UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

COASTAL MEDICAL, INC., et al., Plaintiffs, v. RELIANCE STANDARD LIFE INSURANCE COMPANY Defendant.	)	C.A. No. 15-520-M-LDA

MEMORANDUM AND ORDER

JOHN J. MCCONNELL, JR., United States District Judge.

Plaintiffs Coastal Medical, Inc., ("Coastal") and Joanne Carnevale have brought this action against Reliance Standard Life Insurance Company ("Reliance"), alleging that Reliance improperly denied benefits under a life insurance plan governed by the Employment Retirement Income Security Act of 1974 (ERISA).[1] The parties have filed Cross Motions for Summary Judgment pursuant to Fed. R. Civ. P. 56. ECF Nos. 36 & 43. Reliance argues that Dr. Robert Carnevale's policy lapsed and, therefore, benefits were properly denied. The Plaintiffs do not dispute the lapse but instead claim that Reliance forfeited its right to deny coverage for a myriad of reasons, including statutory violations, waiver, estoppel, and breach of fiduciary duties. Because the Court finds that Reliance has shown that there is no genuine issue as to any material fact such that a jury could

[1] 29 U.S.C. §§ 1001–1461.

find in the Plaintiffs' favor, Reliance's Motion for Summary Judgment is GRANTED, and the Plaintiffs' Motion for Summary Judgment is DENIED.

BACKGROUND

Dr. Carnevale was a physician, founding shareholder, and employee of Coastal until his death on June 27, 2015. As part of his employment with Coastal, he participated in a group life insurance plan, which operated as a funding mechanism for the employer to buy back shares upon the death of a shareholder. This life insurance policy ("Policy") was insured by Reliance and governed pursuant to the agreed upon plan ("Plan"). Up until Dr. Carnevale's death in 2015, the premiums under the Policy were paid, but coverage had actually lapsed on November 1, 2014.

Prior to the Policy with Reliance, Coastal had a life insurance policy with the Standard Life Insurance Company ("Standard"). In 2010, Coastal began negotiations with Reliance as Coastal contemplated replacing Standard as its insurer. In September of that year, Reliance represented in a telephone conference with the Chief Operating Officer of Coastal and the Vice President of Organizational Support and Compliance for Coastal that it would match or enhance all benefits for Coastal shareholders and employees. Later that month, Reliance confirmed these representations in writing.

Reliance sent a contract comparison examining the benefits included in Standard's plan and Reliance's proposed plan to ensure that there would be no

degradation of life insurance or disability insurance upon the carrier change. This chart detailed the benefits offered by Reliance but not all of the terms of the Plan.

There was a relevant difference—coverage. The Standard plan continued coverage of all participants unless the participant's employment was terminated or the participant failed to pay the premium. Under the Reliance plan, participants were required to be active employees and working at least twenty hours a week at the time of their death. This difference in coverage was not indicated in the contract comparison.

In the fall of 2010, Coastal entered into contracts with Reliance for group life insurance and long-term disability insurance. Under the Policy at issue, Coastal obtained $600,000 of life insurance coverage for Dr. Carnevale. Coastal also obtained a second life insurance policy, a voluntary group life insurance policy, in the amount of $30,000 for Dr. Carnevale. And in addition to the two life insurance policies, Dr. Carnevale was also insured under a long-term disability policy.

Pursuant to the Plan, when a participant becomes ineligible, insurance coverage lapses on the first day of the following month. An ineligible participant is, however, granted two ways to extend coverage. One, under the "Continuation of Individual Insurance" provision, an employee's coverage could continue for up to twelve additional months if illness or disability caused the ineligibility. Under this scenario, the plan administrator must simply pay the premiums for the twelve months in order for the employee to remain insured. This option was frequently used when employees intended to return to work within a year. Two, under the

"Conversion Privilege," the employee could convert his or her group coverage into an individual insurance plan. In order to utilize this privilege, "a written application for the policy must be made by the insured within thirty-one (31) days after he or she terminates."

In the Plan, Coastal delegated discretion to Reliance to interpret the terms of the Policy and make claim determinations.

Dr. Carnevale remained an active, full-time employee of Coastal and remained insured under the Policy for three years. However, on October 11, 2013, Dr. Carnevale became totally disabled and stopped working. Thus, because Dr. Carnevale was no longer an active, full-time employee, his eligibility for coverage terminated on the first day of the following month—November 1, 2013. Instead of offering Dr. Carnevale the right to convert his coverage pursuant to the Conversion Privilege, Coastal simply continued to pay the premiums for Dr. Carnevale.

In March 2014, Reliance sent Dr. Carnevale a letter advising him of his possible eligibility for a total waiver of premium under the Plan, and a few months later, Coastal sent an email to Reliance inquiring about Dr. Carnevale's eligibility for this waiver. The Plan included a waiver of premium in the event of a disability, which allows coverage to remain in effect without the need to pay premiums if the insured is totally disabled. But in order to be eligible for the waiver, the participant's disability must have occurred before the participant reached the age of 60. So in response to the inquiry, Reliance sent an email indicating that

Dr. Carnevale was not eligible, explaining that, in order to obtain the waiver, the "disability" had to occur before the age of 60. Because Dr. Carnevale's cancer diagnosis occurred after the age of 60, he was not eligible. Thus, Reliance advised Coastal that it needed to continue paying premiums in order for Dr. Carnevale to remain insured and told Coastal to let it know if it needed any additional clarification.

On November 1, 2014, Dr. Carnevale's coverage lapsed because the continuation of coverage provision that allowed him to remain insured was only available for twelve months. Nevertheless, Coastal, as the plan administrator, continued to pay premiums, and Reliance accepted the premiums until Dr. Carnevale's death on June 27, 2015. After Dr. Carnevale's death, Coastal filed a claim for benefits. In a letter dated July 20, 2015, Reliance determined that Dr. Carnevale was not insured at the time of his death and, therefore, denied Coastal's claim. The Plaintiffs' then appealed, and on October 6, 2015, Reliance upheld its denial. As a result of this denial, the Plaintiffs brought the instant action.

STANDARD OF REVIEW

A motion for summary judgment should be granted if the pleadings, discovery, disclosure materials on file, and any affidavits "show that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). A "'genuine' issue is one that could be resolved in favor of either party, and a 'material fact' is one that has the potential of affecting

the outcome of the case." *Calero-Cerezo v. U.S. Dep't of Justice*, 355 F.3d 6, 19 (1st Cir. 2004) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248–50 (1986)).

The moving party bears the burden of establishing that no genuine issues of material fact exist. *Flovac, Inc. v. Airvac, Inc.*, 817 F.3d 849, 853 (1st Cir. 2016). Once the moving party has made the requisite showing, the non-moving party may not merely rely on allegations or denials in its own pleading; rather, its response must—by affidavits or as otherwise provided in the rule—set out specific facts showing a genuine issue for trial. *Braga v. Hodgson*, 605 F.3d 58, 60 (1st Cir. 2010). In applying this standard, the Court views the record in the light most favorable to the non-moving party, accepting all reasonable inferences favoring that party. *Cont'l Cas. Co. v. Canadian Universal Ins. Co.*, 924 F.2d 370, 373 (1st Cir. 1991). "This standard applies even where . . . the district court is faced with summary judgment motions from all parties." *Id.*

As agreed by all the parties, the Court reviews the issues herein de novo because the issues fall outside the Plan.

DISCUSSION

The Plaintiffs brought this action against Reliance pursuant to 29 U.S.C. § 1132, claiming that Reliance wrongfully denied benefits upon the death of Dr. Carnevale. The Plaintiffs and Reliance agree that, under the terms of the Plan, Dr. Carnevale's Policy lapsed prior to his death, and all agree that Coastal continued paying the premiums, which Reliance accepted. But this is as far as their agreements reach, because when the task of assigning responsibility for the lapse

arises, the arguments diverge. Reliance maintains that, because Dr. Carnevale's coverage lapsed, Reliance properly denied benefits upon the doctor's death. The Plaintiffs, in contrast, do not claim that the terms of the Plan require Reliance to pay benefits but maintain that they are entitled to the benefits because: (1) Reliance committed statutory violations in connection with the Summary Plan Description (SPD), (2) Reliance waived its right to deny coverage by accepting premiums, (3) Reliance should be equitably estopped from benefiting from its misrepresentations to Coastal, and (4) Reliance breached its fiduciary duties.

A. Statutory Violations

Beginning with the statutory violations, the Plaintiffs argue that Reliance failed to comply with the disclosure requirements under ERISA. Under ERISA, the plan administrator—that is, Coastal—was tasked with generating the Summary Plan Description (SPD).[2] *See* 29 U.S.C. §§ 1022(a) & 1024(b); *see also Prouty v. Hartford Life & Acc. Ins. Co.*, 997 F. Supp. 2d 85, 90 (D. Mass. 2014). Nevertheless, Reliance took it upon itself to create the SPD and sent it to Coastal. And Coastal agrees that it received the document. In creating the SPD, Reliance assumed—or so goes the Plaintiffs' argument—a fiduciary duty for the SPD and was thus required to create the plan description in compliance with the relevant ERISA provisions.[3]

The Court begins with the statutory requirements. ERISA requires the SPD to be easy to understand and "sufficiently accurate and comprehensive to

[2] The Court pauses to mention that, on this point, the parties find themselves in agreement. ECF Nos. 45 & 50.

[3] The Court need not express an opinion on this point.

reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a). Furthermore, the SPD must include information about the Plan's requirements with respect to eligibility for participation and benefits as well as information regarding the "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b).

The Plaintiffs' sole complaint is with the lack of information regarding conversion rights. The SPD generated by Reliance consists of a two-page summary of the Plan and a booklet containing a description of benefits.[4] In the two-page summary, there was no discussion of conversion rights, but the benefits booklet contained a full discussion of these rights. The Plaintiffs, acknowledging this fact, ask the Court to limit its inquiry to the initial two-page description at the beginning of the SPD. But to do this, the Court would have to redefine the SPD. The document itself, after all, is a single document with multiple parts that, taken together, constitute the SPD. None of these facts contravene the statutory requirements.

The Plaintiffs do not refute this but instead make a last ditch effort, claiming that the benefits booklet cannot be part of the SPD because it simply restates the Policy. Of course, this shifts the inquiry from what is the SPD to whether the SPD is noncompliant because it is not easy to understand. Other than this bare assertion, the Plaintiffs do not develop an argument for why the SPD is not user

[4] The SPD specifically says, "The following information and the description of benefits provided in this booklet constitute the Summary Plan Description."

friendly or otherwise easy to understand. Nonetheless, after reviewing the SPD, the Court is left with no doubt that it is drafted using easy-to-understand language.

Just to take a belt-and-suspenders approach, the Court also points out that the statutory provisions identified by the Plaintiffs do not require an SPD to include information on conversion rights. *See* 29 U.S.C. § 1022(b); *see also Prouty*, 997 F. Supp. 2d at 91 ("The statute simply does not require that the SPD even include notification to participants and beneficiaries of any conversion rights."). Consequently, the Plaintiffs' claim of statutory violations is doubly doomed.

B. Waiver

Moving on to waiver, the Plaintiffs shift gears and focus on the failure of Reliance to assert the lapse in coverage after the twelve-month period. That is, even though Dr. Carnevale's coverage lapsed on November 1, 2014, Reliance continued billing and accepting premiums for the Policy until June 27, 2015. This conduct, the Plaintiffs urge, constitutes a waiver of Reliance's right to deny coverage.

Unfortunately for the Plaintiffs, waiver cannot be employed to create coverage. Waiver applies to benefits that already exist under a plan, but it cannot operate as a vehicle to create coverage that does not already exist. *See Juliano v. Health Maint. Org. of N.J., Inc.*, 221 F.3d 279, 288 (2d Cir. 2000) ("[W]here the issue is the existence or nonexistence of coverage (e.g., the insuring clause and exclusions), the doctrine of waiver is simply inapplicable." (quoting *Albert J. Schiff Assocs., Inc. v. Flack*, 417 N.E.2d 84, 87 (N.Y. 1980)); *see also Flynn v. Sun Life*

Assur. Co. of Canada, 809 F. Supp. 2d 1175, 1187 (C.D. Cal. 2011) ("[The] concepts of waiver or estoppel cannot be used to create coverage beyond that actually provided by an employee benefit plan."); *cf. Rodriguez-Abreu v. Chase Manhattan Bank, N.A.*, 986 F.2d 580, 587 (1st Cir. 1993) (applying waiver to ERISA benefits).

Under the Plan at issue, Dr. Carnevale became an ineligible plan participant on November 1, 2013, because he was no longer an active, full-time employee. The terms of the Plan, however, allow an ineligible employee to remain on the Plan for up to twelve months after the date of ineligibility. For Dr. Carnevale, this meant that coverage could extend through, but not past, November 1, 2014. So on this score, the Plaintiffs implore the Court to rewrite the terms of the plan so as to continue coverage for ineligible employees indefinitely by paying premiums—or at least for some period of time beyond twelve months. This, in no uncertain terms, is a request to create coverage beyond that which the parties originally bargained.

In sum, under the terms of the Plan, no coverage existed for Dr. Carnevale at the time of his death, and any attempt to find coverage requires creating coverage. To this end, the reach of the waiver doctrine falls short.

C. Estoppel

Next, the Plaintiffs seek to employ the doctrine of equitable estoppel.[5] Similar to the Plaintiffs' waiver claim, this theory for relief is based on the fact that

[5] In this Circuit, it is unsettled whether an equitable estoppel claim may be brought under ERISA's civil enforcement provisions. *See Guerra-Delgado v. Popular, Inc.*, 774 F.3d 776, 782 (1st Cir. 2014). Because the resolution of the summary judgment issue may be had without deciding this unsettled point in the law, the Court, in the interest of not deciding things that do not need to be decided,

Reliance continued to bill Coastal after the Policy lapsed. As a result of receiving the bills, Coastal reasonably believed that the Policy was still in effect. For this reason, equity favors estopping Reliance from denying the existence of coverage, or at least that is what the Plaintiffs claim.

An equitable estoppel cause of action consists of two elements: "(1) the first party must make 'a definite misrepresentation of fact' with 'reason to believe' the second party will rely on it; and (2) the second party must reasonably rely on that representation to its detriment." *Guerra-Delgado v. Popular, Inc.*, 774 F.3d 776, 782 (1st Cir. 2014) (citations omitted). Furthermore, and most salient here, any such cause of action under ERISA is limited to statements that interpret the plan and cannot extend to statements that would modify the plan. *See Law v. Ernst & Young*, 956 F.2d 364, 369–70 (1st Cir. 1992) (discussing the notion that estoppel applies to interpretations but not modifications of ERISA plans).

The Plaintiffs' equitable estoppel theory does not pass muster because it asks the Court to modify a clear provision rather than interpret an ambiguous one. In *Livick v. Gillette Co.*, the First Circuit held that reasonable reliance may arise if a plan beneficiary relies on an informal statement interpreting an ambiguous plan provision. 524 F.3d 24, 31 (1st Cir. 2008). However, "if the provision is clear," the court wrote, "an informal statement in conflict with it is in effect purporting to *modify* the plan term, rendering any reliance on it inherently unreasonable." *Id.* Here, the Plan clearly states when individual eligibility ends, the length of time

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assumes (but does not determine) that ERISA provides an avenue to pursue estoppel claims.

that coverage could be continued by paying premiums (twelve months), and how to convert after those twelve months. These terms do not allow coverage to be extended indefinitely merely through the payment of premiums.[6]

Accordingly, because the Plan clearly recites how coverage can be extended following ineligibility, any reliance on the alleged misrepresentations is unreasonable.

D. Breach of Fiduciary Duty

Turning now to the Plaintiffs' breach of fiduciary duty action, the Plaintiffs advance two arguments on this front. First and foremost, the Plaintiffs claim that Reliance misled Coastal by telling it to keep paying Dr. Carnevale's premiums. Second, the Plaintiffs claim that Reliance misled Coastal by sending bills for Dr. Carnevale's coverage after his coverage terminated.

The Court begins by noting that the Plan delegates the responsibility of apprising insureds of their conversion rights to Coastal.[7] Despite this delegation of

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[6] The Plaintiffs also make a brief assertion that, under the terms of the Standard policy, Dr. Carnevale would be covered. During negotiations between Reliance and Coastal, Reliance agreed to match the benefits or terms—there is a dispute over which—of Coastal's then-current insurer, Standard. While the Plaintiffs' Motion for Summary Judgement does not provide guidance as to the purpose of this argument, the Plaintiffs' Reply indicates that this point factors into the waiver and equitable estoppel claims. Nevertheless, the Court finds this line of reasoning unmoving for the reasons elucidated above in the waiver and estoppel subsections.

[7] The relevant Plan provision states the following:

> If an Insured is entitled to have an individual policy issued to him/her without proof of health, then he/she must be given notice of this right at least fifteen (15) days before the end of the period specified above. Such notice must be: (1) in writing; and (2) presented or mailed to the Insured by you.

authority, the Plaintiffs posit that Reliance committed a breach for two reasons—both of which the Court need only scratch the surface. The first one revolves around a quick email exchange limned below:

> COASTAL: I have a question for you regarding Dr. Carnevale. Should he still be responsible to pay the weekly payroll deduction of $11.06/week for his life insurance? He is still showing up on the bill but I believe this may be a waiver of premium case? Can you please explain to me how that works?
>
> RELIANCE: In order to be eligible for the Life Insurance Waiver of Premium, the disability must begin prior to age 60. Since Dr. Carnevale became disabled at age 62, he would not be eligible for the waiver. Therefore, he would need to continue paying the premiums in order to keep the Life Insurance coverage. Let me know if you need additional clarification.

The Plaintiffs contend that fiduciary liability was triggered based on this interaction because a Plan participant requested information about his rights under the Plan, which requires a complete and correct response.

The Plaintiffs' contention, however, falls flat because Reliance did provide a complete and accurate answer to the inquiry. Coastal only inquired into waiver eligibility, not conversion rights, so an answer limited to the waiver eligibility cannot, without more, be considered misleading.

To hammer this point home, the Court writes briefly to explain the duty to inform given these facts. At this point in Dr. Carnevale's disability, he could still remain on the Plan without having to convert, and Coastal's communication did not inform—or, for that matter, give Reliance any reason to believe—that Dr. Carnevale

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The term "you," as defined in the Policy, means "the employer . . . to which the Policy is issued and which is deemed the Policyholder."

would not be returning to Plan-eligible status or that Dr. Carnevale sought to remain insured after the twelve months. This is not a case where the plan participant is no longer eligible to remain on the group plan and must convert or a case where the plan participant inquired about his conversion rights. *Cf. Eddy v. Colonial Life Ins. Co. of Am.*, 919 F.2d 747, 752 (D.C. Cir. 1990) ("Once [the plan participant] had made clear his situation, [the insurance company] had a duty to provide the material information."). Coastal made a limited inquiry into a different Plan provision that had no bearing on conversion rights. In fact, the Continuation of Individual Insurance provision being employed by Dr. Carnevale is commonly used for participants who are temporarily disabled and return to work within twelve months. Simply put, Coastal's inquiry neither asked for information about conversion rights nor gave Reliance any reason to believe that Dr. Carnevale would not be returning to work but would like to maintain coverage. Therefore, there was no duty to inform on conversion rights.

As for the Plaintiffs' argument that collecting premiums constitutes a breach of fiduciary duty, the Court deems this argument waived. The entirety of this argument in the Plaintiffs' memorandum reads as follows: "[Reliance] misle[ ]d Coastal and Dr. Carnevale . . . by sending bills for premiums to Coastal covering Dr. Carnevale's life." With this single sentence, the Plaintiffs have failed to develop an argument, cite any legal authority, or discuss the claim in any way other than a perfunctory manner. To make matters worse, the issues raised—whether an insurer possesses a fiduciary duty to ensure that it only bills eligible plan

participants—is not subject to a simple solution with existing authority. All of these reasons militate against wading into uncertain waters. *See Higgins v. New Balance Athletic Shoe, Inc.*, 194 F.3d 252, 260 (1st Cir. 1999) ("The district court is free to disregard arguments that are not adequately developed . . . .").

CONCLUSION

In sum, the Court, having rejected all of the Plaintiffs' claims for relief and determined that Dr. Carnevale's coverage lapsed prior to his death, concludes that there is no genuine issue of material fact and that Reliance is entitled to judgment. Accordingly, Reliance's Motion for Summary Judgment (ECF No. 36) is GRANTED, and the Plaintiffs' Motion for Summary Judgment (ECF No. 43) is DENIED.

IT IS SO ORDERED.

John J. McConnell, Jr.
United States District Judge

July 24, 2017