No. _____

IN THE

Supreme Court of the United States

SHARON THURBER,

Petitioner,

v.

AETNA LIFE INSURANCE CO., ET AL.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Section 502(a)(3) of the Employee Retirement Income Security Act (ERISA) authorizes plan administrators to sue their beneficiaries for equitable relief to enforce the terms of the plan. One such form of relief is an action to enforce an equitable lien by agreement. In *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), this Court determined that a Plan may enforce an equitable lien by agreement where it has (1) specifically identified a particular share of (2) a particular fund that is (3) in the defendant's possession and control.

The questions presented are:

(1) Whether an ERISA Plan may enforce an equitable lien by agreement under § 502(a)(3) where it has not identified a particular fund that is in the defendant's possession and control at the time the Plan asserts its equitable lien. The First, Second, Third, Sixth, and Seventh Circuits have held that a Plan may do so, and the Eighth and Ninth Circuits have held that it may not.

(2) Whether a discretionary clause in an ERISA plan mandating that an abuse-of-discretion standard of judicial review be applied to a § 502(a)(1)(B) denial-of-benefits claim is enforceable when the clause was never disclosed to the participant in any plan document, as the Second Circuit held here, or whether the Plan must give participants and beneficiaries clear notice of such a clause, as the Seventh Circuit has required.

PARTIES TO THE PROCEEDINGS

The following were parties to the proceedings in the U.S. Court of Appeals for the Second Circuit:

1. Sharon Thurber, petitioner on review, was plaintiff-counter-defendant-appellant-cross-appellee below.

2. Aetna Life Insurance Co., respondent on review, was defendant-counter-claimant-appellee-cross-appellant below.

3. Quest Diagnostics Inc., Welfare Plan aka The Quest Diagnostics' Aetna Long Term Disability Benefit Plan, aka The Quest Diagnostics' Managed Disability Benefits Plan, The Quest Employee Benefits Administration Committee, as Plan Administrator, respondents on review, were defendants-appellees-cross-appellants below.

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JURISDICTION

The Second Circuit entered judgment on March 13, 2013. Pet. App. 1. This Court's jurisdiction rests on 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 502(a)(3) of the Employee Retirement Income Security Act (ERISA), codified at 29 U.S.C. § 1132(a)(3), provides:

> A civil action may be brought—
>
> (1) by a participant, beneficiary, or fiduciary
>
> (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or
>
> (B) to obtain other appropriate equitable relief
>
> (i) to redress such violations or
>
> (ii) to enforce any provisions of this subchapter or the terms of the plan[.][1]

INTRODUCTION

This case raises an issue of recurring importance that has split and bedeviled the lower courts ever since this Court decided *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), and

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[1] This petition will refer to 29 U.S.C. § 1132 as § 502 of ERISA.

Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006): whether an ERISA Plan can enforce an equitable lien by agreement against a plan beneficiary where it has not identified a particular fund that is in the beneficiary's possession and control at the time the Plan asserts its equitable lien. As the Second Circuit observed, that question—which arises most often when a plan administrator seeks to recover disability "overpayments" from a disabled employee—"continues to perplex courts despite efforts by the Supreme Court during the past decade to shed some light on the matter." Pet. App. 15.

Indeed it has. Before the Second Circuit decided this case, *six* courts of appeal had addressed this question and split four to two, and a seventh (the en banc Fifth Circuit) just declined to decide one way or the other. In the last year alone, four circuit courts have grappled with this question and reached conflicting conclusions about the answer. The Second Circuit has now weighed in as well, and it is has deepened the divide. The lower court held, in express disagreement with the Ninth Circuit, that dissipation of the sought-after fund presents no bar to an ERISA Plan's effort to enforce an equitable lien by agreement.

The time for this Court's review on this question has come. Both sides of this disagreement have now asked this Court to resolve it—because, as it stands, the split has far-ranging negative consequences for both plan fiduciaries and beneficiaries alike. Just last year, in fact, an ERISA plan *fiduciary* sought this Court's review of the Ninth Circuit's decision on this issue. *See* Petition for Writ of Certiorari, *First Unum Life Ins. Co. v. Bilyeu*, No. 12-526 (Oct. 26,

2012), *cert. denied*, 133 S. Ct. 1242. In the fiduciary's words, the question at stake in all of these cases is "of substantial importance to employers and workers across the country," *id.* at 14, because (among other reasons), until this dispute is resolved, national plans (like Aetna's in this case) "will be enforced differently based on where each case is litigated"—leaving both disabled employees and plan fiduciaries unsure about their rights, *id.* at 20.

Review is also warranted on a second question in this case: whether a discretionary clause in an ERISA plan that triggers a deferential, abuse-of-discretion standard of review in the event of a judicial challenge to a Plan's denial of benefits can be enforced when the beneficiary was not given notice of such a clause.

The Second Circuit sparked a circuit split when it held that Aetna's failure to disclose this plan term was of "no consequence," even though employees fare better under the *de novo* standard of judicial review that applies absent such a provision. The Second Circuit's ruling cannot be squared with the Seventh Circuit's decision in *Herzberger v. Standard Insurance Co.*, 205 F.3d 327 (7th Cir. 2000), which held that, because a change in the standard of judicial review is directly relevant to what rights an employee has under an ERISA plan, "employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly." *Id.* at 333.

This disagreement needs to be resolved. ERISA Plans benefit greatly from a deferential standard of review, which effectively insulates all but the most

irrational decisions from reversal. Under the lower court's rule, however, ERISA participants and beneficiaries are entitled to no notice—zero—about a plan term that triggers deferential review. Review should be granted to decide whether this approach can be reconciled with ERISA's overriding goal of "protect[ing] . . . the interests of participants in employee benefit plans . . . by providing for appropriate remedies . . . ." 29 U.S.C. § 1001(b).

STATEMENT OF THE CASE

1. Sharon Thurber worked at Quest Diagnostics for nearly fifteen years before she became disabled in a car accident that occurred in August 2007. Pet. App. 3. As part of her employee benefits package, she was enrolled in Quest's ERISA-governed disability benefits plan, which was administered by Respondent Aetna. Pet. App. 3. After the accident, Ms. Thurber applied and was approved for short term disability (STD) benefits, which lasted for six months. Pet. App. 4.

After those benefits ended, Ms. Thurber submitted a claim for long term disability (LTD) benefits. Pet. App. 4. To support her claim, she introduced a number of reports and letters from her various doctors. Pet. App. 4-5. During its processing of Ms. Thurber's LTD claim, Aetna inquired for the first time as to whether Ms. Thurber had received any other income related to her disability, at which point Ms. Thurber promptly informed Aetna that she had received no-fault insurance payments of $1,202.32 per month while receiving STD benefits. Pet. App. 4, 54. Aetna then denied her LTD claim, finding that she could still perform the functions of her position at Quest. Pet. App. 5.

After exhausting her plan-provided internal appeals, in March 2009 Ms. Thurber challenged the denial of LTD benefits in federal court, Pet. App. 6-7, arguing that Aetna's conclusion that she could still perform her work functions was erroneous and not based on record evidence, Pet. App. 12.

In response, Aetna filed an Amended Answer that included a counterclaim under § 502(a)(3) of ERISA, Pet. App. 7, which gives Plans the right to seek "appropriate equitable relief" from beneficiaries. Relying on several plan provisions that purport to give it the right to sue for overpayment of plan benefits, Aetna asserted for the first time that it was entitled to "equitable restitution of $7,213.92" based on Ms. Thurber's earlier receipt of no-fault insurance benefits. Pet. App. 7.[2]

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[2] The language Aetna relied upon to support its claim specifically provides as follows:

> If payments are made in amounts greater than the benefits you are entitled to receive, the plan may:
>
> - Require you to return the overpayment within thirty (30) days;
> - Stop payment of benefits until the overpayment is recovered;
> - Take legal action, if necessary, to recover the overpayment and any legal fees incurred; or
> - Place a lien, if not prohibited by state law, in the amount of the overpayment on the proceeds of any other income.

Pet. App. 67. Another provision relied on by Aetna also identifies "other income benefits" that, if received, may trigger the right to recover overpayments. According to this provision, these "other" benefits include:

(*Footnote continued*)

2. The district court affirmed Aetna's denial of LTD benefits but rejected its counterclaim for overpayment. Pet. App. 29. On the first issue, the court, over Ms. Thurber's vigorous objections, applied an abuse-of-discretion standard and, under that "extremely deferential standard," dismissed Ms. Thurber's claim for benefits, holding that no genuine issue of material fact existed that could render Aetna's determination arbitrary and capricious. Pet. App. 53. On the second issue, the court held that Aetna's counterclaim for recoupment of overpayments was legal, rather than equitable, relief, and therefore could not qualify as "appropriate equitable relief" under § 502(a)(3). Pet. App. 57.

The parties cross-appealed to the Second Circuit, which affirmed Aetna's benefits determination but reversed the district court's dismissal of Aetna's counterclaim seeking repayment of benefits. Pet. App. 2. In the course of affirming, the court applied an abuse-of-discretion standard of review to Aetna's determination, instead of the more searching *de novo* standard that applies in the absence of a specific provision to the contrary. Pet. App. 7. To justify this decision, the Second Circuit found that both the underlying plan document and the Summary Plan Description (SPD) grant the plan administrator

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> Disability, retirement or unemployment benefits required or provided for under government law, such as benefits under Social Security * * * Workers' Compensation Benefits, Unemployment Compensation Benefits, automobile no-fault wage replacement benefits to the extent required by law, Veterans Benefits . . . .

Pet. App. 64.

discretion with regard to benefit determinations, and that, under this Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this grant of discretion triggers an arbitrary-and-capricious standard of review. Pet App. 10-11.

In so ruling, the Second Circuit rejected Petitioner's argument that, because she had never received the entire plan, the contractual modification could not be given effect in her case. Pet. App. 11. On this point, the Second Circuit held that ERISA Plans need not "specifically convey[] to all members of the plan" what the standard of review is for judicial review of benefits determinations because ERISA does not require such a disclosure and because the standard of review is of "no consequence" to plan beneficiaries. Pet. App. 10-11.

The Second Circuit went on to reverse the district court's ruling that, because Aetna's counterclaim was "legal" rather than "equitable," the claim could not be maintained under § 502(a)(3). Pet. App. 15. Construing this Court's decisions in *Knudson* and *Sereboff*, the panel found that the claim met the basic requirements for maintaining an "equitable lien established *by agreement*," namely that "the insurer seeks specific funds (overpayment resulting from Thurber's simultaneous receipt of no-fault insurance benefits and short-term disability benefits) in a specific amount (the total overpayment, $7,213.92) as authorized by the plan." Pet. App. 19 (emphasis in original).

The Second Circuit did concede that, unlike in *Sereboff*, the "particular fund" from which Aetna sought to recover was not the "the actual third-party income Thurber received; instead it is the benefits

rendered as overpayments as a result of Thurber's receipt of no-fault insurance benefits." Pet. App. 19. That difference was, in the Second Circuit's view, irrelevant, because both funds "constitute particular, identifiable sums over which an insurer may assert an equitable lien." Pet. App. 21.

The Second Circuit also conceded that, unlike in *Sereboff*, the modest third-party benefits received by Petitioner had been spent. Pet. App. 21. The court dismissed this fact as "immaterial," however, reasoning that "[i]f the reason the insurer's claim is equitable is because it is seeking return of property over which it asserts a lien (the overpayments), whether or not the beneficiary remains in possession of those particular dollars is not relevant." Pet. App. 21-22. Instead, the court held, in the "context of an equitable lien by agreement," all that matters "is that the beneficiary did, at some point, have possession and control of the specific portion of the particular fund sought by the insurer." Pet. App. 22.

Finally, the Second Circuit rejected the district court's conclusion that the actual plan language was itself insufficient to establish an enforceable lien. Pet. App. 23-24. Aetna's plan stated only that the Plan "may" assert a lien to recover its alleged overpayments on third-party recoveries identified as "other income," but on nothing else. Despite this limiting language, the Second Circuit held that Aetna could assert a lien on a different fund: "the subset of disability benefits that became overpayments when Thurber received no-fault insurance benefits," Pet. App. 20, even though this fund was not specifically identified by the plan documents. Pet. App. 25-26.

The Second Circuit concluded that permitting the ERISA Plan's claim for overpayment—even if the property had already been dissipated, and even where no specific fund had been identified or segregated—"str[uck] the right balance," Pet. App. 21, by "allowing ERISA [Plans] to bring responsive claims in ongoing federal actions, rather than forcing the parties to litigate two actions, one in federal court and one in state court, unnecessarily." Pet. App. 25-26. This Petition followed.

REASONS FOR GRANTING THE WRIT

I. Review Should Be Granted as to Whether an ERISA Plan May Enforce an Equitable Lien by Agreement Under § 502(a)(3) Where the Plan Has Not Identified a Particular Fund that Is in the Defendant's Possession and Control.

A. The Circuits Are Split on this Issue.

The first reason review is warranted is because the Second Circuit's ruling deepened a preexisting split among the lower courts on whether an ERISA Plan can enforce an equitable lien by agreement where the Plan has not identified a particular fund that is in the defendant's possession and control at the time the lien is asserted. Before describing this split of authority, some background on this Court's complex § 502(a)(3) jurisprudence may be useful.

1. The claim at issue in this case arises under § 502(a)(3) of ERISA, which authorizes ERISA Plans (through their plan administrators) to sue beneficiaries for "appropriate equitable relief" to "enforce . . . the terms of the plan." It is now well-settled that, under this provision, a plan

administrator may bring the "modern-day equivalent of an action in equity to enforce . . . a contract-based lien—called an equitable lien by agreement," to obtain reimbursement of advanced medical expenses. *US Airways, Inc. v. McCutchen*, __ U.S. __, 133 S. Ct. 1537, 1545 (2013) (citing *Sereboff*, 547 U.S. at 364-65).

This Court has explained that several criteria must be satisfied to create an enforceable equitable lien by agreement. *See Knudson*, 534 U.S. at 213-14; *Sereboff*, 547 U.S. at 362-68. First, because § 502(a)(3) limits the available relief to actions enforcing "the terms of the plan," the ERISA plan must contain a reimbursement provision. *See id.* at 361. And, because § 502(a)(3) authorizes only the kinds of relief typically available in equity in the days of the divided bench, the reimbursement provision must: (a) "specifically identif[y] a particular fund, distinct from the [defendant's] general assets"; and (b) specifically identify a "particular share of that fund" to which the Plan is entitled. *Id.* at 363-64 *(*discussing the requirements for this type of equitable remedy as articulated in *Barnes v. Alexander*, 232 U.S. 117 (1914)).

Second, under § 502(a)(3), for a reimbursement claim to be enforceable, the sought-after funds must be in the "possession and control" of the defendant. *Id.* at 363 (internal quotations omitted). Although the "fund over which a lien is asserted need not be in existence when the contract containing the lien provision is executed," it must both exist and be held by the actual defendant at the time the claim is

presented for the action to qualify as "equitable" within the meaning of § 502(a)(3). *Id.* at 366.[3]

2. Even before the Second Circuit decided this case, the applicability of these requirements to equitable actions seeking the return of "overpaid" disability benefits had already created substantial confusion. *See* Pet. App. 15 (explaining that the topic "continues to perplex courts despite efforts by [the Supreme Court] . . . to shed some light on the matter"). In particular, the lower courts are deeply conflicted as to whether an ERISA Plan can enforce an equitable lien by agreement over a fund that has already been dissipated and is no longer in the defendant's possession.

In line with the Second Circuit here, the First, Third, Sixth and Seventh Circuits have held that dissipation is immaterial and that ERISA Plans can establish an enforceable equitable lien by agreement over a beneficiary's disability "overpayments" even where the fund is no longer in the defendant's possession. *See Cusson v. Liberty Life Assurance Co. of Boston*, 592 F.3d 215, 231 (1st Cir. 2010) (finding it immaterial that the plan administrator could not identify "a specific account in which the funds are kept" and could not "prove[] that [the sought-after funds] are still in Cusson's possession"); *Funk v.*

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[3] *Compare Knudson*, 534 U.S. at 214 (holding that, because the funds to which Plan "claim[ed] an entitlement" were not in the defendant's possession, the reimbursement claim was not "equitable" within the meaning of § 502(a)(3)) *with Sereboff*, 547 U.S. at 362-63 (enforcing an equitable lien by agreement where the sought-after funds "were within the possession and control of the Sereboffs").

CIGNA Grp. Ins., 648 F.3d 182, 194-95 (3d Cir. 2011) (dissipation no bar to establishing enforceable equitable lien by agreement for recovery of disability overpayments under § 502(a)(3)); *Gilchrest v. Unum Life Ins. Co. of Am.*, 255 Fed. Appx. 38, 45 (6th Cir. 2007) (observing that the "undisputed averment that the overpayments had been dissipated would seem to be of no avail"); *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614, 621 (7th Cir. 2008) (holding that a plan administrator may bring an overpayment claim under § 502(a)(3) even where the sought-after fund has been dissipated).

The Ninth Circuit, however, squarely disagreed with these circuits in *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012), *cert. denied*, 133 S. Ct. 1242. In that case, the Ninth Circuit held that a fiduciary could not establish an enforceable equitable lien by agreement to recover disability overpayments where "the beneficiary no longer possesses the specifically identified funds." *Id.* at 1094. In the Ninth Circuit's view, that conclusion necessarily followed from this Court's teachings in *Sereboff* and *Knudson* as well as relevant equitable authorities. *Id.* at 1095-96. Like the Ninth Circuit, the Eighth Circuit has also held that dissipation renders an equitable lien by agreement unenforceable. *See Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888, 896 (8th Cir. 2012) (holding that where the defendant "no longer has the property at issue in its

possession, the claim against that party is legal, not equitable").[4]

Adding to the confusion, the en banc Fifth Circuit recently published a fractured opinion on the same question. In *ACS Recovery Services, Inc. v. Griffin*, __ F.3d __, 2013 WL 1890258 (5th Cir. May 7, 2013), the majority declined to decide whether a defendant's dissipation of the at-issue property could defeat an ERISA Plan's equitable claim for reimbursement, observing that it was "arguable" whether this fact was material or not. *See id.* at *8. Judge Prado, on the other hand, wrote separately to make clear that, in his view, "[i]f the defendant does not possess the funds, the underlying basis of the equitable remedy is lost." *Id.* at *10 (concurring in part and dissenting in part). In Judge Prado's opinion, because the defendants in the case did not "possess[] the disputed settlement fund," the overpayment could not be recouped. *Id.* at *12; *see also id.* at *16 (Haynes, J., concurring in part and dissenting in part) (agreeing with Judge Prado that, for an ERISA Plan to create an enforceable equitable lien by agreement under § 502(a)(3), the at-issue funds must actually be in the "defendant-beneficiary's possession or control").

Not surprisingly, in those circuits where the court of appeals has yet to weigh in, the district courts have themselves reached opposing outcomes. In *Epolito v. Prudential Insurance Co. of America*, 737 F. Supp. 2d 1364, 1380 (M.D. Fla. 2010), the court

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[4] Although *Goding* involved an ERISA Plan's claim for reimbursement of medical expenses, the court fully considered the effect that dissipation has on any ERISA Plan's claim to enforce an equitable lien by agreement. 692 F.3d at 895-97.

concluded that *Sereboff* did not "eliminate[] the requirement that the insurer identify an intact, identifiable *res*, in the possession of the insured, on which it seeks to impose the equitable lien," and found that the ERISA Plan could not establish an enforceable equitable lien by agreement. *Id.* at 1383. In *Anderson v. Reliance Standard Life Insurance Co.*, 2013 WL 1190782, at *13 (D. Md. Mar. 21, 2013), by contrast, after noting that "[t]he courts of appeal differ about whether *Sereboff* requires that the overpaid funds be in the claimant's possession for imposition of the equitable lien," the district court opted to allow the claim to go forward even where the fund is "no longer in the claimant's possession." *Id.*[5]

The Second Circuit here deepened this divide when it held that an ERISA Plan need not specifically identify a particular fund in the possession and control of the defendant to create an enforceable equitable lien by agreement. Instead, according to the Second Circuit, an ERISA Plan may enforce an equitable lien by agreement over disability overpayments "whether or not the

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[5] Even in those circuits that have decided this issue, district courts continue to struggle. *See, e.g.*, *Crawford & Co. Med. Benefit Trust v. Repp*, 2012 WL 716921, at *3-4 (N.D. Ill. Mar. 6, 2012) (dismissing § 502(a)(3) claim where ERISA Plan failed to plausibly demonstrate that the defendant was in possession of identifiable, non-dissipated funds that were still in his control); *D & H Therapy Assocs., LLC v. Boston Mut. Life Ins. Co.*, 691 F. Supp. 2d 304, 311 (D.R.I. 2010), *rev'd on other grounds*, 640 F.3d 27 (1st Cir. 2011) (concluding that an ERISA Plan's overpayment claim did "not sufficiently meet the criteria outlined in *Sereboff*" because, *inter alia*, it did not seek a fund "within [the beneficiary's] possession and control").

beneficiary remains in possession of those particular dollars." Pet. App. 22. That holding is directly contrary to the Ninth Circuit in *Bilyeu* and the Eighth Circuit in *Goding*. *See* Pet. App. 19-20 ("[W]e recognize the existence of a Circuit split on the issue.").

* * *

This Court's guidance on this question is needed. Five circuits have held that dissipation does not defeat an equitable lien by agreement; two circuits, have held that it does; and the en banc Fifth Circuit was unable to decide whether dissipation defeats an equitable lien by agreement. Absent review, this conflict will only deepen further, causing more confusion and less uniformity with every year that passes.

B. The Second Circuit's Ruling Is Contrary to Prior Rulings of this Court and Presents an Important Issue of Law.

Review of this issue is also warranted because the Second Circuit's ruling badly distorts this Court's § 502(a)(3) jurisprudence, upends well-settled rules of equity, and is harmful to ERISA beneficiaries and plan fiduciaries alike.

1. To begin, this Court has consistently held that a defendant's actual possession of the sought-after funds is a necessary prerequisite to enforcing an equitable lien by agreement under § 502(a)(3). In *Knudson*, for example, the Court explained that an equitable remedy, unlike a legal one, seeks the return of "money or property [that is] identified as belonging in good conscience to the plaintiff [and can] clearly be traced to particular funds or property

in the defendant's possession." 534 U.S. at 213; *id.* at 214 (equitable remedies could only "restore to the plaintiff particular funds or property *in the defendant's possession*") (emphases added). Thus, "where the property sought to be recovered or its proceeds have been dissipated so that no product remains, the plaintiff's claim is only that of a general creditor, and the plaintiff cannot enforce a constructive trust or an equitable lien upon other property of the defendant." *Id.* at 213-14 (internal citations omitted). In other words: no possession, no equitable remedy. *See, e.g.*, *CIGNA Corp. v. Amara*, __ U.S. __, 131 S. Ct. 1866, 1879 (2011) ("[R]elief that sought a lien or a constructive trust was legal relief, not equitable relief, unless the funds in question were particular funds or property in the defendant's possession.") (quoting *Knudson*, 534 U.S. at 213).

Sereboff concurs. Unlike in *Knudson*, the defendant in *Sereboff was* in possession of the sought-after funds. In holding that the equitable lien was enforceable (i.e., "equitable" under § 502(a)(3)), *Sereboff* emphasized that the "impediment to characterizing the relief in *Knudson* as equitable" was not present—the "portion of the tort settlement due [to the Plan] under the terms of the ERISA plan" was "set aside and preserved in the Sereboffs' investment accounts." *Sereboff*, 547 U.S. at 362-63 (internal quotations and alterations omitted). The Court therefore had no difficulty enforcing the equitable lien over the funds "within the possession and control of the Sereboffs." *Id.* at 363.

2. The Second Circuit threw these lessons out the window. Although the lower court recognized that "this case differs from *Sereboff*" because the sought-

after fund (the "overpayments") had "been dissipated," the panel nevertheless refused to "label[] Aetna's claim as one in law." Pet App. 19. The panel likewise rejected the argument that "because Thurber has spent the no-fault monies," Aetna was "akin to a general creditor seeking a sum of money." Pet. App. 21. These conclusions are directly contrary to *Knudson*'s holding that "where the property sought to be recovered . . . [has] been dissipated[,] . . . the plaintiff's claim is only that of a general creditor, and the plaintiff cannot enforce a constructive trust of or an equitable lien upon other property of the defendant." 534 U.S. at 213-14 (internal citations omitted). And they cannot be squared with *Sereboff*'s teaching that an equitable lien by agreement is only enforceable in equity where the sought-after funds are in the possession of the defendant. 547 U.S. at 362-63.

What is particularly striking about the Second Circuit's holding here is its lack of support. The lower court cited no authority—not treatises, not Restatements, not cases from today or from the days of the divided bench, nothing—justifying its decision to ignore the rule that the dissipation of a sought-after fund defeats an equitable lien by agreement. Instead, it simply observed that its decision "strikes the right balance." Pet. App. at 21.

That reason is no reason at all. Section 502(a)(3) limits plan fiduciaries to only that relief that was "traditionally available in equity." *Knudson*, 534 U.S. at 216. Congress did not authorize courts to simply disregard those equitable rules that feel inconvenient or otherwise unfamiliar in a modern context. "Like it or not," this Court has observed, "the law-equity

dichotomy . . . has been specified by statute; and there is no way to give the specification meaning . . . except by adverting to the differences between law and equity to which the statute refers." *Id.* at 217.[6]

3. The Second Circuit's unsupported ruling is made all the worse by what the plan language actually says (or, really, what it does not say). Unlike the reimbursement provisions in *Sereboff* and *Knudson*, here the plan documents themselves do not establish an enforceable equitable lien by agreement, at least as the Second Circuit framed it. In *Sereboff*, this Court made clear that, to create an enforceable contract-based lien, the relevant plan language must clearly identify "a particular fund, distinct from the [plan beneficiary's] general assets" out of which the

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[6] The Second Circuit's contrary conclusion also flies in the face of well-settled rules of equity—which this Court has repeatedly looked to for guidance in § 502(a)(3) cases. The First Restatement on Restitution, for example, explains that a plaintiff could only recover in equity if it proved that the defendant "once had property legally or equitable belonging to [it]" and "that he *still holds* the property or property which is in whole or part its product." *Restatement (First) of Restitution* § 215 cmt. a (1937) (emphasis added). The Restatement further explains that "if the wrongdoer has used the money of the claimant in speculation and has lost it all, the claimant cannot enforce a constructive trust or equitable lien upon other property of the wrongdoer." *Id.* (where "the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor," and the plaintiff "cannot enforce a constructive trust [ ] or an equitable lien upon other property of the [defendant]."); *see also Restatement (Third) of Restitution and Unjust Enrichment* § 55 cmt. h (2011) ("If the claimant cannot show an equitable entitlement to specific property in the hands of the defendant, the underlying basis of the remedy is lost.").

plan administrator is seeking to recover. 547 U.S. at 364. But here, the Second Circuit authorized Aetna to place a lien on a particular fund—the "overpayments"—that its plan documents did not specifically identify. Instead, the plan documents merely provide that, "[i]f payments are made in amounts greater than the benefits you are entitled to receive, the plan may * * * [p]lace a lien, if not prohibited by state law, in the amount of the overpayment *on the proceeds of any other income*."). Pet. App. 67 (emphasis added).

That the plan's reimbursement provision does not identify the "overpayments" as a distinct fund separate from the Petitioner's general assets should have been dispositive. But the Second Circuit authorized Aetna to place its lien on a particular fund that was never specified in the plan's reimbursement provision. *Sereboff* does not permit this result. *See* 547 U.S. at 363-64 (holding that Mid Atlantic could enforce its equitable lien by agreement because, *inter alia*, it sought to recover out of a particular fund that its reimbursement provision specifically identified).

The Second Circuit offered no logical explanation for its decision to ignore *Sereboff*. The lower court merely asserted that both funds "constitute particular, identifiable sums over which an insurer may assert an equitable lien authorized by its plan." Pet. App. 21. Of course, this just begs the question—does the plan's reimbursement provision authorize a lien over the particular fund? And nothing in Aetna's plan does so for an "overpayment" fund. The Second Circuit's explanation cannot be reconciled with *Sereboff*'s rule that a reimbursement provision which

"fails to specify that recovery come out of" a specific "identifiable fund" does not "meet the requirements . . . for the assertion of an equitable lien for the purposes of [§ 502(a)(3)]." *Popowski v. Parrot*, 461 F.3d 1367, 1374 (11th Cir. 2006) (discussing *Sereboff*).

4. Left to stand, the current split among the lower courts will produce seriously adverse consequences for both beneficiaries and plan fiduciaries. Under the current circuit split, participants in nationwide plans—like Aetna's in this case—will receive different benefits depending on where their case is litigated. ERISA disfavors this circuit-by-circuit approach. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002) (ERISA "induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards . . . .").

For beneficiaries, the differing circuit rules leave them in a precarious position. Disability benefits are "designed, by definition, to replace [an employee's] wages during a period when [she is] unable to work." *D & H Therapy Assocs.*, 691 F. Supp. 2d at 311. That fact creates an "an extremely strong presumption" that these benefits are immediately spent on life necessities—"groceries, rent and the electric bill." *Id.* Yet with no clear uniform rule governing the standards for equitable overpayment claims, employees who receive disability benefits will be uncertain of whether they may later be subject to reimbursement claims seeking money long since spent on daily life needs.

The split of authority harms Plans as well. Indeed, as noted above, both sides of this dispute have sought this Court's help in resolving whether Plans can pursue an overpayment claim for disability benefits under these circumstances. *See* Petition for Writ of Certiorari, *First Unum Life Ins. Co. v. Bilyeu*, No. 12-526 (Oct. 26, 2012), *cert. denied*, 133 S. Ct. 1242. As the *Bilyeu* petition explained, a "patchwork scheme of regulation created by the circuit split will introduce considerable inefficiencies in the benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Id.* at 29-30 (internal quotations and citations omitted). Here again, this outcome would benefit no one.

II. Review Is Warranted on Whether a Plan Term that Triggers a Deferential Standard of Judicial Review May Be Enforced Even if the Term Is Not Disclosed to Beneficiaries.

Review is also warranted as to the second question presented in this case: whether a deferential abuse-of-discretion standard of review may be applied in a case where a plan beneficiary was never given notice of the ERISA Plan's reservation of discretion with regard to benefit determinations. The lower courts are split on the importance of such notice, which has crucial implications for ERISA participants and beneficiaries.

A. The Lower Courts Disagree as to Whether ERISA Beneficiaries Must Be Given Clear Notice that an ERISA Plan Includes a Discretionary Clause.

1. ERISA does not prescribe a specific standard of review when there has been a denial of benefits. In *Firestone*, 489 U.S. at 115, this Court held that "[c]onsistent with established principles of trust law . . . a denial of benefits challenged under [§ 502(a)(1)(B)] 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," in which case a deferential abuse-of-discretion (or arbitrary-and-capricious) standard applies. *Id*. (emphasis added).

In this case, the lower court sparked a circuit split when it applied an abuse-of-discretion standard of review even though the relevant plan documents allegedly specifying this standard were never disclosed to Petitioner. Pet. App. 10-11. "We see no reason why a plan administrator must actually notify a participant of its reservation of discretion," the Second Circuit explained, because "ERISA contains no such edict" and because a discretionary review provision is of "no consequence" to plan participants and beneficiaries. Pet. App. 10-11. While recognizing that "[t]here may be strong arguments that plan provisions that affect the basic terms of the plan . . . should be conveyed directly to plan beneficiaries and not buried in a lengthy and technical contract," the lower court concluded that a

change in the standard of review is not such a provision. Pet. App. 11-12.[7]

In so ruling, the lower court rejected the Seventh Circuit's decision in *Herzberger v. Standard Ins. Co.*, 205 F.3d 327 (7th Cir. 2000), which held that, under ERISA, a beneficiary must be given clear notice of a discretionary clause triggering a deferential standard of review. *Herzberger* recognized that the standard of review is directly relevant to what "rights" an employee has under an ERISA plan. *Id.* at 332. The court reasoned that a plan that delegates a broad degree of discretion to the plan administrator weakens an employee's entitlement to benefits under the plan—a fact that may make it "more important" for an employee "to supplement his ERISA plan with other forms of insurance." *Id.* In light of this fact, *Herzberger* held, "employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told

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[7] A number of other federal courts of appeals have similarly upheld discretionary clauses that were not disclosed to the beneficiary in the SPD. *See, e.g.*, *Fenton v. John Hancock Mut. Life Ins. Co.*, 400 F.3d 83, 89–90 (1st Cir. 2005); *Bolone v. TRW Sterling Plant Pension Plan*, 130 F. App'x 761, 766 (6th Cir. 2005); *Martin v. Blue Cross & Blue Shield of Va., Inc.*, 115 F.3d 1201, 1205 (4th Cir. 1997) *abrogated on other grounds by Williams v. Metro. Life Ins. Co.*, 609 F.3d 622, 634 (4th Cir. 2010); *Cagle v. Bruner*, 112 F.3d 1510, 1517 (11th Cir. 1997); *Wald v. S.W. Bell Corp. Customcare Med. Plan*, 83 F.3d 1002, 1006 (8th Cir. 1996); *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1321 (9th Cir. 1995), *overruled on other grounds by Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 966-67 (9th Cir. 2006) (en banc).

clearly." *Id.* at 333; *cf. Ruttenberg v. U.S. Life Ins. Co. in the City of N.Y.*, 413 F.3d 652, 659 (7th Cir. 2005) ("An employee must be told in clear terms that the administrator reserves the authority to construe terms in the plan.") (citing *Herzberger*, 205 F.3d at 333).

It is hard to imagine a more vivid contrast between views. In the Seventh Circuit's opinion, because the presence of a discretionary clause *vel non* in an ERISA plan determines "the very existence of [a beneficiary's] 'rights,'" such a clause may not be enforced unless the beneficiary has been given clear notice that any judicial challenge to a benefit denial would be subject to a deferential standard of review. *Herzberger*, 205 F.3d at 331. In the Second Circuit's view, in contrast, ERISA participants have no right to even be told of such a clause's existence; an SPD need not mention it (even though that, in itself, violates ERISA's requirement that beneficiaries be told of their "remedies" in the event of a benefit denial, *see* 29 U.S.C. § 1022); and a plan administrator's failure to disclose the clause is "of no consequence." Pet. App. 11. Especially in light of the overall importance of disclosure in ERISA's remedial framework, *see* infra at 26-27, this cannot and should not be the law.

2. That *Herzberger* involved different facts than this case does not render the decision below any less worthy of review. The Second Circuit attempted to dismiss *Herzberger* on the ground that it "did not in any way involve . . . a situation [where, as here] the plan language *did* unambiguously provide for discretion . . . but the employee seeking benefits had not received a copy of [any] document [containing

that language]." Pet. App. 10. That distinction is without a difference. In both cases, the courts' ultimate conclusions rested on fundamentally incompatible beliefs about whether ERISA participants have the right to be given clear notice that a discretionary standard of review will govern any judicial challenge to a denial of disability benefits. *Compare* Pet. App. 11 (an ERISA plan's reservation of discretion is "of no consequence" to beneficiaries because such a provision "is effectively addressed not to the beneficiary, but only to a reviewing court that must act only after an application has been denied."), *with Herzberger*, 205 F.3d at 333 (holding that, if a plan "is going to reserve a broad, unchanneled discretion to deny claims, [plan participants] should be told about this, and told clearly."); *see also Diaz v. Prudential Ins. Co. of Am.*, 424 F.3d 635, 637 (7th Cir. 2005) (explaining that the "critical question [in *Herzberger*] is notice").

In any event, the Second Circuit ultimately addressed and rejected *Herzberger* on its merits, holding that "to the extent . . . *Herzberger* could be read to require actual notice of the insurer's purported reservation of discretion, we cannot detect any basis in law or the statute to support this position." Pet. App. 10. This conclusion—that ERISA does not require that beneficiaries be given any notice of a plan's reservation of discretion—is directly at odds with the core reasoning of *Herzberger*.

Unless review is granted here, this conflict will persist and most likely deepen over the course of time. Of course, if discretionary clauses were

relatively unimportant in the overall ERISA scheme or to ERISA beneficiaries, review might not be warranted. As explained below, however, nothing could be further from the truth.

B. The Second Circuit's Ruling Is at Odds with ERISA's Disclosure Requirements and Contrary to the Interests of ERISA Beneficiaries.

Review is also warranted because the Second Circuit's ruling undermines ERISA's disclosure requirements and, if widely enforced, would have important negative implications for the thousands of ERISA beneficiaries who seek to challenge a benefit denial in a court of law.

1. There is no question that ERISA mandates full disclosure of plan participants' available remedies in the event of a decision to deny them benefits under their plan. ERISA requires that plans "be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). This "core functional requirement[]" ensures that "every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (internal citations omitted) (emphasis in original); *see also Firestone*, 489 U.S. at 118.

"ERISA gives effect to this 'written-plan-documents' scheme through a comprehensive set of 'reporting and disclosure' requirements." *Curtiss-Wright Corp.*, 514 U.S. at 83 (citing 29 U.S.C. §§ 1021-1031). One of these provisions requires that plan administrators periodically furnish beneficiaries

with a SPD, *see* 29 U.S.C. § 1024(b)(1), the purpose being "to reasonably apprise . . . participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a).

One of the "rights" that must be disclosed to participants is the right to seek judicial review of a Plan's denial of benefits. 29 C.F.R. § 2520.102-3(t)(2). Under § 502(a)(1)(B), a participant or beneficiary may file a denial-of-benefits claim in federal court, challenging a plan administrator's adverse benefit determination. This action "lies at the heart of [ERISA]," *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987), because it "protect[s] contractually defined benefits," *Firestone*, 489 U.S. at 113. In keeping with this observation, there is no dispute that SPDs must, at a minimum, disclose to participants that they have the right to seek judicial review in the event a claim for benefits "is denied or ignored." 29 C.F.R. § 2520.102-3(t)(2); *see also* 29 U.S.C. § 1022(b).

2. What *is* in dispute is whether SPDs must disclose the existence of a discretionary clause that would trigger a deferential standard of review. The Second Circuit reasoned that no such disclosure is required because (1) the statute does not mandate it; and, perhaps more importantly, (2) the existence of a discretionary clause is of "no consequence" to ERISA participants. Pet. App. 10-11. In so ruling, the lower court ignored that both ERISA and its implementing regulations require that participants be told of their "remedies" in the event of a benefit denial, and that the judicial standard of review is central to the most important remedy of all—the right to challenge a Plan's decision in court. *See Metro. Life Ins. Co.*, 481 U.S. at 65.

Indeed, a change in the standard of review from *de novo* to abuse-of-discretion represents a seismic shift in the actual benefits a participant or employee has under a plan. Under *de novo* review, "[an] administrator's decision is accorded no deference or presumption of correctness." *Hoover v. Provident Life & Accident Ins. Co.*, 290 F.3d 801, 808-09 (6th Cir. 2002). Under the deferential abuse-of-discretion standard, in contrast, a court may overturn an administrator's decision only if it is "without reason, unsupported by substantial evidence or erroneous as a matter of law." *Miller v. Am. Airlines, Inc.*, 632 F.3d 837, 845 (3d Cir. 2011) (citations and quotations omitted); *see also* Pet. App. 53 (applying the "extremely deferential standard").

It is no surprise that ERISA Plans fare better under the latter approach; that is the entire point of including a discretionary clause in the first place. An increased amount of discretion "opens up to the administrator administering the plan a greater range of permissible choices," which, in turn, "renders 'less solid' the participant's benefits by shifting risk to the participant." *Johnson v. Allsteel, Inc.*, 259 F.3d 885, 888 (7th Cir. 2001). For instance, an amendment that changes a plan's terms so that an event that once triggered a right to benefits now only triggers a right to benefits "in the administrator's discretion" makes it "less certain that the insured will be covered" when the event occurs. *Id.* The upshot is that a deferential standard of review dramatically advances the interests of

ERISA Plans at the expense of the rights of ERISA beneficiaries.[8]

No one seriously disputes this fact. After this Court decided *Firestone*, numerous ERISA Plans rushed to amend their plan documents to grant administrators discretionary authority with regard to benefit determinations. *See* Brendan Maher, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 Wis. L. Rev. 657, n.76 (2009). This alone testifies to the advantages a deferential standard of review confers on ERISA Plans. Since *Firestone* was decided, numerous commentators, both from academia and the judiciary, have noted the powerful impact the standard of review has on an ERISA beneficiary's odds of success in challenging a benefit denial.[9]

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[8] Empirical evidence bears this out. According to one study of disability cases from 1993 to 2003, under a *de novo* standard of review, patients/beneficiaries prevailed 68% of the time, whereas under an arbitrary and capricious standard, patients/beneficiaries won only 28% of the time. *See* Memorandum from Mila Kofman, Assistant Research Professor, Health Policy Inst., & Mark DeBofsky, Professor of Law, The John Marshall Law Sch., to the Comm'r of the Health Policy Inst., a*vailable at* http://www.erisa-claims.com/library/Georgetown%20Study.pdf.

[9] *See, e.g.*, Andrew Stumpff*, Darkness at Noon: Judicial Interpretation May Have Made Things Worse for Benefit Plan Participants Under ERISA Than Had the Statute Never Been Enacted*, 23 St. Thomas L. Rev. 221, 231 (2011) ("The judicial standard applied by a court in reviewing a plan administrator's decision is, not to belabor the obvious, important. Under the *Firestone* standard . . . a court may not overturn any decision, even a wrong one, unless the administrator's decision was so wrong as to have been 'arbitrary and capricious.'"); *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 983 (7th Cir. 1999) (Wood, J., dissenting) (noting that a

(*Footnote continued*)

Even the Second Circuit, despite its ruling here, has previously recognized the importance of the standard of review to ERISA beneficiaries. In *Gibbs v. CIGNA Corp.*, 440 F.3d 571, 577-78 (2d Cir. 2006), the Second Circuit refused to enforce a discretionary clause that was inserted via amendment into an ERISA plan on the ground that a deferential standard of review would "substantively diminish" a beneficiary's vested substantive rights. *Id.* Quoting *Herzberger*—the very case the lower court explicitly disavowed in this case—the *Gibbs* panel explained that "'[t]he very existence of 'rights' under [employee benefit plans] depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has and the more important it may be to him, therefore, to supplement his ERISA plan with other forms of insurance.'" *Id.* at 577 (quoting *Herzberger*, 205 F.3d at 331).

3. The point here—and the one that the Second Circuit failed to grasp *this* time around—is that because a deferential standard of review effectively changes the substantive nature of the benefits to which an employee is entitled, ERISA requires Plans to disclose such a change to its employees and participants. As the Seventh Circuit succinctly put it in *Herzberger*:

> An ERISA plan can stipulate for deferential review; it might be entirely rational for an

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deferential standard of review gives ERISA plan administrators "a uniquely privileged position in the entire field of administrative or quasi-administrative law").

> employee to accede to and even prefer such a plan—it might be cheaper.
>
> * * *
>
> [But] [a]n employer should not be allowed to get credit with its employees for having an ERISA plan that confers solid rights on them and later, when an employee seeks to enforce the right, pull a discretionary judicial review rabbit out of his hat.

205 F.3d at 332-33.

This is not to say that ERISA Plans should be stripped of their authority to insert such clauses in their plan documents. Petitioner's position is simply that, where a plan includes a discretionary clause, participants must be given notice that a judicial challenge to a benefits denial would be subject to a deferential standard of review. The importance of such notice is underscored by the fact that, under *Firestone*, the *default* standard of review is *de novo*: Deferential review is only triggered when an ERISA Plan changes the status quo by including a discretionary clause in a plan. *See* 489 U.S. at 115. That a discretionary clause changes the status quo in favor of ERISA Plans is all the more reason why such a provision should be disclosed to participants; it is, in a very real sense, a game-changer that profoundly affects the rights of all stakeholders.

Such disclosure, moreover, would not be difficult or complicated to insert into an SPD, and thus would not unduly burden ERISA plans or clutter SPDs with complicated legal gobbledygook. All that would be required is short statement to put participants on notice that a denial of benefits may only be

overturned upon a showing that the plan administrator abused its discretion. In any event, requiring such notice is the only rule that makes sense in light of ERISA's disclosure requirements and the fact that one of Congress's core goals in enacting ERISA was to "protect . . . the interests of participants in employee benefit plans . . . by providing for appropriate remedies . . . ." 29 U.S.C. § 1001(b); *see also Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996) (holding that one of ERISA's "basic purposes" is to "protect . . . the interests of participants . . . and beneficiaries").

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

August Term, 2012

(Argued: December 14, 2012 Decided: March 13, 2013)

Docket Nos. 12-370-cv (Lead), 12-521-cv (XAP)

SHARON THURBER,

Plaintiff-Counter-Defendant-Appellant-Cross-Appellee,

-v.-

AETNA LIFE INSURANCE COMPANY,

Defendant-Counter-Claimant-Appellee-Cross-Appellant,

QUEST DIAGNOSTICS, INCORPORATED WELFARE PLAN, AKA THE QUEST DIAGNOSTICS' AETNA LONGTERM DISABILITY BENEFIT PLAN, AKA THE QUEST DIAGNOSTICS' MANAGED DISABILITY BENEFITS PLAN, THE QUEST EMPLOYEE BENEFITS ADMINISTRATION COMMITTEE, AS PLAN ADMINISTRATOR,

Defendants-Appellees-Cross-Appellants.

Before:

WESLEY, HALL, LYNCH, *Circuit Judges*.

Plaintiff-Counter-Defendant-Appellant-Cross-Appellee Sharon Thurber appeals from a January 6, 2012 Decision and Order by the United States District Court for the Western District of New York (Skretny, *J.*) granting Defendant-Counter-Claimant-Appellee-Cross-Appellant Aetna Life Insurance Company's motion for summary judgment on the issue of whether the insurer improperly denied Thurber long-term disability benefits under ERISA. Thurber argues that the district court used the wrong standard of review and further erred by upholding Aetna's decision denying her long-term disability benefits. Because Aetna's reservation of discretion was sufficient to compel use of the arbitrary and capricious standard of review, we AFFIRM the district court's grant of summary judgment to Aetna on its denial of benefits.

Aetna cross-appeals the portion of the district court's Decision and Order denying Aetna's motion for summary judgment on its counterclaim for equitable restitution of overpaid short-term disability benefits. Aetna argues that the plan language gave it the right to seek reimbursement of overpaid benefits pursuant to 29 U.S.C. § 1132(a)(3). What qualifies as "appropriate equitable relief" under ERISA is an open question in this Circuit. We now hold that Aetna's action seeking return of overpaid benefits was properly brought under 29 U.S.C. § 1132(a)(3) as an equitable counterclaim. We REVERSE the district court's denial of summary judgment on the counterclaim.

AFFIRMED IN PART AND REVERSED IN PART.

LISA BALL (Christen Archer Pierrot, Andrew P. Fleming, *on the brief*) Chiacchia & Fleming, Hamburg, NY, *for Plaintiff-Counter-Defendant-Appellant-Cross-Appellee*.

MICHAEL H. BERNSTEIN (John T. Seybert, *on the brief*), Sedgwick LLP, New York, NY, *for Defendant-Counter-Claimant-Appellee-Cross-Appellant and Defendants-Appellees-Cross-Appellants*.

WESLEY, *Circuit Judge*:

Background

Sharon Thurber worked at Quest Diagnostics ("Quest") as a client services representative from 1993 through August 15, 2007. As a full-time Quest employee, Thurber was enrolled in Quest's Employee Retirement Income Security Act (ERISA) disability benefits plan, administered by Aetna Life Insurance Company ("Aetna"). Under the plan, Thurber was entitled to long-term disability benefits if a disabling condition rendered her unable to perform the material and substantial duties of her occupation. According to Thurber's supervisor, her position as a client services representative consisted of sitting for approximately 80% of her shift and alternately standing and walking a short distance for the remaining 20% of the time.

In 1983, Thurber broke both of her legs in a car accident; her right leg is shorter than her left leg as a

result. On or about August 17, 2007, Thurber was involved in another car accident, in which she hit a cement barrier twice while driving on the New York State Thruway. She has not worked since that accident. Aetna approved Thurber's initial claim for short-term disability benefits for "traumatic arthritis in both knees." She received short-term disability benefits for six months, ending on February 20, 2008.

Thurber then submitted a claim for long-term disability benefits. At this time, she informed Aetna that she had received "other income" in the form of no-fault insurance payments of $1,202.32 per month while receiving short-term disability benefits from Aetna. Under the plan, Aetna "may" reduce short- or long-term disability benefits if a beneficiary receives "Other Income Benefits," including no-fault insurance payments. (AR 198.) In addition, any "[i]ncome earned from a part-time return to work at Quest . . . will result in a reduction" of benefits. (*Id.*) The plan also authorizes Aetna to: (1) require the return of overpayments; (2) cease paying benefits until overpayments are recovered; (3) pursue legal action to recover overpayments; or (4) "[p]lace a lien . . . in the amount of the overpayment on the proceeds of any other income." (*Id.* at 201.)

In support of Thurber's claim for long-term disability benefits based on her "intermittent, unpredictable pain," Thurber's orthopedist, Dr. Michael T. Grant, completed a Capabilities and Limitations Worksheet ("CLW") in November 2007. Dr. Grant indicated

that Thurber could engage in occasional sitting and occasional walking, but not in standing, stooping, climbing, crawling, kneeling or twisting, among other limitations. In January 2008, Dr. Grant opined that Thurber "remains totally disabled" due to being "persistently symptomatic in regards to severe post-traumatic arthritis of her knees bilaterally." (*Id.* at 878.) Two months later, another of Thurber's physicians, Dr. Anthony J. Bianchi, completed a second CLW and found that Thurber could frequently (34%-66% of an eight-hour day) sit, stand and walk. Dr. Bianchi noted that Thurber was "still very symptomatic at times," but recommended that she "slowly work up to an 8 hour work day." (*Id.* at 916.)

Based on this information, Aetna denied Thurber's claim for long-term disability benefits on March 31, 2008. Aetna's denial letter summarized the medical reports provided by Thurber's doctors before concluding that the information did not demonstrate that Thurber was unable to perform the functions of her position as a client services representative. Aetna informed Thurber that she could submit any additional information she desired and gave a list of the types of tests and records that might prove helpful. Thurber appealed the denial of benefits in April 2008.

On April 28, 2008, Thurber underwent arthroscopic knee surgery, as suggested by Dr. Grant. Aetna then forwarded Thurber's claim file for an independent medical review by Dr. Lawrence Blumberg, a Board Certified orthopedic surgeon. Dr. Blumberg summarized the medical information provided by Thurber's

physicians, but his report wrongly attributed the March 3, 2008 CLW to Dr. Grant, rather than to Dr. Bianchi. Dr. Blumberg determined that "[i]n spite of claimant's subjective complaints, she has an adequate range of motion to perform sedentary activities," as required by her job, because "[t]here is no evidence that she cannot stand, sit, or ambulate." (*Id.* at 951.) In late May, Aetna denied Thurber's claim on appeal and upheld its original decision.

Although the internal appeals process offers only one level of review, Thurber requested reconsideration of her appeal. She subsequently submitted medical information regarding spinal problems in October 2008, specifically, the results of a static EMG scan. Aetna forwarded Thurber's claim file for two additional independent medical reviews, both conducted by Board Certified orthopedic surgeons. The second independent review physician, Dr. James Wallquist, reviewed Thurber's medical reports and correctly attributed the March 3, 2008 CLW to Dr. Bianchi. Both Dr. Wallquist and Dr. Leela Rangaswamy, Aetna's third independent review physician, concluded that Thurber was functionally impaired from the date of her arthroscopic surgery and for six weeks of recovery thereafter, but not during the periods prior or subsequent. On December 6, 2008, Aetna completed the re-review of its denial of Thurber's claim for benefits and re-affirmed its initial denial.

Thurber filed a complaint in the United States District Court for the Western District of New York (Skretny, *J.*) challenging Aetna's denial of benefits

under ERISA, 29 U.S.C. § 1132(a)(1)(B). Aetna counterclaimed for equitable restitution of $7,213.92 in overpaid plan benefits under 29 U.S.C. § 1132(a)(3). Aetna moved for summary judgment on Thurber's claim and its counterclaim. On January 6, 2012, the district court granted Aetna's motion for summary judgment with respect to Thurber's claims but denied and dismissed Aetna's counterclaim for lack of subject matter jurisdiction under ERISA because it was legal, rather than equitable, in nature.

Thurber appeals from the district court's grant of summary judgment to Aetna on Thurber's claim for disability benefits; Aetna cross-appeals from the district court's denial of its counterclaim.

Discussion

I. Standard of Review

Thurber argues that the district court should have reviewed her claim *de novo* because she allegedly never received the plan documents that clearly reserved Aetna's discretion to assess her eligibility for long-term disability benefits. We disagree.

When an ERISA plan participant challenges a denial of benefits, the proper standard of review is *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority" to assess a participant's eligibility. *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989). If the plan does reserve discretion, the denial is subject to arbitrary and

capricious review and will be overturned only if it is "'without reason, unsupported by substantial evidence or erroneous as a matter of law.'" *Kinstler v. First Reliance Standard Life Ins. Co.,* 181 F.3d 243, 249 (2d Cir. 1999) (quoting *Pagan v. NYNEX Pension Plan,* 52 F.3d 438, 442 (2d Cir. 1995)). Although we do not require the plan to employ any particular language to reserve discretion, the chosen words must clearly convey the administrator's intent. *See Nichols v. Prudential Ins. Co. of Am.,* 406 F.3d 98, 108 (2d Cir. 2005); *Kinstler,* 181 F.3d at 251-52.

Thurber conceded at oral argument that the plan itself and the Summary Plan Description ("SPD") both include language that is sufficient to reserve discretion to Aetna to assess participants' eligibility for benefits.[1] Thurber argues, however, that there is no evidence in the record showing that she actually received either of these plan documents and that, therefore, she cannot be bound by language contained therein. According to Thurber, the only plan document that she received (the "Booklet") does not clearly reserve discretion to Aetna.[2]

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[1] The plan provides Aetna with "discretionary authority to: determine whether and to what extent employees and beneficiaries are entitled to benefits." (AR 54.) Likewise, the SPD states that "[Aetna] has the discretionary authority to determine eligibility for benefits, decide claim appeals, and to interpret provisions of the plan." (*Id.* at 305.)

[2] The Booklet states that "[a] period of disability will be certified by Aetna if, and for only as long as, Aetna determines that you are disabled. . . ." (Doc. #40, Ex. A, 3.) Because we find that

(Continued on following page)

Thurber relies on the Seventh Circuit's decision in *Herzberger v. Standard Insurance Co.,* 205 F.3d 327 (7th Cir. 2000), for her assertion that she must have received actual notice of Aetna's reservation of discretion before Aetna's denial of benefits is entitled to deferential review. In *Herzberger,* the Seventh Circuit reversed and remanded two district court decisions granting summary judgment to plan administrators after the lower courts reviewed eligibility determinations under the arbitrary and capricious standard. *See id.* at 333. The court held that neither plan at issue clearly reserved discretion to the respective plan administrators. *Id.* The court's analysis rested fully on the language of the plan itself, and concluded that language that simply provided that the administrator had to determine eligibility did not imbue the administrator with discretion. *See id.* In explicating this holding, the court further noted that "[t]he employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly." *Id.*

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the plan's reservation of discretion to Aetna was sufficient regardless of whether Thurber had actual notice of the plan's language, we need not decide the controversial question of whether use of the word "determines" in the Booklet is clear enough to reserve discretion under *Firestone. See Fay v. Oxford Health Plan,* 287 F.3d 96, 104 (2d Cir. 2002); *cf. Nichols,* 406 F.3d at 108-09.

Contrary to Thurber's reading, the case did not in any way involve, and the court's language did not address, a situation in which the plan's language *did* unambiguously provide for discretion (as did the SPD), but the employee seeking benefits had not received a copy of either document. That a court will review benefits determinations *de novo* unless the plan documents clearly specify a reservation of discretion does not imply that such a reservation must be specifically conveyed to all members of the plan. In any event, to the extent that the language in *Herzberger* could be read to require actual notice of the insurer's purported reservation of discretion, we cannot detect any basis in law or the statute to support this position. Indeed, the Supreme Court's decision in *Firestone* merely establishes that review under the arbitrary and capricious standard will be inappropriate "unless *the benefit plan* gives the administrator or fiduciary discretionary authority to determine eligibility." 489 U.S. at 115 (emphasis added). *Firestone* says nothing about whether the SPD or other plan documents must contain language clearly reserving discretion – *Firestone* refers to the plan itself. Although plan participants are entitled to receive copies of the SPD, pursuant to 29 U.S.C. §§ 1021, 1022 and 1024, the administrator of an ERISA plan has no obligation to ensure that participants receive copies of the plan itself.

Thus, unless ERISA requires the SPD to contain language setting the standard of review, we see no reason why a plan administrator must actually notify

a participant of its reservation of discretion. ERISA contains no such edict. *See* 29 U.S.C. § 1022(b); 29 C.F.R. § 2520.102-3. Accordingly, to the extent that the Seventh Circuit has articulated an *actual* notice requirement, we disagree that ERISA imposes such an obligation on an insurer that endeavors to reserve discretion.

Here, the language contained in Aetna's plan and the SPD clearly reserves discretion to Aetna for determining participants' eligibility for disability benefits. That Thurber did not have actual notice of Aetna's reservation of discretion is of no consequence. There may be strong arguments that plan provisions that affect the basic terms of the plan, or ones that affect what an applicant must do to become eligible for benefits, should be conveyed directly to plan beneficiaries and not buried in a lengthy and technical contract. However, those arguments do not apply to a provision that is effectively addressed not to the beneficiary, but only to a reviewing court that must act only after an application has been denied. Moreover, a standard that focuses on the language of the plan raises a purely legal standard of review for all participants in the same plan. In contrast, an actual notice standard would make the standard of review different for each individual applicant, based on resolution by reviewing courts of factual disputes – which will frequently pit a participant's fallible and self-interested memory against a plan administrator's reliance on evidence of standard practice – about

whether the particular participant received a copy of the relevant documents.

As a result, we conclude that the district court correctly utilized the arbitrary and capricious standard of review. We review the district court's grant of summary judgment to Aetna *de novo, see Pagan,* 52 F.3d at 441, and thus will review Aetna's denial of long-term disability benefits under the same arbitrary and capricious standard properly used by the district court.

II. The Merits of Thurber's Claim for Benefits

Thurber makes several arguments on appeal for why Aetna acted arbitrarily and capriciously in denying her long-term disability benefits under the plan. Only some of these arguments have sufficient merit to require discussion. We agree with the district court that Aetna's determination of Thurber's eligibility for long-term benefits was supported by substantial evidence. Accordingly, we affirm the district court's grant of summary judgment to Aetna.

First, Thurber argues that Aetna failed to give enough weight to her subjective complaints of pain. Although subjective complaints "if found credible . . . could [be] legally sufficient evidence of disability," *Krizek v. Cigna Group Insurance,* 345 F.3d 91, 102 (2d Cir. 2003), we agree with the district court that Aetna gave sufficient attention to Thurber's subjective complaints of pain before determining that they were not supported by objective evidence. In Aetna's first

denial letter, the insurer "noted that [Thurber] complain[ed] of recurrent discomfort about the right knee." (AR 925.) In its May 2008 denial of benefits on appeal, Aetna commented that "Dr. Blumberg found that in spite of your subjective complaints, you had adequate range of motion to perform sedentary activities." (*Id.* at 947.) Finally, in Aetna's December 2008 final denial on re-review, the letter confirmed that "[t]he consultant noted that Ms. Thurber had had previous knee pain" and the consultant was aware that "[s]he claimed to have pain, stiffness, and 'fatiguability' " on June 10, 2008. (*Id.* at 1118.) Aetna did not abuse its discretion in concluding either that Thurber's subjective complaints of pain standing alone did not warrant finding her eligible for long-term disability benefits, or that objective evidence did not support finding otherwise.

Second, Thurber argues that Dr. Blumberg's error attributing the March 3, 2008 CLW to Dr. Grant, instead of to Dr. Bianchi, is a "critical mistake" because Dr. Blumberg "believed that Dr. Grant found Ms. Thurber to have improved." (Appellant's Br. at 65.) Even if Dr. Blumberg erroneously believed that Dr. Grant had authored the March 2008 CLW, his recommendation to Aetna was based on the substance of the report – which was the most recent CLW available at the time of his review. Moreover, after Dr. Blumberg's review and Aetna's denial of Thurber's appeal, Aetna retained two additional independent physicians to review Thurber's file and subsequently

affirmed its prior denial based on their (correct) reports.

Third, Thurber claims that Aetna did not give sufficient consideration to the total impact of the medical evidence she submitted to support her claim for disability benefits. As the district court correctly determined, the facts prove otherwise. Each of Aetna's three denial letters, along with the reports from three independent Board Certified physicians, explained why Aetna found Thurber's submissions to be insufficient. In addition, Thurber's claim that Aetna failed to credit the objective medical evidence she submitted regarding her neck and spinal problems also fails. Thurber's initial disability claim and all of the supporting documentation from her care providers up until the fall of 2008 focused on injuries to her knees caused by her August 2007 car accident in conjunction with her 1983 car accident. But, even if Thurber's claim extended beyond disabling knee pain, the third independent physician's review and Aetna's subsequent final denial letter both discuss the tests performed on Thurber's spine, demonstrating that Aetna did not arbitrarily ignore this evidence for purposes of assessing her eligibility for benefits.

We have considered Thurber's additional arguments that the rejection of her claim was arbitrary and capricious and find them without merit. We affirm the district court's conclusion that Aetna's eligibility determination was supported by substantial evidence.

III. Aetna's Counterclaim

Aetna brought a counterclaim seeking the return of overpaid short-term benefits pursuant to ERISA, 29 U.S.C. § 1132(a)(3), which authorizes civil actions brought "by a participant, beneficiary, or fiduciary . . . to obtain . . . appropriate equitable relief . . . to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). What qualifies as "appropriate equitable relief" is an issue that continues to perplex courts despite efforts by the Supreme Court during the past decade to shed some light on the matter. *See Sereboff v. Mid Atl. Med. Servs., Inc.,* 547 U.S. 356 (2006); *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002). Here, the district court determined that it did not have subject matter jurisdiction over Aetna's counterclaim because Aetna sought legal, rather than equitable, relief. Because we are convinced that Aetna's counterclaim seeking the return of overpaid benefits constituted an action for "appropriate equitable relief," we reverse.

The Supreme Court first tackled the question of whether 29 U.S.C. § 1132(a)(3) authorizes subrogation-like actions by insurers under an ERISA plan in *Great-West Life & Annuity Insurance Company v. Knudson.* There, the insurer paid approximately $350,000 for the participant's medical expenses under her husband's ERISA plan after a car accident. *See Knudson,* 534 U.S. at 207. The Knudsons subsequently settled their state court tort suit against the car manufacturer and other tortfeasors. *Id.* The state court approved the settlement and directed the

distribution of approximately $250,000 into a Special Needs Trust that, under California law, would provide for medical care. In addition, the state court allotted nearly $375,000 for attorney's fees and costs; $5,000 to reimburse the California Medicaid program; and approximately $14,000 "to satisfy" Great-West's claim. *Id.* at 207-08. Great-West received notice of the proposed settlement and, "calling itself a defendant," unsuccessfully attempted to remove the state action to federal court on the grounds that the state action "involved federal claims related to ERISA." *Id.* at 208.

Great-West simultaneously sought to block the state court settlement in federal court under 29 U.S.C. § 1132(a)(3), claiming that the plan's subrogation provision required the Knudsons to reimburse Great-West from any third-party payments for plan-covered expenses and precluded the state court from limiting Great-West's recovery to the past medical expenses portion of the settlement. The district court denied Great-West's request for a temporary restraining order and Great-West did not appeal. *Id.* The district court ultimately dismissed Great-West's action after the state court approved the settlement. *See id.*

The Ninth Circuit affirmed the dismissal of Great-West's claim, holding "that judicially decreed reimbursement for payments made to a beneficiary of an insurance plan by a third party is not equitable relief and is therefore not authorized" by the statute. *Id.* at 209. On appeal, the Supreme Court explained that it had previously determined that the statute provided only equitable and not legal remedies to

plan administrators to redress violations of the plan or to seek enforcement of plan provisions. *Id.* The Knudsons had not retained any moneys recovered in the state action as those funds were sequestered in the Special Needs Trust pursuant to the state court order. Consequently, Great-West was really trying to enforce its plan provision authorizing the imposition of personal liability if a beneficiary failed to reimburse the insurer after receiving a third-party settlement. *See id.* at 207, 210-12. The Supreme Court saw this as an action at law, for breach of contract, rather than an action at equity, to enjoin the Knudsons from violating the terms of the plan by failing to reimburse Great-West. "[F]or restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession." *Id.* at 214.

By contrast, in *Sereboff v. Mid Atlantic Medical Services, Inc.,* the insurer sought "specifically identifiable funds that were within the possession and control of the Sereboffs." 547 U.S. at 362-63 (internal quotation marks omitted). Like in *Knudson,* the plan participants in *Sereboff* were injured in a car accident and the insurer paid a sum of money, approximately $75,000, to cover medical expenses under their ERISA plan. *Id.* at 360. Subsequently, the Sereboffs settled a tort suit arising out of their accident. *Id.* Mid Atlantic brought an action under ERISA to enforce a plan provision requiring the beneficiary to reimburse the insurer from third-party recoveries. *Id.* The Sereboffs

agreed to set aside a sum of money from their settlement and put it into an investment account until the case had been decided. *Id.*

First, the Court determined that the *nature* of the relief desired in *Sereboff* was equitable because Mid Atlantic sought a specific portion (approximately $75,000) of specifically identified funds (the third-party recovery). *See id.* at 362-63. Second, the Court concluded that Mid Atlantic established that the *basis* for its claim was equitable. *See id.* at 363. The Court discussed the 1914 case (from the time of the divided bench) of *Barnes v. Alexander,* 232 U.S. 117 (1914), in which Justice Holmes described

> the familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing.

Sereboff, 547 U.S. at 363-64 (quoting *Barnes,* 232 U.S. at 121).

Because the Sereboffs' ERISA plan specifically identified a particular share of particular funds subject to return, Mid Atlantic "could rely on [this] familiar rul[e] of equity to collect for the medical bills it had paid." *Id.* at 364 (internal quotation marks omitted). "This rule allowed them to 'follow' a portion of the recovery 'into the [Sereboffs'] hands' 'as soon as [the settlement fund] was identified,' and impose on that portion a constructive trust or equitable lien." *Id.* (quoting *Barnes,* 232 U.S. at 123) (alterations in original). Moreover, the Supreme Court rebuffed the

Sereboffs' contention that Mid Atlantic needed to satisfy "strict tracing rules" before equitable relief was appropriate. *Id.* at 364-65. Instead, the Court confirmed that tracing rules have no import in the context of an equitable lien *by agreement. Id.* at 365.

The Court reached different results in *Knudson* and *Sereboff* because Great-West could not assert an equitable lien on settlement funds contained in a separate entity – the restrictive trust – while Mid Atlantic did not face a similar obstacle. The Sereboffs had possession and control over the specific funds sought by their insurer. As a result, the Court found that the Sereboffs held these funds in constructive trust for Mid Atlantic.

Here, the nature of Aetna's claim is equitable: the insurer seeks specific funds (overpayments resulting from Thurber's simultaneous receipt of no-fault insurance benefits and short-term disability benefits) in a specific amount (the total overpayment, $7,213.92) as authorized by the plan. These funds were entrusted to Thurber.

However, this case differs from *Sereboff* in two ways. First, the "particular fund" (from which Aetna seeks a specific portion of money) is not the actual third-party income Thurber received; instead, it is the benefits rendered overpayments as a result of Thurber's receipt of no-fault insurance benefits. Second, these overpayments have since dissipated. We do not believe either of these distinctions requires labeling Aetna's claim as one in law, though we recognize

the existence of a Circuit split on the issue. *Compare Funk v. CIGNA Grp. Ins.,* 648 F.3d 182, 194-95 (3d Cir. 2011) (finding that "dissipation of the funds [is] immaterial" if an equitable lien by agreement is in place), *and Cusson v. Liberty Life Assurance Co. of Boston,* 592 F.3d 215, 231 (1st Cir. 2010) (determining that an insurer need not identify a "specific account in which the funds are kept or prove[ ] that they are still in [the beneficiary's] possession"), *with Bilyeu v. Morgan Stanley Long Term Disability Plan,* 683 F.3d 1083, 1093-95 (9th Cir. 2012) (holding that "fiduciar[ies] must recover from specifically identified funds *in the beneficiary's possession*" (emphasis in original)).

With respect to the first distinction, Aetna seeks a specific portion (all) of a particular fund (the subset of disability benefits that became overpayments when Thurber received no-fault insurance benefits). Not surprisingly, these overpayments were not segregated from the total disability payments. The Ninth Circuit recently held that an action for the return of "overpaid long-term disability benefits" does not seek "a particular *fund,* but a specific amount of money encompassed *within* a particular fund – the long-term disability benefits [the insurer] paid to [the beneficiary]." *Bilyeu,* 683 F.3d at 1093 (emphases in original). But the beneficiary's literal segregation of funds is irrelevant when the terms of the ERISA plan "put [the beneficiary] on notice that she would be required to reimburse [the insurer] for an amount equal to

what she might get from" third-party sources. *Cusson,* 592 F.3d at 231.

We do not see a basis for distinguishing between certain "funds" identified by ERISA plans – i.e., between "third-party recoveries" and benefits that become "overpayments" as a result of third-party recoveries. Both constitute particular, identifiable sums over which an insurer may assert an equitable lien authorized by its plan. For this reason, we take issue with the Ninth Circuit's view that the "particular fund" (overpayments) sought lacks sufficient specificity by virtue of being an "undifferentiated component of a larger fund" (total benefits). *Bilyeu,* 683 F.3d at 1093.

Regarding the second distinction, Thurber argues that Aetna may not seek return of the overpayments under 29 U.S.C. § 1132(a)(3) because Thurber has spent the no-fault monies she was required under the plan to deliver to Aetna. This, Thurber argues, makes Aetna akin to a general creditor seeking a sum of money. The Third Circuit takes the position that if "there was an equitable lien by agreement that attached to the [third-party benefits] as soon as [the beneficiary] received it, dissipation of the funds [is] immaterial." *Funk,* 648 F.3d at 194. We believe that this strikes the right balance, and we therefore reject the Ninth Circuit's contrary view that insurers may not reach specifically identified assets that have dissipated. *See Bilyeu,* 683 F.3d at 1094-96. If the reason the insurer's claim is equitable is because it is seeking return of property over which it asserts a lien (the

overpayments), whether or not the beneficiary remains in possession of those particular dollars is not relevant as long as she was on notice that the funds under her control belonged to the insurer; she held the money in a constructive trust.

When an ERISA plan creates an equitable lien by agreement between the insurer and the beneficiary, the insurer's ownership of the overpaid funds is established regardless of whether the insurer can satisfy strict tracing rules. *See Sereboff,* 547 U.S. at 364-65; *Bilyeu,* 683 F.3d at 1102 (Rawlinson, *J.,* dissenting). In the context of an equitable lien by agreement, rather than an equitable lien sought as a matter of restitution, all that matters is that the beneficiary did, at some point, have possession and control of the specific portion of the particular fund sought by the insurer. *See Sereboff,* 547 U.S. at 364-65. This is not a case like *Knudson,* in which the beneficiaries never had possession or control of the funds identified for recovery (the settlement). Here, Thurber had possession and control of the overpaid benefits. That she spent the funds over which Aetna exerted an equitable lien is insufficient to void Aetna's right to enforce the plan's subrogation provision and the resulting equitable lien by agreement that Aetna entered into with Thurber.

The basis of Aetna's claim is equitable. The insurer seeks to enforce an equitable lien by agreement on its property – the overpaid funds that Thurber received. For this reason, Thurber's reliance on *Fehn v. Group Long Term Disability Plan for Employees of*

JP Morgan Chase Bank, No. 07 Civ. 8321(WCC), 2008 WL 2754069 (S.D.N.Y. June 30, 2008), is misplaced. In *Fehn,* the plaintiff received disability benefits that erroneously contained salary-continuation payments, for which the plaintiff was not eligible, resulting in a significant overpayment. 2008 WL 2754069, at *1. Unlike the insurer in *Sereboff,* because JP Morgan Chase paid the excess funds in error (believing that the plaintiff was entitled to salary-continuation benefits when, in fact, she was not), the company was asserting a contract claim for money paid by the plan in excess of its terms. It was not seeking recovery of funds held by the defendant that replicated proper plan payments from third parties.[3] *Id.* at *4. Thus, the action was legal, rather than equitable.

The district court's conclusion that it lacked subject matter jurisdiction over Aetna's counterclaim rested in part on its belief that the language contained in Aetna's SPD substantively differed from language in the plans at issue in *Sereboff* and *Cusson.* Aetna's SPD provides that the insurer "may" reduce benefits if a beneficiary receives other income, and "may" require the beneficiary to return any benefits subsequently rendered overpayments. The district court emphasized that the SPD's use of the word

[3] To the extent that the district court in *Fehn* rested its decision on the insurer's inability to "identify segregated funds in plaintiff's possession," 2008 WL 2754069, at *4, we disagree. *See supra* our discussion of *Cusson,* 592 F.3d at 230, and *Funk,* 648 F.3d at 194-95.

"may" "implies a discretionary act, not a conclusive right to the funds." According to the court, this converts Aetna's right to restitution of overpaid benefits into a contractual and legal right, rather than an equitable one. This strikes us as being overly formalistic.

In *Sereboff,* the plan's subrogation language specified the insurer's "right to recover any payments made to you or your dependent by a third party." *Mid Atl. Med. Servs., Inc. v. Sereboff,* 303 F. Supp. 2d 691, 698 (D. Md. 2004). In *Cusson,* the plan gave the insurer "the right to recovery of such overpayments" if a participant received an overpayment on her claim from any source. *Cusson,* 592 F.3d at 230. The district court here cited to these plans as "requir[ing]" beneficiaries to reimburse overpayments to their insurers. But whether the plan "requires" a participant to reimburse an insurer or "may[ ] [r]equire [the beneficiary] to return the overpayment," as one of four options the insurer "may" pursue, is an immaterial distinction. Under either scenario, reimbursement remains dependent on an act committed to the insurer's discretion, namely, requesting or suing for the return of its property. The insurer must still elect to assert its "right to recover." Or, it *may* opt not to pursue this right.

Likewise, a plan that "may" reduce payments if the beneficiary receives income from other sources adequately reserves the insurer's right to lessen the beneficiary's entitlement to benefits. Here, had Aetna been aware that Thurber was receiving no-fault

insurance income while Aetna was still paying short-term disability benefits, the insurer would have had the right to reduce its payments to Thurber, just as it now has the authority to seek return of those overpayments.

We are not persuaded that a different result is compelled by language in Aetna's SPD distinguishing between benefits that "may" be reduced following receipt of "Other Income Benefits" and benefits that "will" be reduced following receipt of income from a part-time return to work. Although we note that Aetna's decision to use two different phrases could signify a meaningful difference, we believe that the insurer's election here is sensible in light of the purpose behind disability benefits: supporting individuals who are unable to work by reason of their impairment. Receiving income from a part-time return to work undermines the very basis for receiving disability benefits; the benefits should never have been paid. Benefits that are overpaid by virtue of the beneficiary receiving additional payments from a third party simply render some portion of the ERISA benefits unnecessary after the fact. Because Aetna had the right to reduce Thurber's short-term disability benefits at the time she received them, Aetna now retains the right under its subrogation provision to compel return of the overpayments.

Thus, the language in Aetna's plan puts a beneficiary on notice that any overpayments she receives

belong to Aetna by virtue of an equitable lien by agreement.[4] That the participant takes immediate possession of the overpayments (and perhaps even keeps possession for a certain period of time) has no bearing on Aetna's right to the property nor on its ability to seek return of the overpayments. We note in closing that the distinction between claims based in law and those sounding in equity is often fine. In close cases, our inclination is to favor judicial efficiency by allowing ERISA insurers to bring responsive claims in ongoing federal actions, rather than forcing the parties to litigate two actions, one in federal court and one in state court, unnecessarily. Here, because we find that Aetna's plan established an equitable lien by agreement, we hold that Aetna presented a claim for "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3) over which the district court had subject matter jurisdiction. We therefore reverse the district court's dismissal of Aetna's counterclaim and remand to the district court with instructions to enter judgment in favor of Aetna.

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[4] Although Thurber did not raise this point in connection with Aetna's counterclaim, even if she never received the SPD, Thurber admitted to possessing the Booklet containing the following language: "[o]ther income benefits . . . will reduce the benefit actually payable." (Doc. #40, Ex. A, 5.)

Conclusion

For the foregoing reasons, the order of the district court is hereby AFFIRMED IN PART and REVERSED IN PART.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

SHARON THURBER,

Plaintiff,

v.

AETNA INSURANCE COMPANY, QUEST DIAGNOSTICS, INCORPORATED WELFARE PLAN (also known as the Quest Diagnostics' Aetna Long-Term Disability Benefit Plan, and also known as The Quest Diagnostics' Managed Disability Benefits Plan), and THE QUEST EMPLOYEE BENEFITS ADMINISTRATION COMMITTEE, as Plan Administrator,

Defendants.

DECISION AND ORDER
09-CV-279S

I. INTRODUCTION

Plaintiff, Sharon Thurber, brings this action seeking declaratory relief concerning her eligibility for long-term disability ("LTD") benefits under the Quest Diagnostics Long-Term Disability Plan (the "Plan"), which is sponsored by her former employer Quest Diagnostics, Inc. ("Quest") and which is governed by 29 U.S.C. §§ 1001, *et seq.*, the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is fully insured by Defendant Aetna Life Insurance Company ("Aetna"). There are presently four motions before this Court: (1) Defendants' Motion for Summary

Judgment (Docket No. 28); (2) Thurber's Motion to Strike the Affidavits of Deborah Laughran and Carole Roy (Docket No. 37); (3) Defendants' Motion to Strike the Affidavit and attached exhibits of Thurber's counsel, Christen Archer Pierrot (Docket No. 50); and (4) Thurber's Motion for Leave to Supplement the Record (Docket No. 53). For the following reasons, both motions to strike are denied, Thurber's motion for leave to supplement is granted, and Defendants' motion for summary judgment is granted with respect to Thurber's claims and denied with respect to its counterclaims.

II. BACKGROUND[1]

A. Facts

Thurber worked at Quest from 1993 to August 15, 2007 as a client services representative. (AR 883.) In this position, Thurber's duties included reporting client concerns, printing, mailing, answering phones, reporting laboratory results, and general clerical work. (AR 883, 863.) In 1983, Thurber was involved in a severe car accident in which she broke both her legs. (AR 965.) As a result of the breaks, her right leg became almost two inches shorter than her left leg. (AR 965.) On August 17, 2007, Thurber was involved in another car accident that damaged and exacerbated

[1] "AR" citations refer to pages of the Administrative Record, which is attached as Exhibits "A" and "B" to the Affidavit of Carole M. Roy.

the previous damage to her knees. She applied for disability benefits on the same day, reporting that she suffered "traumatic arthritis in both knees." (AR 721.) After submitting the proper documentation, her application for short-term disability benefits was granted and she received those benefits for six months, from August 2007 until February 20, 2008. (AR 738, 741, 744.)

After that date, to retain her benefits, Thurber was required to apply for LTD benefits and submit a LTD claim questionnaire. Therein, she stated that she suffered from "intermittent and unpredictable" knee pain. Her claim was assigned to claims specialist Malinda High who reviewed her file, which included office notes from Thurber's orthopedist, Dr. Michael T. Grant, and her chiropractor, Anthony J. Bianchi, D.C. (AR 739, 744.) In his September 14, 2007 Attending Physician Statement, Dr. Grant diagnosed Thurber with degenerative arthritis and noted that her knee "gives out" and is prone to swelling and that she has difficulty walking. (AR 854-856.) Dr. Grant also completed a Capabilities and Limitations Worksheet ("CLW") in which he checked boxes indicating that Thurber could not stand, stoop, kneel, crawl, push, reach above her shoulders, reach forward, bend, carry or twist, but that she could occasionally sit and walk. (AR 866.)

On November 16, 2007, Nurse Sharon Whitaker from Aetna spoke with Thurber's supervisor at Quest, Paul Pilarski, regarding Thurber's job requirements. (AR 730.) He informed Whitaker that her job consisted of sitting for 80% of the day, while the other 20%

required her to be "up and down," walking to a room approximately fifty feet away. (AR 730.) Although the job required no lifting, he noted that it did require her to alternate standing and sitting for approximately 12 hours per week. (AR 730.) However, when told that Thurber's CLW permitted no standing, he stated that indeed the job did not require her to stand. Finally, he informed Nurse Whitaker that Quest would work to accommodate Thurber's needs. (AR 732.)

Dr. Grant also provided Malinda High the results of an evaluation performed on February 2, 2008, where he found the following: (1) she complained of recurrent discomfort around the right knee; (2) she suffered from severe post-traumatic arthritis of her knees with bone-on-bone articulation of the medial joint space and varum[2] deformity; (3) she suffered from a small effusion[3] on both her knees; (5) her right knee range of motion was from 2 to approximately 120 degrees, with no instability; (6) her left knee range of motion was from 0 to approximately 125 degrees with no instability; (7) she walks with a cane; and (8) she remains totally disabled. (AR 911-912).

Dr. Bianchi also completed a CLW, in which he marked boxes indicating that Thurber could occasionally (defined in the CLW as 1%-33% of an eight-hour work day) kneel, lift, and carry and that she

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[2] Varum: angled inward; bowleg. http://www.merriam-webster.com/dictionary/varus

[3] Effusion: Increased fluid. http://www.mayoclinic.com/health/water-on-the-knee/DS00662

could frequently (defined as 34%-66% of an eight-hour work day) stand, sit or walk. (AR 916.) He suggested that Thurber's symptoms required further care, but that she could "slowly work up to an 8[-]hour work day." (AR 916.)

Based primarily on this report, Aetna denied Thurber's LTD claim. (AR 746.)

By letter dated April 5, 2008, Thurber appealed Aetna's decision and notified Aetna that she was scheduled for surgery on April 28, 2008. (AR 933.) To bolster her appeal, Dr. Bianchi submitted office visit notes and a letter advising Aetna that Thurber is unable to work and that she should remain out of work until her surgery. (AR 930-931, 939-941.) Thurber also submitted SOAP[4] notes from her message therapist indicting that Thurber experienced pain and swelling. (AR 943.)

In early May, 2008, Aetna forwarded Thurber's claim to Lawrence Blumberg, M.D., a Board Certified orthopedic surgeon, for review. (AR 949-952.) Dr. Blumberg tried to contact Dr. Grant, but was advised that he does not conduct "peer-to-peers." (AR 951.) After reviewing her file, including, *inter alia,* the aforementioned office notes from Drs. Grant and Bianchi, Dr. Grant's Attending Physician Statement, and Dr. Bianchi's letter, he found that there was not enough

[4] SOAP is an acronym standing for "Subjective," "Objective," "Assessment," and "Plan."

evidence to conclude that she was unable to perform the core duties of her occupation and that any opinion that she was not able to work was "not reasonable or appropriate based on clinical documentation provided." (AR 949-952.)[5]

Based in part on these findings, Carole Roy, Thurber's appeal specialist, concluded that Thurber was not disabled under the terms of the Plan and denied her appeal. (AR 754.)

Although this exhausted her appeal rights under the Plan, Thurber requested a reconsideration of Aetna's decision. (AR 963-965.) In support of her request, Thurber submitted more medical information, including: (1) a letter from Dr. Grant dated May 6, 2008 demonstrating that Thurber underwent arthrosporic knee surgery seven days earlier, that her range of motion after the surgery was "limited and tender", that the surgery went well, and that her surgical wounds were healing nicely (AR 955); (2) a letter dated June 10, 2008, in which Dr. Grant noted that Thurber uses a cane to walk, that she can flex her leg to 125 degrees, and that she remains disabled from work (AR 960); (3) office notes from Dr. Melvin Mangulabnan, M.D., Thurber's primary care physician (AR 971-975); (4) office notes from Dr. Carlos Martinez, M.D., a rheumatologist, dated November 27, 2007 and April 22, 2008, in which he notes that

[5] In his review, Dr. Blumberg mistakenly attributes Dr. Bianchi's CLW to Dr. Grant. (AR 950.)

Thurber was experiencing pain in her knee, but later that she was active and well, noting that he found no swelling in either knee (AR 982-984).

On August 1, 2008, Aetna informed Thurber that her additional information had been received and that it was referring her file to Dr. James Wallquist, M.D., a Board Certified Surgeon, to conduct a second independent review. (AR 540-541.) He concluded that Thurber was functionally impaired for several weeks after her surgery (April 28, 2008 through June 10, 2008), but that she was not impaired either before her surgery (February 21, 2008 through April 27, 2008) or after she healed from the surgery (June 11, 2008 to the date of his review). (AR 1127-1128.)

Yet, this did not complete Thurber's appeal. Now with the assistance of counsel, Thurber submitted more medical documentation. On October 20, 2008, Thurber forwarded the results of a "Spinal Screening Examination" and a thermal scan conducted by Dr. Bianchi. (AR 1000-1007.) These tests demonstrated that Thurber had asymmetries in the vertebrae of her spine. (AR 1004-1007.) She also submitted a Magnetic Resonance Imaging ("MRI") report that showed disc dessication at several vertebrae. (AR 1019.)

On October 30, 2008 Thurber underwent a Functional Capacity Evaluation ("FCE"), which was conducted by Occupational Therapist Mary Orrange. After several tests, Orrange concluded that Thurber "does not qualify for sedentary physical demand level work." (AR 1030.)

Thurber also supplied Aetna with additional office notes from Dr. Grant, which continued to state that Thurber was totally disabled. (AR 1037.)

On December 4, 2008, upon Aenta's request, Dr. Leila Rangaswamy conducted a third independent review. She pointed out that after the April 2008 surgery, Dr. Grant documented that Thurber had regained full range of motion of the knee. (AR 1123.) She also noted that "there are no functional examination findings suggesting that the claimants ability to work has been impacted by an adverse medical effect during the time period in question." (AR 1123.) In sum, she found that the documentation failed to support a finding of functional impairment.

Relying on these opinions, Carole Roy upheld Aetna's previous decision to deny her claim. (AR 767.)

III. DISCUSSION

A. Summary Judgment Standard[6]

Rule 56 of the Federal Rules of Civil Procedure provides that "[t]he court shall grant summary judgment

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[6] "Although there is no right to a jury trial in a suit brought to recover ERISA benefits," *see, e.g., Tischmann v. ITT/Sheraton Corp.*, 145 F.3d 561, 568 (2d Cir.1998), and thus this Court would be the fact-finder at trial, "the district court's task on a summary judgment motion – even in a nonjury case – is to determine whether genuine issues of material fact exist for trial, not to make findings of fact." *O'Hara v. National Union Fire Ins. Co. of Pittsburgh, PA*, 642 F.3d 110, 116 (2d Cir. 2011).

if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." A fact is "material" only if it "might affect the outcome of the suit under governing law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S. Ct. 2505, 2510, 91 L. Ed. 2d 202 (1986). A "genuine" dispute exists "if the evidence is such that a reasonable jury could return a verdict for the non-moving party." *Id.* In determining whether a genuine dispute regarding a material fact exists, the evidence and the inferences drawn from the evidence "must be viewed in the light most favorable to the party opposing the motion." *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 158-59, 90 S. Ct. 1598, 1609, 26 L. Ed. 2d 142 (1970) (internal quotations and citation omitted).

"Only when reasonable minds could not differ as to the import of evidence is summary judgment proper." *Bryant v. Maffucci*, 923 F.2d 979, 982 (2d Cir. 1991) (citation omitted). Indeed, "[i]f, as to the issue on which summary judgment is sought, there is any evidence in the record from which a reasonable inference could be drawn in favor of the opposing party, summary judgment is improper." *Sec. Ins. Co. of Hartford v. Old Dominion Freight Line, Inc.*, 391 F.3d 77, 82-83 (2d Cir. 2004) (citations omitted). The function of the court is not "to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson*, 477 U.S. at 249.

"Summary judgment provides an appropriate mechanism for a court to consider a challenge to the termination of disability benefits under ERISA." *See Alfano v. CIGNA Life Ins. Co. of New York*, No. 07 Civ. 9661, 2009 WL 222351, at *12 (S.D.N.Y. Jan. 30, 2009) (collecting cases). "In such an action 'the contours guiding the court's disposition of the summary judgment motion are necessarily shaped through the application of the substantive law of ERISA.'" *Id.* (quoting *Ludwig v. NYNEX Serv. Co.*, 838 F. Supp. 769, 780 (S.D.N.Y.1993)).

B. Affidavits of Laughran and Roy

Thurber objects to the Laughran and Roy affidavits and seeks to strike them from the record because neither individual was specifically identified in Defendants' initial disclosures pursuant to Federal Rule of Procedure ("Fed. R. Civ. P.") 26. Instead, Defendants' responded:

> Pursuant to applicable ERISA law, the Court's review is limited to the Administrative Record, produced herewith, and Defendants rely on the Administrative Record to support its [sic] claims and defenses that its [sic] decision was not arbitrary and capricious. At this time, other than the parties herein, their agents, servants, and/or employees and those persons identified in the claim file, Defendants know of not [sic] other witnesses regarding

> the within occurrence. Defendants reserve the right to supplement this response.

(Notice of Motion to Strike ¶ 3; Docket No. 38.)

Thurber argues that she was prejudiced when both Laughran and Roy submitted affidavits because the information contained therein – Defendants' actions to avoid conflict of interest issues – was not apart of the administrative record, and if she were aware of that information, she would have engaged in further discovery. She seeks to strike these affidavits under Fed. R. Civ. P. 37(c)(1) or, in the alternative, to engage in further discovery pursuant to Fed R. Civ. P. 56(d) (formerly Fed. R. Civ. P. 56(f) (2009)).

There is no dispute that both Laughran and Roy were, at all times relevant, employees of a party to the litigation, namely Aetna. Defendants response was clear, stating that they were unaware of any parties "*other than the parties herein,* their agents, servants, and or *employees,* and those persons identified in the claim file." (Emphasis added). Thurber concedes that discovery is permissible even in ERISA litigation. Yet, at no time during the discovery period, which ended on February 16, 2010 (Docket No. 15), did Thurber seek discovery or move this Court to compel more specific disclosures. Only now, after a summary judgment motion has been filed, does Thurber seek relief. This, she cannot do. *See Schnur v. CTC Commc'ns Corp. Grp. Disability Plan*, No. 05 Civ. 3297, 2010 WL 1253481, at *10, n. 12 (S.D.N.Y. Mar. 29, 2010) ("If Plaintiff believed that Defendants

did not live up to their discovery obligations, she should have sought Court intervention during discovery, not at this late stage of the proceedings."). Having missed the deadline to conduct discovery, and providing no justifiable reason for doing so, this Court will not impose such a strict form of relief as completely striking Defendants' affidavits from the record.

For substantially the same reasons, Thurber fails to demonstrate that she is entitled to relief under Fed R. Civ. P. 56(d). Under Rule 56(d), if the party opposing summary judgment "shows by affidavit or declaration that, for specific reasons, it cannot present facts essential to justify its opposition, the court may: (1) defer considering the motion or deny it; (2) allow time to obtain affidavits or declaration or to take discovery; or (3) issue any other appropriate order." Fed. R. Civ. P. 56(d). To obtain such relief, the nonmoving party must show: "(1) what facts are sought [to resist the motion] and how they are to be obtained, (2) how those facts are reasonably expected to create a genuine issue of material fact, (3) what effort affiant has made to obtain them, and (4) why the affiant was unsuccessful in those efforts." *Miller v. Wolpoff & Abramson, LLP.*, 321 F.3d 292, 303 (2d Cir. 2003) (alteration in original). The grant of relief pursuant to Rule 56(d) is within the discretion of the district court. *See United States v. Private Sanitation Indus. Ass'n of Nassau/Suffolk, Inc.*, 995 F.2d 375 (2d Cir. 1993).

As an initial matter, the facts sought are not "essential to justify [Thurber's] opposition." Rather, it appears that Thurber merely seeks to question the veracity of the statements submitted by Roy and Laughran. Moreover, the information contained in the affidavits simply relate to one element, among many, that a court should consider in ERISA suits. But more importantly, because Thurber does not demonstrate why she declined to conduct any discovery, much less why those efforts were unsuccessful, she has failed the third and fourth prongs of the analysis.

Finally, notwithstanding the discovery dispute, the Laughran and Roy affidavits are properly before this Court on a summary judgment motion. Recognizing the long-standing doctrine limiting review of ERISA claims to the administrative record, this Court finds the doctrine inapplicable here. *See Daniel v. UnumProvident Corp.*, 261 Fed. Appx. 316, 318 (2d Cir. 2008) ("[T]his concern is not implicated in cases where the extraneous evidence being offered goes to a question that was not, or could not have been, under consideration by the plan administrator."). As in *Daniel*, the information contained in the affidavits is unrelated to the merits of Thurber's disability claim; rather the affidavits are submitted in an effort to demonstrate that Defendants instituted protections against potential bias. As such, the reason behind the doctrine – to prevent federal courts from becoming "substitute plan administrators" – vanishes. *See id.* Thurber's motion to strike the affidavits is consequently denied.

C. Thurber's Motion to Supplement and Defendants' Motion to Strike

Both of these motions concern paragraphs 3 to 6 and exhibits "A" and "B" of the Pierrot Affirmation, which themselves concern Plan documents that Thurber purports to have received from Defendants.[7] Defendants seek to strike these portions of the affirmation arguing that they are based on hearsay, outside of the administrative record, and irrelevant. Thurber seeks to supplement those submissions with affidavits to meet evidentiary requirements. Because this Court finds that any violations based on hearsay were harmless and subsequently corrected though Thurber's affidavit (Docket No. 53-4), and because this Court will find that the affirmation and attached exhibits do not affect the outcome of this case, Thurber's motion is granted while Defendants' motion is denied.

D. Standards of Review of the Plan Administrator's Decision

Thurber's claims in this action fall under the ERISA provision that permits a participant or beneficiary of an employee benefit plan to commence a civil lawsuit "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.

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[7] *See* p. 12, *infra,* for a description of these documents and an explanation of their relevancy.

§ 1132(a)(1)(B). ERISA "permits a person denied benefits under an employee benefit plan to challenge that denial in federal court." *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 108, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) (citing 29 U.S.C. § 1132(a)(1)(B)). A plaintiff challenging the denial of benefits under an ERISA plan bears the burden of proving, by a preponderance of the evidence, that she is "totally disabled" within the meaning of the plan. *Paese v. Hartford Life Accident Ins. Co.*, 449 F.3d 435, 441 (2d Cir. 2006).

Courts review a plan administrator's decision to terminate benefits "under a *de novo* standard unless the benefit plan gives the administrator . . . discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Glenn*, 554 U.S. at 123-24 (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 956-57, 103 L. Ed. 2d 80 (1989)). If the benefit plan vests the plan administrator with discretionary authority, the denial of benefits is subject to a deferential standard of review. *Glenn*, 554 U.S. at 111. Under the deferential standard, a court may not overturn the administrator's denial of benefits unless its actions are found to be arbitrary and capricious. *Pagan v. Nynex Pension Plan*, 52 F.3d 438, 441 (2d Cir. 1995) ("Where the written plan documents confer upon a plan administrator the discretionary authority to determine eligibility, we will not disturb the administrator's ultimate conclusion unless it is 'arbitrary and capricious.'"). "[T]he party claiming deferential review should prove

the predicate that justifies it." *Sharkey v. Ultramar*, 70 F.3d 226, 230 (2d Cir.1995).

Thurber claims that the only Plan documents that she received from Quest in the course of her employment do not grant the Plan administrator discretion to deny her benefits. (Thurber Affidavit ¶¶ 3-6; Docket No. 53-4.) She further claims that she was never made aware of such discretion and therefore Defendants' decision should be reviewed *de novo.* (*Id.* ¶ 7.) Predictably, the Plan documents submitted and authenticated by Defendants unequivocally grant themselves this discretion. Specifically, page 54 of the Administrative Record provides, *inter alia,* that "Aetna shall have discretionary authority to: determine whether and to what extent employees and beneficiaries are entitled to benefits." (AR 54.)

Thurber claims that this document is illegitimate. She argues that the "form and format" on this document is different than the document that was provided in initial disclosures. However, these discrepancies appear to be the result of a printing and software error. (*See* Seybert Declaration; Docket No. 47.) Notably, she does not argue that the substance is different in any significant way. Her remaining arguments calling into question the legitimacy of the document are based on conjecture and are unsupported by legal foundation. In sum, no reasonable fact-finder could credit Thurber's unfounded claim.

Second, even assuming that this section of the Administrative Record – granting Aetna discretionary authority – was fabricated or never disclosed to Thurber, the documents in Thurber's possession sufficiently vest Aetna with the discretion to determine benefit eligibility. Specifically, these documents (Exhibits "A" and "B" of the Pierrot Affirmation) state that "a period of disability will be *certified by Aetna if, and for only as long as, Aetna determines that you are disabled.*" (Pierrot Affidavit, Exhibit A, p. 3; Docket No. 40-2.) This sentence is located at the very top of the page and under the heading "Managed Disability Coverage." This is not an isolated example: the documents provided by Thurber are littered with references to the requirement that Aetna must certify the disability. Although Defendants bear the burden of proof on this issue, such language sufficiently conveys to Thurber that Aetna will have discretion to decide claims for disability. *See Jordan v. Ret. Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1271 (2d Cir. 1995) (magic words such as "discretion" and "deference" may not be necessary to avoid a *de novo* standard of review); *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 622 (2d Cir. 2008) ("A reservation of discretion need not actually use the words 'discretion' or 'deference' to be effective, but it must be clear. Examples of such clear language include authorization . . . to make benefits determinations 'in our judgment.'"); *Fay v. Oxford Health Plan*, 287 F.3d 96, 104 (2d Cir. 2002) (concluding that the benefit plan "invoke[d] discretion by defining 'Medically Necessary' as those services which, '*as*

determined by [the] . . . Medical Director,' meet four listed requirements") (emphasis and second alteration in original). Accordingly, this Court must evaluate Defendants' decision denying Thurber's claim under the arbitrary and capricious standard of review. *See Glenn*, 554 U.S. at 111; *Pagan*, 52 F.3d at 441.

1. Arbitrary and Capricious Standard

The arbitrary and capricious standard of review is narrow, and constitutes the "least demanding form of judicial review of administrative action." *Seff v. NOITU Trust Fund*, 781 F. Supp. 1037, 1040 (S.D.N.Y. 1992). Courts must examine whether the decision came as a result of a considered judgment of the relevant factors, and whether there is a "rational connection between the facts found and the choice made." *Healix Healthcare, Inc. v. Metrahealth Ins. Co.*, No. 97 Civ. 6838, 1999 WL 61832, at *1 (S.D.N.Y. Feb. 10, 1999) (quoting *Bowman Transp. v. Arkansas-Best Freight Sys.*, 419 U.S. 281, 285-86, 95 S. Ct. 438, 440-42, 42 L. Ed. 2d 447 (1974)).

The arbitrary and capricious standard is highly deferential to the plan administrator: "The court may not upset a reasonable interpretation by the administrator." *Jordan*, 46 F.3d at 1271 (2d Cir. 1995). This deferential review "applies to both plan interpretation and factual determinations." *Dorato v. Blue Cross of W.N.Y., Inc.*, 163 F. Supp. 2d 203, 209 (W.D.N.Y. 2001) (citing *Kinstler v. First Reliance*

Standard Life Ins. Co., 181 F.3d 243, 251 (2d Cir. 1999)). As such, "it is inappropriate . . . for the trial judge to substitute his judgment for that of the plan administrator." *Bella v. Metro. Life Ins. Co.*, No. 98-CV-150, 1999 WL 782132, at *5 (W.D.N.Y. Sept. 30, 1999).

Accordingly, the decision to deny benefits "may be overturned only if the decision is 'without reason, unsupported by substantial evidence or erroneous as a matter of law.'" *Kinstler*, 181 F.3d at 249 (quoting *Pagan*, 52 F.3d at 442); *Dorato*, 163 F. Supp. 2d at 209. "Substantial evidence is such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the administrator and requires more than a scintilla but less than a preponderance." *Durakovic v. Bldg. Serv. 32 BJ Pension Fund*, 609 F.3d 133, 141 (2d Cir. 2010) (quoting *Celardo v. GNY Auto. Dealers Health & Welfare Trust*, 318 F.3d 142, 146 (2d Cir. 2003)). In reviewing the administrator's decision, "district courts may consider only the evidence that the fiduciaries themselves considered." *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071(2d Cir. 1995).

E. Defendants' Motion for Summary Judgment on Thurber's Claim

Defendants argue that Thurber did not meet her burden in demonstrating that she was disabled in a manner precluding her from performing her job. They argue that objective evidence in the record does not

support her subjective complaints of pain or her treating physicians' determinations that she is unable to work.

Thurber believes that this conclusion was arbitrary and capricious. She makes several arguments in this regard: (1) Aetna was biased as both the Plan insurer and decision-maker under the Plan; (2) Aetna arbitrarily reversed its own decision that granted her STD benefits; (3) Aetna disregarded medical evidence such as the EMG and thermal scan reports while improperly selecting out-of-context excerpts to support their determination; and (4) Aetna never requested an Independent Medical Examination ("IME").

Despite Plaintiff's concerns, it is not this Court's task to engage in an *ad hoc* weighing of the evidence or to substitute its judgment for that of the administrator. Instead, this Court must only determine if any genuine issue of material fact exists that could render Defendants' decision arbitrary and capricious. Unquestionably, some factual disputes exist, particularly between Thurber's treating physicians and the peer review physicians, but these disputes must create a genuine issue that the Plan administrator's determination was arbitrary and capricious. They do not.

Because the pivotal question is whether Thurber was too disabled to properly perform the functions of her job, those functions play a significant role in Aetna's and this Court's decision. Thurber was a client service representative. According to her own description, she was required to answer phones, work the

switchboard, and mail and print reports. In performing these tasks, she was required to use a computer, copiers, and fax machines. According to her supervisor, she sat for 80% of the day. Despite Thurber's attempt to argue to the contrary, her job could properly be described as "sedentary." Her disability must be analyzed in that light.

In initially denying Thurber's claim, Aetna relied on office notes from Drs. Bianchi and Grant and Dr. Bianchi's CLW. Although Dr. Grant noted that she suffered from post-traumatic arthritis, he also found that she had a wide range of motion and only a small effusion. In his CLW, Dr. Bianchi remarked that she could slowly work up to an 8-hour workday and added that she might need some rest or breaks if necessary. Significantly, Dr. Bianchi noted that Thurber could both sit and stand "frequently." Relying on what is, at best, the ambivalent nature of these findings, and the lack of objective medical evidence, it was not "without reason" for Aetna to deny her claim. Although Dr. Grant took a contrary view, and is convinced that Thurber's disability prevents work, the Plan administrator is not required to "accord any special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003).

On appeal, there is no dispute that Thurber was given ample opportunity to submit documentation of her disability. In fact, Thurber was granted several extensions and two additional reviews, which were not required under the Plan. Reviewing each of these submissions, three physicians unanimously agreed that her disability did not prevent her from work. This demonstrates a "rational connection between the facts found and the choice made." *See Healix Healthcare*, 1999 WL 61832, at *1; *see also Hobson v. Metro. Life Ins. Co.*, 574 F.3d 75, 90 (2d Cir. 2009) ("[Defendant] did not abuse its discretion by considering these trained physicians' opinions solely because they were selected, and presumably compensated, by [defendant]."); accord *McDonald v. W.-S. Life Ins. Co.*, 347 F.3d 161, 169 (6th Cir. 2003) ("Generally, when a plan administrator chooses to rely upon the medical opinion of one doctor over that of another in determining whether a claimant is entitled to ERISA benefits, the plan administrator's decision cannot be said to have been arbitrary and capricious because it would be possible to offer a reasoned explanation, based upon the evidence, for the plan administrator's decision.").

Of course, Thurber points to evidence in the record that suggests otherwise. But the evidence is not so compelling such that a reasonable fact-finder could call Aetna's decision arbitrary and capricious.

Massage Therapist Fahey's SOAP notes reveal only that Thurber experienced pain. Dr. Martinez found her right knee "not swollen and unremarkable" and her left knee "not swollen." Dr. Bianchi submitted a one-sentence letter stating that he felt Thurber could not work, but provided no foundation for this claim, which appears to contradict, at least in part, his earlier findings. Thurber claims that this letter "clarified" his earlier findings. If anything, such a hasty, unsubstantiated conclusion only serves to confuse them.

Thurber also emphasizes Dr. Blumberg's mistaken attribution of Dr. Bianchi's CLW to Dr. Grant. Yet, regardless of whether Dr. Blumberg actually believed that Dr. Grant prepared the CLW or if it was simply an oversight, the substance of the CLW, no matter who prepared it, remains the same – Thurber could frequently sit and stand, which is all her job required.

Perhaps Thurber's most persuasive evidence comes from the FCE performed on October 30, 2008. Occupational Therapist Orrange conducted a series of tests and found that Thurber did not "demonstrate the ability to perform at a sedentary physical demand level work of work [sic]." However, Orrange also found only "moderate limitations" in the pertinent areas of walking, balance, and static sitting. The only "activities to be avoided" were lifting, carrying, crawling, low level postures, and step-ladder climbing. Orrange checked boxes that indicated Thurber should

only sit for 6%-33% of an 8-hour workday, but instead of recommending that she should limit this activity, as she did for static standing, or state that sitting is "not safe," as she did with step-ladder climbing, she merely suggested that Thurber frequently change her position when sitting.

Again, given this conflicting report – in which Orrange concludes that Thurber cannot work, but finds only moderate limitations in the activities associated with her job – it was not unreasonable for Aetna to disagree with Orrange's ultimate conclusion, especially in light of the contrary opinion from Dr. Rangaswamy, who reviewed the FCE. *See Lekperic v. Bldg. Serv. 32B-J Health Fund*, No. 02 CV 5726, 2004 WL 1638170, at *4 (E.D.N.Y. July 23, 2004) ("The mere existence of conflicting evidence does not render the . . . decision arbitrary or capricious.").

Thurber also questions Aetna's decision declining to order an IME. Yet, with little objective evidence in the record supporting Thurber's claim, this Court finds that this decision does not create a triable issue of fact. *See Hobson*, 574 F.3d at 91 ("However, as the four circuits that have addressed the question have concluded, where the ERISA plan administrator retains the discretion to interpret the terms of its plan, the administrator may elect not to conduct an IME, particularly where the claimant's medical

evidence on its face fails to establish that she is disabled.").[8, 9, 10]

Finally, this Court finds that whatever conflict of interest under which Aetna operates as both Plan administrator and Plan insurer, does not tip the scales in Thurber's favor. In *Glenn*, the Supreme Court instructed that such a conflict should "be weighed as a factor in determining whether there is an abuse of discretion." 554 U.S. at 116 (quoting *Firestone*, 489

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[8] Thurber also claims that Aetna's decision was arbitrary and capricious because it did not consider her spinal irregularities. First, there is little support in the record demonstrating that her spinal problems prevented her from performing her job. Second, she did not raise this concern until eight months after her claim for LTD benefits was originally denied. In fact, this concern is not found in her original STD claim, her original LTD claim, or her Complaint. Finally, Dr. Bianchi, her chiropractor, did not mention any spinal problems. Accordingly, this is not a genuine issue of material fact.

[9] This Court has also considered what Thurber calls Aetna's conflicting decision to grant her STD benefits but deny her LTD benefits. But based on the totality of the evidence in the record, summarized above, its determination, although different from its initial judgment (made directly after Thurber was in a car accident), was not arbitrary and capricious. *See Fitzpatrick v. Bayer Corp.*, No. 04 Civ. 5134, 2008 WL 169318, at *9 (S.D.N.Y. Jan. 17, 2008) ("There is nothing in the caselaw suggesting that the burden of proof shifts to the Defendants if the Plaintiff previously received benefits").

[10] Nor does the record indicate that Thurber was not given a full and fair review, as Thurber asserts. To the contrary, she was granted two additional reviews and was permitted to submit a series documents and extend several deadlines. This claim is without merit.

U.S. at 115) (internal quotation marks omitted.) The Court further noted that an insurer may be able to reduce or eliminate a conflict by taking steps like Aetna took here. *See Glenn*, 554 U.S. at 117-18. Namely, by "walling-off" its claims department from its financial department, which Aetna did. *See id.*; (Laughran Declaration ¶ 15.) Aetna also maintains a separate appeals unit distinct from both the claims unit and the underwriters department. (Laughran Declaration ¶ 15.) Lastly, the Court instructed that such a conflict will "act as a tiebreaker when the other factors are closely balanced." *Glenn*, 554 U.S. at 117. Because this Court finds that other factors are not closely balanced, there is no tie to break, and thus the conflict-of-interest factor plays an insignificant role.

Under the extremely deferential standard that this Court must apply, there is no reason to disturb Defendants' decision. Defendants' medical reviewers considered the submitted medical evidence and provided Thurber ample opportunity to submit additional evidence in support of her claim. The Plan vests Defendants with the discretion to determine, based on the evidence submitted, whether a claimant is entitled to benefits. Defendants exercised that discretion in this case, and there is a valid and rational basis in the administrative record for their conclusion that Thurber's ailments did not prevent her from performing the essential functions of her sedentary occupation. As such, this Court finds that there is no genuine issue of material fact that could render Defendants' decision arbitrary and capricious.

F. Defendants' Motion for Summary Judgment on their Counterclaim[11]

The Plan provides that any STD benefits may be offset by "other income," including no-fault wage replacement benefits. (AR 198.) In completing a questionnaire entitled "Other Income," signed February 8, 2008, Thurber indicated that she received $1,202.32 monthly, starting August 16, 2007, from no-fault automobile insurance coverage. Because Thurber never remitted these funds to Defendants, they bring a counterclaim under Section 502(a)(3)(B) of ERISA asserting that Thurber owes them a total of $7,213.92 ($1202.32 per month from August 2007 to February 2008, when her STD benefits expired) in equitable restitution from the no-fault benefits.

Thurber argues that this Court does not have subject matter jurisdiction over Defendants' counterclaim under Section 502(a)(3)(B) of ERISA, which authorizes a civil action by a "participant, beneficiary, or fiduciary . . . to obtain other appropriate equitable relief." 29 U.S.C. § 1132(a)(3). Thurber argues that the counterclaim is not equitable, but legal, rendering it improper under this section.

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[11] No deferential standard of review applies to Defendants' counterclaim. *See Kellner v. First Unum Life Ins. Co.*, 589 F. Supp. 2d 291, 313 (S.D.N.Y. 2008) ("Although Defendant's benefits determinations must be reviewed deferentially, [Defendant] is entitled to no such deference with respect to its counterclaim.").

In support of this contention, Thurber relies on *Fehn v. Group Long-Term Disability Plan for Emps. of J.P. Morgan Chase Bank*, No. 07 Civ. 8321 (WCC), 2008 WL 2754069, (S.D.N.Y. June 30, 2008). There, citing two relevant Supreme Court decisions, the court found that the defendant/ERISA plan-insurer could not recover funds improperly paid to the plaintiff because the money was not limited to a segregated fund. *Id.* at *4. Like Thurber in this case, whatever money the defendant had mistakenly paid to the plaintiff was "dissipated" and thus the court found that the claim sought to impose personal liability, not equitable relief. *Id.* at *3 ("[W]here the property or its proceeds 'have been dissipated so that no product remains,' the plaintiff's claim is that of a general creditor" (quoting *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213, 122 S. Ct. 708, 151 L. Ed. 2d 535 (2002).)).

Defendants distinguish this case by noting that Thurber was on notice that other income benefits would be subject to recoupment and points out that they were not aware of the overpayment until Thurber applied for LTD benefits. In support of this contention, they rely on *Cusson v. Liberty Assurance Co. of Boston*, 592 F.3d 215, 231 (1st Cir. 2010), which addressed the question of overpayment relating to Social Security benefits. There, the court found that although the defendant/ERISA plan-insurer had "not identified a specific account in which the funds are kept," the claim to recoup overpayment of benefits was still equitable because the plan put the

plaintiff/beneficiary "on notice that she would be required to reimburse" the plan insurer for any overpayment. *Id.* at 231.

Yet, in determining whether such relief is equitable or legal, these arguments miss a more fundamental tenant. Restitution in equity is only available where the money in question can be identified as "belonging in good conscience to the plaintiff." *Knudson*, 534 U.S. at 213. Here, contrarily, the money does not "belong" to Aetna. Instead, the Plan simply states, "[y]our STD and LTD benefits may be reduced if you receive Other Income Benefits while you are disabled." (AR 198). Thus, the plain language of the Plan, which Aetna claims gives it an equitable right to funds already disbursed, in fact only states that benefits "*may* be *reduced*." "May" implies a discretionary act, not a conclusive right to the funds. "Reduced" implies that the funds will be limited before disbursement, not that funds must later be returned. Although not relied on by Aetna, three pages later, under the heading "Recovery of Overpayments," the Plan authorizes Aetna to require repayment: "If payments are made in an amount greater than the benefits you are entitled to receive, the [P]lan *may* require you to return the overpayment within thirty (30) days." (AR 201; emphasis added.) Notwithstanding the temporal limitation, the Plan does not explicitly bind the Plan participant to reimburse overpaid funds, but simply grants Aetna the ability to seek the funds. Conversely, in all the plans in the cases relied on by Defendants, each explicitly granted the plan

insurers a right to the funds themselves. *See Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 126 S. Ct. 1869, 164 L. Ed. 2d 612 (2006) ("[The plan] *requires* a beneficiary who 'receives benefits' under the plan for such injuries to 'reimburse [defendant/plan insurer'] for those benefits from '[a]ll recoveries from a third party.'" (Emphasis added; second alteration in original)); *Cusson*, 592 F.3d at 231 (finding that the plan made clear that the plan participant "would be *required* to reimburse [plan insurer] for an amount equal to what she might get from Social Security"); *Fedderwitz v. Metro. Life Ins. Co. Inc.'s Disability Unit*, No. 05 CV 10193(BSJ)(HP), 2007 WL 2846365, at *11 (S.D.N.Y. Sept. 27, 2007) ("[Plan participant] does not contest the fact that he signed an Agreement to Reimburse Overpayment of Long Term Disability Benefits."). Defendants may have a contractual and legal right to exercise their option to seek recovery of the allegedly overpaid funds; but because the Plan only reserves them the right to act, not a right to the funds themselves, they do not have an equitable claim. Accordingly, § 502(a)(3) does not authorize this counterclaim and Defendants' motion for summary judgment is denied.

Although Defendants' couch their counterclaim under § 502(a)(3), to the extent that they seek relief under state contract law, having disposed of all federal claims and because jurisdiction was founded on 29 U.S.C. 1132(e), this Court declines to exercise supplemental jurisdiction under 28 U.S.C. 1367(c).

IV. CONCLUSION

For the foregoing reasons, this Court finds that no genuine issue of material fact exists as to whether Defendants acted arbitrarily and capriciously in denying Plaintiff LTD benefits. Additionally, Defendants' counterclaim seeks legal, not equitable relief and thus this Court lacks subject matter jurisdiction under 29 U.S.C. § 1132(a)(3). Accordingly, Defendants' Motion for Summary Judgment is granted with respect to Plaintiff's claims and denied with respect to its Counterclaim.

V. ORDERS

IT HEREBY IS ORDERED, that Plaintiff's Motion for Leave to Supplement Plaintiff's Opposition (Docket No. 53) is GRANTED.

FURTHER, that Plaintiff's Motion to Strike (Docket No. 37) is DENIED.

FURTHER, that Defendants' Motion to Strike (Docket No. 50) is DENIED.

FURTHER, that Defendants' Motion for Summary Judgment (Docket No. 28) is GRANTED in part and DENIED in part.

FURTHER, that the Clerk of the Court is directed to close this case.

SO ORDERED.

Dated: December 30, 2011
Buffalo, New York

/s/William M. Skretny
WILLIAM SKRETNEY
Chief Judge
United States District Court

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

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SHARON THURBER,

Plaintiff,

-against-

AETNA LIFE INSURANCE COMPANY, QUEST DIAGNOSTICS, INCORPORATED WELFARE PLAN (also known as the Quest Diagnostics' Aetna Long-Term Disability Benefit Plan, and also known as The Quest Diagnostics' Managed Disability Benefits Plan), and THE QUEST EMPLOYEE BENEFITS ADMINISTRATION COMMITTEE, as Plan Administrator,

Defendants.

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Civil Action No.: 09-CV-0279(WMS)(LGF)

DECLARATION OF CAROLE ROY

DOCUMENT ELECTRONICALLY FILED

CAROLE M. ROY, pursuant to 28 U.S.C. §1746(2) declares under penalty of perjury the following:

1. I am currently employed by Aetna Life Insurance Company ("Aetna") as an Appeal Specialist in the Appeals Unit. I am fully familiar with Aetna's procedures concerning the review of long-term disability benefit claims. I was personally involved in

the review of Sharon Thurber's ("Thurber") long-term disability ("LTD") claim on Thurber's first and second administrative appeals, which included review of the applicable plan documents and the administrative record.

2. This Declaration is respectfully submitted in support of Aetna's motion for summary judgment.

3. A true and correct copy of the document setting forth the terms and conditions of the applicable group LTD policy for the Plan sponsored Quest Diagnostics Incorporated ("Quest") and issued by Aetna, identified by policy number GP-699840-A, which is maintained by Aetna in the normal and ordinary course of business, and which was reviewed by me in connection with Thurber's claim, Bates Stamped Thurber 000001 through Thurber 000331, is annexed hereto as **Exhibit "A."**

* * *

I declare under penalty of perjury that the foregoing is true and correct.

Dated: February 15, 2010

/s/ Carol M. Roy
CAROL M. ROY

Aetna Life Insurance Company
151 Farmington Avenue
Connecticut 06156
860-273-0123

Group Policy No. GP-699840 (Connecticut) originally effective September 1, 1986 is *rewritten* to Group Policy No. GP-699840 (Delaware), effective January 1, 2005.

Policyholder No. 662626

Group Life and Accident and Health Insurance Policy

a contract between

Aetna Life Insurance Company
(A Stock Company herein called Aetna)

and

Quest Diagnostics Incorporated
(Policyholder)

Policy Number: GP-699840-A

Date of issue: January 1, 2005

To take effect: January 1, 2005

Policy delivered in: Delaware

This policy will be construed in line with the law of the jurisdiction in which it is delivered.

Based on timely premium payments by the Policyholder, Aetna agrees with the Policyholder, to pay benefits in line with the policy terms.

The duties and the rights of all persons will be based solely on policy terms. This policy is nonparticipating.

Signed at Aetna's Home Office in Hartford, Connecticut on the date of issue.

/s/ Ronald M. Williams
President

Registrar

* * *

Social Security Disability

If you are receiving LTD benefit payments, you are required to apply for Social Security Disability. If you fail to apply or to provide a copy of your application or award letter, Aetna reserves the right to suspend or adjust your benefits by the estimated amount of your award (including the estimated amount of any dependent award).

Reduction in Benefits

Your STD and LTD benefits may be reduced if you receive Other Income Benefits while you are disabled. The reduction is computed as a percent of your predisability earnings, which is then reduced by any other income benefits.

Income earned from a part-time return to work at Quest Diagnostics or earnings received while on an approved rehab program will result in a reduction of the disability benefit.

Other Income Benefits

Other Income Benefits include:

- Awards provided under The Railroad Retirement Act, The Jones Act or The Maritime Doctrine;
- Disability, retirement or unemployment benefits required or provided for under government law, such as benefits under Social Security, Canadian Pension Plan, Quebec Pension Plan, Workers' Compensation Benefits, Unemployment Compensation Benefits, automobile no-fault wage replacement benefits to the extent required by law, Veterans' Benefits;
- Statutory short-term disability benefits;
- Disability or unemployment benefits under:
  - any group insurance plan;
  - any other type of coverage for persons in a group. This includes both plans that are insured and those that are not;
- Retirement benefits paid to the employee by the employer/disability sponsor to the extent that benefits have been funded by the employer;
- Group mortgage or group credit disability plans;

- Disability payments which result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources;
- Benefits due to your disability or retirement, which are payable to: you; your spouse; your children; your dependents.

Proof of Other Income Benefits:

Aetna has the right to require documentation for proof of other income. In addition, for purposes of Federal Social Security, when a timely application for benefits has been made and denied, a request for reconsideration must be made within 60 days after the denial, unless Aetna states, in writing, that it does not require you to do so. Also, if the reconsideration is denied, an application for a hearing before an administrative Law Judge must be made within 60 days of that denial unless Aetna relieves you of that obligation.

You do not have to apply for:

- retirement benefits paid only on a reduced basis; or
- disability benefits under group life insurance if they would reduce the amount of group life insurance;

but, if you do apply for and receive these benefits, they will be deemed to be other income benefits for which proof is required.

If you do not wish to furnish proof of your application or your receipt of other income benefits, this Plan reserves the right to suspend or adjust benefits by the estimated amount of such other income benefits.

Other Income Benefits
Which Do Not Reduce Benefits

The amount of any retirement or disability benefits you were receiving from the following sources before the date a certified period of disability started will not reduce your benefits:

- military and other government service pensions;
- retirement benefits from a prior employer; and
- veterans' benefits for service related disabilities;
- individual disability income policies; and
- Federal Social Security Act.

Also, the amount of any income or other benefits you receive from the following sources will not reduce your benefits:

- profit sharing plans;
- thrift or savings plans;
- 401(k) plans;
- Keough plans;
- employee stock option plans;
- tax shelter annuity plans;

- severance pay;
- individual disability income policies; or
- individual retirement accounts (IRAs).

Recovery of Overpayments

If payments are made in amounts greater than the benefits you are entitled to receive, the plan may:

- Require you to return the overpayment within thirty (30) days;
- Stop payment of benefits until the overpayment is recovered;
- Take legal action, if necessary, to recover the overpayment and any legal fees incurred; or
- Place a lien, if not prohibited by state law, in the amount of the overpayment on the proceeds of any other income.

* * *