

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

TAMMANY HOOVER
Plaintiff,

v.

METROPOLITAN LIFE INSURANCE
COMPANY a/k/a MET DISABILITY
And WARNER-LAMBERT COMPANY

CIVIL ACTION

NO. 05-4323

Diamond, J.

Feb. 14, 2006

MEMORANDUM

Plaintiff Tammany Hoover moves for summary judgment, seeking reinstatement of her long-term disability benefits under the Employee Retirement Income Security Act . See 29 U.S.C. § 1001 et seq. The Disabilities Plan Administrator also moves for summary judgment, arguing that the undisputed evidence shows that its decision to terminate benefits was not arbitrary and capricious. I agree with the Administrator and so grant summary judgment in its favor. I deny Plaintiff’s motion.

LEGAL STANDARDS

Upon motion of any party, summary judgment is appropriate “if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law.” FED. R. CIV. P. 56(c). The moving party must initially show the absence of any genuine issues of material fact. See Celotex Corp. v. Catrett, 477 U.S. 317 (1986). An issue is material only if it could affect the result of the suit under governing law. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986). In deciding whether to grant summary judgment, the district court “must view

the facts in the light most favorable to the non-moving party,” and take every reasonable inference in that party's favor. Hugh v. Butler County Family YMCA, 418 F.3d 265 (3d Cir. 2005). If, after viewing all reasonable inferences in favor of the non-moving party, “the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial,” and summary judgment is appropriate. Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586 (1986); Delande v. ING Employee Benefits, 112 Fed. Appx. 199, 200 (3d Cir. 2004). A grant of summary judgment thus “avoid[s] a pointless trial in cases where it is unnecessary and would only cause delay and expense.” Walden v. Saint Gobain Corp., 323 F.Supp. 2d 637, 641 (E.D. Pa. 2004) (restating Goodman v. Mead Johnson & Co., 534 F.2d 566, 573 (3d Cir.1976)).

Having cross-moved for summary judgment, both sides agree that there are virtually no material facts in dispute. Given my decision to grant summary judgment in favor of the Administrator, however, in describing the background of this case, I have construed the undisputed facts in the light most favorable to Plaintiff. Where the parties disagree on immaterial facts – such as the precise dates on which certain events occurred – I have adopted the Plaintiff’s characterization of these facts. See Butler County, 418 F.3d at 267.

BACKGROUND

Plaintiff Tammany Hoover worked as a secretary for Defendant Warner-Lambert Company from June 2, 1986 until August 26, 2001. (R.430, 439). Sometime after 1998, Plaintiff began to receive treatment from her family practitioner, Jenifer Bruner, for various conditions, including chronic fatigue, headaches, body/muscle aches, joint pain, depression, cognitive

problems, and skin rashes. (*Pl. Memo. in Support of S.J.* at 2, R. 264). After Plaintiff stopped working in August, 2001, she received short-term disability benefits. (*Pl. Memo.* at 2).

While employed by Warner-Lambert, Ms. Hoover received coverage under Warner-Lambert's Long Term Disabilities Plan, administered by Defendant Metropolitan Life and funded by Warner-Lambert. (R.19, R.44-47). The Plan defines total disability as:

The complete inability of an Employee to perform substantially all of the material duties of his or her regular occupation as it is generally performed in the national economy, or perform another occupation for which the Employee is qualified and can earn at least 75% of pre-disability Compensation. The Covered Employee cannot engage in any other employment except as provided under the rehabilitation program described in Article 14.

(R. 9, 26). The Plan confers on MetLife discretionary authority to determine entitlement to benefits. (R.47). To that end, MetLife also has authority to require claimant "to furnish such information as it may request for the purpose of the proper administration of claims, including benefit appeals . . . including medical evidence, satisfactory to MetLife, of the nature, extent and continuation of any illness or disability" (R.48). Finally, the Plan contains specific limitations of eligibility, including:

Notwithstanding any other provisions of this Plan, no benefits shall be payable hereunder with respect to a Total Disability:

(a) resulting from an injury or sickness for which the Covered Employee is not treated by a duly qualified physician or fails to furnish proof of such treatment to MetLife.

(R.32).

After leaving Warner-Lambert, Plaintiff was diagnosed on December 10, 2001 with "probable systemic lupus," a disease that rheumatologist Dr. Thomas Kantor linked to fatigue and fibromyalgia. (R.367). On January 3, 2002, Dr. Kantor reported that Plaintiff could sit for only one hour intermittently, and stand or walk for fifteen minutes intermittently. (R.431, 435).

Plaintiff filed her initial claim for long-term disability benefits on that same day, and the Plan began paying long-term disability benefits on February 27, 2002. (R.429-430). MetLife's electronic diary for Plaintiff's case shows that between February 27 and May 14, 2002, MetLife repeatedly asked for a number of Plaintiff's medical records; she gradually provided them. (R.68-72).

MetLife approved Plaintiff's claim on May 14, 2002, noting that, "given the multiple diagnosis, it is reasonable to assume that fatigue [sic] and pain are currently sufficiently severe to preclude any occ." (R.71-72). MetLife also noted, however, that "improvement is expected" in Plaintiff's condition. Id.

On February 25, 2004, MetLife telephoned Plaintiff seeking any post-February 13, 2003, treatment records – documents the Plan obligated Plaintiff to provide. (R.78). MetLife repeated this request in a letter dated March 3, 2004, emphasizing that it also needed to receive a Medical Authorization and a Personal Profile Questionnaire. (R.308). Although MetLife soon began receiving the treatment records, it did not receive the Authorization and Profile, and so followed up with telephone and letter requests. Plaintiff did not complete these documents and provide them to MetLife until April 24, 2004. (R.289, 299). In the Questionnaire, Plaintiff stated that she suffered from "joint pain, chronic fatigue, inability to concentrate, severe headaches, depression, anxiety," and sleeplessness. (R.283-87). She also reported that her daily routine included a "shower, laundry when needed, mail, [and] organization of home." She identified laundry, vacuuming, dusting, and "shopping when someone can come with me" as housework she regularly performed. Id. In addition, she listed walking, reading, television, and computer usage among her daily activities. Id.

In response to its requests for Plaintiff's medical records, MetLife received a number of documents, including two Attending Physician Statements from Dr. Lisa S. Allen. The first, dated March 11, 2004, stated that Plaintiff was capable of sitting for eight hours continuously, and performing climbing, twisting, bending, stooping, eye/hand, and repetitive fine finger movements. (R.292). Dr. Allen's second statement, dated April 23, 2004, indicated that Plaintiff could sit, stand, or walk for up to one hour and occasionally lift up to ten pounds. (R.303).

On August 9, 2004, MetLife referred Plaintiff's claim to a nurse consultant to evaluate whether there was sufficient information to support a continued determination of total disability. (R.81). On August 26, 2004, the nurse consultant recommended that MetLife obtain additional information from Plaintiff's doctors. On November 5, 2004, Dr. Allen completed a questionnaire at the request of MetLife. Dr. Allen stated she saw Plaintiff every three to four months, and that Plaintiff's symptoms included cognitive problems, headache, and fatigue. (R.275).

In a December 1, 2004 letter, MetLife notified Plaintiff it was disqualifying her for long-term benefits, and noted several bases for its decision:

You must be under the "regular care" of a health care provider to remain qualified for long term disability benefits. This means you must receive medical treatment or services from a licensed health care provider who is most appropriate to treat the medical condition. Once long term disability benefits begin, you must continue to receive generally accepted medical treatment for the condition, including regular visits to a health care provider . . .

Per a 4/23/04 attending physician statement Dr. Allen indicated you can sit/stand/walk 1 hour each continuously, you can lift/carry up to 10 pounds occasionally and that you have persistent pain. . . .

The information in file shows you have complaints of fatigue and pain and that you are capable of activities of daily living. The information in file does not show objective testing or support for cognitive problems or fatigue or support for a disability of such a severity as to preclude you from doing your own job or any other occupation you may be qualified for.

(R.273-74).

Plaintiff appealed the termination on January 19, 2005, by writing a letter to MetLife's appeals unit. (R.258). MetLife acknowledged receiving her letter on February 3, 2005, and referred Plaintiff's file for review by two independent physician consultants: Dr. Mark R. Burns and Dr. Charles G. Bellville. (R.254-57).

Dr. Burns is a New York-licensed physician with board certifications in internal medicine and rheumatology. (R.252-53). On February 15, 2005, he issued a report summarizing the medical records provided by the Plaintiff. Id. Dr. Burns found in part that:

While the patient complains of joint and muscle pain[,] the only physical findings recorded are multiple trigger points. There is no documentation of actual synovitis or of any loss of muscle function. . . .

In summary, the patient has a lupus-like disorder along with depression, pseudotumor cerebri, osteoarthritis of the knees, and fibromyalgia. Review of the medical records from 2004 fails to find documentation of any objective physical limitations. The claimant has muscle trigger points but no other signs of limitation in muscle function. There are the claimant's self-reported symptoms of pain and fatigue. There are also complaints of cognitive dysfunction without any documentation to support this. There's no evaluation of the claimant's depression

[T]he records do not contain any documentation of physical impairments that would have prevented the claimant from working in her own light occupation.

Id. After reviewing the evidence, Dr. Burns concluded that although Plaintiff "would need the opportunity to take breaks," there were "no impairments documented that would preclude employment." Id.

Dr. Bellville is an Oregon-licensed physician with a board certification in psychiatry. (R. 243-45). MetLife sought Dr. Bellville's advice as to whether Plaintiff had "any mental impairment that would have prevented [her] from working in her own occupation as of 12/31/04." Id. Dr. Bellville first observed that Plaintiff provided no record "of a psychological or

psychiatric evaluation.” He also found that the records from her doctors “are not sufficient enough in the area of psychological and cognitive functioning to draw conclusions about the presence of a mental impairment.” Id. Dr. Bellville made particular note of the absence of “objective testing,” such as a “mental status examination,” before concluding that there was no documentation “to suggest that a mental impairment would have prevented her from working, especially as of December 31, 2004.” Id.

On February 22, 2005, after reviewing the reports from Dr. Bellville and Dr. Burns, MetLife denied Plaintiff’s appeal. (R. 246-50). In its notification letter, MetLife restated the eligibility requirements, Plaintiff’s medical history, and the findings of Dr. Bellville and Dr. Burns, before concluding that the evidence “failed to support a severity of impairment that would preclude you from gainful employment.” Id.

Plaintiff filed this action on August, seeking a declaration of her rights under the Plan, and asking me to compel MetLife to reinstate her long-term disability benefits as of December 31, 2004. At the close of discovery, Plaintiff and Defendants both moved for summary judgment, and I heard oral argument on January 23, 2006. I now grant summary judgment in favor of MetLife and Warner-Lambert.

DISCUSSION

I. MetLife’s Decision May Be Overturned Only If It Was Arbitrary and Capricious.

Courts review a denial of ERISA benefits *de novo* except when the plan confers discretionary authority on its administrator to determine eligibility or to construe the plan’s

terms. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). As I have shown, the Warner-Lambert Long Term Disabilities Plan grants discretionary authority to MetLife over both eligibility determinations and plan term construction. Accordingly, I must “review the administrator's exercise of that authority under an ‘arbitrary and capricious’ standard.” Vitale v. Latrobe Area Hosp., 420 F.3d 278, 281-82 (3d Cir. 2005) (quoting Orvosh v. Program of Group Ins. for Salaried Employees of Volkswagen of Am., Inc., 222 F.3d 123, 129 (3d Cir. 2000)). Under this standard, I may overturn MetLife’s decision if “it is without reason, unsupported by substantial evidence or erroneous as a matter of law.” Lasser v. Reliance Std. Life Ins. Co., 344 F.3d 381, 384 (3d Cir. 2003).

Plaintiff argues unpersuasively for less deference and a heightened standard of review, noting that the Third Circuit has authorized a “sliding scale” of declining deference in ERISA cases where the decision-maker faced a structural conflict of interest. Pinto v. Reliance Std. Life Ins. Co., 214 F.3d 377, 383 (3d Cir. 2000). Plaintiff argues that I should employ a “sliding scale” here because: 1) MetLife “may well have a degree of structural conflict or financial interest in the outcome of its claims handling practices,” and 2) MetLife’s termination decision is a “suspicious event[.]” that warrants heightened review even absent a financial conflict. See Pl. Memo at 9.

Plaintiff’s argument fails on both counts. The authority Plaintiff offers underscores that no conflict exists here. Warner-Lambert funds the Plan, but MetLife makes all eligibility decisions. This arrangement ensures that MetLife suffers no financial consequences from its decisions. At oral argument, Plaintiff’s counsel admitted as much, stating that the only “financial conflict” Plaintiff alleges is “insubstantial”: the interest in “pleasing their customer.” Jan. 23, 2006 Tr. at 6. The Third Circuit has rejected Plaintiff’s rationale, holding that where an employer

“fund[s] a plan and pay[s] an independent third party to interpret the plan and make plan benefits determinations,” there is no financial conflict of interest. Pinto, 214 F.3d at 383; see also Vitale 420 F.3d at 281-82; Cerneskie v. Mellon Bank Long Term Disability Plan, 142 Fed. Appx. 555, 557 (3d Cir. 2005). Were it otherwise, the administration of every ERISA plan would be fraught with allegations of “insubstantial” financial conflicts, triggering a heightened standard of review in all instances. This would effectively eliminate the deferential standard of review required by the Supreme Court in Firestone.

Plaintiff alleges a second structural conflict: a \$2822 payment from MetLife or Warner-Lambert to ALLSUP, a company that helped Plaintiff obtain her Social Security benefits. Plaintiff does not explain how a fee paid by MetLife to help Plaintiff use ALLSUP’s services to qualify for Social Security can create a structural conflict.

Plaintiff misreads Third Circuit authority in arguing that I should apply heightened scrutiny even if I do not find a conflict of interest. For instance, in Plaintiff’s view, Kosiba v. Merck & Co. requires me to use the “sliding scale” approach and determine whether to apply a heightened standard of review “even absent an inherent conflict.” See 384 F.3d 58 (3d Cir. 2004). Yet in Kosiba, there was a conflict of interest – Defendant Merck was the funder *and* had “ultimate administrative authority” over the company’s long-term disabilities plan. Kosiba, 384 F.3d at 66.

Plaintiff similarly misreads Pinto as requiring heightened review even where “there is no evidence of an inherent structural conflict.” *Pl. Memo* at 10. As the Pinto Court described, however, a conflict existed because the same entity - an insurance company - had the authority “to fund, interpret, and administer a plan.” 214 F.3d 377, 383. Following Kosiba, the Third

Circuit has continued to apply the sliding scale only when a structural conflict exists. See Vitale, 420 F.3d at 281-82, n.2; Sommer v. Prudential Ins. Co. of Am., 138 Fed. Appx. 426, 427 (3d Cir. 2005) (Pinto and Firestone authorize heightened scrutiny “only if there is good reason to suspect self-dealing on the part of the decisionmaker”); Bader v. RHI Refractories Am., Inc., 111 Fed. Appx. 117 (3d Cir. 2004).

In these circumstances, Plaintiff’s request for heightened scrutiny is contrary to the law of this Circuit. Accordingly, I apply a deferential standard of review to MetLife’s decisions.

II. Substantial Evidence Supports MetLife’s Final Decision.

In applying a “substantial evidence” or arbitrary and capricious standard, I determine whether “there is sufficient evidence for a reasonable person to agree with the decision.” Courson v. Bert Bell NFL Player Retirement Plan, 214 F.3d 136, 142 (3d Cir. 2000). A decision may be supported by substantial evidence even where the record also includes contradictory evidence. See Johnson v. UMWA Health & Retirement Funds, 125 Fed. Appx. 400, 403 (3d Cir. 2005) (a court analyzing an ERISA decision “should affirm [the decision] as long as it is supported by substantial evidence in the record, even if the record also contains substantial evidence that would support a different result”).

As MetLife stated in its December 1, 2004 letter, it terminated Plaintiff’s benefits because: 1) she was not under the regular care of an appropriate, licensed health care provider; 2) her physical limitations had lessened since MetLife had approved her long-term benefits in February, 2002; 3) she was able to perform myriad “daily living” tasks – activities that are inconsistent with long-term disability; and 4) there was no “objective testing” or other medical

support for Plaintiff's complaints of "cognitive problems or fatigue." (R. 273-74). The record shows substantial evidence supports these determinations.

First, there is considerable evidence confirming that Plaintiff no longer suffered from physical limitations that prevented her re-employment. In sharp contrast to Dr. Kantor's 2002 evaluation that Plaintiff could not even sit intermittently for longer than an hour and stand or walk intermittently for longer than 15 minutes, Dr. Allen reported on April 23, 2004 that Plaintiff could now engage in all those activities continuously for 1 hour. Dr. Allen's March 11, 2004 report was more optimistic still, finding that Plaintiff could now sit for eight hours continuously.

Plaintiff's self-reporting reinforced Dr. Allen's descriptions of significant improvement in her condition. For example, in her January 3, 2002 self-evaluation, Plaintiff reported that she could not vacuum or dust, and had hired a helper to do those activities. (R. 436). In her April 24, 2004 profile, however, Plaintiff described her participation in housework and daily activities, including laundry, vacuuming, dusting, walking, reading, and watching television. Like Dr. Allen's reports, Plaintiff's representations show significant improvement in her condition.

The record also shows that Dr. Burns had concluded that "there are no impairments documented that would preclude employment." Dr. Burns similarly observed that many of Plaintiff's alleged conditions, such as cognitive dysfunction and fatigue, were completely undocumented.

In addition, MetLife had received Dr. Bellville's analysis, highlighting the total lack of medical evidence that Plaintiff suffered from, or had received treatment for, any mental impairment. Dr. Bellville concluded that, in the absence of a "mental status examination" or other "objective testing," there simply was no "documentation . . . to suggest that a mental

impairment would have prevented [Plaintiff] from working.”

Finally, MetLife noted in the December 1, 2004 letter that Dr. Allen – Plaintiff’s own attending physician – reported that in the preceding fifteen months, Plaintiff visited her office on just four occasions: September 10, 2003; December 9, 2003; April 20, 2004; and August 10, 2004. This infrequent treatment is confirmed by Dr. Allen’s November 5, 2004 notation that Plaintiff received treatment approximately every “3-4 months.” Both the letter and the Plan itself provide that beneficiaries must be receiving medical treatment and be under the regular care of a health care provider to remain eligible for benefits. (R.25, 273). Plaintiff’s record of infrequent treatment suggests that she was not receiving the regular care that would normally accompany a total disability. See Rosenberg v. Guardian Life Ins. Co. of Am., 2002 U.S. Dist. LEXIS 24683 (S.D.N.Y. 2002) (holding that to receive regular treatment, a claimant must “consult with a physician more than sporadically”).

Despite this substantial evidence supporting MetLife’s decision to terminate, Plaintiff argues that the decision was arbitrary and capricious. I find these arguments unpersuasive because they misapprehend the facts of this case and misconstrue the applicable law.

First, Plaintiff alleges that a termination of benefits is *per se* arbitrary and capricious in the absence of evidence “that [her] condition has changed.” See Pl. Mem. at 15; see also Tr. of Jan. 23, 2006 Hearing at 3 (citing the fact that the “medical evidence from her treating sources [] is very consistent” as a reason it is arbitrary and capricious). Yet the evidence here – much of it from Plaintiff herself – shows that Plaintiff’s condition *had* changed. Dr. Allen and Plaintiff reported improvements in Plaintiff’s capacity to sit, stand, walk, and engage in light housework and daily activities.

Next, Plaintiff argues that I should find MetLife’s decision to be arbitrary and capricious because MetLife failed to base its December 1st denial on specific reasons. Yet, as Plaintiff’s counsel acknowledged at oral argument, the December 1st letter included several specific reasons for the denial: Dr. Allen’s assessment of Plaintiff’s physical abilities, Dr. Allen’s report of her infrequent visits for treatment, and Plaintiff’s own account of her daily activities. (R.273-74; *1/23/06 Tr.* at 4-5). Plaintiff nonetheless argues that MetLife’s statement of reasons amounted to mere “boilerplate.” *1/23/06 Tr.* at 5. Yet, ERISA requires only that MetLife “provide adequate notice . . . setting forth the specific reasons for such denial, written in a manner calculated to be understood.” See 29 U.S.C. § 1133(1). This is exactly what MetLife did here.

Plaintiff also contends that MetLife has acted arbitrarily by requiring objective evidence of cognitive impairment and fatigue when the Plan ostensibly contains no such requirement. This argument is puzzling. As I noted above, the Plan requires Plaintiff to provide MetLife with “*medical evidence, satisfactory to MetLife, of the nature, extent, and continuation of any illness or disability . . .*” (R.48). Thus, the Plan certainly authorized MetLife to require Plaintiff to offer something more than Plaintiff’s own subjective complaints to establish a disabling condition. Plaintiff failed to provide any such medical evidence with respect to her claims of cognitive impairment and fatigue. That failure, combined with considerable evidence – from Drs. Allen, Burns, Bellville, and Plaintiff herself that she was not totally disabled – convinced MetLife to terminate. The Third Circuit has upheld partial reliance “upon a lack of objective evidence,” where the administrator gave all the available evidence “a full and fair review.” Delande v. ING Employee Benefits, 112 Fed. Appx. 199 (3d Cir. 2004). MetLife fully reviewed all available evidence of Plaintiff’s condition. That Plaintiff provided absolutely no medical evidence to

support her complaints of cognitive impairment and fatigue certainly does not undermine MetLife's decision.

Significantly, although Plaintiff correctly notes that the Eighth Circuit has held that “plan administrators may not require objective medical evidence” of fatigue, the Eighth Circuit has not prohibited plan administrators from considering the absence of objective evidence in their decision-making. See Abram v. Cargill, 395 F.3d 882, 887 (8th Cir. 2005); Pralutsky v. Metro. Life Ins. Co., 2006 U.S. App. LEXIS 1142 (8th Cir. 2006). To the contrary, the Eighth Circuit recently concluded that if a plan authorizes the administrator to request “documentation” and “proof” of a disability, it is not “unreasonable . . . to interpret the plan to require provision of objective evidence as part of the ‘proof’ and ‘documentation.’” Pralutsky at *15-*16. See also Hunt v. Metro. Life Ins. Co., 425 F.3d 489, 491 (8th Cir. 2005); Hensley v. IBM, 123 Fed. Appx. 534, 538-39 (4th Cir. 2004). That is precisely the situation that obtains here.

Plaintiff's reliance on decisions rejecting objective evidence requirements for diagnoses such as fibromyalgia and chronic fatigue syndrome is similarly misguided. See Pl. Memo at 25 (citing Mitchell v. Eastman Kodak Co., 113 F.3d 433, 442-43 (3d Cir. 1997); Wilkins v. Hartford Life & Acc. Ins. Co., 299 F.3d 945, 947 (8th Cir. 2002)). Here, MetLife did not disagree with the “diagnosis of Lupus through objective blood tests,” but with whether the manifestations of Lupus left Plaintiff unable to work. *Def. Resp.* at 6. The First Circuit described this distinction in Boardman v. Prudential Ins. Co.:

In this case, Prudential did not require Boardman to present objective medical evidence to establish her illnesses. On the contrary, Prudential was willing to accept that Boardman suffered from the illnesses she reported to her doctors. Rather, Prudential wanted objective evidence that these illnesses rendered her unable to work. While the diagnoses of chronic fatigue syndrome and

fibromyalgia may not lend themselves to objective clinical findings, the physical limitations imposed by the symptoms of such illnesses do lend themselves to objective analysis.

337 F.3d 9, 17 (1st Cir. 2003). Dr. Bellville noted that Plaintiff did not supply records of a “mental status examination” or other testing of Plaintiff’s cognitive functioning. Likewise, the Court in Schlegel v. Life Ins. Co. described evaluations of a claimant’s “orientation, memory, language, and knowledge” abilities in upholding an administrator’s claim denial based on the absence of objective evidence. See 269 F. Supp. 2d 612, 620 (E.D. Pa. 2003). Accordingly, MetLife has not acted improperly by including the absence of objective evidence among its reasons for denial.

Similarly, Plaintiff requests that I conclude that MetLife’s “decision to credit a non-treating physician over [a] treating physician’s opinion . . . was not reasonable.” *Pl. Mem.* at 29, n.4. To the contrary, as described above, MetLife credited many of Dr. Allen’s observations. Even if MetLife had relied only on the views of its consulting doctors, however, “administrators of ERISA plans are not obligated to accord special deference to the opinion of a claimant’s treating physician. [The Plan administrator] is therefore justified in placing reliance on the opinions of its own consulting doctors and need not provide a special explanation of its decision to do so.” Nichols v. Verizon Communs., 78 Fed. Appx. 209, 211-12 (3d Cir. 2003).

Plaintiff further alleges that MetLife has abused its discretion by “cherry-picking” medical evidence, and ignoring the views of the Plaintiff’s treating physicians. MetLife’s letters hardly reveal this to be the case. Rather than single out the most favorable medical evidence – such as Dr. Allen’s March 11, 2004 assessment that Plaintiff could sit for eight hours continuously – MetLife relied on Dr. Allen’s less-optimistic April 23, 2004 evaluation. Nor did

MetLife ignore Dr. Allen's statements about Plaintiff's continued symptoms and other negative medical evidence. Rather, it indicated that it had considered those statements but nonetheless found the evidence insufficient to show a continuing disability.

Significantly, Plaintiff also offers decisions in which the plan administrator made a decision to terminate without any supporting evidence, or where the court applied a standard other than deferential review. For example, the Seventh Circuit in Govindarajan v. FMC Corp. upheld the reversal of an administrator's "completely erroneous assertion" that was completely unsupported by the medical record. 932 F.2d 634 (7th Cir. 1991). Similarly, in Myers v. Hercules, the Fourth Circuit reversed a plan administrator – using that Court's eight-part test – where the administrator's decision contradicted the assessments by all three doctors in the record, who "opined that [claimant] remained totally disabled." 253 F.3d 761 (4th Cir. 2001). Although the Court used the language "arbitrary and capricious" in Rosen v. Provident Life – the only case Plaintiff cites from a court in the Third Circuit – the Court also stated that it would "apply a heightened review . . . caused by [the] insurer's role in both funding and administering the claims. . . ." 2003 U.S. Dist. LEXIS 17402 at *21-*22 (E.D. Pa. 2003). And the case from which Plaintiff apparently takes her "cherry-picking" language is entirely inapposite: in Spangler v. Lockheed Martin Energy Systems, Inc., the Sixth Circuit criticized an administrator for actually withholding medical evidence from the doctor hired to perform an independent evaluation. 313 F.3d 356 (6th Cir. 2002). Plaintiff has not alleged that MetLife withheld information from Drs. Burns and Bellville.

Finally, Plaintiff suggests that I should adopt language from two Eighth Circuit decisions and hold that: 1) MetLife's failure to obtain Plaintiff's Social Security records is a "serious

procedural irregularity” mandating heightened scrutiny; and 2) MetLife was required to furnish copies of Dr. Burns’s and Dr. Bellville’s assessments to Plaintiff before ruling on her appeal. See Pl. Memo. at 32-25 (citing Abram v. Cargill, 395 F.3d 882 (8th Cir. 2005) (copies of reviewing doctor’s reports on appeal); Harden v. Am. Express Fin. Corp., 384 F.3d 498 (8th Cir. 2004) (Social Security records)).

Even if these cases were controlling in the Third Circuit, their reasoning is not applicable here. First, Plaintiff neglects to note that she has not alleged any facts similar to the” procedural irregularity” in Harden. There, the claimant did not submit medical evidence to the plan administrator because the administrator wrongly led the claimant to believe that it had obtained his Social Security records, including the medical evidence. And unlike Abram, where the Eighth Circuit created a right to review the insurer’s responses to a claimant’s new medical evidence, Dr. Burns and Dr. Bellville assessed virtually the same medical evidence considered in the original claim denial. See 395 F.3d at 885 (describing the additional medical evidence submitted for the appeal). I therefore cannot conclude that Plaintiff is entitled to “a continuing cycle of additional reports followed by rejoinders . . . contrary to the regulatory scheme [of] expeditious resolution of appeals” solely to respond to the reviewing doctors’ brief consideration of Plaintiff’s new evidence. See Forrester v. Metropolitan Life Ins. Co., 2005 U.S. Dist. LEXIS 32984 (D.Kan. 2005). Like Plaintiffs’ other arguments, I find these unpersuasive.

III. Plaintiff Concedes that Summary Judgment Should Be Granted in Favor of Warner-Lambert.

Plaintiff also alleges that Warner-Lambert “failed or refused to provide Plan documents”

in violation of §502(c) of ERISA. See Complaint at ¶ 13 - ¶ 15. At oral argument, Plaintiff's counsel stated that this allegation had been withdrawn because the case law is not "strong enough to rely on." *1/23/06 Tr.* at 18. Accordingly, I will not consider this claim further.

CONCLUSION

In sum, Plaintiff asks me to contravene controlling authority, re-weigh the evidence MetLife reviewed, and come to a different decision. The Third Circuit has made clear, however, that I am "not free to substitute [my] own judgment for that of the defendants in determining eligibility for plan benefits." Abnathya v. Hoffman-La Roche, Inc., 2 F.3d 40, 41 (3d Cir. 1993); see also Lasser at 384 (stating the "substantial evidence" standard for arbitrary and capricious review). Accordingly, I grant summary judgment to Defendants.

The Motion for Summary Judgment by MetLife and Warner-Lambert is **GRANTED**.

The Motion for Summary Judgment by Plaintiff is **DENIED**

An appropriate **ORDER** follows.

/s Paul S. Diamond, J.

Paul S. Diamond, J.

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

TAMMANY HOOVER	:	CIVIL ACTION
Plaintiff,	:	
	:	
	:	
v.	:	
	:	NO. 05-4323
METROPOLITAN LIFE INSURANCE	:	
COMPANY a/k/a MET DISABILITY	:	
And WARNER-LAMBERT COMPANY	:	
	:	

Diamond, J.

February 14, 2006

JUDGMENT

AND NOW, this 14th day of February, 2006, upon consideration of the cross-motions for summary judgment (Doc. Nos. 12, 13) and all responses thereto, and for the reasons set forth in the accompanying memorandum, it is **ORDERED** that Defendants' Motion for Summary Judgment is **GRANTED** and Plaintiff's Motion for Summary Judgment is **DENIED**.

JUDGMENT IS ENTERED in favor of Defendants, Metropolitan Life Insurance Company and Warner-Lambert Company, and against Plaintiff, Tammany Hoover.

/s Paul S. Diamond, J.

Paul S. Diamond, J.