UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

LENA M. RAMOS,

Plaintiff,

v.

BANK OF AMERICA,

Defendant.
_____/

No. C 08-1375 PJH

ORDER RE MOTIONS FOR SUMMARY JUDGMENT

The parties' motions for summary judgment came on for hearing before this court on November 10, 2010. Plaintiff appeared by her counsel Joseph Creitz, and defendants appeared by their counsel Kristen Jacoby and Rebecca Hull. Having read the parties' papers and carefully considered their arguments and the relevant legal authority, and good cause appearing, the court hereby GRANTS defendants' motion, and DENIES plaintiff's motion.

BACKGROUND

This is a case brought under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, et seq. ("ERISA"). Plaintiff Lena Monzon Ramos is a former employee of Bank of America ("BofA"). In November 2004, after 22 years with the bank, she left her employment, claiming to be fully disabled and unable to perform any of the functions of her job (Senior Operations Representative).

As set forth in the BofA Associate Handbook, BofA offers "illness, injury and disability benefits" that include occasional illness days, short-term disability ("STD"), long-term disability ("LTD"), worker's compensation for work-related injuries, and long-term care

insurance. Administrative Record ("AR") 0153.

In 2003, defendant Metropolitan Life Insurance Company ("MetLife") issued BofA a group policy of insurance to fund long-term disability ("LTD") benefits payable under the Bank of America Long Term Disability Benefits Plan ("2003 LTD Plan" or "the Plan"). Defendant Bank of America Corporation Corporate Benefits Committee ("BofA Program" or "Program" – sued as "Bank of America") is the administrator of the 2003 LTD Plan. MetLife is an insurer, and is the entity to whom BofA Program delegated its duties as claims administrator.

The Plan grants MetLife discretionary authority to make benefit decisions, as follows:

> In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

AR 0065.

To make a claim for benefits under the LTD Plan, "the claimant must complete the appropriate claim form and submit the required proof." AR 0064. "Proof must describe . . . the nature and the extent of the cause for which a claim is made; it must be satisfactory to [MetLife]." AR 0056.

Plan participants are eligible to receive LTD benefits, following a 180-day Elimination Period, if they become "disabled" while covered under the Plan. See AR 0045, 0051.

The Plan defines "disabled" as follows:

> "Disability" or "Disabled" means that, due to an Injury or Sickness, you require the Appropriate Care and Treatment of a Doctor, unless, in the opinion of a doctor, future or continued treatment would be of no benefit and:
>
> 1. you are unable to perform each of the material duties of your occupation; and
>
> 2. after the first 24 months of benefit payments, you must also be unable to perform each of the material duties of any gainful work or service for which

you are reasonably qualified taking into consideration your training, education, experience, and past earnings; or

3. you, while unable to perform all of the material duties of your own occupation on a full-time basis, are:

a. performing at least one of the material duties of your own occupation or any other gainful work or service on a part-time or full-time basis; and

b. earning currently at least 40% less per month than your Indexed Basic Monthly Earnings due to that same Injury or Sickness.

AR 0050-0051.

The Plan sets forth procedures for making benefit claims with MetLife, including procedures for the submission and determination of claims, review of claims that have been denied in whole or in part, and information regarding a participant's rights under ERISA. AR 0056-0057, 0064-0067.

BofA employees receive sickness and Family and Medical Leave Act ("FMLA")[1] coverage through the STD Plan, which pays income replacement benefits for up to six months (depending on length of employment) to any employee who submits a request completed by the employee and his/her doctor, along with "medical documentation" of "illness, injury or pregnancy disability" sufficient to demonstrate that he/she was "unable to work" for more than 14 consecutive calendar days. AR 0154-0155.

In November 2004, plaintiff applied for benefits under the STD Plan administered by BofA. (MetLife took over administration of the STD Plan in March 2005.) Plaintiff's claim was approved for the period beginning November 19, 2004, and was ultimately extended through June 2, 2005 – the longest period allowable under the provisions of the STD Plan.

In February 2005, MetLife informed plaintiff of her eligibility to apply for LTD benefits. In a letter dated February 21, 2005, MetLife advised plaintiff that in order for her claim to be evaluated, she would have to provide an Attending Physician Statement of

[1] Under the FMLA, an employer must approve a leave to an otherwise eligible employee, if the employee reports (and her doctor certifies) a "serious health condition," defined as "an illness, injury, impairment, or physical or mental condition that involves – (A) inpatient care in a hospital, hospice, or residential medical care facility; or (B) continuing treatment by a health care provider." 29 U.S.C. § 2611(11).

Functional Capacity ("APS"); an Employee Statement; contact information for all physicians who had treated her for the allegedly disabling condition; an authorization to release medical information; and information regarding training, education, experience, job description, plus proof of age and a copy of her driver's license. AR 0365. MetLife instructed plaintiff that in addition to the APS, her physician "should also include all office notes and test results from [the] date of disability that support the stated diagnosis and restrictions and limitations." Id.

MetLife added that the above forms "must be completed and returned by March 21, 2005, to give your claim consideration and to minimize delay in benefit payments that may be due," and that "[u]nless we receive these forms by March 21, 2005, we will assume you are no longer interested in pursuing your claim for disability and will close your file." AR 0365-0366.

Plaintiff submitted her application for LTD benefits in March 2005. She listed her job duties as performing data entry, typing, and receiving incoming wires. AR 0352. She described her medical condition as shortness of breath, with constant coughing, with symptoms that "feel like an asthma attack." AR 0349. She reported that her current medications included albuterol, ferosemide, Singulair®, Advair®, Ecotrin®, Phenergan®, Nexium®, and Relpax®. AR 0353.

Plaintiff stated that the date of first treatment for her condition was 2003; that her last day of work as an Operations Representative was November 15, 2004; and that the date her disability began was November 19, 2004. AR 0348. She listed three physicians who had treated her within the past two years – Dr. Melanie Lee, a specialist in internal medicine; Dr. John Hadley, a specialist in pulmonology; Dr. Agustin Argenal, a specialist in cardiology. AR 0348-0349.

Based on the Plan's 180-day elimination period, plaintiff was not eligible for LTD benefits unless she showed that she was disabled, and that she had been continuously disabled throughout the period from November 15, 2004 to and including May 15, 2005. See AR 0045, 0051.

With her application, plaintiff submitted an APS from her pulmonologist, Dr. Hadley, dated March 8, 2005. See AR 0360-0362. The APS provided the "latest reading" of plaintiff's blood pressure, taken December 22, 2004. AR 0361. The APS stated that plaintiff had been diagnosed with cardiac asthma and congestive heart failure, and reported that plaintiff could not work due to "extreme asthma and coughing attacks" that left her "unable to talk." Id.

The APS also stated, however, that plaintiff could sit continuously for 8 hours, stand intermittently for 1 hour, and walk intermittently for 1 hour. While she had no ability to climb, she could lift up to 20 pounds occasionally, and could twist/bend/stoop, reach above shoulder level, and operate a motor vehicle. She could also perform repetitive tasks with both hands. Id.

The APS indicated that the treatment plan for plaintiff's condition included referral to a cardiologist, "nebulizer therapy," and a prescription for cough syrup; and stated that improvement was "possible, if cough & asthma become controlled; cough medicine given." Id. The APS included the notation, "See records attached." AR 0360. However, no records were attached or received by MetLife. AR 0312.

According to MetLife's claim file notes, a MetLife case manager contacted Dr. Hadley's office on March 15, 2005, regarding the missing records, and was told they were in the possession of plaintiff. Id. A MetLife case manager then spoke with plaintiff, who claimed she had sent the records to MetLife once, but that they had been returned to her. She stated that she had sent them again on March 11 or 12, 2005. AR 0313. However, according to MetLife, it never received the records.

Because of the lack of medical records supporting plaintiff's claim, MetLife denied the claim in a letter dated March 23, 2005. The letter stated that MetLife had reviewed the information submitted by plaintiff – the Initial Claims Packet, and the APS signed by Dr. Hadley on March 8, 2005 – but that certain information had not been received. AR 0341-0342. Specifically, MetLife reminded plaintiff that she had previously been instructed to provide "[a]ll office notes and test results from your date of disability that support the stated

diagnosis and restrictions and limitations." AR 0342. MetLife added that "[o]nce the requested medical information is received, your claim will be evaluated based on the medical records provided." Id.

The claim file notes of the same date reiterate that the February 21, 2005 letter to plaintiff requested medical information by March 21, 2005; that plaintiff had provided the APS, but that additional records were necessary to make the claim decision; that the claim would be denied for lack of proof of disability; and that the medical (records) would be reviewed upon receipt. AR 0313.

MetLife's claim file notes reflect that plaintiff called MetLife on April 11, 2005, requesting a call-back regarding the medical records needed. She also stated that her last appointment was in December 2004 and that her next appointment was April 29. AR 0284. A case manager returned plaintiff's call on April 12, 2005, and advised her to re-fax the medical records to MetLife. AR 0285.

On April 15, 2005, MetLife received a copy of Dr. Hadley's certification to the California Employment Development Department ("EDD"), submitted in connection with plaintiff's application for state disability benefits, dated February 25, 2005, stating that plaintiff had congestive heart failure and cardiac asthma, causing her to experience extreme shortness of breath and asthma attacks, and a chronic cough. AR 0303. Dr. Hadley estimated that plaintiff would be able to return to work at some point in 2005. (The date is illegible.) AR 0304. He indicated that the date of last treatment was December 28, 2004; and that the date of the next appointment was April 29, 2005. AR 0303.

On April 28, 2005, plaintiff called MetLife regarding her denied claim. The case manager advised plaintiff that the claim had been denied because the only medical information MetLife had was an APS from Dr. Hadley, which had a note stating that "records" were attached. However, the case manager advised, MetLife did not receive any records. The claim file note states that plaintiff reported that she had gone for "testing" that day, but it had to be stopped due to her breathing problems, and that she had an appointment with Dr. Hadley the following day and would follow up on the missing

information. The note also indicates that plaintiff had coughed multiple times during the telephone conversation. AR 0288.

On May 5, 2005, MetLife received a Supplemental APS from Dr. Hadley, dated April 29, 2005, which was almost identical to the March 8, 2005, APS that MetLife had received previously. AR 0300-0302. However, in this Supplemental APS, Dr. Hadley stated that he had advised plaintiff to cease her usual occupation, adding that she had not been advised to return to work, and that her condition was "permanent – until conditions & symptoms improve." AR 0301. Under "Subjective Symptoms" and "Objective Findings," Dr. Hadley simply referred MetLife to "records previously sent" as supporting his diagnosis, AR 0300, although MetLife asserts that no records had in fact been provided.

On May 18, 2005, plaintiff appealed the denial of her LTD claim. On May 19, 2005, MetLife received the following records: (1) a Pulmonary Function Laboratory Report dated June 10, 2004, which had been ordered by Dr. Lee; (2) an Echocardiogram Report dated November 23, 2004, and signed by Dr. Argenal, noting "[m]inimal left atrial enlargement," "[e]vidence suggesting mitral valve repair with appearance of minimal stenosis and thickened leaflets apparent," "[m]oderate aortic insufficiency," "[m]ild-to-moderate tricuspid insufficiency," "no evidence of mitral insufficiency," "[p]ulmonary pressures are normal," and "no diastolic disfunction;" (3) a single sheet of office visit notes regarding a December 22, 2004, cardiac consultation with Dr. Argenal, noting plaintiff's history of past mitral valve issues, including the notation "mitral valve repair - appears O.K.," and setting an appointment for a follow-up visit a year later, in December 2005; (4) a letter dated January 24, 2005 from Dr. Hadley, addressed "to whom it may concern," stating that plaintiff "may qualify for permanent disability for her heart and lung condition," noting that "[s]he has been diagnosed with Mitral Stenosis, Asthma, and Aortic Insufficiency," and that "[w]ith having these diagnoses she is unable to perform her regular duties at work;" and (5) a duplicate of the March 8, 2005 APS. AR 0291-0294.

Upon MetLife's receipt of the additional materials, a MetLife nurse consultant reviewed plaintiff's medical information, on both the STD and LTD claims. On May 23,

2005, in compliance with 29 C.F.R. § 2560.503-1(h)(3), (4) (full and fair review of claim and adverse benefit determination requires that "appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment"), the nurse consultant recommended referral of plaintiff's LTD claim for independent medical review by a cardiologist and a pulmonologist, and completed a referral form. AR 0330-0331. The referral form indicated the medical specialities requested, provided a brief summary of plaintiff's claim, the names of plaintiff's treating physicians, and the issues and questions to be addressed by the independent physician consultants.

Accordingly, MetLife obtained two medical opinions through a third-party vendor, Reed Review Services ("RRS"). The referral asked the independent physician consultants to review the medical records and to determine whether the information supported functional limitations; and if so, to identify the specific restrictions and limitations needed, as well as the clinical medical evidence that supported the restrictions and limitations.

Leonard Sonne, M.D., who is board-certified in pulmonary diseases and internal medicine, reviewed plaintiff's file and medical records, and prepared a report of his opinions dated May 27, 2005. See AR 0325-0326. Dr. Sonne noted that plaintiff was a 46-year-old female with a past history of rheumatic fever. He noted further, "She had a mitral valve repair in 1990. She has aortic insufficiency. Left ventricular ejection fraction is 64% and normal. O2 saturation on room air is 98%." The documents reviewed by Dr. Sonne included "Internal review notes;" "Disability claim attending statement;" the January 24, 2005 letter from Dr. Hadley; the June 10, 2004 pulmonary function studies; the November 23, 2004 echocardiogram; and a medication list. AR 0325.

Dr. Sonne found no objective documentation of any limitation, restriction or impairment. Specifically, he found no office visit notes describing the history, examination findings, treatment, or response to treatment; and no exercise testing provided for review. Dr. Sonne noted that plaintiff had been employed as an Operations Representative for BofA, which is a sedentary occupation. Overall, he found "insufficient objective

documentation to substantiate any restriction, impairment or limitation." AR 0326.

Mark Friedman, M.D., board-certified in cardiovascular diseases and internal medicine, also reviewed plaintiff's file and medical records, and prepared a report of his opinions dated June 1, 2005. See AR 0327-0329. Dr. Friedman noted that plaintiff was a 46-year-old female with a history of rheumatic heart disease, "with mitral stenosis and aortic insufficiency who has had a remote surgical procedure for mitral valve repair in 1990." He also noted a past history of a remote CVA and a history of asthma. AR 0327. The documents reviewed by Dr. Friedman included Dr. Hadley's March 8, 2005 and April 29, 2005 Attending Physician Statements; the January 24, 2005 letter from Dr. Hadley; and the November 23, 2004 echocardiogram report by Dr. Argenal. Id.

Dr. Friedman noted that plaintiff's cardiac status "has been stable with an echocardiogram performed 11/23/2004 demonstrating normal LV size and function with a LV ejection fraction of 64%, minimal residual mitral stenosis, normal estimated pulmonary artery pressure, and moderate aortic insufficiency." Id. He noted further that plaintiff was being followed by Dr. Argenal, who had recommended follow-up appointments and echocardiograms, on an annual basis. Id.

Dr. Friedman found that plaintiff's history would support certain restrictions and limitations, including permanent restrictions on strenuous physical activity; heavy lifting; climbing stairs and ladders; exposure to dirt, dust, and fumes; and activity that could cause chest trauma. AR 0328. Nevertheless, he found that the medical records provided did not support "functional limitations related to the patient's history of rheumatic heart disease, prior mitral valve surgery and residual aortic insufficiency." Id.

Based on the records provided, Dr. Friedman concluded that plaintiff's heart condition was and continued to be stable, and found no support for the diagnosis of congestive heart failure reported by plaintiff's pulmonologist, Dr. Hadley. Specifically, Dr. Friedman found that the November 2004 echocardiogram "demonstrating normal LV systolic and diastolic function with normal LV chamber size, and only mild residual mitral stenosis and moderate aortic insufficiency, would not support that the patient has clinical

[congestive heart failure]." Id.

In a letter dated June 20, 2005, MetLife informed plaintiff that the denial of her LTD benefits claim had been upheld on appeal. AR 0323-0324. The letter explained that the medical information submitted in support of the appeal had been reviewed by MetLife and by two independent physician consultants, and that it did not support plaintiff's claimed inability to perform the functions of her sedentary occupation. The letter informed plaintiff that she had exhausted the Plan's administrative remedies, and that a copy of the documents and records relevant to her claim would be provided if she requested them.

In a July 15, 2005 letter to MetLife, plaintiff requested a copy of the "documents, records, or other information" relevant to her claim, as well as copies of any medical reports created by the physician consultants. She also requested a copy of her "policy." AR 0321. The letter was received on July 22, 2005, and MetLife sent plaintiff a complete copy of the LTD claim file, including the administrative record, on August 1, 2005. MetLife also informed plaintiff that any request for Plan documents (including copies of insurance contracts, summary plan descriptions, and annual reports) should be directed to the Plan's administrator, BofA Program, and gave her the necessary contact information. AR 0320.

Meanwhile, on January 13, 2005, plaintiff filed an application with the Social Security Administration ("SSA") for Social Security Disability Insurance ("SSDI") benefits. The SSA denied her application initially on March 1, 2005, and again upon reconsideration on June 15, 2005. However, on December 13, 2006, the SSA granted plaintiff's application for SSDI benefits, finding that she had been disabled since November 2004.

On May 23, 2007, plaintiff sent a letter to BofA Program requesting a number of documents, including documents she had previously received from MetLife. BofA Program responded on June 27, 2007, and sent plaintiff (in care of her attorney) the Bank of America Associate Handbook 2005 (the Summary Plan Description); the 2006 Addendum to that Associate Handbook; the Employee Benefit Plan, Bank of America, Long Term Disability Benefits, Full-Time Employees, January 1, 2003; Bank of America Group Benefits Program, effective January 1, 2003; the Employee Benefit Plan, Bank of America, Long

Term Disability Benefits, Effective January 1, 2005 (Certificate of Insurance). BofA Program did not send plaintiff a copy of the administrative record because it was not within the Program's custody.

Plaintiff filed this action on March 11, 2008, alleging failure to provide LTD benefits, under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and 29 C.F.R. § 2560.503-1, and under ERISA § 404(a)(1)(A), (B), (D), 29 U.S.C. § 1104(a)(1)(A), (B), (D) (the "denial of benefits" claim). Plaintiff also asserts a claim of entitlement to statutory penalties under ERISA § 502(c), 29 U.S.C. § 1132(c), for failure to provide documents, against BofA Program (the "penalties" claim). Each side now seeks summary judgment.

DISCUSSION

A. "Denial of Benefits" Claim

1. Legal Standard

Under ERISA § 502, a beneficiary or plan participant may sue in federal court "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B); see also Aetna Health Inc. v. Davila, 542 U.S. 200, 210 (2004).

A claim of denial of benefits in an ERISA case "is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Montour v. Hartford Life & Acc. Ins. Co., 588 F.3d 623, 629 (9th Cir. 2009). If the plan confers such discretion, then the denial is reviewed for an abuse of discretion. Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 110-11 (2008) ("Glenn"). This court previously ruled that the standard of review in this case is abuse of discretion. See Order, filed January 29, 2010.

Under an abuse of discretion review, the dispositive issue is whether the denial of benefits was reasonable. Winters v. Costco Wholesale Corp., 49 F.3d 550, 553 (9th Cir. 1995); see also Conkright v. Frommert, __ U.S. __, 130 S.Ct. 1640, 1651 (2010). 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. Boyd v. Bert Bell/Pete Rozelle NFL Players Retirement Plan, 410 F.3d 1173, 1178 (9th Cir. 2005). A finding is "clearly erroneous" when, even it is supported by evidence, the reviewing court "on the entire evidence is left with the definite and firm conviction that a mistake has been committed." Id. (quotations omitted). A court must "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." Id. (citing Estate of Shockley v. Alyeska Pipeline Serv. Co., 130 F.3d 403, 405 (9th Cir. 1997)).

Where there is a structural conflict of interest because the claim fiduciary is also the funding source for the Plan, that conflict does not lead to a less deferential standard of review; rather, the conflict is merely one additional factor to be considered in determining whether a fiduciary abused its discretion. Glenn, 554 U.S. at 111-12 ; see also Saffon v. Wells Fargo & Co. Long Term Disability Plan, 522 F.3d 863, 868 (9th Cir. 2008). "A district court, when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's reason for denying insurance coverage." Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 968 (9th Cir. 2006)

Among the factors the court may consider are whether there is evidence of bias, whether the fiduciary failed to investigate a claim adequately or ask the plaintiff for necessary evidence, whether the fiduciary failed to credit a claimant's reliable evidence, and whether the fiduciary's decision is against the weight of evidence in the record. Id. Other factors courts have found relevant include whether the administrator acknowledged or distinguished a contrary disability determination by the SSA, Glenn, 554 U.S. at 118; whether the administrator presented outside medical reviewers with all the relevant evidence, id.; and whether the administrator conducted an in-person medical evaluation or relied instead on a paper review, Montour, 588 F.3d at 630.

An administrator can mitigate a conflict "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." Glenn, 554 U.S.

at 117. In addition, "[w]hen an administrator can show that it has engaged in an 'ongoing, good faith exchange of information between the administrator and the claimant,' the court should give the administrator's decision broad deference . . . ." Abatie, 458 F.3d at 972.

Ordinarily, summary judgment is appropriate if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). In ERISA actions, however, where the plaintiff is challenging the plan administrator's denial of benefits and the district court has already determined that the review is 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), overruled in part on other grounds by Abatie, 458 F.3d at 966-69; see also Nolan v. Heald College, 551 F.3d 1148, 1154 (9th Cir. 2009). Thus, a summary judgment motion resting on the administrative record is not a typical summary judgment, but rather, is a procedural vehicle for determining whether benefits were properly granted or denied.

On the other hand, the traditional rules of summary judgment do apply to evidence outside of the administrative record, including the requirement that the evidence must be viewed in the light most favorable to the non-moving party. Nolan, 551 F.3d at 1150.

2. The Parties' Motions

Plaintiff argues that in denying her claim for LTD benefits, MetLife abused its discretion under ERISA § 502(a)(1)(B), and breached its fiduciary duties under ERISA § 404(a)(1). Plaintiff asserts that summary judgment should be granted in her favor on this "denial of benefits" claim, because MetLife's actions were arbitrary and capricious, and unreasonable, and because its administration of her LTD claim was "infected by bias and conflict of interest" and is therefore entitled to diminished deference.

Defendants contend that plaintiff's motion must be denied and that summary judgment must be granted in their favor, because regardless of plaintiff's diagnoses, the medical records she submitted did not show a level of functional impairment sufficient to

meet the definition of "disability" under the Plan, and that MetLife, the claims administrator, did not abuse its discretion when it denied the claim.

Plaintiff makes a number of arguments, which can be roughly allocated among five main contentions – that MetLife's decision to deny LTD benefits was generally arbitrary and capricious; that the decision to deny LTD benefits was unreasonable because it was inconsistent with the decision to approve the request for STD benefits; that the denial of LTD benefits was inconsistent with the terms of the Plan because MetLife improperly required that plaintiff's claim be supported with "objective" evidence; that MetLife's reliance on the opinions of the outside medical reviewers was unreasonable because MetLife did not provide them with complete information and did not require an in-person Independent Medical Examination ("IME"); that it was an abuse of discretion for MetLife to deny the claim for LTD benefits without waiting for the SSA to make its determination regarding plaintiff's application for SSDI benefits, or, alternatively, to refuse to revisit its denial of LTD benefits after the SSA issued a favorable ruling on the claim for SSDI benefits.

In addition, plaintiff contends that the allegedly improper actions taken by MetLife establish that its claims procedures are affected by the structural conflict of interest, and that the court should therefore apply a diminished degree of deference to MetLife's interpretation of the Plan and should view MetLife's articulated reasons for denying her claim for LTD benefits with skepticism. Plaintiff also argues that MetLife has not provided any admissible evidence showing that its claims procedures are not affected by the structural conflict of interest, or that it has taken any measures to mitigate the conflict.

a. Whether the decision to deny benefits was generally arbitrary and capricious

Plaintiff argues that the denial of LTD benefits was generally arbitrary and capricious, and constituted a breach of fiduciary duty, because MetLife decided to deny her claim before it had received her application; and because it failed to investigate her claim and failed to request that she provide specific medical information or tests.

First, in support of the assertion that MetLife decided to deny her claim before it had

received her application, plaintiff cites to a February 21, 2005 note in the claim file, stating, "ICP sent to Associate . . . Action Plan: F/U for ICP from Associate. If no response, deny clm for lack of proof of disability. Will review any medical upon receipt." AR 309. Plaintiff contends that this note shows that MetLife intended to deny the claim before even communicating with her.

However, as MetLife asserts, this note merely shows that plaintiff had already been advised that if she did not return the completed forms by March 21, 2005, the claim would be denied. The addition of the phrase "[w]ill review any medical upon receipt" also reflects what MetLife told plaintiff when it denied her claim for lack of medical support – that she needed to provide all office notes and test results that supported the claimed disability, and that MetLife would review the additional records upon receipt. The note does not establish any intent to deny the claim before it was even submitted.

Second, plaintiff argues that MetLife failed to investigate her claims. She contends that despite the fact that she gave MetLife the authorization to obtain information directly from her doctors, MetLife never contacted her treating physicians. However, the claim file reflects that on March 15, 2005, the very day that MetLife received the completed APS from Dr. Hadley, a MetLife case manager contacted Dr. Hadley's office to request the referenced "attached" medical records, and was told that Dr. Hadley's office had given the records to plaintiff.[2] AR 0312. MetLife then contacted plaintiff, who claimed she had mailed the records to MetLife once, but that they had been returned to her, and that she had already "resent" them, on March 11 or 12, 2005. AR 0313.

Third, plaintiff asserts that MetLife breached its fiduciary duty by failing to specify what specific additional medical documentation it required. The administrative record reflects that with her initial application, plaintiff submitted only the March 8, 2005 APS completed by Dr. Hadley. AR 0341-0342. In her application, she described her job duties as performing data entry, typing, and receiving incoming wires. AR 0352. In the APS, Dr.

[2] Plaintiff did not sign the authorization to release records to MetLife until March 31, 2005. AR 0308.

Hadley stated that plaintiff had been diagnosed with cardiac asthma and congestive heart failure, and that she could not work due to "extreme asthma and coughing attacks" that left her "unable to talk." AR 0361. However, he also indicated that plaintiff could sit continuously for eight hours, could twist/bend/stoop, reach above shoulder level, and perform repetitive tasks with both hands. Id.

Because the APS indicated both that plaintiff could not work, and that she could perform tasks similar to those she identified as constituting her job duties, the documentation fell short of what the Plan required claimants to provide – evidence of disability and inability to perform the material duties of her regular job.

After receiving no additional records, despite having requested them from both plaintiff and Dr. Hadley's office, AR 0312-AR 0313, MetLife denied the claim. In the March 23, 2005 denial letter, MetLife clearly informed plaintiff what additional information was required – "[a]ll office notes and test results from your date of disability that support the stated diagnosis and restrictions and limitations." AR 0342. MetLife also advised plaintiff that if she provided the requested medical information, her claim would be "evaluated based on the medical records provided." Id.

Nevertheless, plaintiff claims that MetLife did not provide her with sufficient information regarding the medical records that were necessary to perfect her claim. In support, she cites Saffon, 522 F.3d at 870-71, where the Ninth Circuit found an abuse of discretion because the claims administrator (also the insurer) failed to explain "in a manner calculated to be understood by the claimant" what she must do to perfect her claim. Id., 522 F.3d at 870-71 (citing 29 C.F.R. § 2560.503-1(g)).

The facts in Saffon are clearly distinguishable from the facts in this case. In Saffon, the claims administrator originally approved the claimant's request for LTD benefits, but then terminated the benefits after a year on the basis that the claimant "no longer me[t] the definition of disability," and advised the claimant that she could appeal the decision by providing "objective medical information to support your inability to perform the duties of your occupation." Id. at 866, 869. In this case, by contrast, MetLife told plaintiff that she

needed to submit "[a]ll office notes and test results from your date of disability that support the stated diagnosis and restrictions and limitations." AR 0342. The court in Saffon noted the claimant's difficulty in ascertaining what was intended by "objective medical information." Saffon, 522 F.3d at 869. Here, MetLife made a request for specific types of medical evidence.

In response to the denial letter, plaintiff submitted a copy of Dr. Hadley's February 25, 2005, certification to the EDD, and a copy of Dr. Hadley's supplemental APS, dated April 29, 2005, which was almost identical to the original March 8, 2005, APS. In addition, with her May 2005 appeal, she submitted a pulmonary function laboratory report dated June 10, 2004; an echocardiogram report dated November 23, 2004; a single sheet of office notes regarding a December 22, 2004 consultation with Dr. Argenal; a letter from Dr. Hadley dated January 24, 2005, stating that plaintiff "may qualify for permanent disability for her heart and lung condition."

After receiving no further information from plaintiff or her doctor, MetLife provided the independent physician consultants with a copy of the record for their review. As noted above, the physician consultants reviewed all records submitted by plaintiff, and found that the evidence did not support the claimed disability. Notwithstanding MetLife's clear description of the additional records required, plaintiff submitted no office notes from any of her three treating physicians, other than the one page from Dr. Argenal. The only test results were the report of the June 2004 pulmonary function test (which predated the claimed onset of disability), and the November 23, 2004 echocardiogram report, which, as Dr. Friedman explained, did not support the diagnosis of congestive heart failure.

This paucity of records is somewhat surprising, in view of the fact that in her application for LTD benefits, plaintiff stated that she had been hospitalized on March 8, 2005 (the same date that Dr. Hadley completed the APS that MetLife received on March 15, 2005), yet no medical record she submitted (including Dr. Hadley's supplemental APS dated April 29, 2005) confirmed or even mentioned this hospitalization. Plaintiff also told the MetLife claim manager in a April 28, 2005 telephone conversation that she had

undergone unspecified "testing" that very day, but that the testing had to be stopped due to her breathing problems. Yet nowhere in the records she submitted is there any mention of that "testing" or who ordered it.

b. Whether the decision to deny the claim for LTD benefits was inconsistent with the decision to approve the request for STD benefits

Plaintiff asserts that MetLife's decision to deny benefits under the LTD Plan was unreasonable, because only a few months before that decision, it had found that plaintiff was entitled to STD benefits. Plaintiff contends that having found her entitled to STD benefits, MetLife was obligated to find her disabled and eligible for benefits under the LTD Plan.

Plaintiff argues that the LTD Plan's requirement that the claimant establish the inability "to perform each of the material duties of [his/her] own occupation" should have been construed in the same way as the requirement in the STD Plan. She asserts that these were "similar claims" and that MetLife should have treated them "consistently" under the requirements of 29 C.F.R. § 2560.503-1(b)(5) ("claims procedures for a plan will be deemed to be reasonable only if . . . where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants").

Documents submitted by MetLife show that it was BofA that received and approved plaintiff's STD claim. MetLife did not begin to administer plaintiff's STD claim until March 18, 2005, almost a month after it received her LTD claim. MetLife's denial of the claim for LTD benefits was not inconsistent with BofA's determination that plaintiff was entitled to STD benefits. The STD benefits were administered under a different plan than the LTD benefits, with different eligibility standards, and requiring two distinct determinations.

The standard applied to the STD claim was the standard set out by the FMLA – that is, whether a medical provider had certified a "serious health condition" that precluded working. Eligibility for STD benefits under the BofA Plan was limited to a maximum number of weeks, depending on the length of time of employment. The standard applied to LTD claim was set forth in the LTD Plan – plaintiff was required to provide proof of "disability," as

defined in the Plan.

c. Whether the denial of LTD benefits was inconsistent with the terms of the Plan

Plaintiff contends that MetLife's denial of benefits was inconsistent with the terms of the Plan, as the Plan does not require that a claim be supported with "objective" evidence or "objective" proof of disability. Plaintiff also argues that because the Plan involves an "own occupation" policy, it was an abuse of discretion for MetLife to fail to obtain a description of plaintiff's job duties from BofA before finding her not disabled.

Generally, an ERISA "participant or beneficiary" who is suing "to recover benefits due to him under the terms of the plan," ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), must establish his or her entitlement to benefits. Glazer v. Reliance Standard Life Ins. Co., 524 F.3d 1241, 1247 (11th Cir. 2008); see also Farley v. Benefit Trust Life Ins. Co., 979 F.2d 653, 658 (8th Cir. 1992). Here, in addition, the Plan places the burden of providing proof of disability on the claimant. The Plan provides that MetLife will pay benefits "[w]hen we receive proof that you are Disabled." AR 0052. "Proof must describe the . . . nature and extent of the cause for which a claim is made; it must be satisfactory to us." AR 0056. To submit a claim for disability benefits, "the claimant must complete the appropriate claim form and submit the required proof." AR 0064.

MetLife was entitled to seek objective proof of functional impairment. See e.g., Walker v. Metropolitan Life Ins. Co., 2010 WL 1946898 at *13-14 (C.D. Cal., May 12, 2010) (due to discretion granted insurer as claims administrator to interpret terms of plan, insurer had discretion to require objective evidence of disability); see also Wiley v. Cendant Corp. Short Term Disability Plan, 2010 WL 309670 at *9 (N.D. Cal., Jan. 19, 2010); Thompson v. Insurance and Benefits Tr./Comm. Peace Officers Res. Assoc. of Calif., 670 F.Supp. 2d 1052, 1067 (E.D. Cal. 2009). The very concept of "proof" connotes objectivity. See Maniatty v. UnumProvident Corp., 218 F.Supp. 2d 500, 504 (S.D.N.Y. 2002) (where plan document requires "proof" but does not require that "proof" be "objective," insurer does not abuse its discretion by requiring objective evidence to support a claimed lack of

functionality).

Plaintiff was diagnosed with various physical conditions – mild mitral stenosis, moderate aortic insufficiency, cardiac asthma, congestive heart failure – which are generally observable by a clinician in an examination or with testing. This is not a case like Salomaa v. Honda Long Term Disability Plan, __ F.3d __, 2011 WL 768070 (9th Cir., March 7, 2011), where the court found that the plan administrator had improperly demanded objective tests to establish the existence of a condition (chronic fatigue syndrome) for which there are no objective tests, see id., 2011 WL 768070 at *8-10; or a case like Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869 (9th Cir. 2004), where the court noted that "[o]bjective tests are administered to rule out other diseases, but do not establish the presence or absence of fibromyalgia," id. at 872, overruled on other grounds by Abatie, 458 F.3d at 955.

Plaintiff provided a description of her job duties in her application for LTD benefits. Before denying plaintiff's claim on appeal, MetLife obtained review by two outside medical consultants, to whom it provided a complete copy of plaintiff's LTD claim record. It was because of the lack of objective medical support for plaintiff's claimed disability based on cardiac and pulmonary conditions, that both outside medical reviewers found that there was insufficient evidence to establish a functional limitation that would have prevented plaintiff from performing her job duties.

d. Whether MetLife's reliance on the opinions of the independent medical consultants was reasonable

Plaintiff argues that MetLife's reliance on the opinions of the outside medical reviewers was unreasonable, because the reviewers were not provided with complete information. First, plaintiff contends that the materials given to the reviewers should have included the STD claim file and a description of her job duties; and that MetLife should have advised the reviewers that, according to the April 28, 2005 claim file notes, plaintiff had coughed multiple times during a telephone call with the case manager, and had also told the case manager that she had gone for "testing" that day, but that it "had to be

stopped due to her breathing problems." See AR 0288.

In seeking a review of plaintiff's claim for LTD benefits and the supporting medical information, MetLife was not required to submit the STD claim file to the independent physician consultants. MetLife sought the review in aid of its determination whether plaintiff was eligible for LTD benefits commencing 180 days after the onset of claimed disability (November 14, 2004). The question posed to the consultants was whether the medical information plaintiff had submitted in support of her claim for LTD benefits supported functional limitations – and if so, what specific restrictions and limitations were needed, and what specific clinical medical evidence supported those restrictions and limitations. As explained above, the STD Plan and the LTD Plan had different eligibility standards, and required two distinct determinations.

As for plaintiff's assertion that MetLife abused its discretion by not advising the independent physician consultants that plaintiff had told a MetLife case manager in March 2005 about the unidentified "testing" that had to be stopped "due to her breathing problems," AR 0288, a comment in the administrator's claim file cannot be considered the equivalent of objective medical evidence, which could reasonably be reviewed by an outside medical reviewer. If, in fact, such "testing" was conducted, it was plaintiff's responsibility to have the referring doctor submit a report of the results of the "testing" to MetLife.

Nor is the court persuaded by plaintiff's argument that because one of the independent medical consultants (evidently referring to Dr. Sonne) complained that there was insufficient documentation to support the asserted functional restrictions, this establishes that MetLife did not provide all plaintiff's records. This is not a fair reading of Dr. Sonne's statement. The problem, as defendants note, was that the evidence provided by plaintiff and her doctor did not establish the existence of a functional impairment severe enough to keep her from performing her regular job duties of typing, data entry, and receipt of wires – not that MetLife withheld some crucial part of the file from the outside reviewers.

Second, plaintiff contends that it was improper for MetLife to provide the

independent physician consultants with only a paper record to review, with no allowance for a face-to-face examination of plaintiff. There is no requirement in ERISA that the claims administrator order an in-person IME of a claimant, and consulting physicians' opinions based on reviews of medical records are an acceptable basis of an administrator's determination. See Jordan, 370 F.3d at 879-80 (plan administrator, in accepting opinion of "reviewing physician" over opinion of plaintiff's treating physicians, did not abuse discretion); see also Kushner v. Lehigh Cement Co., 572 F.Supp.2d 1182, 1192 (C.D. Cal. 2008) (ERISA does not require IMEs).

While it might be an abuse of discretion in some circumstances for the claims administrator to fail to order an IME of a claimant, this is not one of those cases. Where, as here, the ERISA claims administrator retains the discretion to interpret the terms of the plan, and there is no objective support for the claimed disability, the administrator may elect not to conduct an IME. See Manning v. American Republic Ins. Co., 604 F.3d 1030, 1041 (8th Cir.) (ERISA plan administrator is not required to order an IME when the claimant's evidence is facially insufficient to support a finding of disability), cert. denied, 131 S.Ct. 648 (2010); Hobson v. Metropolitan Life Ins. Co., 574 F.3d 75, 91 (2nd Cir. 2009) (where ERISA plan administrator retains discretion to interpret terms of plan, administrator may elect not to conduct IME, particularly where claimant's medical evidence on its face fails to establish disability); Williams v. Aetna Life Ins. Co., 509 F.3d 317, 325 (7th Cir. 2007) (finding reasonable a denial of benefits where the ERISA plan administrator refused to order an independent review and there was a lack of "objective support" regarding the claimant's "functional abilities").

The medical evidence submitted by plaintiff and her physicians failed to establish that she was functionally impaired from performing her occupation within the meaning of the Plan's definition of "disability," which meant that she failed to establish eligibility for Plan benefits. The same medical evidence was evaluated by independent physicians in appropriate specialties, who found that plaintiff was not functionally impaired from working as a result of her diagnosed medical issues. MetLife was entitled to credit the medical

opinion of those physicians, and did not abuse its discretion in doing so.

e. Whether it was an abuse of discretion for MetLife to fail to consider the SSA's favorable determination

Plaintiff makes two distinct arguments with regard to the SSDI claim and the SSA's favorable decision. First, she complains that MetLife encouraged her to apply for SSA benefits, but then "adjudicated her LTD claim with terminal swiftness" and "reversed its prior disability determination" (referring to the prior approval of STD benefits) before the SSA process "could even run its course." She contends that it was an abuse of discretion for MetLife to encourage her to apply for SSDI benefits and to then proceed to rule on the LTD benefits claim instead of waiting for the determination by the SSA.

However, plaintiff has cited no authority in support of this proposition. Moreover, ERISA regulations require that notification of a disability benefit determination on review must ordinarily be provided to the claimant "within a reasonable time," but not less than 45 days after receipt of the request for review. See 29 C.F.R. § 2560.503-1(i)(1)(i), (3)(i). Thus, it would have been unreasonable for MetLife to have delayed reaching a decision for 18 months.

Second, plaintiff contends that MetLife's "refusal" to consider the favorable SSA determination before denying her claim for LTD benefits was an abuse of discretion. Plaintiff concedes that a claims administrator is not bound by the SSA's determination, but argues that under Montour, a complete disregard for a contrary conclusion raises questions about whether the adverse benefits determination was the product of a principled and deliberative reasoning process. See Montour, 588 F.3d at 635.

As indicated above, the SSA granted plaintiff's claim for SSDI benefits on December 13, 2006, nearly 18 months after MetLife had advised plaintiff that her claim for LTD benefits had been denied on appeal, and that she had exhausted her administrative remedies. The cases cited by plaintiff in support of this argument (that it was an abuse of discretion for MetLife to fail to consider the SSA decision) all generally stand for the proposition that where a LTD claims administrator encourages or even compels a claimant

to apply for SSA benefits, and the claimant receives a favorable determination from the SSA, it is an abuse of discretion for the LTD claims administrator to subsequently deny an LTD claim, or to terminate benefits, without considering the SSA determination. See Glenn, 554 U.S. at 124 (Roberts, C.J., concurring); Montour, 588 F.3d at 635-36; Calvert v. Firstar Finance, Inc., 409 F.3d 286, 294-95 (6th Cir. 2005), cited in Hobson, 574 F.3d at 91; Holler v. Hartford Life and Acc. Ins. Co., 737 F.Supp. 2d 883, 896-97 (S.D. Ohio 2010).

Here, however, unlike the situation in, for example, Montour, where the SSA reached a favorable decision years before the insurer terminated the claimant's benefits, MetLife denied the claim approximately 18 months before the favorable SSA decision. The question whether a claim determination was an abuse of discretion must be resolved from the record that was before the claim administrator when the decision was made, together with any "conflict-of-interest" evidence that the reviewing court finds admissible. See Abatie, 458 F.3d at 970. MetLife could not have considered the fact of the SSA determination when it was deciding the claim for LTD benefits, as SSA did not approve plaintiff's claim for SSDI benefits until a year and a half after the final determination by MetLife of plaintiff's LTD claim.[3]

Furthermore, the decision granting plaintiff's application for SSDI benefits was based in large part on evidence that was not available at the time of MetLife's denial of her claim for LTD benefits. In particular, the SSA found that the opinion of plaintiff's treating physician, Dr. Hadley, was "sufficiently supported by the medical evidence, particularly the history and records of [plaintiff's September 2006] hospitalization." Because that hospitalization occurred more than a year after MetLife had denied plaintiff's claim for LTD benefits, the fact that it provided strong support for the SSDI benefits determination is irrelevant to this case. As defendants correctly point out, plaintiff's receipt of SSDI benefits does not entitle her to LTD benefits, and there is no authority the court is aware of that requires reopening a closed LTD claim following a favorable determination by the SSA.

[3] For this reason, plaintiff's claim that MetLife abused its discretion by not seeking plaintiff's medical records from the SSA is also without merit.

f. Effect of MetLife's structural conflict on its exercise of discretion

Plaintiff asserts that the court should view MetLife's exercise of discretion with a high degree of skepticism, for two main reasons – first, because MetLife's structural conflict of interest impacted many of its actions or decisions in this case; and second, because MetLife has provided no admissible evidence showing that its claims procedures are not affected by the structural conflict of interest.

In considering whether a claims administrator has abused its discretion, the court is required to "weigh" the conflict more or less "heavily," depending on the other evidence that is available. Saffon, 522 F.3d at 868 (quoting Abatie, 458 F.3d at 968). If there is no evidence of malice, self-dealing, or a parsimonious claims-granting history, the court should view the conflict with a low level of skepticism. Id. On the other hand, the fact of the conflict weighs more heavily if, for example, there is evidence that the administrator has given inconsistent reasons for denial of the claim, had failed to adequately investigate the claim or ask the claimant for necessary evidence, or has repeatedly denied benefits to deserving claimants by interpreting plan terms incorrectly. Id.

Plaintiff argues that the facts in this case warrant a "heavy" weighing of MetLife's structural conflict. Among other things, she asserts that MetLife's denial of the LTD claim was inconsistent with its prior approval of her request for STD benefits, and that MetLife improperly refused to consider the STD file as part of the LTD claim. She also contends that MetLife failed to adequately investigate her claim because it failed to contact her doctors for additional information, failed to order an IME, and relied on a "paper review" by the outside medical consultants; that MetLife failed to identify the specific information it required her to provide for a favorable decision; that MetLife improperly found that she could perform sedentary work despite having failed to obtain a job description; that MetLife retained outside medical reviewers from a company that was "biased" because it receives millions of dollars in revenue from MetLife for reviews of MetLife's claims; and that MetLife improperly refused to consider the favorable SSA determination,

While the court weighs the financial conflict of interest in its analysis of whether

MetLife abused its discretion in denying plaintiff's claim, the court finds no evidence presented in this case showing any malice, self-dealing, or parsimonious claims granting on the part of MetLife. In addition, for the reasons stated above in subsections (a) through (e), the court finds that none of the actions identified by plaintiff supports a finding that MetLife's decision was biased or affected by the structural conflict. Finally, the court finds that MetLife's reliance on the reports by the independent physician consultants was reasonable. As defendants argue, the fact that a physician makes his or her living, at least in part, reviewing claims for a claims administrator does not necessarily warrant reviewing a determination with enhanced skepticism. See Letvinuck v. Aetna Life Ins. Co., 2009 WL 5184459 at *15 (C.D. Cal., Dec. 17, 2009) (fact that outside medical reviewers make their living, at least in part, reviewing claims for Aetna proves little, as Aetna would likely be hard pressed to find someone to review its claims for free).

Plaintiff also argues that MetLife provided no admissible evidence showing that its claims procedures are not affected by the structural conflict of interest. With their motion, defendants submitted a declaration by Gregory Hafner, a Director in the Department of Disability Product Management at MetLife, attached as an exhibit to a declaration by Rebecca A. Hull, counsel for MetLife.[4]

Mr. Hafner states that he has personal knowledge of MetLife's claims handling practices, that MetLife reviews each claim for disability benefits on its own merits and consistently (regardless of how benefits are funded), and that every claim decision is based solely upon information in the individual claimant's claim file. He also summarizes the various measures MetLife has taken in order to ensure the integrity of its claims processing. For example, he states that MetLife's finances are kept separate from claims; that MetLife's claims offices are geographically separate from its finance offices; that employees who administer disability claims do not report to Finance Department

[4] Plaintiff has filed a motion to "strike" the Hull Declaration and the Hafner Declaration appended thereto. The motion appears to be nothing more than an evidentiary objection. For the reasons discussed above, the court assigns little probative weight to the Hafner Declaration.

employees, and Finance Department employees do not make, direct, or have any association with claim decisions; and that claims specialists do not have access to claim reserve information, and do not receive compensation, awards, bonuses, other financial benefits or performance recognition based upon the value or the number of the claims they deny or terminate.

Defendants contend that under Glenn, such evidence substantially diminishes the potential significance of the structural conflict of interest, and that the conflict should therefore be given little if any weight in the court's analysis of whether the decision regarding plaintiff's LTD benefits was an abuse of discretion.

Plaintiff argues, however, that the Hafner Declaration is inadmissible hearsay, and that Mr. Hafner fails to articulate any basis for his purported personal knowledge of the facts he asserts. Plaintiff also contends that the declaration is of little relevance because it post-dates the claims determination that is at issue in this case, and does not state that the procedural safeguards were in place at the time MetLife denied her claim. Plaintiff asserts that MetLife has provided no other evidence that it has put any procedures in place to reduce bias or to insure accurate claims, and that this failure to establish the existence of procedures, protocols, or safeguards is evidence of the impact of the conflict of interest.

The declaration, which is dated February 10, 2010, was originally filed in Beaver v. Bank of the West Welfare Benefits Plan, C-09-2177 WHA (N.D. Cal.) in support of a motion noticed for hearing on March 18, 2010. Mr. Hafner states, "I have been informed that the dates relevant to this litigation are January 2008 forward. Prior to that date, and to the present, all of the procedures listed [in the declaration] have been in place."

Defendants concede that the declaration was filed by MetLife in another ERISA benefits case, but claim that it was MetLife's counsel's understanding that comparable measures were in place at the time relevant to plaintiff's own claim. Defendants assert that their counsel told plaintiff's counsel that MetLife could provide an updated declaration addressing the specific time period in which plaintiff's claim was administered, but that plaintiff's counsel never sought any further information regarding Mr. Hafner or his

testimony.

The court finds that the Hafner declaration is of marginal relevance to the claims in this case, as there is no evidence that the procedures Mr. Hafner describes were in fact in place in 2005 when MetLife was evaluating plaintiff's claim for LTD benefits. Thus, plaintiff's objections to the Hafner Declaration are sustained. Nevertheless, the court also finds that MetLife's failure to provide evidence showing that it had procedures in place to ameliorate the effect of the structural conflict is not sufficient, standing alone, to warrant a finding that MetLife abused its discretion when it denied plaintiff's claim.

While it is true that a structural conflict of interest exists in this case, the court finds no evidence that the conflict affected the administration of plaintiff's claim. Even in the face of a conflict of interest, discretionary review still applies if the plan documents so provide, because "a systemic conflict of interest does not strip a plan administrator of deference." Conkright, 130 S.Ct. at 1646-47. A structural conflict bears little weight, absent evidence that it "tainted the entire administrative decisionmaking process." Montour, 588 F.3d at 631. Here, plaintiff has not provided evidence establishing any of the factors that the Supreme Court or the Ninth Circuit have identified as indicating bias or bad faith.

B. "Penalties" Claim

1. Legal Standard

ERISA provides a private cause of action against a plan administrator who fails or refuses to comply with a request for information that the administrator is required to furnish.

> Any administrator . . . who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

29 U.S.C. § 1132(c)(2). Only plan administrators – not third-party claims administrators – may be sued under § 1132(c). Sgro v. Danone Waters of North America, Inc., 532 F.3d 940, 945 (9th Cir. 2008).

2. The Parties' Motions

Plaintiff seeks summary judgment on the "penalties" claim, arguing that BofA Program violated ERISA by failing to provide her with the administrative record of her LTD benefits claim, and that she is therefore entitled to statutory penalties under 29 U.S.C. § 1132(c)(2).

Plaintiff claims that both she and her attorney made "multiple requests for MetLife's administrative record," and that neither BofA nor MetLife has ever provided all its components. In particular, plaintiff argues that the administrative record for plaintiff's LTD claim should have included the contents of the STD claims file, and also should have included any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination.

The record shows that on July 15, 2005, plaintiff wrote to MetLife to request copies of the "documents, records or other information" in MetLife's possession that were relevant to her claim, copies of the independent physician consultant's reports, and a copy of "the policy." AR 0321. On August 1, 2005, MetLife sent plaintiff a complete copy of her claim file, including the administrative record. AR 0320. MetLife also advised plaintiff that any request for Plan documents, including copies of insurance contracts, summary plan descriptions, and annual reports, should be directed to BofA, the Plan Administrator. Id.

More than a year and a half later, on May 27, 2007, plaintiff sent a letter to BofA Program requesting numerous documents relating to the denial of her claim for LTD benefits, including Plan documents and the "administrative record." On June 27, 2007, BofA Program sent plaintiff, through her attorney, copies of all LTD Plan documents.

Plaintiff's main complaint appears to be that the administrative record she was provided did not include the STD claim file.[5] Plaintiff argues that the "administrative record"

[5] As the court found with regard to the "denial of benefits" claim, however, the STD Plan and the LTD Plan are separate and independent, and contain different eligibility requirements. Notwithstanding the fact that plaintiff applied for, and received, STD benefits for the maximum period, she was still required to separately apply for and demonstrate eligibility for benefits under the LTD Plan. Plaintiff has not sued the STD Plan, and any consideration of the STD benefits is irrelevant to the present case, which involves a claim that MetLife failed to pay

in an ERISA benefit case includes all materials the insurer considered in reaching its determination, and all materials it had in its possession but did not consider – claims policies, procedures, and guidelines; evidence of safeguards it uses to ensure fair, accurate, and consistent claims handling; and anything else that is "relevant" to the claims determination. In support, she cites Montour, 588 F.3d at 632 n.4 (administrative record in an ERISA case consists of "the papers the insurer had when it denied the claim"), and also cites 29 C.F.R. § 1560.503-1(g), (h), and (m).

Defendants argue that plaintiff's motion should be denied, and that summary judgment should be entered in BofA Program's favor, for three reasons. First, defendants contend that plaintiff cannot base a claim for recovery of penalties from BofA Program on the text of ERISA or any case law. They note that 29 U.S.C. § 1132(c)(2) imposes penalties only for a plan administrator's failure to "comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary." However, they assert, the only requirement set forth in "this subchapter" (29 U.S.C. §§ 1001-1191c) regarding requests for information by ERISA claimants is the following: "The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated." 29 U.S.C. § 1024(b)(4).

Defendants contend that in this case, BofA Program provided plaintiff (through her counsel) exactly what was required – copies of the relevant Plan documents, in compliance with § 1024(b)(4). They argue that the Program had no duty to provide the "administrative record" because it is not a document under which the Plan is "established or operated."

Second, defendants assert that BofA Program was not obligated to provide plaintiff with a copy of the LTD claims file because it was in the possession of MetLife, the claims administrator. They contend that BofA Program told plaintiff that she would need to

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benefits under the LTD Plan.

request the file from MetLife. They also note that the LTD claims file pertains only to the claim for LTD benefits (not to STD benefits), and that plaintiff's request sought only documents relating to the claim for LTD benefits.

Third, defendants assert that even if BofA Program was required to provide plaintiff with all the documents she requested, including the LTD claim file, penalties are not warranted, because plaintiff cannot show that BofA Program acted in bad faith, or that she was prejudiced by BofA Program's failure to produce the administrative record.

Plaintiff bases her construction of "administrative record" on subsections (g), (h), and (m) of 29 C.F.R. § 2560.503-1. This regulation was promulgated by the Secretary pursuant to 29 U.S.C. § 1133, which imposes obligations on ERISA plans with regard to the "full and fair hearing" of a denial of benefits.

> In accordance with regulations of the Secretary, every employee benefit plan shall –
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133.

The regulation sets forth "minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries." 29 C.F.R. § 1560.503-1(a). Under subsection (g), a plan administrator that makes an adverse benefits determination must provide a claimant with written or electronic notification of the decision, and, "[i]f an "internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination," must set forth

> either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making such adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

29 C.F.R. § 1560.503-1(g)(1)(v)(A).

Under subsection (h), every benefit plan "shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan," and such claims procedures "will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review" of an adverse benefit determination unless the claims procedures, among other things, "[p]rovide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." 29 C.F.R. § 1560.503-1(h)(2)(iii).

Under subsection (m), a "document, record, or other information" is considered "relevant to" a claim for benefits if the document, record, or information

> (i) Was relied upon in making the benefit determination;
>
> (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; [or]
>
> (iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination[.]

29 C.F.R. § 1560.503-1(m)(8)(i)-(iii).

Plaintiff contends that because under subsection (m), documents or records "relevant" to the claims administrator's determination are documents or records "submitted, considered, or generated" in the course of making the benefit determination, any medical documents submitted in support of her STD claim would have been both "relevant" and "papers the insurer had when it denied the claim," as would the rules, guidelines, protocols, or other similar criteria that MetLife relied on in denying her claim for LTD benefits.

Plaintiff argues § 1132(c) is not limited to plan documents, and that an administrator's failure to produce any document "relevant" to a claim determination can subject it to penalties. Plaintiff cites to Sgro, where the Ninth Circuit stated that "[t]he amendments [to 29 C.F.R. § 2560.503-1] . . . broadened administrators' duties: Administrators must how turn over, on request, the documents 'generated in the course of making the benefit determination.'" Sgro, 532 F.3d at 945.

The "Scope and Purpose" provision of 29 C.F.R. § 2560.503-1 provides, "In accordance with the authority of . . . 29 U.S.C. § 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries." 29 U.S.C. § 1135 merely authorizes the promulgation of regulations to implement ERISA, while § 1133 identifies the minimum claim procedures, including notices of denials and opportunity for an appeal of adverse decisions. While § 2560.503-1 does impose requirements on plans with regard to claim procedures, nothing in the statutory or regulatory scheme suggests that an ERISA claimant may bring an action for civil penalties under § 1132(c) for a plan's failure to comply with those requirements.

Indeed, the Third, Sixth, Seventh, and Eighth Circuits have ruled that § 1132(c) may not be used as a basis to impose civil liability for the violation of § 1133, or regulations promulgated thereto. See Brown v. J.B. Hunt Transp. Servs., Inc., 586 F.3d 1079, 1089 (8th Cir. 2009); Wilczynski v. Lumbermens Mut. Cas. Co., 93 F.3d 397, 405-07 (7th Cir. 1996); Stuhlreyer v. Armco, Inc., 12 F.3d 75, 79 (6th Cir. 1993); Groves v. Modified Ret. Plan for Hourly Paid Employees of Johns Manville Corp. & Subsidiaries, 803 F.2d 109, 116-18 (3d Cir. 1986).

Plaintiff argues, however, that under Sgro, an ERISA claimant in the Ninth Circuit is authorized to seek civil penalties under § 1132(c)(2) for a plan's failure to provide "relevant" information concerning his denied benefits claim. Plaintiff is reading too much into Sgro. In that case, the plaintiff sued both the plan administrator (his employer) and the claims administrator (the insurer). He sought civil penalties under § 1132(c), alleging that he had asked "defendants" for a "complete copy of [his] claim file," and that "defendants" had not complied with the request. Sgro, 532 F.3d at 944-45. The district court dismissed the complaint for failure to state a claim.

On appeal, the Ninth Circuit concluded the claim was properly dismissed because plaintiff had not specified which defendant he had directed the request to, and the proper party could only be the plan administrator. Id. at 945. The court added that "it seems

possible for [plaintiff] to amend his complaint to state a claim against [the administrator]," noting that under § 2560.503-1, "[a]dministrators must now turn over, on request, the documents 'generated in the course of making the benefit determination." Id. The court then suggested that where a third party makes the benefit determination, the plan administrator "may not have the needed documents on hand, so it will have to get them from the third party." Id.

This court is not persuaded that this suggestion – which was not essential to the holding of the case – supports plaintiff's position. Nevertheless, even if the court assumes that a plan administrator can be liable under 1132(c)(2) for civil penalties for failing to provide documents as defined under the regulation promulgated pursuant to § 1133, the court finds that in this case, penalties are not warranted.

The imposition of penalties for failing to provide documents requested by a participant or beneficiary, is left to the discretion of the district court. McDonald v. Pension Plan of NYSA–ILA Pension Tr. Fund, 320 F.3d 151, 163 (2nd Cir. 2003); Paris v. F. Korbel & Bros., 751 F.Supp. 834, 839 (N.D. Cal. 1990). Whether a penalty should be imposed depends upon the administrator's bad faith or intentional conduct, the length of the delay, the number of requests made, and the extent and importance of the documents withheld, and the existence of any prejudice to the participant or beneficiary. See McDonald, 320 F.3d at 163; Romero v. SmithKline Beecham, 309 F.3d 113, 120 (3d Cir. 2002).[6]

Where there has been no prejudice to the claimant, and where the plan administrator has acted promptly to provide information that it was able to provide, courts

[6] Most courts that have considered the role of prejudice or damages in the inquiry have concluded that while they are factors that the court may consider, neither is necessary to the determination under § 502(c)(1). See Mondry v. American Family Mut. Ins. Co., 557 F.3d 781, 806 (7th Cir. 2009); Brown v. Aventis Pharma., Inc., 341 F.3d 822, 825 (8th Cir. 2003); Bannistor v. Ullman, 287 F.3d 394, 407 (5th Cir. 2002); Yoon v. Fordham Univ. Faculty & Admin. Ret. Plan, 263 F.3d 196, 204 n. 11 (2d Cir. 2001); Faircloth v. Lundy Packing Co., 91 F.3d 648, 659 (4th Cir. 1996); Moothart v. Bell, 21 F.3d 1499, 1506 (10th Cir. 1994); but see Byars v. Coca-Cola Co., 517 F.3d 1256, 1271 (11th Cir. 2008) ("While a district court may not deny penalties solely on the basis of a lack of prejudice, prejudice is a factor that a court should consider in exercising its discretion.").

have consistently declined to assess penalties. See, e.g., Byars, 517 F.3d at 1270 (penalties not warranted because, among other things, employer believed in good faith that plaintiff already had requested documents, and plaintiff was not prejudiced); Moore v. LaFayette Life Ins. Co., 458 F.3d 416, 437 (6th Cir. 2006) (penalties not warranted where plaintiff had not demonstrated prejudice due to employer's failure to provide summary plan description); Kaiser Permanente Employees Pension Plan v. Bertozzi, 849 F.Supp. 692, 702 (N.D. Cal. 1996) (penalties not warranted because defendant did not act in bad faith and defendant's ERISA violation did not prejudice plaintiff).

In this case, plaintiff cannot show that she was prejudiced, as she had already been provided with a complete copy of the administrative record of her LTD claim denial by MetLife. Moreover, she has made no showing of bad faith by BofA Program, which acted promptly to provide plaintiff with all the Plan documents, and did not hide the existence or location of the administrative record from plaintiff. BofA Program provided all documents within its possession, and displayed no intent to keep documents away from plaintiff.

Even if Sgro can be read to hold that a plan administrator may be liable for penalties for failing to provide non-plan documentation that it would have to get from third parties, plaintiff here had already accomplished the only thing that Sgro arguably requires a plan administrator to do – get the documents from a third party – as she had already obtained the administrative record of her LTD claim from MetLife.

CONCLUSION

In accordance with the foregoing, the court GRANTS defendants' motion and DENIES plaintiff's motion.

IT IS SO ORDERED.

Dated: March 15, 2011

PHYLLIS J. HAMILTON
United States District Judge