

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

<b>JOHN S. CHMIELOWIEC,</b>	:	
<b>Plaintiff,</b>	:	<b>CIVIL ACTION</b>
	:	
<b>v.</b>	:	
	:	
<b>H.B. FULLER COMPANY LONG</b>	:	
<b>TERM DISABILITY PLAN, et al.,</b>	:	<b>No. 02-7137</b>
<b>Defendants.</b>	:	

**MEMORANDUM AND ORDER**

**SCHILLER, J.**

**July 15, 2003**

Plaintiff John Chmielowiec commenced this action on September 4, 2002, alleging that Defendants H.B. Fuller Company Long Term Disability Plan (“Plan”), H.B. Fuller Company (“Fuller”), and Aetna Life Insurance Company (“Aetna”), as Administrator and Fiduciary of the Plan, violated the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. § 1001 *et seq.*, by finding that Plaintiff was not disabled within the meaning of the Plan and, therefore, was no longer entitled to receive long term disability (“LTD”) benefits. After the close of discovery, the parties filed cross-motions for summary judgment. For the reasons set forth below, I grant Plaintiff’s motion.

**I. BACKGROUND**

In 1997, Mr. Chmielowiec, who was then in his early thirties, began working at Fuller in its Package Converting Group as a sales representative. As of July 1999, Plaintiff’s job duties at Fuller included visiting four to five customers per week, which entailed driving approximately seven hundred miles per week. (Pl.’s Ex. B, McConnell Dep. at 20; Pl.’s Ex. C.)<sup>1</sup> In addition, Plaintiff was

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<sup>1</sup> “Pl.’s Ex.” refers to the exhibits accompanying Plaintiff’s motion for summary judgment. “Aetna” refers to Administrative Record in this matter which are stamped “Aetna \_\_\_\_\_.”

occasionally required to lift boxes weighing up to fifty pounds. (Pl.'s Ex. C.)

In late July 1999, Mr. Chmielowiec became disabled from full-time employment and was diagnosed with Chronic Fatigue Syndrome ("CFS") and other ailments. (Aetna 762, 777.) Aetna certified Mr. Chmielowiec as disabled effective July 26, 1999 and paid the managed disability benefits to which Plaintiff was entitled for one hundred eighty days. (Pl.'s Ex. D, Barrows Dep. at 11-14.)

Prior to approving Mr. Chmielowiec's claim for LTD benefits, Aetna required Plaintiff to submit to a functional capacity evaluation ("FCE") and an independent medical examination ("IME") performed by John S. Bomalaski, M.D. (Pl.'s Ex. B, McConnell Dep. at 56-57; Pl.'s Ex. F; Pl.'s Ex. G.) Aetna found that Plaintiff was eligible to receive LTD benefits effective January 22, 2000. (Pl.'s Ex. E.)

In March 2000, Aetna required Plaintiff to undergo a second IME. (Pl.'s Ex. B, McConnell Dep. at 57-58; Pl.'s Ex. H.) In a letter summarizing the results of the IME, Russell J. Stumacher, M.D., P.E. concluded that Plaintiff "indeed has a variant of Chronic Fatigue Syndrome and has been considerably disabled as a result." (Pl.'s Ex. H at 4.) Dr. Stumacher also indicated that he expected "a remission at some undetermined time in the future" and recommended that Plaintiff be examined again in six to eight months. (*Id.* at 4,5.)

In July 2001, Mr. Chmielowiec underwent an additional examination performed by Elizabeth Genovese, M.D. (Pl.'s Ex. J at 3-4.) In IME reports dated July 26, 2001 and August 16, 2001, Dr. Genovese acknowledged that Plaintiff suffered from fatigue, but found that the fatigue should not become "a reason for him to stay out of work but instead should be managed proactively." (Pl.'s Ex. J at 3-4.) Dr. Genovese also recommended that Plaintiff attend work hardening sessions. (*Id.*) After

receiving the IME, Aetna authorized and paid for Mr. Chmielowiec's participation in a work hardening regimen at Magee Rehabilitation ("Magee") in Philadelphia. (Pl.'s K; Fogel Decl. ¶ 5.) From August 2001 until Aetna ceased authorizing payment for the work hardening sessions in November 2001, Plaintiff attended these sessions at Magee approximately three to five days per week. (*Id.* ¶ 6.) Aetna received weekly reports about Plaintiff's status in the work hardening program. (Aetna 354, 358, 363, 364, 366, 369, 370, 372.)

In November 2001, an Aetna claims analyst, Mary McConnell, determined that the available evidence indicated that Plaintiff was capable of returning to the sales representative position. (Aetna 352.) In December 2001 or January 2002, Aetna sent Plaintiff a letter indicating that it had determined that Plaintiff was capable of performing his own occupation and terminated Plaintiff's LTD benefits as of November 30, 2001. (Aetna 795.) Plaintiff disagreed with this determination and filed appropriate administrative appeals. His appeals were reviewed by a medical director and an appeals analyst; both found that Plaintiff was not disabled within the meaning of the Plan. (Aetna 11-14, 325-31.)

## **II. SUMMARY JUDGMENT**

Summary judgment is appropriate when the record discloses no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *See* FED. R. CIV. P. 56(c); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986). In reviewing the record, "a court must view the facts in the light most favorable to the nonmoving party and draw all inferences in that party's favor." *Armbruster v. Unisys Corp.*, 32 F.3d 768, 777 (3d Cir. 1994). The moving party bears the burden of showing that the record reveals no genuine issue as to any material fact and that the

moving party is entitled to a judgment as a matter of law. See FED. R. CIV. P. 56(c); *Anderson*, 477 U.S. at 247. Once the moving party has met its burden, the non-moving party must go beyond the pleadings to set forth specific facts showing that there is a genuine issue for trial. See FED. R. CIV. P. 56(e); see also *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 585-86 (1986). “There is no issue for trial unless there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party.” *Anderson*, 477 U.S. at 249. “Such affirmative evidence – regardless of whether it is direct or circumstantial – must amount to more than a scintilla, but may amount to less (in the evaluation of the court) than a preponderance.” *Williams v. Borough of W. Chester*, 891 F.2d 458, 460-61 (3d Cir. 1989).

### **III. DISCUSSION**

#### **A. Standard of Review Under § 1132**

Section 502(a)(1)(B) of ERISA provides that a plan participant may bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B) (2003). In *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that “a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” *Id.* at 115. In cases where a plan grants such authority, as is the case here (*Aetna* 846-47, 849, 869, 874), the reviewing court may overturn the administrator’s decision only if it is “without reason, unsupported by substantial evidence or erroneous as a matter of law.” *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993)

(citations omitted). However, the *Firestone* Court also noted that “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.” 489 U.S. at 115 (quotation omitted). Recognizing that courts had struggled to “give effect to this delphic statement,” *Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377, 383 (3d Cir. 2000), the Third Circuit held that a “higher standard of review is required when reviewing benefits denials of insurance companies paying ERISA benefits out of their own funds.” *Id.* at 390. After reviewing different approaches taken by other appellate courts, the Third Circuit concluded that it could find “no better method to reconcile *Firestone*’s dual commands than to apply the arbitrary and capricious standard, and integrate conflicts as factors in applying that standard, approximately calibrating the intensity of review to the intensity of conflict.” *Id.* at 393. That is, the Third Circuit set forth a “sliding scale method, intensifying the degree of scrutiny to match the degree of the conflict.” *Id.* at 379. In applying this method, evidence of procedural anomalies warrant application of more weight to the conflict along the sliding scale, thereby requiring a greater degree of skepticism. *See id.* at 394.

Here, the presence of at least three significant anomalies necessitates the application of a heightened standard of review. First, as is discussed further below, it is undisputed that Aetna mistakenly evaluated Plaintiff’s claim under an inapplicable definition of disability. Second, Aetna’s determination that Mr. Chmielowiec was no longer disabled was based on a selective consideration of the available medical evidence. Significantly, in reaching the determination, Aetna focused on a Work Hardening Weekly Update Report completed by Kathleen Fogel. (Aetna 83.) This report stated that Plaintiff had demonstrated that he was capable of driving two hundred miles, but did not indicate over what time period that distance could be driven. Because Plaintiff’s position entailed

driving seven hundred miles per week, Plaintiff would only have been capable of returning to his position if the distance referred to was a daily – as opposed to a weekly – total. Despite the fact that prior Work Hardening Update Reports indicated that Plaintiff’s demonstrated driving capacity was only a fraction of the seven hundred mile weekly requirement (Pl.’s Ex. K (Fogel Decl. ¶¶ 8-9, Ex. 2)), Aetna relied on the sole indication, ambiguous on its face, that Mr. Chmielowiec could satisfy his position’s driving requirement. Aetna’s reliance on this evidence is even more striking considering the fact that Aetna did not attempt to clarify what period of time the author of the report was referring to. (*Id.* ¶¶11-12.) Had it done so, Aetna would have learned that Plaintiff had not demonstrated that he could drive seven hundred miles in a week. This kind of selectivity strongly supports the application of greater scrutiny to Aetna’s determination. *See Pinto*, 214 F.3d at 394 (finding that anomaly occurred when administrator relied on part of advice in medical report while discarding other findings in same report). Lastly, during the administrative appeals process, Aetna failed to produce all the documents requested by Plaintiff’s counsel (Pl.’s Ex. O), and did not reach a decision regarding Plaintiff’s appeal in a timely fashion (Aetna 875 (stating final decision will be reached within sixty days of receipt of request unless notice given to claimant of special circumstances); Aetna 10 (letter stating appeal requested in letter dated February 14, 2002); Aetna 11 (letter dated July 1, 2002 notifying Plaintiff of final decision)). In view of these anomalies, Aetna’s decision deserves only minimal deference.<sup>2</sup>

## **B. Review of Termination of LTD Benefits**

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<sup>2</sup> A statement made by an Aetna employee underscores Aetna’s financial incentives to terminate Plaintiff’s benefits: “If [Plaintiff] is not going to pass test change, we can give him some minimal assistance with job leads that may help [Plaintiff return to work] prior to july [sic] for additional cost savings.” (Aetna 539 (emphasis added).)

Although courts can look outside the administrative record for purposes of determining the appropriate level of scrutiny, their substantive review is limited to the evidence that was before the plan administrator at the time of the denial of benefits. *See Pinto*, 214 F.3d at 395 (“district court may take evidence regarding the conflict interest, and ways in which the conflict may have influenced the decision.”); *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3rd Cir. 1997) (in reviewing administrator’s decision, courts must look to “record as a whole” consisting of evidence that was before administrator). My examination of the administrative record leads me to conclude that Aetna’s decision to terminate benefits cannot pass muster.

The Plan provides:

You will be deemed to be disabled while either of the following applies to you:

- In the first 24 months of a certified period of disability:  
  
You are not able, solely because of disease or injury, to perform the material duties of your own occupation; except, if you start work at a reasonable occupation you will no longer be deemed disabled.
- After the first 24 months of a certified period of disability:  
  
You are not able, solely because of disease or injury, to work at any reasonable occupation.

(Aetna 846.) In the instant case, more than twenty-four months elapsed from the time Plaintiff was certified as disabled until the time Aetna determined that he was no longer entitled to benefits. As such, Plaintiff’s claim should have been reviewed under the “any reasonable occupation” standard, but Aetna instead employed the “own occupation” standard. (Pl.’s Ex. L; Aetna 13-14.)

Under the own occupation standard which was employed, Aetna’s determination is clearly contrary to the evidence in the administrative record. Simply, the evidence shows that Plaintiff was

unable to fulfill two of the requirements set forth in his job description, i.e., the lifting requirement and the driving requirement. Consequently, Aetna's determination cannot pass muster under the heightened review required by *Pinto*.

Although the Third Circuit has not explicitly addressed the appropriate standard of review, several other courts of appeals have held that a district court has discretion in its choice of remedy in ERISA benefits denial cases. See *Cook v. Liberty Life Assurance Co.*, 320 F.3d 11, 24 (1st Cir. 2003); *Zervos v. Verizon New York, Inc.*, 277 F.3d 635, 648 (2d Cir. 2002); *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1163 (9th Cir. 2001); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 697 (7th Cir. 1992). This case does not present circumstances where remanding the case for further administrative proceedings would be warranted; rather, Plaintiff's benefits should be reinstated retroactively to the date of termination.

Aetna's letter informing Plaintiff that his benefits had been terminated makes clear that the termination was based on the conclusion that he could perform his own occupation; the letter is without any discussion of the any reasonable occupation standard. As such, Plaintiff never had an opportunity – or reason – to challenge any determination under the any reasonable occupation standard. (Pl.'s Ex. L.) Similarly, any contention by Aetna that Plaintiff's benefits could have been terminated under the any reasonable occupation standard would violate Plaintiff's right to a full and fair review of his claim. See 29 U.S.C. § 1133 (2003); *Grossmuller v. Int'l Union, United Auto. Aerospace & Agric. Implement Workers of Am.*, 715 F.2d 853, 857-58 (3d Cir. 1983) (“[T]o be ‘full and fair,’ the review must provide a claimant with knowledge of the opposing party’s contentions and a reasonable opportunity to meet them. . . .”). I note that Aetna remains free in the future to initiate

further review of Mr. Chmielowiec's continuing eligibility for LTD benefits. *See Halpin*, 962 F.2d 698.<sup>3</sup>

#### IV. CONCLUSION

Accordingly, I grant Plaintiff's motion for summary judgment and reinstate his benefits retroactively to the date on which the benefits were terminated.

An appropriate Order follows.

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<sup>3</sup> The cases cited by Defendants are inapposite. Any reliance on *Sandoval v. Aetna Life & Casualty Ins. Co.*, 967 F.2d 377 (10th Cir. 1992), is misplaced because the instant case does not involve evidence obtained after the completion of the administrative appeals process. *See Sandoval*, 967 F.2d at 378-79. Additionally, Defendants' citation to *Duhon v. Texaco, Inc.*, 15 F.3d 1302 (5th Cir. 1994) for the proposition that a plaintiff's "attempt to circumvent congressional mandate [that plan fiduciaries, not the federal courts, have primary responsibility for claims processing] by failing fully to argue his claim and provide supporting evidence during the administrative appeal process, in the hopes that his case could be decided instead in the federal courts, must fail." 15 F.3d 1302, 1309 (5th Cir. 1994). Here, Aetna provided Plaintiff with only a small number of the documents requested, rendering any argument that Plaintiff failed to fully participate in the appeals process is untenable in light of Aetna's own conduct.

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<b>TERM DISABILITY PLAN, et al.,</b>	:	<b>No. 02-7137</b>
<b>Defendants.</b>	:	

**ORDER**

**AND NOW**, this 15<sup>th</sup> day of **July, 2003**, upon consideration of the parties' cross-motions for summary judgment and their supplements thereto, following oral argument on the parties' cross-motions for summary judgment, and for the foregoing reasons, it is hereby **ORDERED** that:

1. Plaintiff John Chmielowiec's Motion for Summary Judgment (Document No. 15) is **GRANTED**. Summary Judgment is **GRANTED** in favor of Plaintiff and against Defendants H.B. Fuller Company Long Term Disability Plan, H.B. Fuller Company, and Aetna Life Insurance Company, as Administrator and Fiduciary of the H.B. Fuller Long Term Disability Plan. Defendants shall reinstate Plaintiff's benefits retroactively to November 30, 2001.
2. Defendant's Motion for Summary Judgment (Document No. 13) is **DENIED**.
3. The Clerk of Court is directed to close this case for statistical purposes.

**BY THE COURT:**

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**Berle M. Schiller, J.**