof, not as granting Reliance discretion to determine whether the proof was satisfactory. The prepositional phrase “to us,” as written in the Plan, is more naturally read as modifying “submit” rather than “satisfactory.”

Ehrman v. The Henkel Corporation Long Term Disability Plan, 194 F. Supp.2d 813, 818 (C. D. Ill. 2002): The language of the LTD Plan is as follows:

“Total Disability” exists when Prudential determines all of the following conditions are met:

- (1) Due to sickness or accidental injury, both of these are true:
 - (a) You are not able to perform, for wage or profit, the material and substantial duties of your occupation.
 - (b) After the Initial Duration of a period of Total Disability, you are not able to perform for wage or profit the material and substantial duties of any job for which you are reasonably fitted by your education, training, or experience.

Based on the language of the LTD plan, the Court found that Prudential lacked the discretion to determine benefit eligibility. Prudential's language did not track the Seventh Circuit's safe harbor established in *Herzberger*. Furthermore, the language did not make "reasonably clear that the Plan Administrator is to exercise discretion." *Id.* Here, the phrase "when Prudential determines" does not make reasonably clear to an employee that the administrator is exercising its discretion, and instead merely states that the Plan Administrator will determine eligibility.

Parker v. Union Planters Corp., 203 F. Supp.2d 888, 893-4 (W.D. Tenn. 2002): The plan document provides that the Plan Administrator "shall have authority to control, interpret and manage the operation and administration of the Agreement." The Court found that this plan grants some discretion to the administrator, but it is not sufficient to trigger the more deferential review. There is a qualitative difference between determining the sufficiency of a claim that a participant is disabled, and determining whether, under the defined terms of a contract, a participant is eligible for benefits. The former involves a subjective judgment as to the sufficiency and veracity of the claim presented, whereas the latter involves objective contractual interpretation. When the plan itself has granted the administrator the discretion to subjectively evaluate the sufficiency of a claim for benefits, the administrator's decision should be given some deference. Otherwise, the administrator's decision should be reviewed *de novo*. In the present case, rather than requiring the Plan Administrator to exercise subjective judgment to determine whether a claim is sufficient, the plan document merely requires the Plan Administrator to interpret the contract and grant benefits when its defined terms have been met. Therefore, the Court reviewed the claim *de novo*.

Ballinger v. Eaton Corp., 212 F. Supp.2d 1086, 1091 (S. D. Iowa 2002): "...the LTD Plan states that "the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan." [it] "... further states that "the Plan Administrator and the Claims Administrator shall have discretionary authority to determine eligibility for benefits." These passages clearly and explicitly state that the administrator has discretionary authority to determine eligibility for benefits. *Stahl v. Exxon Corp.*, 212 F.Supp.2d 657, 665 (S. D. Tex. 2002); Here, the Plan provides the Plan Administrator discretionary authority to interpret the Plan:

The Administrator-Benefits (and those to whom the Administrator Benefits has delegated authority) shall be vested with full and final discretionary authority to determine eligibility for benefits, to construe and interpret the terms of the core benefit plans in their application to any participant or beneficiary, and to decide any and all appeals relating to claims by participants or beneficiaries. Furthermore, the specific responsibilities of the Administrator-Benefits include "exercising discretionary authority to interpret the core benefit plans in conducting a full and fair review of claims by participants and beneficiaries, with such interpretation being conclusive for all participants and beneficiaries."

Armstrong v. Great Lakes Higher Edu. Corp., 2002 WL 459077 (D. Minn. 2002): The plan document provides that "[n]othing in this document is intended to ... restrict the Corporation's right to ... interpret the provisions of this Plan." ... Although this language is not unequivocal, it is far more discretion-granting than the standard policy terms that trigger *de novo* review under Eighth Circuit case law. Therefore, the Court held that the plan explicitly granted discretion to Great Lakes, and applied the abuse-of-discretion standard.

D. Evidentiary Issues

Hall v. UNUM Life Ins. Co., 300 F.3d 1197, 28 EB Cases 2441 (10th Cir. 2002): The court, in a case of first impression, considered the extent to which evidence outside the administrative

record is admissible in an ERISA case subject to *de novo* review. Plaintiff injured her shoulder in a bicycle accident and underwent multiple surgeries. UNUM initially approved the plaintiff's claim for long-term disability benefits and began paying her. Approximately, a year and half later, UNUM reevaluated the plaintiff's claim. Based in part on surreptitious video surveillance of the plaintiff engaged in physical activities, UNUM stopped paying benefits. The plaintiff was subsequently diagnosed with "thoracic outlet syndrome" and underwent further surgeries. Unsuccessfully seeking reconsideration of the decision discontinuing benefits, the plaintiff informed UNUM of the additional medical treatment, but not the surgeries.

After the plaintiff filed suit, UNUM moved for judgment on the administrative record. The district court denied UNUM's motion and further declined to apply an arbitrary and capricious standard of review. At trial, the district court admitted and relied on evidence of the plaintiff's subsequent surgeries in reaching its decision that UNUM incorrectly discontinued the plaintiff's benefits. On appeal, UNUM argued that the district court improperly admitted the evidence of the surgeries because it was outside the scope of the administrative record.

Following the Fourth Circuit's holding in *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 16 EB Cases 2625 (4th Cir. 1993), the Tenth Circuit held that the district court should ordinarily restrict *de novo* review to the administrative record, but may supplement that record "when circumstances clearly establish that additional evidence is necessary to conduct adequate *de novo* review of the claims decision." The court emphasized, however, that supplementation should only be permitted in unusual cases. Quoting *Quesinberry*, the court noted the following non-exclusive list of circumstances that could warrant admission of additional evidence: (1) claims involving complex medical questions or involving the credibility of medical experts; (2) claims involving limited review procedures with little or no evidentiary record; (3) claims involving interpretation of plan terms; (4) claims involving a potential conflict of interest; (5) claims that would have been insurance contract claims prior to ERISA; and (6) instances where there is additional evidence that the claimant could not have presented during the administrative process. The court explicitly stated, however, that district courts are not required to admit additional evidence when these circumstances exist.

Applying the new rule to the facts at hand, the Tenth Circuit found that the evidence of the plaintiff's surgeries was of the type that could not have been presented in the administrative process because they occurred after she filed suit. Finding that this evidence was of "obvious importance" to the question of whether the plaintiff was disabled, the court stated that it was admissible. On the basis of this evidence, the court affirmed the district court's ruling in favor of the plaintiff.

Ray v. UNUM Life Ins. Co., 2002 U.S. App. LEXIS 26510 (10th Cir. 2002): Plaintiff, a partner at Gibson, Dunn & Crutcher, filed a claim for long term disability benefits alleging that she was unable to continue working because of "severe fatigue, headaches, dizziness, chest pain and an allergic reaction to chemicals." UNUM denied the plaintiff's claim, finding that she remained able to work as a real estate lawyer from her home and other locations. The plaintiff unsuccessfully appealed the denial three times. After her third appeal, UNUM offered to send the plaintiff to the University Disability Consortium in Boston for further medical evaluation. The plaintiff refused and instead filed suit.

Following a bench trial, the district court, applying the arbitrary and capricious standard of review, ruled in favor of the plaintiff and found her entitled to disability benefits. In reaching that decision, the court found a conflict of interest, "indicia" of bad faith and a lack of substantial evidence to support UNUM's denial of the plaintiff's claim. UNUM appealed the ruling, claiming

that the district court misapplied the arbitrary and capricious standard of review by failing to give UNUM's decision the appropriate level of deference.

On appeal, the Tenth Circuit held that the district court's incorrectly applied the arbitrary and capricious standard of review because the plan did not afford UNUM discretion to make claims decisions (despite the fact that neither party raised the issue). Instead of reviewing UNUM's decision itself, the Tenth Circuit remanded the case for the district court to conduct a *de novo* review. In making the remand decision, the Tenth Circuit noted that because the district court applied the arbitrary and capricious standard of review, it had not considered evidence outside of the administrative record. Citing its recent decision in *Hall v. UNUM Life Ins. Co.*, 300 F.3d 1197 (10th Cir. 2002), the court found that because such evidence might be necessary to conduct an adequate *de novo* review, it had no choice but to remand the case to allow the district court to consider such evidence.

Alford v. DCH Foundation Group Long Term Disability Plan, 311 F.3d 955 (9th Cir. 2002): The plaintiff argued that the district court erroneously refused to expand the administrative record to include medical evidence that the plaintiff allegedly submitted to the defendant after it made the decision denying her claim and after the deadline for submitting additional evidence set forth in UNUM's letter to the plaintiff denying her claim. The Ninth Circuit rejected the plaintiff's argument, indicating that under an abuse of discretion standard of review, a district court is limited to reviewing the documents that were before the Plan Administrator at the time of making the benefits determination: "Permitting a district court to examine evidence outside the administrative record would open the door to the anomalous conclusion that a Plan Administrator abused its discretion by failing to consider evidence not before it." Because the plaintiff sought to expand the administrative record to include documents that she had not submitted in a timely manner to the defendants and which were not considered by the defendants in making the claims decision, the Court rejected the plaintiff's argument that it was error for the district court not to review these materials.

Jebian v. Hewlett Packard Co. Employee Benefits Organization Income Protection Plan, 310 F.3d 1173 (9th Cir. 2002). The plaintiff, a software engineer for Hewlett Packard, suffered a series of shoulder and back impairments over an eight-year period that precipitated his claim for long-term disability benefits. Relying on a vocational assessment that indicated that the plaintiff could tolerate "sitting, walking, trunk bending, overhead reaching and squatting," the defendant plan denied the plaintiff's claim. Approximately three months after receiving notice of the denial, the plaintiff submitted an appeal arguing that the plan had misread and overlooked important medical records that established that his claim should be granted. Under the terms of the plan, the defendant had sixty days in which to respond to plaintiff's appeal. In the event the defendant did not respond within sixty days nor inform the plaintiff that it could take an additional sixty days longer to respond, the claim was deemed denied. The defendant did not respond to the plaintiff's appeal for 119 days and further stated that it needed additional medical documentation to make a decision. Ultimately, the defendant did not make a final decision denying the plaintiff's appeal until almost a year after the initial appeal. Thereafter, the plaintiff filed suit. The district court, applying an abuse of discretion standard of review, granted summary judgment to the defendant.

On appeal, the Ninth Circuit first examined whether the district court applied the appropriate standard of review. Specifically, the Court addressed the question of whether a Plan Administrator's decision could be afforded judicial deference when the underlying claim has been "deemed denied" by operation of the terms of the plan and Department of Labor regulations. Answering that question in the negative, the Ninth Circuit found that the district court should have reviewed the defendant's denial of the plaintiff's appeal under the *de novo* standard of review. Further, the Court, recognizing

that under the *de novo* standard of review a district court has discretion to consider evidence outside of the administrative record, remanded the case to the district court to permit it to consider taking additional evidence as it deemed necessary.

Morgan v. Contractors, Laborers, Teamsters & Engineers Pension Plan, 287 F.3d 716, 27 EB Case 2320 (8th Cir. 2002): Plaintiff was an owner of a construction company and sought pension benefits from the defendant Plan upon his retirement. Although an owner, the plaintiff had been a member of the union and performed bargaining unit work; moreover, the union made contributions to the Plan on the plaintiff's behalf for many years. The Plan denied the plaintiff's claim asserting that he had not established that he had worked regularly as an "employee" for a sufficient period of time to be eligible to participate in the Plan. The plaintiff appealed the decision, but his appeal was denied. The plaintiff then filed suit. Following a hearing at which the Trustees testified about the basis for their decision to deny the plaintiff's claim, the district court held that the Trustees did not abuse their discretion in denying the plaintiff's claim.

On appeal, the Eighth Circuit found that although the Plan granted the Trustees discretionary authority to determine the plaintiff's eligibility for benefits, the plaintiff produced "material, probative" evidence of a conflict of interest that warranted applying a less deferential standard of review. Using the sliding scale approach outlined in *Woo v. Deluxe Corp.*, 144 F.3d 1157, (8th Cir. 1998), the Court considered evidence produced by the plaintiff regarding procedural irregularities in the Trustees' decision making process. Specifically, the plaintiff argued that the Trustees based their decision on personal observations, hearsay and other information outside the administrative record, and further failed to provide any of this information to the plaintiff prior to the appeal hearing in violation of the terms of the Plan. Finding that the plaintiff satisfied the *Woo* sliding scale requirements, the Court applied the *de novo* standard of review to the Trustees' decision and found in favor of the plaintiff.

Waggener v. UNUM Life Ins. Co., 2002 U.S. Dist. LEXIS 22697 (S.D. Cal. 2002): The plaintiff, a former partner with Gibson, Dunn & Crutcher, began receiving long-term disability benefits after she was diagnosed with chronic fatigue syndrome. After ten years, UNUM reevaluated the plaintiff's claim and, on the basis of independent medical examinations and surveillance videotapes, stopped paying benefits. After her appeal was denied, the plaintiff filed suit.

The plaintiff propounded interrogatories and requests for production in which she sought: (1) the identity of each person who participated the evaluation or handling of the plaintiff's claims and/or appeal and who is not a current employee; (2) for each of those persons who was an independent contractor the number of times UNUM had employed that person to participate in evaluating or handling a claim and the compensation paid on each occasion; (3) the identity of every attorney who provided claims or legal advice regarding the plaintiff; (4) the identity and position of every person who participated in the decision to terminate the plaintiff's benefits; (5) the identity of persons involved in evaluating the plaintiff's appeal; (6) all lawsuits against UNUM from 1998 to the present involving disability claims based on chronic fatigue syndrome or improper use of surveillance; and (7) all documents relating to the plaintiff, surveillance of the plaintiff, claims guidelines, the selection of independent medical examiners, the definition of disability in the plan at issue, communication with Gibson, Dunn regarding the plaintiff or the plan at issue, communications with any insurance regulatory body, any of the twenty physicians who examined the plaintiff, any plans to "toughen claims practices," and complaints by employees of unfair claims practices. In response, UNUM sought a protective order.

The Court held that the plaintiff was entitled to conduct limited discovery regarding whether UNUM's position as both Plan Administrator and payor created a conflict of interest that tainted its

claims decision with respect to the plaintiff. The Court noted, however, that such discovery should be narrowly tailored to determine the existence and extent of the alleged conflict of interest. Accordingly, the Court limited discovery to (1) information necessary to demonstrate “the manner in or extent to which the conflict of interest affected UNUM’s decision making process” and “address any shortcomings in the record or decision making process caused by the conflict,” and (2) information regarding the independence or neutrality of the physicians utilized by UNUM for medical opinions relative to the plaintiff’s claim. Specifically, the Court ordered UNUM to: (1) identify all persons involved in the evaluation and/or termination of the plaintiff’s claim and appeal; (2) identify the extent to which physicians or other independent contractors who participated in evaluating the plaintiff’s claim previously participated in claim handling for UNUM; and (3) produce documents relating to the plaintiff, the plaintiff’s claim, UNUM’s surveillance of the plaintiff, claims guidelines at the time the plaintiff’s claim was terminated, the selection of independent medical examiners, and the underwriting or definition of “disability” in the policy at issue.

For a good contrast to the *Waggener* opinion, see *Cerrito v. Liberty Life Assurance Company*, 209 F.R.D. 663 (M.D. Fla. 2002), in which the court, with virtually no analysis, denied the defendant’s motion for a protective order and held that the plaintiff was entitled to conduct discovery.

Sheehan v. Metropolitan Life Ins. Co., 2002 U.S. Dist. LEXIS 11789 (S.D.N.Y. 2002): The district court held the plaintiff was entitled to conduct discovery with respect to his allegation that his employer improperly influenced Defendant Metropolitan Life to deny his claim for long-term disability benefits. In reaching the holding, the Court first found the *de novo* standard of review applied based on the defendant’s inability to produce a copy of the plan at issue. The Court noted that when conducting *de novo* review it was permitted to consider evidence outside of the administrative record for good cause. Good cause included circumstances where a “demonstrated conflict of interest” existed in the administrative reviewing body. Interpreting the plaintiff’s allegation of improper influence as an allegation of a conflict of interest, the Court found that the plaintiff was entitled to conduct discovery regarding the existence and extent of the alleged improper influence.

Phillips-Foster v. UNUM Life Ins. Co., 302 F.3d 785 (8th Cir. 2002): The Court denied Appellee’s motion to strike material that was not part of the administrative record, but submitted by the appellant in the appendix on appeal. In making its ruling, the court noted that the material allowed consisted of documents that “should have been” in the claims file.

Peltzer v. Life Ins. Co. of N. Am., 28 EB Cases 2765 (N.D. Ill. 2002): The District Court denied Plaintiff’s motion to compel depositions on the grounds that the long-term disability plan at issue afforded the Defendant discretion to make claims decisions, thereby limiting the Court’s review to the four corners of the administrative record.

Brooks v. General Motors Corp., 203 F. Supp. 2d 818 (E.D. Mich. 2002): the Court granted Defendants’ motion to strike materials submitted by the plaintiff outside of the administrative record where the plaintiff had failed to allege in her complaint that there was any procedural defect in the claims process.

Zack v. Hartford Life & Accident Ins. Co., 27 EB Cases 3006 (D. Kan. 2002): Defendant’s motion for protective order to limit discovery to the administrative record was denied *de novo* standard of review was applicable and therefore the Court was permitted to consider all available facts in reviewing the Defendant’s’s claims decision.

E. Conflict of Interest

Leahy v. Raytheon Co., 2002 WL 31819562 (1st Cir. Sept. 11, 2002): Plaintiff claimed MetLife, as Plan Administrator of an employee benefit plan, had a conflict of interest involving its use of an outside physician to review Plaintiff's medical records. The First Circuit Court disagreed, holding "common sense dictates that retaining outside physicians to assist in evaluating disability claims, without more, does not constitute a conflict of interest." Since there was no other evidence presented, the Court ruled there was no conflict of interest.

The First Circuit Court's conclusion was reinforced by the incentive-based nature of the Plan; a voluntary employee-funded entity. [The Court noted,] market forces were "at work." It reasoned if MetLife denied valid claims, employees would withdraw from the Plan, thus reducing MetLife's role "and, presumably, its compensation." However, if MetLife awarded undeserved benefits, Plan participants would experience increased premiums and thus be inclined to withdraw from the Plan. "Either way, the structure of the Plan furnishes an incentive for MetLife to be unbiased in its handling of claims. This is telling, for courts should not lightly presume that a Plan Administrator is willing to cut off its nose to spite its face."

Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc. Employee Health and Welfare Plan, 298 F.3d 191, 28 EB Cases 2015 (3rd Cir. 2002): Plaintiff, who participated in an employer-funded and administered employee benefit plan, was injured in a motorcycle accident while intoxicated. He sued his employer seeking to recover medical expenses arising from the accident. The District Court granted Defendant's motion for summary judgment, finding no conflict of interest where the employer was also the Plan Administrator. It applied the arbitrary and capricious standard of review, noting that the risk of a conflict of interest is decreased where the employer also funds the plan (as opposed to an insurance company) because an employer has "incentives to avoid loss of morale and higher wage demands that could result from denial of benefits." However, the Court noted that a conflict could still exist.

The employer/Plan Administrator had purchased excess loss insurance to pay any amount in excess of the employer's deductible. The District Court ruled this mandated the conclusion there was no conflict of interest. The Third Circuit Court disagreed: Despite the excess loss insurance, the employer was responsible for paying \$22,522.78 of the \$81,000.00 in claims. Further, since Plaintiff ceased being an employee of the company while his claim for benefits was still under consideration, when the decision to deny his claims was made "the counterbalancing of its [the employer's] monetary self-interest by possible concerns about the impact of its decision on morale and wage demands would thereby be lessened." In other words, the employer/Plan Administrator's treatment of ex-employees would not affect the morale and wage demands from its current employees, so there was less incentive to handle claims fairly.

The Third Circuit reviewed the District Courts grant of summary judgment, finding heightened scrutiny was, clearly appropriate. It went on to seek the appropriate standard of review to apply, finding the Fifth Circuit's "sliding scale," and the arbitrary and capricious standard to be "helpful, albeit imprecise." Because the conflict was not extraordinary, it did not slide very far down the 'scale,' and it conducted a "somewhat heightened" review. Finding that, despite Plaintiff's 0.252% blood alcohol level at the time of the accident, no facts were cited by the administrator for its conclusion that the Plaintiff 'caused or contributed to' his injuries. Further, the Third Circuit noted it is the insurer's duty to prove facts that bring a loss within an exclusionary clause of the policy.

Weinberger v. Reliance Standard Life Ins. Co., 2002 WL 31746546 (3rd Cir. Dec. 6, 2002). The District Court applied a “moderately deferential” standard of review where the decision-maker, Reliance, was also funded benefits. The Court found aspects of Reliance’s decision-making procedure “troubling.” Namely, the Plan’s Administrator rejection of the only medical evidence by a physician who had actually examined Plaintiff and a finding of disability by the Social Security Administration. Furthermore, in assessing whether Plaintiff could perform his own occupation, the Plan Administrator relied on the “Description of Occupational Titles,” and ignored a description provided by the Plaintiff of his actual duties in that position. These indications of a possible conflict of interest lead the Court to find that the District Court/s application of “moderate scrutiny” (see above) was, under the circumstances, “unduly deferential.”

Phillips-Foster v. UNUM Life Ins. Co. of America, 302 F.3d 785, 29 EB Cases 1673. (8th Cir. 2002). Plaintiff’s spouse sought to collect on a policy of life insurance provided through his employer. The insurance company refused to pay because it appeared that the insured might have conspired with his wife and another man to commit his own murder so that the insured’s wife could collect on the policy. [The deceased was a voodoo priest and a practitioner of tantric sex.]

Plaintiff claimed that Defendant UNUM breached its duties because, *inter alia*, the decision-maker had a conflict of interest. Plaintiff argued that the conflict arose because UNUM derived direct financial benefit from not paying her claim, and UNUM failed to follow proper procedures in that it 1) remained silent about its obligation to pay the \$100,000 basic life benefit portion of the policy Plaintiff filed suit (at which time it interpleaded the funds); 2) failed to make a timely claim determination; 3) failed to pay a repatriation benefit; 4) failed to analyze evidence contrary to its position, 5) failed to obtain expert opinion on whether Foster committed suicide; and, 6) failed to provide the entire claims file to the District Court.

The Eighth Circuit found that the irregularities cited by Plaintiff were insufficient by themselves to require a higher standard of review, and Plaintiff must show that UNUM’s potential conflict and failure to meet claim deadlines were enough to raise “serious doubts as to whether the result reached was the product of an arbitrary decision, or the Plan Administrator’s whim.” The Court noted that within a month of Foster’s death, investigators alerted UNUM that they considered Plaintiff to be a suspect in a conspiracy to cause the insured’s death, and there was a “high probability” that Foster was involved in his own death. Further, the basic life benefit was contested by Foster’s first wife. Therefore, it was not unreasonable for UNUM to delay its determination, including the determination as to the repatriation benefit. The Court found no procedural irregularities in UNUM’s failure to retain an expert or in its reliance on the tentative conclusions of Douglas County Investigators as to the cause of Foster’s death when UNUM’s own investigation supported the same conclusion.

Finally, Plaintiff was not entitled to a less-deferential standard of review because UNUM failed to provide the District Court with a complete claims file. The Court found the disputed items (the ones allegedly not produced) neither particularly helpful nor persuasive for either side.

Nord v. Black & Decker, 296 F.3d 823, 28 EB Cases 2771 (9th Cir. 2002): Plaintiff/employee sought disability welfare benefits from the Black & Decker Disability Benefits Plan. Black & Decker admitted it acted as both funding source and administrator of the plan (an inherent conflict of interest), but the administration of the Plan in Plaintiff’s case had been delegated to MetLife. However, Plaintiff alleged that in carrying out its duties, MetLife acted as an agent of Black and Decker, not as an independent executor.

Plaintiff argued the Plan Administrator arbitrarily ignored Black & Decker's own human resources representative's opinion (based in part on an IME doctor's report that, showed sufficient impairment to prevent Plaintiff from performing his job even though Plaintiff was only partially impaired.) The Plan Administrator also ignored the opinion of three treating physicians that Plaintiff was no longer capable of occupying his former position. Plaintiff had argued that the rejection of these opinions constituted material probative evidence that the Plan was operating under an actual conflict.

The Ninth Circuit noted that Black & Decker, as funding source and the Plan's Administrator, was operating under and inherent conflict of interest. Despite the conflict, to apply the "less deferential" standard of review, Plaintiff would also have to provide material, probative evidence tending to show that the fiduciary's self-interest caused a breach of the Plan Administrator's fiduciary's obligations to the beneficiary.

The Court also found the Plan Administrator's rejection of the conclusion of its own human resources representative was "not only high-handed, but also certainly some evidence of a conflict." The District Court erred in failing to take into account the fact that the Plan Administrator rejected the prevailing opinions of the treating physicians. The Administrator could reject the opinions of the treating physicians only if it gave "specific, legitimate reasons for doing so that are based on substantial evidence in the record." Based on this, the Circuit Court found Black & Decker breached its fiduciary duty because of the conflict of interest. Conducting a *de novo* review, the Ninth Circuit found no reasonable trier of fact could conclude that Plaintiff was not disabled. The District Court's denial of summary judgment was reversed.

Hall v. UNUM Life Ins. Co. of America, 300 F.3d 1197, 28 EB Cases 2441 (10th Cir. 2002): Plaintiff filed suit against her long-term disability insurer after the termination of her benefits. Plaintiff argued the admission of additional evidence by the District Court was appropriate because, *inter alia*, the payor and the administrator of Plaintiff's benefits were the same entity. However, the Court noted the "inherent conflict" that existed would not automatically mean the admission of additional evidence. A court should only reduce its deference to the Administrator's decision to the extent that an actual conflict exists. Without such a showing, the District Court should not have admitted the additional evidence.

Turner v. Delta Family-Care Disability and Survivorship Plan, 291 F.3d 1270 (11th Cir. 2002): Plaintiff argued a less deferential standard should have been applied by the District Court because of the Plan Administrator's conflict of interest. The conflict existed because Delta was making decisions regarding funds contributed by Delta. Additionally, Plan funds were disbursed, Delta was obligated to replenish them. The monies were paid from a trust funded by Delta through irrevocable periodic contributions, the Plan had finite resources to pay benefits, and decisions on disbursements were made by a committee made up of Delta employees.

In a previous decision, the Eleventh Circuit ruled the funding structure utilized by this Plan "eradicates any alleged conflict of interest so that the arbitrary and capricious standard of review applies." (citing *Buckley v. Metropolitan Life*, 115 F.3d 936 (11th Cir. 1997)). Plaintiff attempted, unsuccessfully, to convince the Court to adopt the holding of the Ninth Circuit in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1138 (2001), in which applied a less deferential standard because, *inter alia*, in that case the Administrative Committee was appointed by the Delta Board of Directors. The Eleventh Circuit referred to its own case law on the matter and declined to apply a less deferential standard of review.

Olive v. American Express Long Term Disability Plan, 183 F. Supp. 2d 1191, 27 EB Cases 2020 (C.D. Cal. 2002) gave *de novo* review of the denial of a disability claim due to a financial conflict. Complainant provided material evidence by showing the denial letter was inadequate due to a lack of specificity and the criteria for rejecting the claim was unclear. The court did not cite the DOL Claims Procedure, but relied upon the language of Section 503.

F. Interpretation of Ambiguous Plan Provisions

Bergt v. Retirement Plan for Pilots Employed by MarkAir Inc., 293 F.3d 1139, 28 EB Cases 1398 (9th Cir. 2002): Plaintiff was a participant in the Employee Stock Ownership Plan (“ESOP”). The Company also created an ERISA retirement plan allowing pilots or former pilots, to participate. A section of the retirement plan excluded otherwise eligible employees who were “participants in any other pension, profit sharing, or retirement plan which is ‘qualified’ by the Internal Revenue Service and to which the Company is contractually obligated to contribute . . .” The Company also issued a summary of the retirement plan, called a *Summary Plan Document* (“SPD”), that specified “if you are a member of another Company-sponsored retirement or profit sharing plan, you cannot be a member of this plan.” Plaintiff applied for benefits and was denied. He appealed. The plan committee concluded that the section under which he claimed benefits was ambiguous. It denied his claim, relying on extrinsic evidence because: (1) the Master Agreement did not specify the basis of the contractual obligation (*i.e.*, by collective bargaining agreement or Internal Revenue Code); (2) it did not say whether the contractual obligation to contribute had to be annual or over the life of the plan; and, (3) the phrase “which is qualified . . .” could be read to modify only “retirement plan” or could modify pension plan, profit- sharing plan, and retirement plan.

The Circuit found the provisions of the plan unambiguous. “The phrase, ‘to which the company was contractually obligated to contribute,’ simply meant the Company is legally obligated, pursuant to a contract, to contribute. This phrase was not reasonably susceptible to a different interpretation,” and Plaintiff was entitled to participate in the plan.

Guyther v. Department of Labor Federal Credit Union, 193 F. Supp. 2d 127, 27 EB Cases 2342 (DC DC 2002): A plan was entitled to deference in its interpretation of an ambiguous contract where the plan interpreted that contract the same way for 20 years.

Fitts v. Federal National Mortgage, 191 F. Supp. 2d 67, 27 EB Cases 1769 (DC DC 2002): Long Term Disability plan defined “mental illness” as “mental, nervous, or emotional disease.” The court held this clause was ambiguous, and applied the doctrine of *contra proferentum*, in favor of the participant. The Plan Administrator argued bipolar disease fell within plan’s definition of “mental illness.” The Court rejected the argument since the participant provided sufficient evidence of physical relationship between body and bipolar disorder to support finding that her illness did not fall within plan’s definition of “mental illness.”

Provident Life and Accident Insurance Co. v. Cohen, 28 EB Cases 1058 (DC Md. 2002). Long Term Disability plan provided Participant was totally disabled only if he could not perform all of the substantial duties of his regular occupation. The plan also had a residual disability clause providing that if an insured could not perform all of his duties, but could perform one or more of those duties, he was only residually disabled, and thus not entitled to benefits. The Court concluded that insurance policies with provisions providing for both total and partial disability must be construed as a whole.

Televantos v. Lyondell Chemical Co., 27 EB Cases 2113 (3rd Cir. 2002) (*unpublished*). A Court may look at extrinsic evidence to determine if a contract term is ambiguous.

Plaintiffs claimed SPD was ambiguous because it did not expressly inform them they were required to apply for SSDI benefits, and would be required to reimburse the insurer for any retroactive payment of SSDI benefits received. The Court found the amended plan was not ambiguous and insurer's interpretation was reasonable. *Garst v. Wal-Mart Stores, Inc.*, 27 EB Cases 2283 (6th Cir.), *cert. denied*, 28 EB Cases 2920 (2002) (*unpublished*).

G. Estoppel Theories and Misrepresentation

1. SPD Provisions Providing More Generous Benefits

Bergt v. Retirement Plan for Pilots Employed by Mark Air, Inc., 293 F.3d 1139, 28 EB Cases 1398 (9th Cir. 2002): Bergt was a pilot for Mark Air, and eventually serving as the company's President and Chairman of the Board of Directors. Bergt participated in the company's employee stock ownership and profit sharing plans. The company also had an ERISA retirement plan in which Bergt believed he was eligible to participate. When Bergt filed a claim for benefits under the retirement plan many years later, his claim was denied. The basis for the denial was an inconsistency between the terms of the retirement plan and the SPD regarding to the eligibility of employees who participated in other company pension, profit sharing, or retirement plans. The Court noted that the typical case involving such an inconsistency was due to the SPD providing more generous benefits than the Plan. However, here it was the retirement plan that was more generous allowing Bergt to participate, while the terms of the SPD prohibited Bergt from receiving a plan benefit. Consistent with the cases involving inconsistencies between a plan and the SPD, the Court held the provision more favorable to the employee (here, the unambiguous plan provision) controlled over the conflicting SPD.

Giunta v. Mobil Corporation Employee Severance Plan, 205 F. Supp. 2d 715, 28 EB Cases 1810 (S.D. Tex. 2002): The court was faced with the atypical situation of a Plan providing more generous benefits than the SPD. In a footnote, the Court explained that, under unequivocal Fifth Circuit case precedent, when an employee relies upon a term contained in the SPD, but contradicted in the plan, the ambiguity created must be resolved in favor of the employee. The Court, however, was faced with an employer attempting to enforce a provision found solely in the SPD. The Court was not convinced the SPD provision was enforceable against the employee based on that distinction. The Court, on other grounds, found in favor of the employer and denied severance benefits.

Hart v. Equitable Life Assurance Soc., et al., 2002 U.S. Dist. LEXIS 22928 (S.D.N.Y. 2002): Defendants allowed its employees to request a statement of severance benefits through a voice response unit. The benefit statements were generated by the computer then mailed to the employee's home. They were never reviewed by a benefits department employee for accuracy. Accordingly, each benefit statement bore a cautionary label providing that the statement was an estimate only and that the final benefit amount may differ from the estimate. Hart requested and received several of these statements. Each indicated an amount that, in reality, was more than twice the amount she was entitled to under the plan. Hart had been credited with 10 years of service she had not earned. When Hart was terminated, she asked for the benefit amount she relied in the benefit statements, and was given an amount, she was given an amount far less than expected. In response, Hart brought a lawsuit, alleging an estoppel theory based on her reliance on the amounts set out in the benefit statements. The Court held Hart's estoppel claim was defeated by the disclaimers displayed on each of the statements she received. The more generous benefits set out in the benefit statements could

not create a material misrepresentation or reasonable reliance thereon due to the disclaimers. Further, given the mistaken credits (versus an intent to deceive), the Court opined that “extraordinary circumstances” necessary for an equitable estoppel claim were absent.

Armbruster v. K-H Corporation, 206 F. Supp. 2d 870, 28 EB Cases 1687 (E.D. Mich. 2002): Plaintiffs filed a class-action lawsuit challenging their employer’s decision to provide medical insurance coverage on a shared-cost basis. The Plaintiffs originally were provided medical coverage free of cost with the employer bearing the cost of the retirement plan. The SPDs distributed by the employer to its employees and retirees specifically provided medical benefits would be provided to retirees and the cost would be paid by the employer. The Plaintiffs also claimed the employer made oral representations it would bear the cost of the medical coverage. In the midst of a buyout and a subsequent bankruptcy of the successor, the employees and retirees were notified that retirees would have to share the cost of medical coverage. The Plaintiffs, among other claims, asserted estoppel claims based on the language of the SPDs and the oral representations of the employer. The Court ruled that the Plaintiffs’ estoppel claims failed under these facts. According to the Court, although the SPDs contained clear language promising company-paid medical benefits, the SPDs, through a reservation of rights clause, unambiguously provided the retirement plan, including the payment of medical benefits, may be modified or terminated at any time. *Citing Sprague v. General Motors*, 133 F.3d 388 (6th Cir. 1998). The Court held that in the face of this clearly articulated right to amend, there could be no reasonable or justifiable reliance on statements allegedly suggesting anything to the contrary. Absent justifiable reliance, Plaintiffs’ estoppel claims failed.

Hooven, et al., v. Exxon Mobile Corporation, 28 EB Cases 1842 (E.D. Pa. 2002): The Plaintiffs worked for their employer when a merger was announced. In an effort to retain employees, the employer created a severance plan providing employees with monetary benefits if they were terminated as part of the merger. The employer distributed an SPD outlining these benefits. After the merger, the employer invoked a provision of the severance plan not in the SPD excluding the Plaintiffs from the severance plan in the event of a divestiture. The Plaintiffs made an equitable estoppel claim when they were denied severance benefits. The Court held the Plaintiffs’ estoppel claim survived summary judgment, in part, because a factfinder could infer the terms of the SPD misled the Plaintiffs concerning their severance benefits in the event of a divestiture and they relied on the terms of the SPD to their detriment.

Burstein, et al., v. Retirement Account Plan for Employees of Allegheny Health Education and Research Foundation, 28 EB Cases 2800 (E.D. Pa. 2002): Plaintiffs worked for an employer that had a defined benefit plan available for qualified employees. Under the terms of the plan, an employee could become vested after completing five years of service with the employer. The SPD for the plan provided with regard to termination of the plan, an employee became vested regardless of the employee’s years of service. The Plan was eventually terminated due to bankruptcy and the employer distributed a letter denying Plaintiffs benefits under the plan because they did not have five years of service. The Plaintiffs brought suit asserting, among other things, equitable estoppel. The Court denied the Plaintiffs’ estoppel claims because neither the PBGC nor any of its agents, acting within the scope of their authority, engaged in affirmative misconduct that was reasonably relied upon by the Plaintiffs. In a footnote, however, the Court stated even if the statements in the SPD were a material misrepresentation, the Plaintiffs failed to show any detrimental reliance. The Court explained that the Plaintiffs had no right to benefits under the unambiguous terms of the plan. Therefore, according to the Court, the Plaintiffs could not claim wrongful deprivation of plan benefits because they took some action forfeiting rights to plan benefits that they otherwise would have had.

2. Representations That Are Inconsistent With Unambiguous Written Plan Provisions

Kamler v. H/N Telecommunication Services, Inc., 305 F.3d 672, 28 EB Cases 2741 (7th Cir. 2002): Kamler agreed to work for his employer under the condition that his employment package would include health insurance. Although Kamler was promised the health insurance, he never filled out the required enrollment forms as required by the Plan. Notwithstanding a delay and a multitude of problems in presenting the enrollment form, when finally presented with the enrollment form, Kamler did not fill the form out as required by the plan due to privacy concerns. When he raised these concerns with his employer, he was told the employer would discuss the issues with the insurer. Kamler heard nothing more about the issues. Kamler's employment was terminated early after he completed his assignment for the employer. Two weeks later, Kamler suffered a heart attack. Neither the employer nor its health insurance plan paid Kamler's medical expenses. Kamler argued that through oral and written representations from the employer and the health insurance provider he was led to believe he had coverage. Although the district court granted summary judgment based on a lack of standing, the Seventh Circuit concluded Kamler had standing but found that he did not have a viable estoppel claim against the health benefits plan. The Court utilized a four-part test to address the estoppel claims. Because the Court concluded that: 1) there was no knowing misrepresentation of plan terms; 2) there would be no reasonable reliance on any alleged misrepresentations; and, 3) the plan was unambiguous relating to the enrollment requirement, no estoppel claim would lie.

Perreca v. Gluck, et al., 295 F.3d 215, 28 EB Cases 1513 (2nd Cir. 2002): Perreca worked for his employer Sternberger as a truck driver. He was a union member for the first several years of employment. Sternberger had a pension plan, for which Michael Gluck served as a trustee and eventually was the sole member of the plan's administrative committee. The terms of the plan clearly prohibited any payments into the plan on behalf of union members. Perreca later left the union and was promoted to Night Manager at Sternberger. Perreca claimed that Gluck orally promised that, despite his having been a union member for several years, Perreca would be considered a member of the plan from the beginning of his employment at Sternberger. Perreca applied for retirement benefits, when this promise was not upheld, Perreca brought suit alleging, among other theories, promissory estoppel. Perreca's promissory estoppel claim was denied. The Circuit Court upheld the District Court's grant of summary judgment on the issue. Finding that Perreca, as a matter of law, could not rely upon an oral promise to modify the terms of an ERISA plan.

Richmond v. NCR Corporation, 2002 U.S. Dist. LEXIS 20639 (S.D. Ohio 2002): Defendant offered a certain group of its employees an enhanced early retirement package providing an unreduced pension and lump sum payment. Included in this package was a reference to current life and health insurance coverages that would be provided to employees with 10 years of vesting service. Several years later, Defendant informed the retirees that Defendant was no longer going to offer the subject health insurance benefits. The retirees sued seeking to estop the employer from denying its obligation to provide the health benefits. Although the Court recognized that promissory estoppel is a viable theory of relief under ERISA in the Sixth Circuit, the Court found that the employees could not meet the elements of an estoppel claim. Specifically, the Court found that the documents explaining the early retirement plan and the life and health insurance plans clearly did not contain a promise for a lifetime health benefit and that there could be no reasonable reliance on any contrary representation.

Beaver v. Earthgrains Baking Companies, Inc., 216 F. Supp. 2d 920 (N.D. Iowa 2002): Beaver worked for an employer that provided severance benefits under an ERISA severance plan. Beaver's employer was acquired by another employer. The new employer circulated a memorandum entitled "Retention of Employment" to certain employees of the old employer creating a retention agreement for these employees to accept or decline. The memorandum contained a provision discussing severance payments. As part of this memorandum, the vice president of the new employer sent an email that answering questions employees had in reference to the severance payments under the retention agreement. The email provided employees could still receive a severance payment, even if they did not sign the retention agreement or, signed the agreement and later resigned. Ultimately, this representation proved incorrect. Another vice president of the employer later issued a letter explaining that the email was based on a misinterpretation of the former employer's severance plan and benefits would not be paid to those who declined the retention agreement or accepted and later resigned. Beaver attempted to obtain these benefits after she accepted the agreement and resigned. She was denied benefits and brought suit. As part of her case, Beaver made an estoppel argument against the employer. The Court, however, found that estoppel claim was not viable. The Court held that the language of the former employer's severance plan was unambiguous, and that the new employer's misinterpretation of that clear language did nothing to change the conditions for receipt of benefits under the plan.

Brockett v. Reed, 2002 U.S. Dist. LEXIS 22765 (S.D.N.Y. 2002): Brockett and Crawford were employees of a company that had a profit sharing plan. Brockett and Crawford were terminated from employment. They were given an option to sign a resignation/severance agreement that, among other things, promised them "continued participation" in the profit sharing program through the end of the year. Brockett and Crawford chose to sign the resignation/severance agreement, and their accounts were credited with the company's contribution to the plan for the remainder of the year. A new company purchased their old employer and withdrew the money contributed to Brockett and Crawford's plan accounts for their terminal year. The new company pointed to the unambiguous language in the Plan that said the employer will not make contributions to the Plan for any employee terminated during a plan year. Brockett and Crawford claimed that the language in the resignation/severance agreements amended the Plan and, thereby, they were entitled to the contributions in spite of the Plan's language to the contrary. The Court agreed. Notwithstanding the fact the agreements were found to have amended the Plan, the Court went on to hold that Brockett and Crawford would still have been able to survive summary judgment on the basis of a promissory estoppel claim under ERISA. The Court found the two employees were able to meet the elements of an estoppel claim, including the element of demonstrating an injury caused by detrimental reliance on a promise. Even though the two employees would have been fired, whether or not they signed their resignation letters, they forfeited the power to withhold their consent to the termination of their employment in reliance on the fact that they would receive an additional plan contribution. For the Court, this was enough to satisfy the injury element of the estoppel claim.

Ramos v. SEIU Local 74 Welfare Fund, 28 EB Cases 1040 (S.D.N.Y. 2002): Ramos was a union member who was covered by a multi-employer benefit plan. The terms of the fund in regard to eligibility were unambiguous. To be eligible for single coverage under the fund, an employee must work 60 hours in a payroll period. To be eligible for family or dependent coverage, an employee must work 150 hours in a payroll period. Ramos contacted a benefit claims supervisor and inquired whether the fund would cover the expenses of an out of country birth. The claims supervisor told Ramos that the expenses would be covered. Ramos, however, failed to work the requisite 150 hours in the payroll period and was therefore ineligible for family coverage. When Ramos made a claim for the expenses of his child's birth, the claim was denied. Ramos brought a suit claiming promissory estoppel. The Court granted summary judgment for the Defendants. In

the Second Circuit, promissory estoppel claims require an additional element of “extraordinary circumstances” to estop the denial of benefits under an ERISA plan. The Court found that the facts were not extraordinary because there was no deception or intentional inducement and the eligibility terms of the fund were unambiguous.

Zack v. Hartford Life and Accident Insurance Company, 27 EB Cases 3006 (D. Kan. 2002): Zack, a pediatrician, practiced at a hospital. Then, Zack and other doctors, formed their own private practice. The doctors looked for a company to replace the insurance coverage and benefits they had at the hospital. The doctors chose a company that provided a “no loss/no gain” provision in its policy. This provision was extremely important to Zack, as a cancer survivor in remission, because it meant the plan would accept all participants as they were under the prior plan. Unfortunately, the insurance company made false representations that the “no loss/no gain” policy was included in the plan when in fact they had left it out. Subsequently, Zack made a claim for benefits due to reoccurrence of his cancer and was denied. Zack brought an estoppel claim to prevent the denial of benefits. Citing Tenth Circuit precedent, the Court asserted that to uphold an estoppel claim under ERISA there must be either a challenged representation of an unambiguous term of an employee benefit plan based on lies, fraud, intent to deceive, or other egregious or extraordinary circumstances; or the representation interpreted an ambiguous term of the plan. The Court, construing the evidence in Zack’s favor in deciding whether to allow an amended complaint, found that Zack could meet the first of these two possibilities for estoppel and, therefore, permitted an estoppel claim to be added.

McConnell v. Costigan, 29 EB Cases 1053 (S.D.N.Y. 2002): McConnell and two other attorneys, brought suit against their former firm to recoup profit-sharing contributions never provided to them by the firm. The firm established a pension benefit plan for its employees, to which the firm could make profit-sharing contributions. The firm had been designated the Plan Administrator. The terms of the Plan were unambiguous and clearly provided that the employer’s profit-sharing contributions were discretionary. The firm, however, distributed an informal memorandum that provided the firm would continue its practice of making profit-sharing contributions equal to 5% of eligible compensation. Plaintiffs claimed that not only did this memorandum amend the Plan, it also created a promise that estopped the firm from denying the contributions. The Court disagreed and granted summary judgment for the firm based on the fact that the memorandum did not amend the Plan. In a footnote, the Court opined that the Plaintiffs had no estoppel claim because they failed to make a showing of extraordinary circumstances, as the memorandum was informal; there was no evidence of false statements or that the firm lied; and the promise was more of a prediction than an assurance.

Brant v. The Principal Life and Disability Insurance Company, 195 F. Supp. 2d 1100, 28 EB Cases 1849 (N.D. Iowa 2002): Brant’s employer provided life insurance to its employees. Brant became unable to perform his normal job with the employer and applied for long term disability (LTD) benefits. The human resource manager sent Brant a letter that stated Brant had been approved for LTD and that these benefits would continue without any cost to Brant. The life insurance policy, however, had a covered-during-disability (CDD) provision that provided that a participant need not pay premiums if he becomes disabled. The life insurance policy had requirements that Brant admitted he did not meet. Accordingly, the employer notified Brant that his life insurance policy was being terminated. The Court found that any reliance by Brant on the human resource manager’s representation was misplaced because the CDD provision was unambiguous. Thus, the Court held Brant could not prevail on a promissory estoppel theory.

3. Representations Contrary to the Plan's Interpretation of Ambiguous Written Plan Provisions

Davis v. Combes, 294 F.3d 931, 28 EB Cases 1385 (7th Cir. 2002): Brenda and David Combs were a married couple that had several life insurance policies. Each of their life insurance policies was affected by several changes in the named beneficiaries. The life insurance plan offered by Brenda's last employer originally named David and his daughter as the beneficiaries. Unbeknownst to David, Brenda attempted to change the beneficiary under that policy to her sister, Linda Davis. Brenda filled out the beneficiary designation form, but forgot to sign and date it. The effectiveness of this attempted change was in dispute. After Brenda died suddenly, David discovered the attempted beneficiary change and brought a suit against Linda Davis to obtain the money from the policy for himself and his daughter. The District Court allowed David to do this via a federal common law estoppel theory. The Circuit Court asserted that estoppel is at best a difficult theory to use with respect to an ERISA plan. In ruling on Brenda's attempted change of the beneficiary, the Court used a four-element test to determine if equitable estoppel could prevent Linda Davis from taking the money under the life insurance plan's current terms. The Court concluded that the estoppel claim failed because there was no knowing misrepresentation in writing from Brenda to David that he was still the plan's beneficiary.

Beach v. Mutual of Omaha Insurance, 2002 U.S. Dist. LEXIS 21455 (Dist. Kan. 2002): Kevin Beach is the son of Barry Beach, who worked for an employer that provided a group health insurance plan. Kevin was an eligible beneficiary under the Plan as long as he remained unmarried, under the age of 23, and a full-time student at an accredited college. When Kevin dropped out of full-time enrollment, the Plan dropped him as an eligible beneficiary. Approximately six months later, Kevin enrolled at another full-time college and paid his full tuition. Barry contacted his insurance agents and was orally assured that Kevin would be covered under the Plan. After these assurances but before Kevin could actually start back at college, Kevin was in an automobile accident and made claims on the Plan for medical benefits. The claims were denied because Kevin had not yet begun to attend classes. Kevin brought suit, and as one of his theories to recover the medical benefits, Kevin asserted an estoppel claim. The Court, based on Tenth Circuit precedent, stated that if an estoppel claim is brought under ERISA it would only be recognized if (1) the challenged representation concerned an unambiguous term of an employee benefits plan but was based on lies, fraud, intent to deceive or other egregious or extraordinary circumstances; or (2) the representation constituted an interpretation of an ambiguous term of an employee benefits plan. The Court ruled that Kevin's estoppel claim survived summary judgment because the Plan was ambiguous as to whether the term full-time student means enrolling in versus actually attending classes.

Cogan v. Phoenix Life Insurance Company, 27 EB Cases 2326 (D. ME 2002): Plaintiffs worked as sales representatives for an employer that provided a deferred compensation plan. The Plaintiffs' original employer was purchased by another company. In conjunction with this purchase, the Plan Administrator, Phoenix Life, amended the plan. The original terms of the Plan made employees eligible to receive a lump-sum payment of their accrued benefits when their employment with the original employer was eliminated. The amendment made an employee's lump-sum payment contingent upon the elimination of his/her position with the new employer. The Plaintiffs brought suit under an equitable estoppel theory. The Court granted summary judgment for the Defendants. The Court asserted that an equitable estoppel claim under ERISA is limited to situations where the subject provisions of the Plan are ambiguous and oral representations interpreting the Plan are made to the employee. The Court ruled that the Plaintiff failed to allege the existence of any ambiguous Plan provision or that any oral representations concerning such a provision were made.

Swearingen v. Honeywell, 189 F. Supp. 2d 1189, 27 EB Cases 2471 (D. Kan. 2002): Plaintiff is the common law wife and widow of Steve Swearingen, who was an employee of Honeywell, Inc. Plaintiff sought survivor pension benefits from Honeywell. In that vein, Honeywell's in-house counsel sent a letter to Plaintiff that outlined the benefits payable to Plaintiff under Honeywell's plans. One of the benefits mentioned was a survivor income benefit. Plaintiff detrimentally relied on Honeywell's representation regarding the availability of benefits. Almost a year later, another in-house attorney for Honeywell sent Plaintiff a letter stating that the former representations regarding benefits available to Plaintiff was incorrect. The letter explained that Mr. Swearingen was in fact not eligible for the survivor benefits because she did not meet pertinent plan requirements at the time of her husband's death. Plaintiff claimed that the plan's terms were ambiguous as to her eligibility for the survivor income benefits. Plaintiff brought a suit and claimed that Honeywell was estopped from denying her the survivor benefits based on the representations made to her in the in-house counsel's first letter. Although the Court agreed that the Tenth Circuit did indicate that if an equitable estoppel claim were available it would apply only with respect to an employer's representations that constituted an interpretation of an ambiguous plan term. Citing, *Averhart v. US West Management Pension Plan*, 46 F.3d 1480, at 1486 (10th Cir. 1994). The Court found that Plaintiff's estoppel claim satisfied this requirement and, therefore, survived summary judgment.

4. Misrepresentations Made by a Fiduciary

McGrath v. Lockheed Martin Corp., 29 EB Cases 1101 (6th Cir. 2002): The appellate court affirmed a trial court's order that an employer as an ERISA fiduciary breached its fiduciary duty by incorrectly informing an employee that the employee had to remain on "active payroll" to take advantage of a pending proposed change in the early retirement plan.

James v. Pirelli Armstrong Tire Corp., 305 F.3d 439 (6th Cir. 2002): The appellate court reversed a trial court's decision that the employer, as an ERISA fiduciary, did not breach its fiduciary duty to employees who, in group meetings and exit interviews, received materially misleading or inaccurate and misleading information regarding future change requests pertaining to retiree medical benefits even if the employees did not affirmatively request such information. Although the SPD contained a reservation of rights clause permitting the employer to change retirement medical benefits in the future, the employer nevertheless affirmatively led retiring employees to believe that the employer would not change the retirement medical benefits. The employer subsequently amended the retirement plan to provide less in benefits than represented to the retired plaintiffs. The Sixth Circuit approved *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 57 F.3d 1255 (3d Cir. 1995) and *McMunn v. Pirelli Tire L.L.C.*, 161 F. Supp. 2d 97 (D. Conn. 2001).

Kamler v. H/N Telecommunication Services, Inc., 305 F.3d 672, 28 EB Cases 2741 (7th Cir. 2002): The appellate court rejected a former employee's claim that he was misled by his former employer into not applying for the employer's group health and disability plans thus leaving him without health insurance coverage. Although the employer informed the employee on several occasions that forms needed to be completed and the employee admitted he had always had to file a form to enroll in a health plan before, the employee claimed that the verbiage of the requests for the employee to fill out forms also misled the employee to believe that he already had coverage and that the employer, by failing to answer the employee's questions about confidentiality, misled him into believing he already had coverage. The appellate court analyzed the claim as one rooted in estoppel and, as a predicate to liability, required both specific written misrepresentations by the employer that the employee need not fill out the forms and that the alleged misrepresentations be made intentionally. Further, the court held that the employee could not reasonably rely upon the alleged verbiage representing the employee already had coverage where, among other things, the

plan document unambiguously required the completion of enrollment forms to obtain coverage. The court also rejected the employees' breach of fiduciary duty claim because a fiduciary need not emphasize the requirements it had already communicated with the employee.

Davis v. Combes, 294 F.3d 931, 28 EB Cases 1385 (7th Cir. 2002): The court reversed a trial court by rejecting an estoppel claim raised by the employee's spouse and directed at the employee. The employer accepted an unsigned and undated change of beneficiary form for a life insurance policy and issued a letter which confirmed that the change of the beneficiary form was effective. The employee had made oral representations to her husband that she would provide for him through the purchase of life insurance policies. The husband claimed the wife was equitably estopped from changing the beneficiary. Curiously, the Seventh Circuit applied the estoppel test identified in *Downs v. World Center Press*, 214 F.3d 802 (7th Cir. 2000), and rejected the husband's claim. The appellate court then adopted the substantial compliance doctrine to validate the incomplete beneficiary change form.

Beach v. Mutual of Omaha Insurance Co., 2002 U.S. Dist. LEXIS 21455 (D. Kan. 2002): The court denied a motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) as to an equitable estoppel claim under ERISA predicated on willful and/or reckless misrepresentations. The court predicted that the Tenth Circuit would recognize an equitable estoppel claim under ERISA if the misrepresentation was an intentional effort to mislead as to an unambiguous plan provision or a representation that constitutes an interpretation of an ambiguous plan provision. Since the plaintiff employee alleged willful and/or reckless misrepresentations, the employee stated a claim upon which relief could be granted.

Marchall v. Ormet Corp., 228 F. Supp. 2d 811 (S.D. Ohio 2002): The court denied a motion to dismiss a complaint under Federal Rule of Civil Procedure 12(b)(6) where the plaintiff alleged that the employer had incorrectly advised him that he was not eligible for disability retirement benefits and the employee, therefore, did not pursue an appeal of the denial of his benefit claim. When benefits were awarded several years later the plaintiff sued, alleging various state law claims which were pre-empted by ERISA. The court noted that the facts supporting the state law breach of fiduciary duty, fraud and misrepresentation claims would support certain ERISA claims if properly pled. The court permitted the plaintiff time to amend the complaint to state an ERISA based claim.

Arnbruster v. K-H Corp., 206 F. Supp. 2d 870, 28 EB Cases 1687 (E.D. Mich. 2002): The court granted summary judgment as to the plaintiffs' ERISA breach of fiduciary duty claims. The plaintiffs argued that the Defendant along with plaintiffs' employer, had promised to pay the employees cost of retirement medical benefits for life. The court rejected this claim, noting that the pertinent plan documents contained reservations of the right to amend the plan. The court construed the representations of lifetime benefits as correct when made but nevertheless subject to change. The Defendant did not breach its fiduciary duty as alleged. Furthermore, since the plan documents were not ambiguous, the plaintiffs' equitable and promissory estoppel claims failed.

Burstein v. Retirement Account Plan for Employees of Allegheny Health Education & Research Foundation, 28 EB Cases 2800 (E.D. Pa. 2002): The court granted a motion for failure to state a claim pursuant to Federal Rule of Civil Procedure 12(b)(6) against misrepresentations brought by a putative class of employees. The employees, who were employed less than 5 years, were not entitled to plan benefits under a cash balance defined benefit retirement plan. The employees claimed that the plan brochure and SPD contained misrepresentations causing the employees to believe that their rights had vested. The court, citing *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 58 F.3d 896 (3rd Cir. 1995), required allegations of misrepresentations,

reasonable reliance and extraordinary circumstances to adequately plead estoppel. The court refused to apply estoppel to the Pension Benefit Guaranty Corporation which, for purposes of an estoppel claim, is treated as a governmental entity. The court rejected the remaining estoppel questions based on lack of standing since the parties before the court did not make the alleged misrepresentations. The court rejected the SPD and plan brochure misrepresentation claims as a predicate to breach of fiduciary duty because no reliance was made on the alleged representation where the employees were not vested and could do nothing to become vested before such employee's five year anniversary.

Brant v. The Principal Life & Disability Insurance Co., 195 F. Supp. 2d 1100, 28 EB Cases 1849 (N.D. Iowa 2002): The court granted summary judgment against estoppel and breach of fiduciary duty claims brought by an employee whose life insurance coverage was cancelled by Principal after the employer allegedly informed the employee that he would no longer need to contribute to maintain his life insurance policy coverage. The employee sued both Principal and his employer. The court dismissed the promissory estoppel claims as an effort to obtain money damages by informal amendment to the plan where did not provide for lifetime basic life insurance benefits. The court also dismissed the promissory estoppel claim as to Principal since Principal did not make the alleged misrepresentations. The court first analyzed the breach of fiduciary duty by misrepresentation claim as one for equitable estoppel. The court applied both the Third Circuit's extraordinary circumstances test announced in *Curcio v. John Hancock Mutual Life Insurance Co.*, 33 F.3d 226 (3rd Cir. 1994) and Seventh Circuit test identified in *Coker v. Trans-World Airlines, Inc.*, 165 F.3d 579 (7th Cir. 1999). Although the court found that the misrepresentation was material, it rejected the equitable estoppel claims since no evidence showed that the misrepresentation was intentional and the employee's reliance on the misrepresentation was not reasonable.

Dobson v. Hartford Financial Services, 196 F. Supp. 2d 152, 28 EB Cases 2658 (D.Conn. 2002): The court granted summary judgment against a beneficiary's breach of fiduciary duty claims. The plan document did not state that beneficiaries were entitled to delay interest but the plan provider admitted that it paid delay interest *ex gratia* as a policy matter. The beneficiary, whose received delayed payments as a result of a suspension of benefits, sued claiming that the provider had a fiduciary duty to disclose the availability of delay interest but did not do so. The court found that since the plan document did not provide for delay interest, that no fiduciary duty existed to inform the beneficiary of the *ex gratia* practice of paying delay interest.

McCoy v. Board of Trustees of the Laborers' International Union, 188 F. Supp. 2d 461 (D.N.J. 2002): The court applied the tests announced in *Daniels v. Thomas & Betts Corp.*, 263 F.3d 66 (3rd Cir. 2001) and *Adams v. Freedom Forge Corp.*, 204 F.3d 475 (3rd Cir. 2000), to reject a beneficiary's claim for breach of fiduciary duty based upon alleged misrepresentations. The beneficiary was awarded retroactive benefits by the trial court which then determined that, based upon the award of benefits, the beneficiary had not suffered any detriment from relying on the alleged misrepresentation.

In re Managed Care Litigation, 185 F. Supp. 2d 1310 (S.D. Fla. 2002): The court determined that neither a SPD nor a Plan Administrator was required by ERISA to disclose financial incentives paid to providers or employees in the claims review process. Therefore, no breach of a fiduciary duty occurred.

5. Misrepresentation Made Prior to the Establishment of a Plan

Mushalla v. Teamsters Local No. 863 Pension Fund, 300 F.3d 391, 28 EB Cases 2098 (3rd Cir. 2002): The appeals court held that the employer did not violate its fiduciary duty by failing to inform the employee of a retirement plan change which was not being given serious consideration

at the time when the employee inquired about the possibility of pension plan changes. The employer correctly stated at the relevant time that no pension increase was being considered. The employee received the information from another person who received the information from the employer. The court defined “serious consideration” as requiring a specific written proposal being discussed by senior management for the purposes of implementation. The court rejected an invitation from the plaintiffs to distinguish *Fischer v. Philadelphia Electric Co.*, 96 F.3d 1533 (3rd Cir. 1996) from cases involving multi-employer plans.

Hart v. Equitable Life Assurance Soc., 2002 U.S. Dist. LEXIS 22928 (S.D.N.Y. 2002): The court granted summary judgment against a retired employee who, for a period of ten years or more, received estimates of her future retirement benefits which were significantly inflated by a data error in the computer system used to generate the estimates. More recently, the estimated benefit information was mailed to the employee before she retired. The estimates contained express notations that the future benefit listed was only an estimate of benefits as opposed to a guaranty of the estimated benefits and also expressly stated that the plan documents controlled the amounts actually due. The estimate incorrectly credited the employee with ten extra years of service which resulted in approximately an additional \$1,000.00 per month in estimated benefits. The error was discovered when the employee requested benefits. The employer paid the lesser amount of benefits claiming that the estimates were subject to change and the plan determined the amount owed to the employee. The Second Circuit requires proof of a material misrepresentation, reliance and damage plus “extraordinary circumstances” to make out an estoppel claim in the ERISA context. The cautionary language in the written estimates precluded the estoppel claim. Moreover, the written estimates did not breach rise to an “affirmative misrepresentation” which would violate a fiduciary duty. Lastly, the employee failed to demonstrate “extraordinary circumstances” inasmuch as the error in benefits estimates was accidental.

In *Beach v. Commonwealth Edison Co.*, 28 EB Cases 2298 (N.D. Ill. 2002), the court denied a motion for summary judgment requested by the Defendant employer accused of misrepresenting that it was not considering adopting any retirement incentive plans for the particular department which employed the plaintiff when the employer adopted such a plan shortly after the plaintiff employee retired. While the employer had taken certain measures prior to plaintiff’s resignation to plan, draft and discuss a proposed retirement incentive program, the employer argued that since the new plan offering was not given “serious consideration” before the plaintiff resigned, no beach of fiduciary duty existed. The plaintiff responded by arguing that the materiality standard applied to determine whether the employer breached its fiduciary duty. The court found that a misrepresentation occurred and that a fact issue existed with regard to the materiality of the representation that the particular department would not have a severance plan.

Nydes v. Equitable Resources, Inc., 27 EB Cases 2520 (10th Cir. 2002) (*unpublished*): The appellate court affirmed summary judgment where an employee failed to create a genuine issue of material fact showing that the Plan Administrator was seriously considering a change to a retirement plan when the Administrator informed the employee of the plan benefits. The employee also failed to raise an issue of fact showing that he could have taken advantage of the plan modification as his employment, in any event, would have ended prior to the effective amendment date for the plan.

H. Summary Judgment

Geiger v. Unum Life Insurance Co. of America, 213 F. Supp. 2d 813, 28 EB Cases 2760 (N.D. Ohio 2002): Plaintiffs filed suit regarding alleged wrongful denial of benefits under an ERISA plan. After removal, Defendants moved to dismiss on the grounds of ERISA preemption. Though the court found Plaintiff’s state law claims preempted, it denied Defendant’s motion to dismiss on

the grounds that Plaintiffs could assert ERISA claims. In dicta, the court noted that the *Wilkins* summary judgment procedure appeared to apply only where an ERISA plan does grant its Administrator discretionary authority to determine eligibility for benefits or to interpret the terms of the plan.

Waters v. Pension Benefit Guaranty Corp., 28 EB Cases 2234 (E.D. Tenn. 2002): Plaintiff filed suit seeking disability pension benefits denied by the Pension Benefit Guaranty Corp. (“PBGC”). PBGC moved for summary judgment. The Court noted that in actions against the PBGC, like an ERISA action, the proper procedure for adjudicating a denial of benefits “is in the nature of a review of the Administrator’s decision at issue, not a bench trial of summary judgment action.”

Parker v. Union Planers Corp., 203 F. Supp. 2d 888 (W.D. Tenn. 2002): Plaintiff filed suit against Defendant alleging a denial of benefits claim under section 502 of ERISA, and wrongful termination for purposes of interfering with the attainment of benefits in violation of section 510 of ERISA. Citing *Wilkins*, the court noted that summary judgment was inappropriate in addressing section 502 ERISA denial of benefit claims. According to the court, summary judgment, is appropriate for adjudicating section 510 ERISA claims. The court noted that *Wilkins* requires the District Court to conduct a *de novo* review based solely upon the administrative record and render findings of fact and conclusions of law accordingly. *Parker*, 203 F. Supp. 2d at 892. The court also noted that *Wilkins* did not alter the arbitrary and capricious standard announced in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

Wages v. Sandler O’Neill and Partners, LLP, 27 EB Cases 2814 (6th Cir. 2002) (*unpublished*): Plaintiff sued under ERISA regarding Defendant’s denial of her claim for permanent disability benefits under an employment benefit plan. The District Court granted summary judgment in Defendant’s favor, concluding that as a matter of law, the administrative record failed to show that the decision to deny benefits was arbitrary and capricious. The Court of Appeals noted that the district court disposed of Plaintiff’s case on summary judgment contrary to the procedure set forth in *Wilkins v Baptist Healthcare System, Inc.*, 150 F.3d 609 (6th Cir. 1998), but held that because the District Court properly applied the “arbitrary and capricious” standard of review, reliance on summary judgment standards did not warrant reversal.