

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

LARAINÉ CANNON,	:	CIVIL ACTION
	:	
Plaintiff,	:	
	:	
v.	:	
	:	
THE VANGUARD GROUP, Inc.,	:	
	:	
Defendant.	:	NO. 96-5495

MEMORANDUM

Reed, J.

June 11, 1998

Plaintiff LaRaine Cannon brings this lawsuit against defendant The Vanguard Group, Inc. seeking to recover long term benefits allegedly owed her. This action is governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132 (“ERISA”). Pending before the Court is the motion of plaintiff for summary judgment. (Document No. 35). For the following reasons, I will deny the motion.

I. BACKGROUND

Plaintiff was employed as a Processing Associate by defendant The Vanguard Group, Inc. (“Vanguard”). Plaintiff was covered by a policy of group insurance providing employment disability benefits to employees of Vanguard.¹ Continental Casualty Company (also known as the CNA Insurance Companies) is the Plan Administrator.

On January 31, 1995, plaintiff was injured in an incident that occurred outside her place of employment in a local supermarket. Plaintiff has not worked at Vanguard since that

¹ I will refer to the policy of insurance providing total disability benefits, which plaintiff attaches to her Amended Complaint, as the “Plan.” (Amended Complaint, Ex. A). I note that the Plan, as attached, contains only pertinent portions and is not complete.

date. Plaintiff collected short term disability benefits under the Plan until June 20, 1995. She timely filed an application for long term disability benefits, for which she was denied.

Plaintiff filed a complaint in state court against defendant CNA Insurance Companies, which defendant removed on August 7, 1996 to the United States District Court for the Eastern District of Pennsylvania. The Court ruled that the complaint alleges a claim pursuant to group disability plan of plaintiff's employer, which is thus an employee benefit plan governed by ERISA, and thus removal was proper. (Order dated 10/3/96, Document No. 10). On February 3, 1997, plaintiff filed an Amended Complaint (Document No. 23), whereby plaintiff substituted her employer Vanguard for the Plan Administrator, CNA Insurance Companies, as named defendant, alleging a breach of contract claim and a bad faith claim under state law.² Defendant Vanguard on April 7, 1997 answered the Amended Complaint and asserted, *inter alia*, that the contract and bad faith state law claims were preempted by ERISA. (See Answer at ¶ 11 and Ninth Affirmative Defense, Document No. 30).

II. SUMMARY JUDGMENT STANDARD

Under Federal Rule of Civil Procedure 56(c), summary judgment “shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” Fed. R. Civ. P. 56(c). The district court is required, in resolving a motion for summary judgment, to determine whether “the evidence is such that a reasonably jury could return a verdict for the nonmoving party.”

² I have determined in a separate order on this same date that plaintiff's bad faith claim is preempted by ERISA. See Ferry v. Mutual Life Ins. Co. of N.Y., 868 F. Supp. 764, 770-72 (W.D. Pa. 1994); Rallis v. Trans World Music Corp., No. 93-6100, 1994 WL 96264, at *4 (E.D. Pa. Mar. 25, 1994).

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). In making this determination, the evidence of the nonmoving party is to be believed, and the district court must draw all reasonable inferences in the nonmovant's favor. See id. at 255.

The moving party has the initial burden to identify evidence that he believes shows an absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 324 (1986). If this is accomplished, the burden shifts to the nonmoving party to “do more than simply show that there is some metaphysical doubt as to the material facts.” Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586 (1986). The nonmoving party may not rely merely upon bare assertions, conclusory allegations, or suspicions. Fireman's Ins. Co. of Newark v. DuFresne, 676 F.2d 965, 969 (3d Cir. 1982).

III. ANALYSIS

A. Whether Administrator Has Discretion under the Plan

The United States Supreme Court in Firestone Tire and Rubber Company v. Bruch held that “a denial of benefits challenged under [ERISA] is to be reviewed under a *de novo* standard, unless the benefit plan gives the administrator authority to determine eligibility for benefits or to construe the terms of the plan.” 489 U.S. 101, 115 (1989).

Whether a plan confers discretionary powers upon the plan administrator depends upon the terms of the plan. Luby v. Teamsters Health, Welfare and Pension Trust Funds, 944 F.2d 1176, 1180 (3d Cir. 1991). Discretionary powers may be either expressly granted or implied by a plan's terms. Id. In Luby, the Court of Appeals for the Third Circuit affirmed the finding of the lower court that the language in the plan conferred discretion to select a system of administration, but not for deciding whether to pay benefits on a case-by-case basis. Id. The

Luby court observed that the plan did “not refer specifically to any power to decide disputes between beneficiary claimants” and that the plan “neither states or implies that fact-based beneficiary determinations are to be accorded deference on review.” Id. The court continued, “If a plan’s grant of general administrative power is construed to be the general grant of discretionary power to decide all disputes arising under the [p]lan, then an ERISA plan administrator’s decisions might all be subject to deferential review.” Id. at 1180-81.

Applying the precedent in Luby, I find that the policy at issue here reserves no such discretion, expressly or impliedly, to the Plan Administrator. To support its argument that the Plan grants the Plan Administrator discretion, defendant points to several provisions in the Plan and related documents that: (1) require “due written proof of loss,” (Plan at 7);³ (2) authorize the Plan Administrator to undergo an examination by an independent physician to determine the validity and extent of disability (Def. Ex. B, Summary Plan Description at 3);⁴ and

³ The relevant provisions provide:

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

TIME OF PAYMENT OF CLAIM. Benefits will be paid monthly immediately after We receive due written proof of loss.

(Plan at 7). Defendant argues that the modifier “due” means that the proof submitted to the plan administrator must be adequate, thus demonstrating that Plan Administrator must be satisfied that the claimant is entitled to compensation under the plan.

⁴ This provision provides:

Verification of Disability

You must be under the direct care of a doctor, who will periodically be required to certify in writing that you continue to be disabled, and you must be following a prescribed course of treatment recommended by that doctor. Vanguard and the Comprehensive Disability Management administrator and/or insurance carrier reserve the right to request written proof of disability and/or require the employee to undergo an examination by an independent physician to

(3) oblige the Plan Administrator to notify, in writing, the employee when a claim for disability income benefit is denied (Def. Ex. C, Vanguard Navigational Guide at 13).⁵

I am not persuaded that the language contained in these provisions is sufficient to warrant a deferential “arbitrary and capricious” standard of review. At most, this language confers only *de minimis* discretion. Based on my review of the Plan and related documents, I find that there is no language, express or implied, that refers to any discretionary power of the Plan Administrator to determine disputes on a case-by-case basis arising from a beneficiary’s claim of disability. See Luby, 944 F.2d at 1181.⁶

determine the validity and extent of the disability. . . .

(Def. Ex. B, Summary Plan Description at 3).

⁵ This provision provides:

All claim decisions for the disability income benefit should be communicated to the crew member in writing.

(Def. Ex. C, Vanguard Navigational Guide at 13).

⁶ In addition, most of the post-Firestone decisions in the Third Circuit that have applied a deferential review involved policy provisions unlike the language contained in the Plan at bar. See, e.g., Morris v. Paul Revere Ins. Group, 986 F. Supp. 872, 883 (D.N.J. 1997) (policy provides that plan administrator “has full, final, complete, conclusive, and exclusive discretion to determine eligibility for coverage and benefits”); Pokol v. E.I. Du Pont de Nemours and Co., Inc., 963 F. Supp. 1361, 1371 (D.N.J. 1997) (plan provides that “Board of Benefits and Pensions retains discretionary authority to determine eligibility for benefits hereunder and to construe the terms and conditions of the [Plan]”); Stout v. Bethlehem Steel Corp., 957 F. Supp. 673, 677, 690 (E.D. Pa. 1997) (plan provides that Plan Administrator shall “decide such question as may arise in connection with the operation of this Plan” and “[i]f any difference shall arise . . . with respect to a determination of the Plan Administrator . . . [the affected person] may requests a review of the matter by the [Employee Benefits Administration Committee]” and “[t]he Committee shall have full power and authority to interpret or construe any provision of the Plan which may be ambiguous, or with respect to which there is any disagreement between the Plan Administrator and any Participant”); Perri v. Reliance Standard Life Ins. Co., Civ. No. 97-1369, 1997 WL 476386, at *5 (E.D. Pa. Aug. 19, 1997) (plan provides that “Plan Administrator has the sole discretion and authority to apply, construe, and interpret all Plan provisions, to grant or deny all claims for benefits, and to determine eligibility issues”).

I also note that, in VanVolkenburg v. Continental Cas. Co., a district court in the Western District of New York affirmed the magistrate’s finding that the policy, which was, like in our case, issued by the Continental Casualty Company, did not reserve discretion for the plan administrator. 944 F. Supp. 198, 200-01 (W.D.N.Y. 1996). Although it is not known whether the policy in VanVolkenburg contains similar language to the Plan at bar, I believe it is worthy of mention here.

At least in one recent decision, however, a district court applied a deferential standard of review where the policy provision did not expressly confer discretion. In Walker v. Smithkline Beecham & Chemco, Civ. No. 96-5273, 1997 WL 137331, (E.D. Pa. Mar. 24, 1997), aff'd, 133 F.3d 912 (3d Cir. 1997), the plaintiff was seeking severance payment allegedly due him under the plan. The court found that the plain language of the plan granted discretion to defendants to determine eligibility. Id. at *6-7. The relevant provision stated that “separation pay may be granted to . . . [an] employee who is permanently laid off as a result of a reduction in force or whose job is eliminated.” Id. at *7. The court was persuaded by the placement of the verb “may” and stated that if defendants had wanted, they could have used more categorical language, such as “will be granted to” Id.

The categorical language contemplated by the Walker court is actually present in the Plan here. The relevant language in the Plan provides:

TOTAL DISABILITY BENEFIT. We will pay the Monthly Benefit for each month of Total Disability which continues after the Elimination Period. . . .

RESIDUAL DISABILITY BENEFIT. We will pay a Residual Disability Benefit for each month of Residual Disability which follows: (1) the Elimination Period; or (2) a period for which Total Disability Benefits were payable. . . .

(Plan at 4). And, as mentioned earlier, the policy states:

TIME OF PAYMENT OF CLAIM.

Benefits will be paid monthly immediately after We receive due written proof of loss.

(Plan at 7). Also, under the Long Term Disability portion of the Summary Plan Description, states that “[a]ll disability benefits are paid directly to you.” (Def. Ex. B at 7, Summary Plan Description).

The only area granting discretion in the Plan is found under Payment of Claim provision, which states:

PAYMENT OF CLAIM. All Disability benefits are paid to the Insured Employee. Any accrued Disability or Survivor Income benefits unpaid at the Insured Employee's death will be paid to the named beneficiary, if any. If there is no surviving named beneficiary, payment *may be made, at Our option*, to the surviving person or persons . . . of the following classes . . . (a) spouse; (b) children; . . . (c) parents; or (d) estate. If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We may pay up to \$1,000 to any relative or beneficiary of the Insured Employee whom We deem to be entitled to this amount. . . .*

(Plan at 7) (emphasis added).

This discretionary language, however, deals with payments to beneficiaries, and not whether an employee has a Total Disability within the meaning of the Plan. Moreover, it shows that the Plan was capable of clearly articulating discretionary power in certain instances, but did not do so with respect to Total Disability benefits.⁷ In the absence of similar language with respect to determining Total Disability criteria, I cannot apply a deferential standard of review. Therefore, I conclude that a *de novo* standard of review is appropriate.

B. Interpretation of "Total Disability" under the Plan

Because I review the denial of benefits *de novo* to determine whether a genuine issue of material fact exists, I must first decide whether the Plan Administrator applied a correct interpretation to the meaning of Total Disability. Under a *de novo* standard of review, the court must "adopt the most reasonable understanding of the term." Bruch v. Firestone Tire and Rubber Co., 828 F.2d 134, 148 (3d Cir. 1987).

⁷ Given the relative ease with which drafters of employee benefit plans could insert boilerplate language to ensure the application of a deferential standard of review over the decisions of the plan administrator, I am even less inclined to infer any discretion from the language contained in the Plan.

Total Disability is defined in the Plan as follows:

“Total Disability” means that because of Injury or Sickness, the Insured Employee is:

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

(Plan at 3). Plaintiff argues that provisions (1) and (2) are separate, independent clauses because they are separated by semicolons and are not joined by a conjunction. Plaintiff thus asserts that she meets the definition of disabled if she provides evidence that she is either continuously unable to perform all the substantial and material duties of her regular occupation or is under the regular care of a physician and not gainfully employed in any occupation for which she is qualified. Plaintiff also argues that defendant misrepresented the definition of Total Disability in a letter dated April 22, 1995 (Pl. Ex. E); (Def. Ex. D) and in a letter dated September 5, 1995. (Pl. Ex. H); (Def. Ex. G).

Both arguments lack merit. First, I find that, based on a comparison of the definitions of Total Disability set forth in the Plan and the two letters, the language is virtually identical. Thus, defendant did not materially misrepresent the definition in any way. Second, I find from the plain, unambiguous language of the Plan that the definition of Total Disability is satisfied only if *all three* clauses are met. This conclusion is consistent with the use of punctuations and the conjunction “and” contained in the definition.

Plaintiff further argues that defendant imposed conditions, *i.e.*, that a claimant for total disability benefits provide objective evidence of the disabling condition, that were not expressly outlined under the Plan. I reject this argument as well. I find that plaintiff must show

that she meets the requirements of Total Disability by presenting proof, beyond subjective complaints, that she is unable to perform the substantial and material duties of her regular occupation, that she is under the regular care of a physician, and that she is not gainfully employed in any occupation for which she is or becomes qualified. Moreover, the Plan requires that plaintiff submit “due” written proof of loss (Plan at 7), which further demonstrates that proof, beyond subjective complaints, is required. And, finally, plaintiff was specifically advised of this requirement in a letter dated April 22, 1995. (See 4/22/95 Letter, Pl. Ex. E; Def. Ex. D).⁸ In the context here, where the Plan requires “due” proof of loss, where plaintiff was specifically advised that she had to provide objective evidence, and where medical evidence of the etiology of the alleged disabilities (severe neck, back, shoulder, knee, and leg pains) is available,⁹ I conclude that, even under a *de novo* review, defendant did not err by requiring plaintiff, to simply produce objective evidence to meet the definition of Total Disability.

C. Material Facts in Dispute as to Whether Plaintiff Is Totally Disabled under the Plan

Defendant argues that the Plan Administrator considered all the medical records, x-rays, MRIs, and physicians’ reports submitted by plaintiff, but that these submissions failed to

⁸ The 4/22/95 Letter stated, in pertinent part:

diagnostic Objective evidence means medical signs and findings established by medically acceptable techniques which show the existence of a medical impairment that results from an anatomical, physiological or psychological abnormality which could reasonably be expected to produce the pain or other symptoms alleged. Subjective complaints alone shall not be considered conclusive evidence of disability.

(4/22/95 Letter, Pl. Ex. E; Def, Ex. D).

⁹ Cf. Mitchell v. Eastman Kodak Co., 113 F.3d 433, 442-43 (3d Cir. 1997) (holding that it was arbitrary and capricious for administrator to deny claimant benefits because of lack of clinical evidence of such etiology of chronic fatigue syndrome (CFS) where CFS has no known etiology; but stating that in some contexts requiring evidence of the etiology of an allegedly disabling symptom would be appropriate).

render plaintiff totally disabled within the meaning of the Plan. Defendant neither presents nor discusses any medical information other than that submitted to the Plan Administrator by plaintiff.

On April 22, 1995, defendant sent a letter to plaintiff denying her claim for disability benefits. This letter outlined the medical information reviewed by defendant and explained why defendant believed the medical data available failed to render plaintiff totally disabled. (Pl. Ex. E); (Def. Ex. D). On September 5 1995, defendant sent another letter to plaintiff again denying her disability benefits. (Pl. Ex. H); (Def. Ex. G).

Upon a review of the materials available to defendant when making its determination¹⁰ as well as the two letters sent to plaintiff denying the benefits, I find that there are material facts in dispute as to whether plaintiff was totally disabled within the meaning of the Plan. According to the 4/22/95 letter from defendant to plaintiff, defendant based its denial of benefits on the following medical information: (1) x-rays taken on 2/7/95 indicated minimal soft tissue swelling on the left and right knee, and no significant findings with respect to the left shoulder; (2) an MRI of the cervical spine and the lumbar spine performed on 2/27/95 showed no significant findings; (3) an MRI of the left shoulder taken on 3/1/95 showed no significant findings; (4) an examination of plaintiff by Dr. Nathan Schwartz of the Pain Treatment Center on 3/10/95, showed that Dr. Schwartz was unable to find neurological deficits; and (5) plaintiff had stated to her physicians that she suffers severe pain in her knee, ankle, shoulder, and back, neck and that she complained of stiffness and numbness. (Pl. Ex. E; Def. Ex. D). In the 9/5/95 letter

¹⁰ A district court exercising *de novo* review is not limited to the evidence that was before the Plan Administrator when it decided to deny Total Disability benefits. See Luby, 944 F.2d at 1184-85. The parties here, however, do not present any evidence beyond what was available to the Plan Administrator.

to plaintiff, defendant stated, in relevant part:

The medical information does indicate that there are some objective medical findings, however, these findings do not appear to be severe enough to produce pain and limitations that would preclude you from performing the duties of your sedentary occupation on a full-time basis. Our records indicate that you are a Processing Associate and have the ability to move about as needed for comfort.

Our records also reflect that you have had back problems for years but you continued to work until you slipped and fell in January of this year which resulted in soft tissue injuries on your knee and shoulder. . . .

The medical findings do not substantiate a condition to a magnitude that would render you Totally Disabled from the substantial and material duties of your occupation as a Processing Associate.

(Def. Ex. G). In addition to the two letters, defendant presents evidence that plaintiff's position as Processing Associate, which entails processing corrections into clients' accounts via a computer, is predominantly sedentary and requires only minimal physical exertion. (Def. Ex. F, Employer's Job Activities Statement).

The reasons articulated by defendant in the two letters combined with the information provided in the Employer's Job Activities Statement provide a reasonable, logical factual basis for the denial of benefits.¹¹ Defendants have sufficiently pointed to various medical records, x-rays, MRIs, and physicians' reports to show that a material issue of fact exists as to the extent and severity of plaintiff's disability and whether plaintiff is unable to perform the substantial and material duties of a Processing Associate. I find that a reasonable fact finder could, on this record, conclude, after a *de novo* review of the pertinent medical information, that plaintiff was not totally disabled. Because defendant has presented sufficient evidence to create a

¹¹ I find that a reasonable fact finder could find that the statements made by defendants in the 4/22/95 and 9/5/95 letters are not mere conclusory allegations or bare assertions, but are based upon logical analysis and have factual support in the evidentiary record. (See Pl. Ex. B).

material issues of fact, I conclude that plaintiff is not entitled to summary judgment.

IV. CONCLUSION

For the foregoing reasons, I will deny the motion for summary judgment.

An appropriate Order follows.

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

LARAINÉ CANNON,	:	CIVIL ACTION
	:	
Plaintiff,	:	
	:	
v.	:	
	:	
THE VANGUARD GROUP, Inc.,	:	
	:	
Defendant.	:	NO. 96-5495

ORDER

AND NOW, on this 11th day of June, 1998, upon consideration of the motion of plaintiff LaRaine Cannon for summary judgment pursuant to Federal Rule of Civil Procedure 56(c) (Document No. 35), and the response of defendant The Vanguard Group thereto, and the reply brief of plaintiff, as well as the pleadings, depositions, affidavits, and admissions on file, and for the reasons set forth in the foregoing memorandum, it is hereby **ORDERED** that the motion for summary judgment is **DENIED**.

IT IS FURTHER ORDERED that the parties shall submit a joint report to the Court no later than **July 20, 1998** as to the status of settlement. If the parties need the assistance of the Court in facilitating settlement negotiations, the report should so indicate. Otherwise, the parties should be prepared to have the case listed for trial.

LOWELL A. REED, JR., J.