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

CHARLES R. KAELIN, M.D., Plaintiff,	:	
v.	:	CIVIL ACTION
TENET EMPLOYEE BENEFIT PLAN, BENEFITS ADMINISTRATION COMMITTEE OF THE TENET EMPLOYEE BENEFIT PLAN, RELIANCE STANDARD LIFE INSURANCE COMPANY, and TENET HEALTHCARE CORPORATION, Defendants.	:	NO. 04-2871

Memorandum and Order

YOHN, J. August ___, 2006

The plaintiff in this ERISA action, Charles R. Kaelin, M.D., filed suit after the defendant, Reliance Standard Life Insurance Company ("Reliance"), denied his application for long-term disability benefits. Previously, the court ruled that Reliance's determination of the applicable elimination period was arbitrary and capricious. Now, the court must fashion the proper remedy. Reliance urges the court to remand the case to it to redetermine Kaelin's entitlement based on application of the proper elimination period, while Kaelin argues that remand is unnecessary and the court should award him benefits forthwith. For the reasons that follow, the court will remand the case to Reliance.

I. Factual and Procedural Background[1]

From November 28, 1995 to September 4, 2003, Kaelin, a board-certified and licensed

[1] This statement of facts is drawn largely from the court's December 20, 2005 opinion. *See Kaelin v. Tenet Employee Benefit Plan*, 405 F. Supp. 2d 562 (E.D. Pa. 2005).

orthopedic surgeon, practiced medicine under an employment contract with National Medical Hospital of Wilson County, Inc., d/b/a University Medical Center ("UMC"), in Lebanon, Tennessee. (Pl.'s Stmt. of Material Facts/Def.'s Response ("Agreed Facts") ¶¶ 3-4.) UMC was an indirect subsidiary of Tenet until November 1, 2003. (*Id.* at ¶ 5.) Tenet purchased the Reliance Policy (Policy No. LSC 103763), a policy of group long-term disability insurance that became effective January 1, 2000. (*Id.* at ¶ 6; Joint Appendix 169-98.) The Reliance Policy contained the following language:

> "Totally Disabled" and "Total Disability" mean, that as a result of an Injury or Sickness:
>
> (1) during the Elimination Period, an Insured cannot perform each and every material duty of his/her regular occupation; and
>
> (2) for the first 24 months for which a Monthly Benefit is payable, an Insured cannot perform the material duties of his/her regular occupation;
>
> (a) "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness an Insured is capable of performing the material duties of his/her regular occupation on a part-time basis or some of the material duties on a full-time basis. An Insured who is Partially Disabled will be considered Totally Disabled, except during the Elimination Period.

(J.A.178.) The Reliance Policy defined "elimination period" as ninety consecutive days of total disability during which no benefit is payable, and stated that said period started on the first day of total disability. (J.A. 175, 177.)

On June 28, 2001, plaintiff was injured in a jet ski accident, which resulted in various injuries to his right knee and leg. (Agreed Facts ¶ 14; J.A. 153.) Following the accident, plaintiff stopped working full-time at UMC and did not return to work at all for approximately one month. (Agreed Facts ¶ 17.)

Plaintiff returned to work at UMC on August 1, 2001 and worked on a reduced hours/intermittent leave basis from that date until January 21, 2002, when he ceased working to undergo reconstructive surgery on his right knee – surgery that resulted in increased knee pain. (*Id.* at ¶ 20; J.A. 266-68.) On March 4, 2002, Kaelin again returned to work on a part-time basis, and continued through April 26, 2002, when he again stopped working due to his injuries. (J.A. 206.) Kaelin eventually returned to work again on August 15, 2002, before stopping again in January 2003. (J.A. 33, 56, 229.)

When plaintiff ceased work on April 26, 2002, he timely applied for long-term disability benefits under the Plan on Reliance's standard claim form. (Agreed Facts ¶ 23, 25; J.A. 206-11.) Reliance received plaintiff's claim forms on May 7, 2002. (J.A. 206.)

By letter dated July 25, 2002, Reliance denied plaintiff's claim for benefits, stating that plaintiff's "original date of loss was June 29, 2001." (J.A. 152-54.) Reliance concluded that plaintiff was "not totally disabled from performing each and every material duty of [his] occupation during the elimination period and [did] not meet the qualifications of disability as outlined in the policy." (J.A. 154.)

By letter dated August 7, 2002, plaintiff requested a review of Reliance's denial of disability benefits, stated that he "did NOT apply for full time disability until April 26, 2002," and notified Reliance that he "anticipate[d] going back to part-time work on Wednesday, August 14, 2002." (J.A. 149.) Reliance responded on August 21, 2002, stating that it would "be making *a new determination* and will send a new letter regarding your claim now that we know of the error." (J.A. 134 (italics added).) The "error" was Reliance's statement in the initial claim denial that plaintiff's original date of loss was June 29, 2001.

By letter dated September 20, 2002, Reliance notified plaintiff that it had completed its evaluation of his "2nd application for Long Term Disability benefits," and that he had been denied. (J.A. 112-15.) Reliance found that "[e]ven though there are some restrictions to the type and duration of surgeries you can perform, you do not meet the definition of total disability as it is written according to the [Reliance Policy]." (J.A. 114.) Reliance corrected the previous "error" and acknowledged that plaintiff "last worked on April 26, 2002 and his elimination period was over July 25, 2002." (J.A. 117.)

Plaintiff timely appealed the September 20, 2002 adverse benefit determination by letter dated November 6, 2002, and by letter dated February 3, 2003, Reliance once again denied the claim, stating that it had determined that he was not totally disabled under the terms of the Reliance Policy. (Agreed Facts ¶¶ 42-43, 45, 48; J.A. 99-106, 109, 85, 5-10.) In this February 3 letter, Reliance determined that plaintiff's elimination period ran from June 28, 2001 through September 26, 2001, despite the fact that this determination was contrary to that in the September 20, 2002 denial of benefits. (Agreed Facts ¶ 49.) In addition to finding that Kaelin was not totally disabled during the elimination period, Reliance also determined that Kaelin had ceased being a full-time employee of UMC on August 1, 2001, and therefore his eligibility for coverage under the Reliance Policy had terminated on that date. (J.A. 7-9; Agreed Facts ¶ 53.)

On February 4, 2005, Kaelin filed an eight-count amended complaint against defendants the Tenet Employee Benefit Plan, the Benefits Administration Committee of the Tenet Employee Benefit Plan ("the Committee"), Reliance Standard Life Insurance Company ("Reliance"), and Tenet Healthcare Corporation ("Tenet"). On May 9, 2005, Kaelin filed a motion for summary judgment, arguing that he was entitled to benefits under the Reliance Policy. On the same date,

Reliance also filed a motion for summary judgment, arguing that Kaelin was not entitled to benefits, both because he was not "totally disabled" during the elimination period and because he was not eligible for coverage on April 27, 2002.

On December 20, 2005, the court denied both sides' motions for summary judgment. *See Kaelin v. Tenet Employee Benefit Plan*, 405 F. Supp. 2d 562 (E.D. Pa. 2005). The court first analyzed Reliance's structural conflicts of interest and the procedural anomalies in its review of Kaelin's claim, as directed by *Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377 (3d Cir. 2000), and determined that a significantly heightened arbitrary and capricious standard of review applied. Accordingly, the court stated that while it could not "'substitute its own judgment for that of plan administrators under either the deferential or heightened arbitrary and capricious standard,'" *Kaelin*, 405 F. Supp. 2d at 580 (quoting *Stratton v. E.I. Dupont De Nemours & Co.*, 363 F.3d 250, 256 (3d Cir. 2004)), it would "'examine the facts before the administrator with a high degree of skepticism,'" *id.* (quoting *Pinto*, 214 F.3d at 394). The court also ruled that Kaelin's elimination period began on April 27, 2002 and that he was not able to perform surgery during the elimination period. However, the court concluded that there remained genuine issues as to: (1) whether Reliance acted arbitrarily and capriciously under the heightened standard in determining that office work was a material duty of Kaelin's occupation; and (2) if office work was one of Kaelin's material duties, whether Reliance acted arbitrarily and capriciously under the heightened standard in determining that he could perform office work during the elimination period. In addition to ruling that these two questions involved genuine issues of material fact, the court concluded that the administrative record was insufficiently developed to allow resolution of these points.

On December 28, 2005, Reliance filed a motion for reconsideration, challenging only the court's ruling that Kaelin was eligible for coverage under the Reliance Policy on April 27, 2002. Reliance argued that because Kaelin started working part-time on August 1, 2001, he was no longer a full-time employee and thus not eligible for coverage. On March 31, 2006, the court denied Reliance's motion.

After the court's memorandum and order denying Reliance's motion for reconsideration, the court held a status conference on May 23, 2006 to review the case's procedural posture and discuss the propriety of a remand to Reliance. Kaelin opposed a remand. Reliance favored a remand but was concerned that if it filed a motion for remand it would not be able to raise the issue as to the start of the elimination period on appeal. I, therefore, directed briefing on the remand issue by both parties.

On June 21, 2006, Kaelin filed a memorandum opposing remand, and on July 13, 2006, Reliance filed a memorandum supporting remand.

II. Discussion

In the court's December 20, 2005 memorandum and order, it concluded that it was arbitrary and capricious for Reliance to apply an elimination period running from June 28, 2001 until September 26, 2001, instead of from April 27, 2002 until July 25, 2002. The court is now left to fashion a remedy. "Once a court finds that an administrator has acted arbitrarily and capriciously in denying a claim for benefits, the court can either remand the case to the administrator for a renewed evaluation of the claimant's case, or it can award a retroactive reinstatement of benefits." *Cook v. Liberty Life Assur. Co. of Boston*, 320 F.3d 11, 24 (1st Cir. 2003). The district court has "considerable discretion" in selecting a remedy. *Id.*

Remand is the appropriate remedy in cases where: (1) the plan administrator "has misconstrued the Plan and applied a wrong standard to a benefits determination," *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 460 (9th Cir. 1996); *see also Addis v. Limited Long-Term Disability Program*, 425 F. Supp. 2d 610, 620 (E.D. Pa. 2006); (2) the plan administrator has "fail[ed] to make adequate findings or to explain adequately the grounds of [its] decision," *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1288 (10th Cir. 2002);*see also Gallo v. Amoco Corp.*, 102 F.3d 918, 923 (7th Cir. 1996) (stating "[t]he remedy when a court or agency fails to make adequate findings or to explain its grounds adequately is to send the case back to the tribunal for further findings or explanation. . . . unless the case is so clear cut that it would be unreasonable for the plan administrator to deny the application for benefits on any ground"); or (3) "[t]he present record is incomplete," *Miller v. United Welfare Fund*, 72 F.3d 1066, 1075 (2nd Cir. 1995). On the other hand, "[c]ases that call for reinstatement usually either involve claimants who were receiving disability benefits, and, but for their employers' arbitrary and capricious conduct, would have continued to receive the benefits, or they involve situations where there is no evidence in the record to support a termination or denial of benefits." *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 477 (7th Cir. 1998).

While the Third Circuit has not been called upon to define the precise contours of remand's applicability in ERISA cases, it has utilized this remedy. In *Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc. Employee Health and Welfare Plan*, 298 F.3d 191, 193 (3d Cir. 2002), a claimant filed suit after being denied payment of medical claims arising from an accident that occurred while he was driving under the influence of alcohol. The insurer denied coverage on

the ground that driving while intoxicated is an illegal activity, and the plan "exclude[d] coverage for any charge for care, supplies, or services which are . . . [c]aused or contributed to by the [insured's] commission or attempted commission of a felony, misdemeanor, or being engaged in an illegal occupation or activity." *Id.* at 193 (internal quotation marks omitted). However, the Third Circuit ruled that this decision was arbitrary and capricious, because "the administrator did not believe that it had to actually find a causal connection in the way we believe the plan in question requires." *Id.* at 200. The court concluded "because the administrator misperceived its task, we will remand for it to consider in the first instance whether there is evidence from which it could reasonably conclude that Smathers' intoxication played a causative role in his injuries." *Id.*; *see also Syed v. Hercules Inc.*, 214 F.3d 155, 162 (3d Cir. 2000) (stating "the remedy for a violation of § 503 [of ERISA] is to remand to the plan administrator so the claimant gets the benefit of a full and fair review").

Further, the Fourth Circuit has remanded a claim to the administrator for a redetermination after concluding that the administrator initially denied the claim based on the application of an incorrect elimination period, *Evans v. Metropolitan Life Ins. Co.*, 358 F.3d 307, 312 (4th Cir. 2004), which is the precise situation presented by the instant case.

As noted above, Reliance erred in this case by applying the wrong standard: it based its consideration of Kaelin's eligibility on the wrong elimination period. Thus, the court will remand the case to Reliance to determine whether Kaelin is entitled to benefits based on an application of the correct elimination period "unless no new evidence could produce a reasonable conclusion permitting denial of the claim or remand would otherwise be a 'useless formality.'" *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2nd Cir. 1995); *see also Grosz-Salomon v.*

Paul Revere Life Ins. Co., 237 F.3d 1154, 1163 (9th Cir. 2001) (explaining that remand is inappropriate where "there [was] no evidence in the record to support a termination or denial of benefits. . . . [because] a plan administrator will not get a second bite at the apple when its first decision was simply contrary to the facts") (first modification in original).

Kaelin argues that remand is inappropriate because the record is clear that, upon application of the correct elimination period, he is entitled to benefits.[2] The court has already concluded that Kaelin was unable to perform surgeries during the elimination period, and Kaelin argues that surgery was his only material duty. He further argues that even if seeing patients or performing office work were a material duty, there is no evidence that he was able to do either during his elimination period. If Kaelin were correct that the record was so one-sided on these issues, remand would be inappropriate. However, there are two problems with Kaelin's argument: (1) the record as presently developed is ambiguous about his entitlement to benefits; and (2) the record is insufficiently developed for the court to resolve the ambiguity. As the Seventh Circuit has stated, the administrator's "decision to deny [the insured's] claim was arbitrary and capricious, but not necessarily wrong." *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 478 (7th Cir. 1998).

Before describing the evidence concerning Kaelin's alleged disability, it is useful to review the Reliance Policy's terms and their definitions. The Policy provides for benefits for an individual who, during the elimination period, "cannot perform each and every material duty of his/her regular occupation." The Third Circuit has defined "regular occupation" as "the usual

[2] The court notes that this position is in contrast with the court's December 20, 2005 opinion, and assumes that Kaelin is asking the court to reconsider that opinion.

work that the insured is actually performing immediately before the onset of disability." *Lasser*, 344 F.3d at 386. Thus, Kaelin's regular occupation was whatever work he was actually performing immediately before April 27, 2002. The next task is to determine which duties of the individual's regular occupation are material. Courts have resolved materiality inquiries in different, albeit consistent, ways: the Third Circuit has based a materiality decision on the percentage of earnings attributable to the duty in question, *id.* at 387, while a district court has stated "'[a] duty is 'material' when it is sufficiently significant in either a qualitative or quantitative sense that an inability to perform it means that one is no longer practicing the 'regular occupation,'" *Byrd v. Reliance Standard Life Ins. Co.*, No. Civ.A.04-2339, 2004 WL 2823228, at *3 (E.D. Pa. Dec. 7, 2004) (quoting *Lasser v. Reliance Standard Life Ins. Co.*, 146 F. Supp. 2d 619, 636 (D.N.J. 2001)).

Based on these formulations, there is evidence in the record that suggests seeing patients/performing office work was part of Kaelin's regular occupation, and that it was material. First, on June 10, 2002, in response to Reliance's request for information about his job duties (J.A. 156), Kaelin submitted a letter to Reliance that explained the following:

> Since the date of my accident was June 28, 2001, I have made a couple of attempts to return to work. My duties were the same as always, seeing patients and performing surgery, however, the difference is that I have not been able to perform not only the number of surgeries, but I am also not able to perform any lengthy surgeries because of my limitation on standing. I further require an assistant on just routine arthroscopies and I also require assistance in the office as well.

(J.A. 155.) Additionally, there is evidence in the record that shows that Kaelin spent a substantial amount of time seeing patients. Before his January 2002 surgery, he usually saw over 100 patients a month, and he continued to see patients after that surgery, including in March and

April 2002. (J.A. 56.) Further, while not controlling because it concerned a different orthopaedic surgeon, the Third Circuit, in discussing "what [the orthopaedic surgeon] did in the course of his regular occupation" listed among the doctor's duties "[seeing] patients during office hours." *Lasser*, 344 F.3d at 387. Finally, Dr. Askin stated that a "physically impaired orthopaedic surgeon is not without some usefulness," because he could aid in "doing office hours and administrative activities." (J.A. 12.) This is not to say that seeing patients *was* a material duty of Kaelin's regular occupation – the letters from Kaelin's doctors argue forcefully that performing surgery is the only material duty of an orthopaedic surgeon. However, the court concludes that the issue – which Reliance did not clearly resolve in its previous denial letters – is in sufficient dispute that remand would not be a "useless formality." This conclusion is reaffirmed by the fact that the record is not clearly developed as to the material duties of Kaelin's regular occupation.

Kaelin also argues that even assuming that seeing patients was a material duty of his regular occupation, the record is clear that he was unable to do so during the elimination period. This assertion, however, is undermined by the fact that the record shows that Kaelin continued to see patients at least through part of April 2002. Kaelin contends that he was assisted all the while, but the record is unclear about the extent of Kaelin's dependence. Thus, remand is also appropriate for this issue because the record on this point does not support only Kaelin's side, the record contains limited information about Kaelin's condition during the elimination period, and Reliance's earlier decisions did not adequately resolve the issue.

The cases that Kaelin presents to challenge remand involve situations where the record is clear that the claimant is entitled to benefits. For example, in *Carney v. International*

Brotherhood of Electrical Workers Local Union 98 Pension Fund, 66 Fed. Appx. 381, 386 (3d Cir. 2003),[3] while the Third Circuit approved the district court's decision to award benefits directly in lieu of remanding the case to the insurer, "[t]he Trustees' speculative opinions and suspicions concerning the genuineness of Carney's disability were entirely unsupported by any medical evidence in the administrative record." Similarly, in *Zervos v. Verizon New York, Inc.*, 277 F.3d 635, 648 (2d Cir. 2002), the court concluded that remand was inappropriate because "the administrative record did not contain substantial evidence supporting a denial of benefits and in fact could only be read to support granting coverage." As noted above, the instant case presents a different situation, where Kaelin's entitlement is by no means clear cut. *See Rekstad v. U.S. Bancorp*, 451 F.3d 1114, 1121 (8th Cir. 2006) (remanding claim because "[t]his is not a case where it is so clear-cut that it was unreasonable for [the insurer] to deny [the claimant] benefits").

In addition to these arguments, Kaelin also argues that Reliance has waived its right to challenge his entitlement to benefits during the alternate elimination period because it did not raise that defense in its final denial letter. This argument is also without merit. Waiver requires "intentional relinquishment or abandonment of a known right or privilege." *United States ex rel. O'Connor v. New Jersey*, 405 F.2d 632, 634 n.2 (3d Cir. 1969). The court first notes that there is mixed authority about the viability and reach of waiver claims in ERISA proceedings.

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[3] The court also notes that the Third Circuit has recently reminded district courts not to accord not precedential opinions more weight than they are due; specifically, the court stated that while the Third Circuit does not prohibit citation to NPOs, "members of [the Third Circuit] regard them for what they are worth – the opinion of three members of the court in a particular case." *In re Grand Jury Investigation*, 445 F.3d 266, 276 (3d Cir. 2006).

See Lauder v. First Unum Life Ins. Co., 284 F.3d 375 (2d Cir. 2002) (waiver is applicable in ERISA cases on fact-specific basis); *White v. Provident Life & Accident Ins. Co.*, 114 F.3d 26, 29 (4th Cir. 1997) (holding that "the federal common law under ERISA . . . does not incorporate the principles of waiver and estoppel"); *Farley v. Benefit Trust Ins. Co.*, 979 F.2d 653, 659-60 (8th Cir. 1992) (stating that "[e]ven assuming that a waiver of policy provisions could be asserted in an ERISA case . . . nothing in [the insurer's] letters expresses any intention to surrender its right to enforce applicable provisions of the policy other than the ones cited in those letters"); *Loyola Univ. of Chicago v. Humana Ins. Co.*, 996 F.2d 895, 901 (7th Cir. 1993) ("The mere omission of a defense in a letter to a plan beneficiary does not constitute a waiver of the defense."). Indeed, ruling that any defense not raised in a communication between the insurer and the insured is waived would seem to conflict with the Third Circuit's decision in *Gritzer v. CBS, Inc.*, 275 F.3d 291, 295 (3d Cir. 2002). In *Gritzer*, the court was faced with an insurer that denied benefits without providing any reasons for the denial. *Id.* at 295-96. Thus, the first time that the insurer presented reasons was before the district court. *Id.* The Third Circuit reviewed this "new" reason *de novo*, without referring to waiver. *Id.* at 296.

Even accepting the Second Circuit's articulation of the role of waiver in ERISA cases, there is no evidence that Reliance intentionally forfeited its right to argue that Kaelin was not disabled during the elimination period beginning April 27, 2002. Reliance has argued from the start that Kaelin is not disabled under the terms of the Policy, and has never indicated that this argument is limited to a specific elimination period. Indeed, in its second denial letter, Reliance concluded that Kaelin was not disabled during the elimination period now in effect. In addition, this case is distinguishable from *Lauder*, the key case applying waiver to an ERISA claim. In

Lauder, an insurer rejected a claim on the basis that the claimant was not covered by the policy on the date of the injury. 284 F.3d at 377-78. The claimant had provided the insurer with medical evidence describing the extent of her injury, and completed a Release of Medical Information form so that the insurer could access her medical records. *Id.* at 378. The insurer originally "made a request for medical records, but then canceled the request a few days later on the ground that it did not want to incur the expense of pursuing the matter." *Id.* The district court rejected the insurer's argument that the claimant was not covered, and also found that the insurer had waived any argument that the claimant was not disabled. *Id.* On appeal, the Second Circuit affirmed the district court's waiver ruling, concluding that "[The claimant] also submitted a Release of Medical Information so that [the insurer] could pursue an investigation of her disability. [The insurer], of course, chose not to do so. Therefore, what [the insurer] waived by its conduct was its right to *investigate*; the underlying disability itself was established." *Id.* at 381. Here, Reliance did investigate Kaelin's disability, so cannot have waived that right. Further, the underlying disability in this case is hotly contested, and has been for the entire proceeding. Thus, the court holds that Reliance has not waived its right to argue or investigate Kaelin's disability during the elimination period beginning April 27, 2002.

Based on these considerations, the court will remand the case to Reliance so that it may determine in the first instance whether Kaelin is eligible for benefits upon application of the appropriate elimination period. This decision is consonant with the general preference for "[t]he question of [a claimant's] eligibility [to] be resolved by the plan in the first instance, not by the court." *Grossmuller v. Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am.*, 715 F.2d 853, 859 (3d Cir. 1983); *see also Saffle*, 85 F.3d at 461 ("It is not the court's

function *ab initio* to apply the correct standard to [the participant's] claim. That function, under the Plan, is reserved to the Plan administrator.") (internal quotation marks omitted); *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 398 (5th Cir. 1998) ("We would stand ERISA on its head if we countenanced bypassing the procedures provided by the statute for making benefits decisions in favor of making the initial benefits decision ourselves.").

On remand, Reliance should consider the specific duties that Kaelin performed immediately before the commencement of his elimination period (April 27, 2002), and may also consider his duties upon his return to work after the elimination period. Reliance should consider the specific services Kaelin provided the patients that he saw during those periods, whether Kaelin was assisted in these duties by another doctor, and if so, to what extent. Once Reliance determines the duties of Kaelin's regular occupation, it should decide which of those duties were material, by reference to the standards described above. Upon reaching these preliminary decisions, Reliance should evaluate whether Kaelin was able to perform any of his material duties during the elimination period. To aid Reliance in reaching these decisions, Kaelin should submit additional evidence and Reliance should conduct additional investigation on these points.

An appropriate order follows.

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

CHARLES R. KAELIN, M.D., Plaintiff,	:	
v.	:	CIVIL ACTION
TENET EMPLOYEE BENEFIT PLAN, BENEFITS ADMINISTRATION COMMITTEE OF THE TENET EMPLOYEE BENEFIT PLAN, RELIANCE STANDARD LIFE INSURANCE COMPANY, and TENET HEALTHCARE CORPORATION, Defendants.	:	NO. 04-2871

Order

AND NOW, this _____ day of August, 2006, upon consideration of plaintiff Charles R. Kaelin's Memorandum in Opposition to Remand Claim Under 29 U.S.C. § 1132(a)(1)(B) to Reliance Standard Life Insurance Company (Document No. 56), and defendant Reliance Standard Life Insurance Company's Memorandum Regarding Remand of the Claim, IT IS HEREBY ORDERED that plaintiff's claim for disability benefits is remanded to Reliance Standard for further proceedings consistent with the court's opinions of December 19, 2005, March 31, 2006, and this date.

IT IS FURTHER ORDERED that:

1. Within 30 days of the date of this Order, plaintiff shall file with Reliance Standard any additional evidence to further develop the record.

2. Upon expiration of the time for plaintiff to submit additional evidence for the record, Reliance Standard shall have 45 days to obtain additional evidence and to make a final decision on plaintiff's claim. There shall be no administrative appeal of this decision.

3. After Reliance Standard renders its final decision, either party may file an appeal with this court, which will retain jurisdiction.

4. This case shall be placed on the civil suspense docket pending Reliance Standard's redetermination of plaintiff's entitlement to benefits and any possible appeal to the court therefrom.

/s William H. Yohn Jr., Judge

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William H. Yohn Jr., Judge