United States District Court
For the Northern District of California

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CARL T. EDWARDS,

Plaintiff,

v.

AT&T DISABILITY INCOME PLAN,

Defendant.
_______________________________/

No. C 07-4573 PJH

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Before the court are the parties' cross motions for summary judgment. Having read the parties' papers and carefully considered their arguments and the relevant legal authority, and good cause appearing, the court hereby GRANTS defendant's motion and DENIES plaintiff's motion.

BACKGROUND

This is an action brought under the Employment Retirement Income Security Act of 1974, 29 U.S.C. § 1001, et seq. ("ERISA"), alleging unlawful denial of long-term disability benefits. Plaintiff Carl T. Edwards is a former employee of the American Telephone and Telegraph Company, and later, of Pacific Bell Telephone Company ("Pacific Bell"). Plaintiff was a participant in the SBC Umbrella Benefit Plan No. 1 (now known as the AT&T Umbrella Benefit Plan No. 1), an employee welfare benefit plan governed by ERISA. The AT&T Umbrella Benefit Plan No. 1 combines numerous benefit plans – including the AT&T

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Disability Income Plan – into one welfare benefit plan.[1]

A. The Terms and Administration of the Plan

The AT&T Disability Income Plan ("the Plan") provides for short-term disability benefits ("STD Plan benefits") and long-term disability benefits ("LTD Plan benefits") to eligible participants, who are either employees or former employees of one of the participating companies (which include Pacific Bell). Plaintiff was an employee of Pacific Bell from February 2000 through August 18, 2006. His last position was Manager of Network Services.

Under the Plan, eligibility for LTD benefits requires that an employee's condition meet the definitions set forth in the Plan. The Plan defines "Long Term Disability" as "the period, immediately following a period of fifty-two (52) weeks for which Short Term Disability benefits are payable under the Plan for a Total Disability. AT&T Long Term Disability Plan ¶ 2.13. The Plan defines "Total Disability," in relevant part, as follows:

> "Total Disability" or "Totally Disabled" means, with regard to Long Term Disability, that because of Illness or Injury, an Employee is prevented from engaging in any employment for which the Employee is qualified or may reasonably become qualified based on education, training or experience. An Employee is considered Totally Disabled if he is incapable of performing the requirements of a job other than one for which the rate of pay is less than 50% of his Basic Wage Rate at the time his Long Term Disability started. . . .

Id. ¶ 2.26.

The Plan provides that AT&T, Inc. ("AT&T" – formerly SBC) is the Plan Administrator.[2] Id. ¶ 2.20. The Plan confers discretionary authority on AT&T, "to administer the Plan in all of its details, exclusive of granting and denying of claims, subject to the applicable requirements of law." Id. ¶ 5.2.1. Pacific Bell is not now and never has been the Plan Administrator, and has never had responsibility for administering any of the AT&T Plans, or for determining eligibility for STD or LTD Plan benefits for its employees.

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[1] Plaintiff named the AT&T Disability Income Plan as the defendant in this action. Defendant asserts, however, that the proper defendant is the AT&T Umbrella Benefit Plan No. 1, as the Disability Income Plan was merged into the Umbrella Plan, effective January 1, 2001.

[2] AT&T, Inc. was formed in 2005, when SBC Communications Inc. purchased former AT&T Corporation.

In addition, the Plan requires the Plan Administrator to appoint one or more Claims Administrators. Id. ¶ 5.4. The Plan expressly vests absolute discretion in the Claims Administrator, who "shall have full and exclusive authority and discretion to grant and deny claims under the Plan, including the power to interpret the Plan and determine the eligibility of any individual to participate in and receive benefits under the Plan." Id. ¶ 5.4.4. The decisions of the Claims Administrator with regard to eligibility of Plan participants to receive benefits under the Plan, and with regard to interpretation of the provisions of the Plan, are "final and conclusive" and "not subject to further review." Id.

Sedgwick Claims Management Services, Inc., ("Sedgwick") is a third-party administrator. Effective April 2001, AT&T appointed Sedgwick as the Claims Administrator for the Plan, including for claims brought by employees of Pacific Bell; and Sedgwick has served as the Claims Administrator continuously since that date.

The Agreement for Administration of Disability Claims under SBC Disability Plans and Administration of SBC's Job Accommodation Process ("the Agreement"), entered into between SBC (now AT&T) and Sedgwick on April 14, 2003, governs Sedgwick's administration of AT&T's disability plans, including the Plan.

Until March 1, 2006, the Sedgwick employees who reviewed and evaluated claims for STD and LTD benefits under the Plan worked in a unit of Sedgwick known as the SBC Medical Absence and Accommodation Resource Team ("SMAART"). Effective March 1, 2006, the name of that unit was changed from SMAART to the AT&T Integrated Disability Service Center ("IDSC"). Sedgwick's IDSC Quality Review Unit reviews claimant appeals of disability claims.

The Agreement between AT&T and Sedgwick provides that any of the services to be performed by Sedgwick under the Agreement may be performed by Sedgwick or any of its subsidiaries without prior written approval by AT&T. AT&T has no control over Sedgwick's day-to-day decisions regarding the outcome of claims. Apart from its obligations under the Agreement, Sedgwick does not have any other affiliations or financial associations with AT&T, Inc., or any of its subsidiary companies.

Under the Agreement, Sedgwick's responsibilities include reviewing, processing, investigating, evaluating, deciding, and maintaining STD and LTD claims brought by Pacific Bell employees. Sedgwick approves or denies claims for STD and LTD benefits under the Plan, and reviews denied disability claims on appeal. In its capacity as reviewer of appeals, Sedgwick operates as a Plan Fiduciary, as defined by ERISA.

Sedgwick provides specified services in connection with administering claims brought under the Plan. As the Claims Administrator for the Plan, Sedgwick has complete discretion to determine whether a participant is disabled. The Agreement provides that Sedgwick's employees work exclusively for Sedgwick, and are not employees or agents of AT&T, Inc.

Pursuant to the Agreement, AT&T Inc. established a demand deposit account (the "Account") that is used by Sedgwick to pay LTD benefits under the AT&T disability plans, including the Plan. Since January 1, 2003, the Account has been funded by AT&T Inc. Prior to January 1, 2003, the Account was funded by the SBC Voluntary Employees Beneficiary Association Trust, which was funded by SBC's affiliates, including Pacific Bell. Each affiliate would contribute its share of funds to the Trust based on the amount of benefits paid from the Trust to the affiliate's employees.

Sedgwick is not, and has never been, required to advance or pay its own funds to pay STD or LTD Plan benefits, losses or expenses under any of the AT&T Inc. disability plans, including the Plan. Sedgwick notifies the Plan when a participant's claim for STD or LTD Plan benefits has been approved, and if so, for what period of time.

Sedgwick has no role in the Plan's funding, and has never been a source of the funds that are used to pay disability benefits under the Plan. AT&T pays Sedgwick a flat fee for the provision of its claims services. Pursuant to the Agreement, the amount of the fee is not linked to the outcome of any claim, or to the general approval or denial rate for benefits claims or the outcome of reviews of appeals. Neither Sedgwick, nor any of its individual employees, has ever been given any financial incentive for approving or denying a claim for STD or LTD benefits, or for reversing or upholding a denial of benefits on

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appeal.

The Agreement does not address or establish a target or goal for Sedgwick's rate of claim approval, rate of claim denial, or how it decides an appeal. Nor does the Agreement provide for any incentives for Sedgwick or any Sedgwick employee relating to meeting a certain target or goal for the rate of approval, denial, or decision on appeal.

Neither AT&T nor Sedgwick has an affiliation with any of the medical professionals who complete the independent physician advisor reports. AT&T has no role in selecting the medical professionals who complete the independent physician advisor reports, and Sedgwick's role is limited to designating the type of professional whose opinion is required, based on the nature of the claim and the stated medical condition.

B. Background Facts

On August 12, 2005, plaintiff applied for STD Plan benefit payments, based on medical diagnoses of peripheral neuropathy and resultant syncope (fainting or temporary loss of consciousness) due to autonomic dysfunction; diabetic neuropathy; diabetes; hypertension; and heart disease. His application was approved, and he received STD benefits for 52 weeks. On April 21, 2006, Sedgwick's IDSC advised plaintiff that his STD benefits would expire on August 17, 2006. Sedgwick further advised plaintiff that he might be eligible for LTD benefits as of August 18, 2006, and invited him to submit LTD benefits application documentation.

On May 8, 2006, Sedgwick LTD Case Manager Nayra Rosenston contacted plaintiff by telephone to explain the LTD benefits claim process. She reviewed, with plaintiff, his permanent work restrictions, and his participation in the internal job search. Plaintiff confirmed that he could perform "desk-type work" and identified his treating physicians as Drs. Mahmood, Pong, and Chung. Plaintiff reported that his daily activities included "self-care, cooking, driving grandkids to/from school, [and] dishes . . . " and confirmed that he could drive.

Sedgwick confirmed receipt of plaintiff's LTD benefits application on May 15, 2006. In the "Statement of Employee" that plaintiff submitted as part of the application, he

answered "Yes" to the question, "If you are unable to return to your job[,] are you able to perform some other job?" He answered "Deskwork only" to the question "If yes, what type of job?" Plaintiff also indicated that he had various computer skills and could type 40 words per minute.

Sedgwick's LTD unit obtained medical records and other information that plaintiff had submitted in support of his continuing STD benefits, and reviewed that information in connection with the LTD application. Several of plaintiff's 2006 medical records identified limitations and restrictions that plaintiff's treating neurologist, Dr. Mujahid Mahmood, placed on his return to work.

Plaintiff had consulted Dr. Mahmood on November 16, 2005, complaining of multiple episodes of syncope and presyncope. Dr. Mahmood's examination showed decreased sensory function in the lower extremities in a stocking distribution. Dr. Mahmood made no comment regarding reflexes, though he observed no obvious weakness. He suspected that plaintiff had peripheral neuropathy, and ordered an MRI and an MRA of the brain to rule out vertebral basilar insufficiency and obstructive sleep apnea syndrome.

Plaintiff saw Dr. Mahmood again on December 7, 2005. Dr. Mahmood reported that plaintiff could not tolerate the MRI, and that lab studies were unremarkable. Dr. Mahmood suggested that plaintiff might have autonomic neuropathy due to his diabetes.

Plaintiff returned to see Dr. Mahmood on February 3, 2006. Dr. Mahmood reported that plaintiff's syncope improved with "slowly changing to upright positions," and that plaintiff was being "more vigilant re walking in the dark, watching where he places his feet, etc." Dr. Mahmood indicated that plaintiff's peripheral neuropathy was "stable" and "most likely secondary to long h/o DM." Dr. Mahmood also felt that plaintiff's diabetes was "the likely cause of his postural syncope due to resultant autonomic dysfunction." He recommended aggressive treatment of the diabetes, optimizing hydration, and also recommended that plaintiff change body positions slowly.

On February 10, 2006, Dr. Mahmood released plaintiff to return to work: "OK to return to work – but accommodation should be made to ensure Pt. can rise slowly from

sitting to standing position. Also needs to stay well hydrated." Dr. Mahmood clarified plaintiff's restrictions and limitations on February 14, 2006: "Caution when changing from sitting to standing. No repetitive bending, kneeling, climbing ladders/hills. Limit driving. Desk work/sitting OK." Dr. Mahmood indicated, among other things, that plaintiff could "[s]it 8 hours" and "[s]tand/walk/drive minimal minutes per hour."

In a letter dated February 21, 2006, Dr. Mahmood wrote to plaintiff, "You have a history of Peripheral Neuropathy and resultant Syncope due to Autonomic Dysfunction. These conditions significantly limit your ability to change positions quickly, stand or walk for prolonged periods, especially when safety factors/conditions are a consideration. This limitation is permanent . . . . Any accommodations that can be made in regards to work conditions, disability considerations, etc. would be most beneficial."

On July 5, 2006, plaintiff's application for Social Security Disability Insurance ("SSDI") benefits was approved. The Social Security Administration ("SSA") found that plaintiff "became disabled under our rules on August 12, 2005."

On August 8, 2006, Sedgwick referred plaintiff's medical records to an Independent Physician Advisor, Barbara Parke, M.D., Board Certified in Physical Medicine and Rehabilitation, for a file review. Sedgwick requested that she address two questions – "(1) What are the medically supported r/ls (please clarify who [sic] much walking, standing and driving he is able to do) and (2) Duration?" Dr. Parke reviewed plaintiff's medical records and confirmed that plaintiff was able to perform sedentary work eight hours a day, and also confirmed the medical limitations set by Dr. Mahmood.

Also on August 8, 2006, Sedgwick obtained a Transferable Skill Assessment ("Assessment"), based on plaintiff's training, education, and experience. The Assessment was based on a review of medical chart notes and records provided by the case manager, on plaintiff's reported employment history and educational background, and on his demonstrated skills.

The Assessment found that based on plaintiff's work history and education, "he has demonstrated the following: attention to detail, good customer service skills and excellent

communication skills . . . [and] the ability to perform a variety of duties, including multi-tasking and repetitive short cycle work." The Assessment noted that plaintiff "has the skills to control, direct, and plan the activities of others . . . [and] the ability to supervisor [sic] employees and makes [sic] judgments and decisions." In addition, he is "proficient in Excel and Access . . . [and] has the ability to type 40 words per minute."

The Assessment identified five alternative occupations that plaintiff could perform, within his restrictions. Three of those occupations – manager of customer service, office manager, and supervisor of clerical, generic, satisfied the Basic Wage Rate percentage calculation under § 2.26 of the Plan.

By letter dated August 24, 2006, Sedgwick denied plaintiff's LTD benefits claim, effective August 18, 2006. In the letter, Sedgwick stated that the denial was based on a review of the medical documentation provided by Dr. Mahmood, plaintiff's treating neurologist. Sedgwick advised plaintiff that the medical information provided by Dr. Mahmood was "also reviewed by a Physician Advisor, who rendered an opinion that the clinical evidence supported restrictions from driving and your ability to perform sedentary work."

Sedgwick noted further that "[a] transferable skills analysis completed by a certified rehabilitation consultant identified alternative occupations you are vocationally qualified to perform within your medical restrictions. . . . The occupations are sedentary in nature. The median wages for those occupations, specific to your labor market, provide median wages commensurate to 50% of your basic wage rate at the time Long Term Disability benefits would commence."

Sedgwick added, "If you disagree with our determination, you or your authorized representative may . . . submit[ ] a written appeal within 180 days after you receive this denial notice" and "may also submit additional medical or vocational information, and any facts, data, questions or comments you deem appropriate for us to give your appeal proper consideration."

On November 2, 2006, Sedgwick received a letter dated October 25, 2006, from

plaintiff's counsel Daniel Gruber, stating plaintiff's intent to appeal the denial of LTD benefits, and requesting "a complete copy of the claim file/administrative record," as well as copies of the policy at issue, the Summary Plan Description governing plaintiff's claim for benefits, and any claim manuals or guidelines used in the handling of plaintiff's claim. Mr. Gruber added, "After we have received a copy of the Administrative Record, we will forward all additional information and documentation we believe should be considered as part of the appeal of the denial of Mr. Edwards' claim."

Sedgwick acknowledged receipt of the appeal by letter dated November 30, 2006, through its AT&T Integrated Disability Service Center's Quality Review Unit ("QRU"). The letter advised plaintiff that the request for the appeal would be reviewed by the QRU, and that he would receive a written response by January 28, 2007. The letter added that "[m]edical records including chart notes, diagnostic tests, and hospital summaries, relevant to this absence, should be submitted regardless of the length of the disability."

On December 22, 2006, the QRU provided plaintiff's counsel Mr. Gruber with copies of the LTD and STD claim files, and advised how to obtain copies of Plan documents.

On February 27, 2007, the QRU received copies of plaintiff's medical records, along with a cover letter from his counsel Mr. Gruber. Plaintiff submitted medical records from various hospitals and physicians covering the period January 1975 through June 30, 2006. The majority of those records pertained to his history of cardiovascular disease and treatment. Plaintiff did not provide any updated medical records for the period July 1, 2006, through February 27, 2007, and did not provide any updated information concerning his condition, his work limitations, or his existing limitations.

In the accompanying cover letter, Mr. Gruber stated that plaintiff was not eligible for any of the positions identified in the transferable skills analysis: "He applied for positions that appeared to fall within the realm of his physical abilities and basic wage rate. He was denied interviews for all of them because he was informed that his restrictions would not allow him to perform the responsibilities of those particular jobs. . . .[T]here are no positions that meet the policy criteria and which Mr. Edwards can safely perform."

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The QRU followed up with a telephone call, and a letter to plaintiff's counsel dated March 8, 2007, again inviting him to submit any additional medical records that might assist in the QRU's review, and again advising that the QRU's decision would be final and not subject to further review.[3] The QRU did not receive any additional medical records from plaintiff.

On March 8, 2007, Sedgwick's QRU forwarded plaintiff's medical records, together with the claim log, for review by four Independent Physician Advisors: Dr. Leonard Sonne, Board Certified in Pulmonology and Internal Medicine; Dr. Gary P. Greenhood, Board Certified in Internal Medicine; Dr. Joseph J. Jares, Board Certified in Neurology; and Dr. Michael J. Rosenberg, Board Certified in Cardiology, Internal Medicine, and Interventional Cardiology. In their March 15, 2007 reports, these four physicians reached the same conclusion as plaintiff's treating physicians – that plaintiff could work a sedentary job, eight hours a day, with accommodations.

Dr. Sonne, the pulmonary medicine specialist, noted that notwithstanding the prior diagnosis of sleep apnea, plaintiff's February 2006 sleep study findings revealed no objective evidence of apneas or hypopneas – in short, "no evidence of clinically significant sleep apnea." In addition, while plaintiff had a 45-year history of smoking cigarettes, until 1999, Dr. Sonne found "no documentation of wheezing, cough, and shortness of breath from a pulmonary perspective." From a pulmonary medicine and sleep medicine perspective, he found "no objective documentation of any restriction, limitation, or impairment that would preclude full-time work in any position from 8/18/06 to [March 2007] or at any time in the medical file."

Dr. Greenhood, the internist, stated that in view of the fact that plaintiff's file was also

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[3] The Summary Plan Description provides,

> If a claim for benefits is denied in whole or in part, the claimant may appeal this denial in writing within 60 days after it is received. . . . The [appeal] decision will be furnished to the claimant in writing within 60 days, or, if extended, within 120 days after receipt of a written request for review, and will include the specific reasons for the decision. . . . This decision is final and not subject to further review.

being reviewed by a cardiologist, a neurologist, and a pulmonary medicine specialist, he would not address plaintiff's asserted coronary artery disease, peripheral and autonomic neuropathies, syncope, or disordered sleep, but would limit his comments to hypertension and diabetes mellitus (without the associated neuropathy or coronary artery disease). After reviewing the clinical findings reflected in plaintiff's medical records, Dr. Greenhood found no indication of malignant or accelerated hypertension, or retinopathy, nephopathy, or peripheral vascular disease related to hypertension. With regard to diabetes mellitus, he found no evidence of retinopathy, ketosis, seizures, hyperosmolar changes, or peripheral vascular disease. He concluded that "[f]rom an internal medicine perspective divorced from cardiac, neurologic, and pulmonary medicine issues, the submitted [medical records] do not support work absence from 8/18/06 to [March 2007]."

Dr. Jares, the neurologist, recounted plaintiff's medical and neurological history, and noted his attending physicians' recent diagnoses. He observed that both the tilt table test and the electrophysiological testing for recurring syncope had been normal, and that there was no evidence of significant neurological abnormalities such as weakness, reflex loss, gait dysfunction, or ataxia. Dr. Jares concluded that based on the "symptoms of autonomic insufficiency probably secondary to diabetes mellitus" and "syncopal-like sensations probably reflecting autonomic dysfunction," plaintiff should be restricted from working at heights or around hazardous or dangerous equipment and should avoid rapid changes in body posture, but also noted that this condition "would not preclude [plaintiff] from doing essentially sedentary work." Dr. Jares found "no evidence of a condition so severe that [plaintiff] would be unable to perform sedentary work with appropriate safety precautions and procedures."

Finally, Dr. Rosenberg, the cardiologist, reviewed plaintiff's medical records and determined that "[f]rom a cardiovascular perspective [plaintiff] has evidence of preserved left ventricular function and no evidence of significant myocardial ischemia or malignant rhythm disturbance." In Dr. Rosenberg's opinion, plaintiff "would be capable of moderate workload, and certainly light/sedentary work from . . . 8/18/06 to [March 2007]. Dr.

Rosenberg noted that plaintiff's syncope was "more a presyncopal/dizziness sensation . . . the symptoms of which were reported to have improved with slow arising." He found that there was no evidence of a cardiovascular disorder sufficiently severe to prevent plaintiff from working "at a sedentary, light or moderate level," although plaintiff "should avoid working at heights in an unsupported fashion."

In a letter dated March 19, 2007, Sedgwick advised plaintiff's counsel Mr. Gruber that based on the review of plaintiff's LTD benefits claim by the QRU, it had determined to uphold the denial of benefits. Sedgwick summarized the findings of the four Independent Physician Advisors, and noted that while they had referenced some findings, none were documented to be sufficiently severe to prevent plaintiff from performing any employment for which he was qualified or might reasonably become qualified based on his education, training, or experience as of August 18, 2006. Sedgwick advised further that under the terms of the Plan, the QRU's decision was final.

Plaintiff filed the present action on September 4, 2007, asserting a claim under ERISA, 29 U.S.C. § 1132(a)(1)(B), for unpaid benefits. Each side now seeks summary judgment.

DISCUSSION

A. Legal Standards

Ordinarily, summary judgment is appropriate if the pleadings and materials demonstrate 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). ERISA actions challenging a denial of benefits, however, require a slightly different analysis.

It is well-established that a challenge to an ERISA plan's denial of benefits under 29 U.S.C. § 1132(a)(1)(B) is reviewed de novo, unless the benefit Plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 963 (9th Cir. 2006) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)). When it is shown that the administrator has such discretion, the court will apply an abuse of discretion standard of

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review. Id.

"When the decision to grant or deny benefits is reviewed for abuse of discretion, a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exists, do not apply." Bendixen v. Standard Ins. Co., 185 F.3d 939, 942 (9th Cir. 1999). In addition, however, where the court considers evidence outside of the administrative record to determine the contours of the abuse-of-discretion standard, the traditional rules of summary judgment apply – "e.g., the requirement that evidence be viewed in the light most favorable to the non-moving party." Nolan v. Heald College, 551 F.3d 1148, 1154 (9th Cir. 2009).

Here, defendant requests that the court review the denial of benefits under the abuse of discretion standard, find that the denial was reasonable and supported by the administrative record, and grant its motion for summary judgment. Plaintiff, on the other hand, asserts that the court should review the denial of his claims de novo and find that he is entitled to LTD benefits under the Plan from August 18, 2006, to the present time. Thus, the court must decide whether the court should review AT&T's denial of plaintiff's disability claims de novo, or under an abuse of discretion standard; and whether AT&T properly denied plaintiff disability benefits.

B. Proper Standard of Review

As noted above, a decision whether to apply de novo review or an abuse of discretion standard depends on the wording of the Plan itself. As the Ninth Circuit has held, "for a Plan to alter the standard of review from the default of de novo to the more lenient abuse of discretion, the Plan must unambiguously provide discretion to the administrator." Abatie, 458 F.3d at 964.

Here, the SBC [now AT&T] Umbrella Benefit Plan No. 1 provides as follows:

> The Plan Administrator is the named fiduciary of the Plan, and has the power and duty to do all things necessary to carry out the terms of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, to make findings of fact, determine the rights and status of participants and others under the Plan, and decide disputes under

the Plan. To the extent permitted by law, such interpretations, findings, determinations, and decisions shall be final and conclusive on all persons for all purposes under the Plan.

AT&T Umbrella Benefit Plan No. 1 at 12.

Under the standards enunciated in Abatie, this language constitutes an unambiguous grant of discretionary authority on AT&T. See Abatie, 458 F.3d at 963 (The Plan at issue stated that "[t]he responsibility for full and final determinations of eligibility for benefits; interpretation of terms; [and] determinations of claims ... rests exclusively with Plan administrator."). For as in Abatie, where the Ninth Circuit noted that Plan language "granting the power to interpret Plan terms and to make final benefits determinations confers discretion on the Plan administrator," the Plan here also grants AT&T the discretionary authority to "interpret the provisions of the Plan," and to "make findings of fact, determine the rights and status of participants and others under the Plan, and decide disputes under the Plan."

Seeking to avoid this conclusion, plaintiff argues that AT&T has a structural conflict of interest, sufficient to alter the standard of review from abuse of discretion to de novo review. A "structural conflict of interest" exits where the same entity acts "as both the Plan administrator and the funding source for benefits." See Abatie, 458 F.3d at 965 ("[A]n insurer that acts as both the plan administrator and the funding source for benefits operates under what may be termed a structural conflict of interest."); see also Nolan, 551 F.3d at 1153.

Setting aside for a moment the question whether AT&T has a structural conflict of interest, the court notes that it is not true that were the court to find that such a conflict exists, the standard of review would be altered from abuse of discretion to de novo.
In deciding whether such conflicts are sufficient to alter the standard of review from abuse of discretion to de novo review, the Abatie court held that abuse of discretion review is required "whenever an ERISA plan grants discretion to the Plan administrator," and that to the extent a conflict of interest exists, the abuse of discretion review is to be informed "by the nature, extent, and effect on the decision-making process of any conflict of interest that

may appear in the record." Abatie, 458 F.3d at 967.

Put another way, "[w]here a plan administrator operates under a conflict of interest – in this case – a structural conflict, a court must weigh the conflict "as a factor in determining whether there is an abuse of discretion." Metropolitan Life Ins. Co. v. Glenn, 128 S.Ct. 2343, 2348 (2008), quoted in Nolan, 551 F.3d at 1153. Consideration of the conflict can "affect judicial review," and a court must consider the conflict whenever it exists, and must temper the abuse-of-discretion standard with skepticism "commensurate" with the conflict. Abatie, 458 F.3d at 959; see Nolan, 551 F.3d at 1154.

In other words, abuse of discretion review is mandated once the court deems that discretionary authority is delegated to the Plan administrator. Rather than weighing – as in pre-Abatie cases – the conflict of interest issue to determine whether abuse of discretion review should be discarded in favor of de novo review, the court is instead required to weigh the conflict of interest "as a factor in abuse of discretion review," requiring a "case-by-case" balancing. Abatie, 458 F.3d at 968; see also Glenn, 128 S.Ct. at 2351-52.

Thus, because the Plan in the present case unambiguously conferred discretion upon AT&T, the appropriate standard of review is abuse of discretion. To the extent any conflict of interest exists, the court would consider it as one factor to be weighed against others in determining whether AT&T's denial of plaintiff's claim for LTD benefits was reasonable.

In this case, however, plaintiff presents no evidence of conflict in the record or beyond to warrant a high level of skepticism in the abuse-of-discretion analysis. In Glenn, the Supreme Court held the existence of a structural conflict of interest is more important where "circumstances suggest a higher likelihood that it affected the benefits decision." 128 S.Ct. at 2351. Factors relevant to this determination are whether the insurance company administrator "has a history of biased claims administration;" whether the administrator "has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the

inaccuracy benefits." Id.

In the present case, while it is true that AT&T is both the funding source and the Plan Administrator, the Plan requires AT&T to appoint a Claims Administrator, and also vests absolute discretion in the Claims Administrator to "grant and deny claims under the Plan" and to "interpret the Plan and determine the eligibility of any individual to participate in and receive benefits under the Plan."

The administrative record reflects that Sedgwick, the entity appointed by AT&T to serve as Claims Administrator, is solely responsible for administering claims under the Plan, including approving or denying and reviewing appeals; and that AT&T is solely responsible for paying the approved claims and does not assert any power in claims determination. Specifically, the service agreement between Sedgwick and AT&T indicates a separation of the Plan Administrator from the Claims Administrator to such an extent that there is no apparent structural conflict of interest.

Moreover, additional evidence provided by AT&T – evidence in the declarations of Susan HagEstad and Nancy Watts – shows that AT&T does not exert any control over claims denied by Sedgwick and does not otherwise encourage Sedgwick to deny claims; that Sedgwick is paid a flat fee for its services, unrelated to whether it grants or denies benefit claims; that Sedgwick's rate of approval or denial of benefits does not affect the compensation of the Sedgwick employees who make decisions about claims under the Plan; and that the independent physician advisors are selected by an independent clearing house unaffiliated with AT&T, the Plan, or Sedgwick.

Because Sedgwick has no direct economic interest in whether the claims are approved or denied, there is no risk of any conflict of interest in Sedgwick's administration of the claims. This fact sets this case apart from cases such as Glenn and Nolan, where the same entity both funded and administered the plans at issue.

In Glenn, the Supreme Court noted that the Sixth Circuit had found it relevant that the claims administrator had encouraged the plaintiff to argue to the SSA that she could do no work, had received the bulk of the benefits of her success in doing so (the remainder

going to the lawyers it recommended), and had then ignored the agency's finding in concluding that the plaintiff could in fact do sedentary work. Glenn, 128 S.Ct. at 2352 (citing Glenn v. MetLife, 461 F.3d 660, 666-69 (6th Cir. 2006)). The Court noted further that it was also relevant that the administrator had emphasized a report that favored a denial of benefits while de-emphasizing other reports suggesting a contrary conclusion, and failed to provide its independent experts with all of the relevant evidence. Id. (citing Glenn v. MetLife, 461 F.3d at 669-74).

The Court emphasized that in examining for a possible conflict of interest, courts should consider whether a given factor suggests "a higher likelihood that it affected the benefits decision," or whether, to the contrary, "the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances," thereby reducing any conflict "to the vanishing point." Id. at 2351.

Here, plaintiff provides no evidence to counter AT&T's showing of the independence of Sedgwick – as Claims Administrator – from AT&T – the Plan Administrator. Plaintiff's only argument is that a conflict of interest is demonstrated by Sedgwick's failure to consider the SSA's determination that plaintiff is disabled, and failure to advise the independent physician advisors that plaintiff was approved to receive SSDI benefits.[4]

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[4] Plaintiff also asserts that a conflict of interest is demonstrated by AT&T's failure to share the independent physician advisors' reports with plaintiff until the final decision on the appeal had been issued; and by AT&T's alleged misstatement of plaintiff's physical restrictions and limitations in its vocational assessment. Plaintiff does not explain, however, how these facts – if true – establish a conflict of interest.

The independent physician's reports were completed at Sedgwick's request as part of the appeal process, and their conclusions agreed with those of Dr. Mahmood. Plaintiff was repeatedly encouraged to supply additional medical evidence supporting his claim and appeal, but chose not to do so. The Plan clearly states that the decision of the Claims Administrator on appeal is final and not subject to further review, and plaintiff was so advised on more than one occasion.

As for the vocational assessment, the record shows that the job accommodation specialist who performed the assessment considered all the restrictions and limitations indicated by Dr. Mahmood – "No driving; able to walk and stand for 5 minutes every hour; able to sit 8 hrs/day. Able to speak, type [noting the absence of documentation supporting inability to type], perform sedentary activities 8 hrs/workday." Plaintiff takes issue with the conclusion

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Under the circumstances of this case, these factors do not suggest that the benefits decision was motivated by AT&T's financial interest. The fact that the Plan required plaintiff to apply for Social Security benefits does not in itself demonstrate a conflict of interest.[5] Courts have routinely recognized that an LTD benefits plan may apply a different – and more restrictive – standard in determining who is "disabled" than does the SSA, and have held that the plan's more restrictive standard is enforceable. See e.g., Madden v. ITT Long Term Disability Plan for Salaried Employees, 914 F.2d 1279, 1285 (9th Cir. 1990) (plan fiduciary did not abuse discretion in crediting medical evidence in record showing lack of disability despite Social Security award in favor of claimant); Hoskins v. Bayer Corp. and Business Services Long Term Disability Plan, 564 F.Supp. 2d 1097, 1105 (N.D. Cal. 2008) (defendant plan was not bound by determination reached by SSA); Wallace v. Intel Corp., 2005 WL 3369460 at *9 (D. Ariz., Dec. 12, 2005) (plan administrator's failure to consider plaintiff's Social Security award was not "material, probative evidence" that it acted as a conflicted fiduciary in denying her claim); O'Neil v. Fireman's Fund Am. Ret. Plan, 2005 WL 1562799 (N.D. Cal., June 22, 2005) at *7 (SSA award does not show that a plan administrator abused its discretion in denying benefits).

The situation in Glenn, to which plaintiff attempts to analogize the facts of his case, differed markedly because MetLife was both the insurer and the plan administrator, and was "authorized both to decide whether an employee is eligible for benefits and to pay those benefits." Glenn v. MetLife, 461 F.3d at 666. Thus, there was "an apparent conflict of interest." Id.

On top of that, the Sixth Circuit noted, MetLife assisted the claimant in obtaining

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that he was "able to type," but he never supplied any medical documentation to support his claim that he could not type, pointing only to the limitation (by Dr. Mahmood in February 2006) of "[n]o repetitive bending, kneeling, climbing" and "repetitive hand motions occasionally," which plaintiff mischaracterizes as a limitation of "no repetitive hand motion." Moreover, plaintiff stated in his April 25, 2006, application for LTD benefits that his office skills included typing 40 words per minute.

[5] Indeed, plaintiff applied for SSDI benefits five months before he applied for LTD benefits.

Social Security benefits, "steer[ing] her to a law firm specializing in securing disability benefits" from the SSA, and reaped a financial benefit of its own when that assistance was successful, but failed to give any weight to SSA's determination that plaintiff was totally disabled. Id. at 667-69. The court found that because of the evidence of conflict of interest, the failure to evaluate the SSA determination was a "significant factor to be considered" in determining whether MetLife's denial of benefits was arbitrary or capricious.

For purposes of the present action, however, it is important to note that the evidence shows that Sedgwick, which made the final decision denying plaintiff's claim, acted independently of AT&T. In addition, plaintiff has pointed to no evidence that she provided AT&T or Sedgwick with any documentation of the SSA's benefits determination. The mere fact that plaintiff is deemed disabled by the SSA does not mean that plaintiff should also be deemed disabled under the provisions of the Plan.

Social Security disability benefits determinations are made in view of the combined effect of all impairments from which an individual may suffer, and the statute defines "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." See 42 U.S.C. § 423(d).

This standard differs from the Plan's narrower definition of "Total Disability" – that "because of Illness or Injury, an Employee is prevented from engaging in any employment for which the Employee is qualified or may reasonably become qualified based on education, training, or experience" – which incorporates the definition of "Illness" as "any disabling condition medically substantiated and treated by a Physician that renders an Employee incapacitated from performing the duties of any job assigned by the Participating Company."

C. Analysis

Having determined that the applicable standard of review is abuse of discretion, and that there is no evidence in the record of conflict of interest, the court turns to the question

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whether AT&T properly denied plaintiff's claim for LTD benefits. Under the abuse of discretion standard, the court can set aside the administrator's discretionary determination only when it is arbitrary and capricious. Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869, 875 (9th Cir. 2004). "[A] decision grounded on any reasonable basis is not arbitrary or capricious, and that in order to be subject to reversal, an administrator's factual findings that a claimant is not totally disabled must be clearly erroneous." Id. (citation and quotation omitted).

Pursuant to this standard of review, the issue before the court is not whether AT&T reached the "correct" decision; the issue is whether there is substantial evidence in the record to support AT&T's decision. See Snow v. Standard Ins. Co., 87 F.3d 327, 331-32 (9th Cir. 1996) (decision is supported by "substantial evidence" where there is relevant evidence that reasonable minds might accept as adequate to support conclusion, even if two inconsistent conclusions can be drawn from evidence), overruled on other grounds, Kearny v. Standard Ins. Co., 175 F.3d 1084 (9th Cir. 1999). Even decisions directly contrary to evidence in the record may not necessarily amount to an abuse of discretion. Taft v. Equitable Life Assur. Soc., 9 F.3d 1469, 1473 (9th Cir. 1993).

Rather, an ERISA administrator abuses its discretion only if it renders a decision without explanation, construes provisions of the plan in a way that conflicts with the plain language of the plan, or relies on clearly erroneous findings of fact. See Bendixen, 185 F.3d at 944; see also Boyd v. Bert Bell/Pete Rozelle NFL Players Retirement Plan, 410 F.3d 1173, 1178 (9th Cir. 2005) (the district court should uphold the decision of an ERISA plan administrator "if it is based upon a reasonable interpretation of the plan's terms and was made in good faith").

Here, there is little evidence to support a finding that the decision to deny plaintiff's claim for LTD benefits was arbitrary or capricious. As noted above, the decision to deny the claim was made by the Plan's Claims Administrator – Sedgwick. The record makes clear that Sedgwick followed its policies and procedures, applied the terms of the Plan correctly, and satisfied ERISA's procedural requirements. Sedgwick provided plaintiff with

a written explanation of the reason for the denial of the claim, advised him of his right to appeal, and provided all claim and Plan documents requested, as well as ample opportunity to provide additional medical evidence in support of his claim and appeal. See Abatie, 458 F.3d at 969.

Plaintiff was represented by counsel in the appeal, and Sedgwick tolled the review process numerous times to allow plaintiff's counsel additional time to collect and submit medical records. Moreover, after receiving the documents submitted in support of the appeal, Sedgwick invited plaintiff's counsel to submit additional records. Plaintiff and his counsel had sufficient notice of what was necessary to satisfy Plan requirements, and also had ample opportunity to provide the information to Sedgwick.

Substantial evidence in the administrative record supports Sedgwick's determination to deny plaintiff's claim. First, the administrative record confirms Sedgwick's consideration of plaintiff's medical records, which documented his treating physician Dr. Mahmood's determination that his condition allowed him to return to work with restrictions. Those restrictions did not preclude plaintiff from sedentary "desk work," and indeed, Dr. Mahmood specifically stated, "Desk work/sitting OK." Independent Physician Advisor Dr. Barbara Parke reviewed plaintiff's medical records, and confirmed the extent and duration of plaintiff's restrictions and limitations, in agreement with Dr. Mahmood.

Sedgwick also obtained a Transferable Skills Assessment, which considered plaintiff's medical restrictions as well as his education and experience. The Assessment identified three occupations that plaintiff was reasonably capable of performing, and which paid more than 50% of plaintiff's Basic Wage Rate at the time his LTD Plan benefits would have started. Those occupations comported with the medical restrictions that limited plaintiff to sedentary desk work.

Plaintiff suggests that the Assessment is somehow invalid or inaccurate because he has been unsuccessful in obtaining a new position through an internal job search. But the Plan's definition of "Total Disability" does not require Sedgwick to place plaintiff in a job with Pacific Bell, or even to identify a specific employer for plaintiff. See Pannebecker v. Liberty

Life Assur. Co. of Boston, 542 F.3d 1213, 1219 & n.4 (9th Cir. 2008) (defendant did not abuse its discretion in relying on transferable skills analysis to identify sedentary occupations when it also did not consider issues outside plan requirements, such as plaintiff's most recent salary or station in life).

Under the Plan's definition of "Total Disability" with regard to LTD, a claimant's medical condition must be one that prevents him from "engaging in any employment for which [he] is qualified or may reasonably become qualified based on education, training, or experience." Sedgwick identified three such occupations. Sedgwick also provided plaintiff with ample opportunity to obtain additional medical evidence to support his claim that his restrictions preclude him from working at the occupations identified in the Assessment.

Nevertheless, in support of his appeal and his claim that he could not work, he provided Sedgwick with the same 2006 records from Dr. Mahmood that had previously been submitted in connection with the claim for STD benefits. He provided no records from any treating physician for the period after June 30, 2006, through his February 27, 2007 appeal. Although plaintiff challenged some of the conclusions reached by the Transferable Skills Assessment – specifically, the question whether his condition would preclude him from typing – he did not challenge the accuracy of the underlying restrictions. More significantly, he offered no supplemental medical records or a contrary skills analysis confirming his counsel's opinion of his restrictions and limitations, or his capacity to work.

Based on the information provided to Sedgwick, it was reasonable for Sedgwick to conclude that none of the historical information supported plaintiff's claim for LTD benefits. Specifically, nothing in Dr. Mahmood's February 2006 records – which released plaintiff to return to work doing "desk work" and sitting for 8 hours a day, with some restrictions – or any other medical records provided by plaintiff in support of his appeal documented a condition so severe as to preclude plaintiff from performing any employment.

In addition, under the circumstances, it was reasonable for Sedgwick to rely on the reports provided by the four Board-certified Independent Physician Advisors. After reviewing hundreds of pages of medical information and other related documents, each of

these medical specialists concluded (in agreement with plaintiff's treating neurologist) that the medical evidence did not establish that plaintiff was not able to perform any occupation, with accommodation. To the contrary, they concluded that plaintiff was capable of performing sedentary work, with certain restrictions.

CONCLUSION

The record before the court establishes that the Plan's determination was reasonable, was made in good faith, and fully complied with ERISA's requirements. In accordance with the foregoing, the court GRANTS defendant's motion for summary judgment and DENIES plaintiff's motion.

IT IS SO ORDERED.

Dated: March 11, 2009

PHYLLIS J. HAMILTON
United States District Judge

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