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United States District Court
For the Northern District of California

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

PATRICIA BROYLES,
Plaintiff,
v.
A.U.L. CORPORATION LONG-TERM
DISABILITY INSURANCE PLAN,
Defendant.

No. C-07-5305 MMC

**ORDER DENYING PLAINTIFF’S MOTION
FOR JUDGMENT UNDER RULE 52;
GRANTING DEFENDANT’S CROSS-
MOTION FOR JUDGMENT UNDER RULE
52; GRANTING DEFENDANT’S MOTION
TO STRIKE; FINDINGS OF FACT AND
CONCLUSIONS OF LAW**

STANDARD INSURANCE COMPANY,
Real Party in Interest

[Docket Nos. 46, 51, 52]

Before the Court are (1) plaintiff Patricia Broyles’s (“Broyles”) motion for judgment and (2) defendant A.U.L. Corporation Long-Term Disability Insurance Plan and real party in interest Standard Insurance Company’s (“Standard”) opposition and cross-motion for judgment,¹ each brought pursuant to Rule 52 of the Federal Rules of Civil Procedure. Having read and considered the parties’ respective submissions filed in support of and in opposition to the motions, the Court hereby rules as follows.

¹Although not titled as such, defendant’s filing is both an opposition and a cross-motion.

1 **BACKGROUND**

2 Broyles worked as a claims payable adjuster for the A.U.L. Corporation beginning in
3 1998. In September, 2005, she ceased work and applied for disability benefits through a
4 long-term disability plan (“LTD plan” or “the Plan”) issued by Standard Insurance Company
5 (“Standard” or “plan administrator”). The LTD plan is an employee welfare benefit plan
6 governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et*
7 *seq.* (“ERISA”). Standard issued the policy constituting the Plan, and is responsible for
8 determining whether an employee qualifies for disability benefits under the terms of the
9 Plan.

10 **A. Terms of the Long-Term Disability Plan**

11 The Plan provides benefits to covered employees who meet the Plan’s definition of
12 disability. For the first twenty-four months that an employee claims benefits, the Plan
13 requires that the employee be “unable to perform with reasonable continuity the Material
14 Duties of [the employee’s] own occupation.” (Administrative Record (“AR”) 445.)² After
15 twenty-four months, a claimant must be unable to perform the Material Duties of any
16 occupation for which he or she is qualified by reason of “education, training or experience.”
17 AR 444. “Material Duties” are defined as “the essential tasks, functions and operations,
18 and the skills, abilities, knowledge, training and experience, generally required by
19 employers from those engaged in a particular occupation.” *Id.* Broyles’s occupation was
20 defined by her employer and the plan administrator as sedentary. AR 409.

21 Under the terms of the Plan, an employee’s coverage terminates upon the
22 occurrence of certain specified events. In that regard, the Plan provides:

23 Your insurance ends automatically on the earliest of:

24

25 (4) the date your employment terminates.

26 (5) the date you cease to be a Member. However, your insurance will be

27 _____
28 ²Each page of the Administrative Record bears various sets of numbers. For ease
of reference, the Court uses herein the last three digits of the Bates stamp.

1 continued during the following periods when you are absent from Active
2 Work, unless it ends under any of the above.

3

4 (b) during a leave of absence if continuation of your insurance under
5 the Group Policy is required by a state-mandated family or medical
6 leave act or law.

7 AR 446.

8 **B. Broyles's Claim for Benefits**

9 On March 18, 2005, Broyles underwent surgery to repair the collapsed arch in her
10 right foot. AR 190. When she returned to work in April, she had a cast on her leg and used
11 a wheelchair to get around. AR 291. Initially, Broyles's recovery from the surgery
12 progressed smoothly. On June 13, 2005, her orthopedic surgeon, Dr. Pfeffer, noted that
13 she was "doing well" and that she could tolerate weight-bearing activities with the use of an
14 orthotic device. AR 201. Later in the summer, however, she experienced some setbacks
15 in her recovery, and at an August 12, 2005 follow up visit, Dr. Pfeffer noted significant
16 swelling in her foot. AR 184.

17 Thereafter, on September 13, 2005, Broyles was demoted and relieved of her
18 supervisory responsibilities. AR 324. She ceased work on September 14, 2005. AR 173.
19 The following day, September 15, 2005, Broyles again visited Dr. Pfeffer. Dr. Pfeffer's
20 office notes from that visit do not include any notation to the effect that Broyles was advised
21 to stop working. AR 204. On November 28, 2005, however, Broyles applied for benefits
22 under the Plan, claiming disability as of September 15, 2005. AR 277-79.

23 As part of the claims process, Standard obtained Broyles's medical records and sent
24 an Attending Physician's Statement ("APS") form to Dr. Pfeffer. Dr. Pfeffer's notes on the
25 APS form are brief and not fully responsive to the inquiry. For example, where the form
26 asks for the "date you recommended patient should stop working," Dr. Pfeffer responded
27 "Yes." AR 181. Similarly, a subsequent section of the form asks: "What reasonable work
28 or job site modifications could the employer make to assist the individual in return to work?"

1 Dr. Pfeffer responded, “sedentary work.” Id.

2 On March 28, 2006, Standard notified Broyles by letter that it had denied her claim.
3 Standard noted therein that Broyles’s job was sedentary, and, citing Dr. Pfeffer’s responses
4 on the APS form, found Broyles was able to perform the material duties of that sedentary
5 position. AR 409-10. The letter further advised Broyles that she had the right to appeal the
6 determination, and that she could submit additional information demonstrating why she was
7 unable to perform sedentary work. AR 408.

8 In April 2006, Broyles had total knee replacement surgery on her left knee, and
9 thereafter, in October 2006, was tentatively scheduled for total knee replacement surgery
10 on her right knee in 2007. AR 254.³

11 On July 25, 2006, Broyles notified Standard that she was starting the appeals
12 process and intended to submit additional medical records and letters from her treating
13 physicians. AR 373. In the following months, several Standard employees had follow-up
14 conversations with Broyles to make sure they had received all the information that she
15 planned to submit. AR 379-84. Broyles was assisted by counsel in her appeal, and her
16 counsel provided copies of Broyles’s medical records, physical therapy records and
17 prescription medication records. In particular, Broyles obtained a letter from Dr. Shifflett,
18 her knee surgeon, who began treating her in February 2006. In his letter, dated
19 October 11, 2006, Dr. Shifflett stated that in his opinion, Broyles was “unable to do her
20 regular job, which requires prolonged sitting.” AR 254. Additionally, Broyles obtained a
21 letter from Dr. Pfeffer, dated November 11, 2006, supplementing the responses he had
22 given on the APS form. In that letter, Dr. Pfeffer provided his opinion that Broyles “has
23 been incapable of working in her own and any other occupation either on a full or part time
24 basis, including doing sedentary work, since September 15, 2005.” AR 390.

25 Standard forwarded Broyles’s claims file to Dr. Waldram, an independent physician
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27
28 ³It appears that the latter surgery had not been performed as of the time Standard issued its final denial in March 2007. See AR 421.

1 consultant (“IPC”) who is Board certified in orthopedics.⁴ Based on his review of the file,
2 Dr. Waldram concluded: “I do not see how specifically status post total knee or status post
3 surgery for flat foot would be troublesome in a sitting posture.” AR 265. Consequently, in
4 Dr. Waldram’s opinion, Broyles “could work at a sedentary level job on a full time basis.”
5 Id.

6 On February 7, 2007, Standard notified Broyles that it had denied the appeal of her
7 claim. AR 416. In that letter, Standard stated it had received and reviewed the additional
8 records and physicians’ letters Broyles had submitted, but that it found Broyles was
9 capable of engaging in sedentary work, citing the opinion of its IPC Dr. Waldram. AR 416.
10 The letter also informed Broyles that any disability resulting from her knee surgery was not
11 covered under the Plan. In that regard, Standard advised Broyles that she was on unpaid
12 leave under the Family Medical Leave Act until December 8, 2005, after which time her
13 coverage under the Plan automatically terminated, and that because her knee surgery was
14 not performed until April 2006, it was not covered. AR 414.

15 After the denial of her appeal, Broyles’s file was automatically sent to the
16 Administrative Review Unit (“ARU”), a separate division within Standard, for an additional
17 level of review. The ARU retained Dr. Mandiberg, a physician Board certified in
18 orthopedics, to conduct a second IPC review of Broyles’s file. Dr. Mandiberg concluded: “I
19 cannot see why [Broyles] cannot do a sit-down job with the ability to stand up and move
20 around as needed.” AR 274. In Dr. Mandiberg’s opinion, Dr. Shifflett and Dr. Pfeffer’s
21 proffered assessments were not supported by the medical records. Id.

22 On March 15, 2007, Standard issued its final denial of Broyles’s claim. The denial
23 letter stated that the medical records did not support Broyles’s treating physicians’
24 conclusions that she was unable to engage in sedentary work. AR 419-424. The letter
25 further advised Broyles of her right to file suit under ERISA to recover benefits. On October
26

27 ⁴ It is unclear from the record whether Dr. Waldram received a copy of Dr. Pfeffer’s
28 November 11, 2006 letter. The letter was provided to Dr. Mandiberg, Standard’s second
IPC, and both consultants were provided with a copy of Dr. Shifflett’s October 11, 2006
letter, which stated his opinion that Broyles was not able to engage in sedentary work.

1 18, 2007, the instant action was filed.

2 DISCUSSION

3 Broyles seeks herein disability benefits under the Plan pursuant to § 502(a)(1)(B) of
4 ERISA, 29 U.S.C. § 1132(a)(1)(B), which statute affords a plan participant a cause of
5 action “to recover benefits due to him under the terms of his plan, to enforce his rights
6 under the terms of the plan, or to clarify his rights to future benefits under the terms of the
7 plan.” Id.

8 A. Legal Standard

9 1. Abuse of Discretion Standard

10 The standard of review applicable to a plan administrator’s denial of ERISA benefits
11 is dependent upon the terms of the benefit plan. Firestone Tire & Rubber Co. v. Bruch, 489
12 U.S. 101, 115 (1989). If, “the benefit plan gives the administrator or fiduciary discretionary
13 authority to determine eligibility for benefits or to construe the terms of the plan,” an abuse
14 of discretion standard is applied; otherwise, the denial is reviewed de novo.

15 In the instant action, by order filed July 28, 2008, the Court denied plaintiff’s request
16 for de novo review and found the standard of review applicable herein is abuse of
17 discretion. (See Order Denying Plaintiff’s Motion for De Novo Standard of Review (“July 28
18 Order”).) In so ruling, however, the Court explained that it would “take any evidence of []
19 structural conflict of interest into consideration when conducting a review for abuse of
20 discretion.” (See id. at 2 (citing Metropolitan Life Ins. Co. v. Glenn, ___ U.S. ___, 128 S. Ct.
21 2343, 2351 (2008)); Abatie v. Alta Health Life Ins. Co., 458 F.3d 955, 967 (9th Cir. 2006)
22 (en banc).)

23 In Glenn, the Supreme Court held that even where the plan administrator has a
24 conflict of interest, for example, where it acts both as the funding source of the plan and
25 evaluates claims made thereunder, the standard of review remains deferential. Id. at 2350-
26 51. Such conflict, however, is a “factor” that the court must “take into account” along with
27 other relevant factors in assessing a plan’s exercise of discretion. Id. at 2351. As the
28 Supreme Court explained, such conflict “should prove more important (perhaps of great

1 importance) where circumstances suggest a higher likelihood that it affected the benefits
2 decision” and “should prove less important (perhaps to the vanishing point) where the
3 administrator has taken active steps to reduce potential bias and to promote accuracy.” Id.
4 at 2351.

5 Similarly, the Ninth Circuit has held that where the plan administrator has a conflict
6 of interest, a court should apply an “abuse of discretion review, tempered by skepticism
7 commensurate with the plan administrator’s conflict of interest.” Abatie, 458 F.3d at 959.
8 To determine the level of skepticism to apply, a court must consider “all the facts and
9 circumstances.” Id. at 968. As the Ninth Circuit, in Abatie, explained:

10 The level of skepticism with which a court views a conflicted administrator’s
11 decision may be low if a structural conflict of interest is unaccompanied, for
12 example, by any evidence of malice, of self-dealing, or of a parsimonious
13 claims-granting history. A court may weigh a conflict more heavily if, for
14 example, the administrator provides inconsistent reasons for denial, fails
adequately to investigate a claim or ask the plaintiff for necessary evidence,
fails to credit a claimant’s reliable evidence, or has repeatedly denied benefits
to deserving participants by interpreting plan terms incorrectly or by making
decisions against the weight of evidence in the record.

15 Id.

16 **2. Consideration of Outside Evidence and Defendant’s Motion to Strike**

17 When evaluating an ERISA administrator’s denial of benefits, a court “may, in its
18 discretion, consider evidence outside the administrative record to decide the nature, extent
19 and effect on the decision-making process of any conflict of interest; the decision on the
20 merits, though, must rest on the administrative record once the conflict (if any) has been
21 established.” Id. at 970. In making a disability determination on the merits, a court may
22 consider evidence outside of the administrative record only when procedural irregularities
23 prevented full development of the administrative record. Id. at 973.

24 Here, Broyles urges the Court’s consideration of two pieces of evidence outside the
25 administrative record. First, Broyles offers a declaration by Dr. Pfeffer, dated October 10,
26 2008, in which Dr. Pfeffer more fully explains his opinion that plaintiff is not able to engage
27 in sedentary work and to which he attaches several documents, including his Curriculum
28 Vitae and additional medical records. (See Decl. of Glenn Pfeffer, M.D., filed Oct. 10,

1 2008.) Second, Broyles offers a declaration by her attorney, attaching an award of benefits
2 by the Social Security Administration (“SSA”) dated June 3, 2007, which determination was
3 made after Standard’s final review of Broyles’s claim but was based on a finding that
4 Broyles was disabled as of September 15, 2005, the date of disability Broyles claimed
5 under the LTD plan. (See Decl. of Laurence F. Padway, filed Oct. 10, 2008.)

6 The extrinsic evidence offered by Broyles does not serve to inform the Court’s
7 determination as to the effect of the instant structural conflict on Standard’s decision-
8 making process. Neither the declaration by Dr. Pfeffer nor the SSA benefit award was
9 available at the time Standard made its decision to deny benefits, and, consequently, the
10 plan administrator cannot be said to have abused its discretion in not having considered
11 them. Nor has Broyles identified any procedural irregularities that in any manner prevented
12 full development of the administrative record. Rather, as discussed below, the
13 administrator clearly advised Broyles as to what additional evidence was required to
14 support her claim and gave her ample opportunity to submit additional documentation,
15 including a letter from Dr. Pfeffer.⁵ Moreover, SSA disability determinations are not binding
16 on ERISA administrators because the two determinations are based on different standards.
17 Madden v. ITT Long Term Disability Plan, 914 F.2d 1279, 1286 (9th Cir. 1990). Notably,
18 unlike an ERISA administrator, the SSA is required to defer to the opinion of the claimant’s

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20 ⁵The Court is not persuaded by Broyles’s contention that she is entitled to
21 supplement the record because the plan administrator, late in the appeals process,
22 articulated a new basis for denying her claim, specifically, that there was no evidence that
23 she was unable to sit due to her foot condition. Although the plan administrator used
24 slightly different language in each denial, its grounds for denial remained unchanged and
25 were clearly communicated to Broyles. The initial denial letter stated that in order to perfect
26 her claim for benefits, Broyles needed to submit evidence demonstrating that she was
27 “unable to perform sedentary work.” AR 408. The letter denying her first appeal stated that
28 based on a review of her file, the physician consultant “does not see how specifically status
post total knee or status post surgery for flat foot would be troublesome in a sitting
posture.” AR 415. The final denial letter stated that “medical records do not support that
you would have been unable to perform sedentary level work.” AR 420. Because the
administrator did not base its denial on a new ground after the administrative record was
closed, plaintiff is not entitled to supplement the record with outside information. See
Saffon v. Wells Fargo & Co. Long Term Disability Plan, 522 F.3d 863, 871-72 (9th Cir.
2008) (allowing plaintiff to present additional evidence when plan administrator relied on
newly articulated rationale in its final denial of claim).

1 treating physician. See Black & Decker Disability Plan v. Nord, 538 U.S. 822, 829-30
2 (2003).

3 Accordingly, defendant's motion to strike the above-referenced declarations is
4 GRANTED.

5 **3. Factors Warranting Increased Skepticism**

6 Broyles contends that, even without considering the additional declarations, the
7 evidence in the administrative record demonstrates Standard's decision to deny benefits
8 should be viewed with increased skepticism. In that regard, Broyles argues that the
9 administrator failed to adequately explain what information she had to submit to qualify for
10 benefits, and failed to fully investigate her claim. As set forth below, however, the record
11 does not support Broyles's contentions.

12 When determining a claim for benefits, ERISA administrators have a duty to
13 adequately investigate the claim. Boonton v. Lockheed Medical Benefit Plan, 110 F.3d
14 1461, 1463 (9th Cir. 1997). In carrying out that duty, a plan administrator is required to
15 engage in "meaningful dialogue" with the claimant, and, in particular, "[i]f benefits are
16 denied in whole or in part, the reason for the denial must be stated in reasonably clear
17 language, with specific reference to the plan provisions that form the basis of the denial."
18 Id. Further, "if the plan administrators believe more information is needed to make a
19 reasoned decision, they must ask for it." Id. As reflected in the record herein, the plan
20 administrator fully met its obligations.

21 First, Standard clearly explained to Broyles the kind of additional information that
22 would be required to support her claim. Although Broyles asserts Standard never asked
23 her or her treating physicians to explain why she could not perform sedentary work, the
24 initial letter denying her claim expressly made just such a request. Specifically, that letter
25 stated: "Additional information which would be helpful to a reconsideration of your claim
26 should include medical documentation that supports your limitations and restrictions . . .
27 [and your claim that you] are unable to perform sedentary level work." AR 408. In
28 response, Broyles submitted additional documentation, including physical therapy records,

1 additional medical records relating to her knee replacements, as well as letters from Dr.
2 Pfeffer and Dr. Shifflett, each stating his opinion that Broyles was not able to work. In
3 addition, the record demonstrates that Broyles had multiple conversations with one of the
4 administrator's disability benefits analysts, who followed up with her to make sure Standard
5 had received all of the additional information she planned to submit and afforded her
6 multiple extensions of the deadline for such submissions in order to ensure she had time to
7 assemble letters from her doctors. AR 379-84.

8 Broyles also contends the administrator failed to adequately investigate her claim
9 because it relied on a review of her medical records rather than ordering an independent
10 medical examination. Contrary to Broyles's contention, however, ERISA does not require a
11 plan administrator to obtain an independent medical examination, and consulting
12 physicians' opinions based on reviews of medical records are an acceptable basis of an
13 administrator's determination. See Jordan v. Northrop Grumman Corp. Welfare Benefit
14 Plan, 370 F.3d 869, 879-80 (9th Cir. 2004) (holding plan administrator, in accepting opinion
15 of "reviewing physician" over opinion of plaintiff's treating physicians, did not abuse
16 discretion), overruled on other grounds by Abatie, 458 F.3d 955; see also Kushner v.
17 Lehigh Cement Co., 572 F. Supp.2d 1182, 1192 (C.D. Cal. 2008) (holding ERISA does not
18 require independent medical examinations).

19 Additionally, plaintiff argues, the plan administrator failed to adequately investigate
20 her claim because the two physicians it consulted, although Board certified in orthopedics,
21 did not specialize in foot and ankle injuries. The Court disagrees. Federal regulations
22 interpreting ERISA require that plan administrators making an adverse benefit
23 determination based on medical judgment "shall consult with a healthcare professional who
24 has appropriate training and experience in the field of medicine involved in the medical
25 judgement." 29 C.F.R. § 2560.503-1(h)(3)(iii). It constitutes an abuse of discretion for an
26 administrator to rely on the opinion of a physician who has no expertise in the relevant field.
27 See Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 535, 538 (9th Cir. 1990) (holding
28 administrator erred in relying on opinion of doctor who had no experience in treating autism

1 and who based his opinion on informal conversations with psychiatrists); see also Zavora v.
2 Paul Revere Life Ins. Co., 145 F.3d 1118, 1122-23 (9th Cir. 1998) (holding administrator
3 erred in denying benefits where claim based on eye injury and administrator relied on
4 opinion of physician who was not ophthalmologist). Plaintiff cites to no authority, nor has
5 the Court located any, holding a plan administrator may rely only on opinions from
6 physicians practicing within the same sub-specialty as the claimant's treating physician.

7 In sum, the plan administrator clearly explained to Broyles what additional
8 information was needed to support her claim, allowed ample time for her to provide such
9 supplemental information, and relied on opinions from qualified medical personnel.
10 Consequently, Broyles has not demonstrated the existence of a conflict of interest beyond
11 the structural conflict conceded by Standard, nor has Broyles identified any other conduct
12 warranting a heightened degree of skepticism. Accordingly, the Court will review the
13 administrator's exercise of discretion with a low level of skepticism.

14 **B. Standard's Exercise of Discretion**

15 When reviewing for abuse of discretion, the Court "cannot substitute [its] judgment
16 for the administrator's. . . [and] can set aside the administrator's discretionary determination
17 only when it is arbitrary and capricious." Jordan v. Northrop Grumman Welfare Benefit
18 Plan, 370 F.3d at 875. "An ERISA administrator abuses its discretion only if it (1) renders a
19 decision without explanation, (2) construes provisions of the plan in a way that conflicts with
20 the plain language of the plan or (3) relies on clearly erroneous findings of fact." Boyd v.
21 Bert Bell/Pete Rozelle N.F.L. Ret. Plan, 410 F.3d 1173, 1178 (9th Cir. 2005). Here, Broyles
22 does not argue that Standard failed to explain its denial or erred in construing any provision
23 of the Plan. Rather, she argues that Standard's decision was based on several clearly
24 erroneous findings of fact.

25 First, Broyles contends that Standard incorrectly interpreted Dr. Pfeffer's statements
26 on the APS form and, further, ignored Dr. Pfeffer's subsequent letter and a letter from
27 another treating physician that stated she was unable to engage in sedentary work.
28 Neither such assertion is supported by the record. An ERISA administrator must have a

1 reasonable basis for its decision, and may not arbitrarily refuse to credit a claimant's
2 reliable evidence. Black & Decker, 538 U.S. at 834. The administrator is not required,
3 however, to give special deference to the opinions of treating physicians, and may rely on
4 the opinions of its own consultants. Id. Additionally, simply because "the administrator
5 ultimately rejects the applicant's physicians' views does not establish that it ignored them."
6 Jordan, 470 F.3d at 878.

7 Here, contrary to Broyles's characterization of the APS form, Dr. Pfeffer's
8 statements were unclear and open to conflicting interpretations. See AR 181.
9 Consequently, the administrator's interpretation of Dr. Pfeffer's remarks as stating Broyles
10 could engage in sedentary work was not clearly erroneous. Moreover, both physician
11 consultants considered Dr. Pfeffer's subsequent clarifying letter and Dr. Shifflett's letter,
12 each of which stated Broyles was unable to engage in sedentary work. AR 273-75. The
13 consultants, however, found the conclusions reached therein were unsupported by
14 Broyles's medical records. Dr. Mandiberg notes, for example, that "[t]here is nothing in the
15 medical records in the way of doctors' notes to support [Dr. Pfeffer and Dr. Shifflett's]
16 statements," and that "nobody has given a reason why a person with foot problems cannot
17 do a sedentary job." AR 273-274. Under such circumstances, the administrator did not
18 abuse its discretion in relying on the reports of two qualified physician consultants who
19 disagreed with plaintiff's treating physicians.

20 Next, Broyles contends that Standard did not consider the records relating to the
21 physical therapy she received. Broyles submitted her physical therapy records on
22 October 27, 2006, in connection with her appeal, AR 255-56, and the records were
23 provided to the physician consultants who reviewed Broyles's file. Dr. Waldram noted, for
24 example, that he received and reviewed the physical therapy records, as well as
25 information regarding Broyles's 2006 knee replacement surgery. AR 266. Additionally,
26 Standard's final denial letter references the physical therapy records, see AR 419-24,
27 noting, inter alia, that the physical therapy discharge report included the opinion that
28 Broyles had "progressed to a point of tolerating at least 45 minutes of consistent

1 cardiovascular exercise,” and that she was discharged from physical therapy because she
2 informed her therapist that she wanted to discontinue physical therapy and join a gym, AR
3 422.

4 Third, Broyles contends, Standard should have considered whether her two knee
5 replacement surgeries, which occurred in 2006 and 2007, prevented her from engaging in
6 sedentary work. As Standard noted in its denial letters, plaintiff’s coverage, under the
7 terms of the Plan, lapsed on December 8, 2005, well before either of the surgeries was
8 performed.⁶ Consequently, any disability resulting from the surgeries was not covered
9 under the Plan, and the plan administrator did not abuse its discretion in failing to consider
10 such subsequent information when making its disability determination. Moreover,
11 irrespective of whether Standard had an obligation to consider Broyles’s knee surgery and
12 planned knee surgery, it nonetheless provided information about those procedures to its
13 physician consultants, who included the information in their reviews. AR 267, 274. Dr.
14 Waldram, who conducted the initial independent review of plaintiff’s file, expressly noted
15 that Broyles’s medical condition following knee surgery would not interfere with her ability to
16 work in a sedentary position. AR 265.

17 Broyles further contends that Standard failed to consider her own reports of pain.
18 The record as to Broyles’s self-reported symptoms, however, contains information
19 inconsistent with a finding of disabling pain. For example, in October 2005, although
20 Broyles reported to her physical therapist that she had pain in her toe and heel, she told her
21 physical therapist that she was able to work at a desk. AR 247. Additionally, as noted,
22 plaintiff’s physical therapy discharge report stated she was able to tolerate at least 45

23
24 ⁶Broyles contends that although the surgeries did not occur until after her coverage
25 had lapsed, the administrator nonetheless should have considered her knee problems
26 because, according to Broyles, symptoms of a degenerative condition do not appear “out of
27 nowhere like a Jack in the Box” and were present during the period when she was covered
28 by the LTD plan. (See Broyles’s Brief Supp. J’mnt at 15.) Again, the administrative
record does not support Broyles’s argument. Pain diagrams filled out by Broyles as part of
her physical therapy program in September 2005 and January 2006 do not show that she
was experiencing pain in her knees. AR 245, 250. Indeed, there is no indication in the
record that Broyles had any problems with her knees until February 2006, when she began
treatment with Dr. Shifflett. AR 254.

1 minutes of consistent cardiovascular exercise, and, further, that she was able to “minimize”
2 her foot and ankle pain with the use of crutches. AR 252.

3 In light of such conflicting information, both as to the severity of, and factors
4 precipitating, Broyles’s pain, the administrator’s interpretation of the record, and
5 determination that Broyles’s pain was not disabling, were reasonable and not based on
6 clearly erroneous findings of fact. See Jordan, 370 F.3d at 879; Snow v. Standard Life Ins.
7 Co., 87 F.3d 327, 331-32 (9th Cir. 1996) (holding denial of benefits not abuse of discretion
8 “where there is relevant evidence [that] reasonable minds might accept as adequate to
9 support a conclusion even if it is possible to draw two inconsistent conclusions from the
10 evidence.”) (alteration in original) (internal quotation and citation omitted), overruled on
11 other grounds by Kearney v. Standard Ins. Co., 175 F.3d 1084 (9th Cir. 1999) (en banc).

12 Lastly, Broyles’s claims the plan administrator relied on an erroneous synopsis of
13 her medical records, which synopsis was prepared by one its employees. In particular, the
14 synopsis incorrectly stated that at the time Broyles ceased working, she was only taking the
15 over-the-counter medication Aleve to manage her pain, when in fact she also was taking
16 prescription medications at the time. AR 212-214, 267. Although the synopsis is, in part,
17 incorrect, the record is devoid of any evidence that it had an impact on the plan
18 administrator’s decision to deny benefits. None of the letters explaining the denial of
19 Broyles’s claim mentions the synopsis. Indeed, it was never sent to Dr. Waldram, who
20 based his conclusions on plaintiff’s prescription records, which were forwarded to him for
21 review. AR 212-14. Although the synopsis was sent to Dr. Mandiberg, he also received a
22 complete copy of Broyles’s prescription records, and there is no reference in his report to
23 the inaccurate statement, let alone to his reliance thereon. Because the plan administrator
24 did not base its decision on the incorrect information in the synopsis, plaintiff’s contention
25 that the denial was premised on clearly erroneous facts is without merit.

26 Having considered the administrative record and the parties’ respective arguments
27 with respect thereto, the Court finds the plan administrator did not abuse its discretion in
28 finding Broyles did not meet the Plan’s definition of disabled. Accordingly, defendant and

1 real party in interest are entitled to judgment on Broyles's claim for benefits.

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CONCLUSION

For the reasons stated above:

- 1. Plaintiff's motion for judgment on her claim for benefits is hereby DENIED.
- 2. Defendant and real party in interest's cross-motion for judgment on plaintiff's claim for benefits is hereby GRANTED.

IT IS SO ORDERED.

Dated: November 12, 2009


MAXINE M. CHESNEY
United States District Judge