No. ______

In the Supreme Court of the United States

SUN LIFE & HEALTH INSURANCE COMPANY,
a Connecticut corporation,
Petitioner,

v.

R. JEFFREY EVANS,
Respondent.

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

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

This petition presents a question of importance under the Employee Retirement Income Security Act of 1974 ("ERISA"). In *Conkright v. Frommert*, 559 U.S. 506 (2010), the Court held that it is the primary responsibility of the designated fiduciary to make benefit determinations and that a prior erroneous decision will not divest an administrator of its discretionary authority to interpret the terms of the plan and to make benefit determinations. Multiple circuits have agreed and recognized that a federal court may not substitute itself for the plan fiduciary on issues not previously addressed as part of the prior claim determination. The Ninth Circuit, now joining one other circuit, permits a court to make claim decisions and interpret ERISA plan terms without giving the claim administrator the first opportunity to do so. The decision below, results in a 4 to 2 circuit split on the question presented, putting claim administrators in the position of having to conduct otherwise prohibited discovery and putting courts in the role of substitute claim administrators, usurping the discretionary authority of ERISA fiduciaries and making benefit determinations.

The question presented here is whether a decision by a court that the administrator's initial decision was mistaken permits the court to make determinations in the first instance on claim issues the plan previously had no reason to address or whether the court is required to remand the claim to the plan for an initial determination on those issues.

PARTIES TO THE PROCEEDINGS BELOW

Petitioner here, and defendant/appellant below, is Sun Life and Health Insurance Company. Respondent here and plaintiff/appellee below is R. Jeffrey Evans.

CORPORATE DISCLOSURE STATEMENT

Sun Life and Health Insurance Company is a subsidiary of Sun Life Financial, Inc.

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OPINIONS BELOW

The opinion of the Ninth Circuit in this case (App. 1) is unreported. The district court's memorandum of decision (App. 11) is also unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 22, 2015. App. 9. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 503 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1133, provides in relevant part that:

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

STATEMENT OF THE CASE

The question presented by this petition involves the extent to which a federal court is permitted under ERISA to make eligibility determinations without an underlying decision by the administrator. To better

understand the issue, general background information relevant to the question will be provided followed by the procedural history of this case.

A. ERISA Administrative Review Procedures

1. While the dispute in this case concerns a claim for welfare benefits, ERISA also governs most pension plans. 29 U.S.C. § 1002(3). Accordingly, the issue presented in this petition has far-reaching implications on all types of employer-sponsored benefit plans.

In enacting ERISA, Congress sought "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). Therefore, applying trust law, this Court has long recognized that when the administrator is delegated discretionary authority, its decisions must be reviewed under a deferential arbitrary and capricious judicial standard of review. *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 (1989). *See also, Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105, (2008). In *Glenn*, the Court held that this deference to the administrator's decisions must be followed regardless of whether the administrator acts under a conflict of interest.

In *Conkright*, the Court rejected the argument of plaintiffs that the administrator lost its right to make the benefit decision and in turn deference based on a prior violation of ERISA. *Conkright*, 559 U.S. at 507. The Court recognized that the position of the plaintiffs

would be contrary to the goals of ERISA, including predictability of results. *Id*.

The primary role of the administrator in administering claims under ERISA was further highlighted in *Conkright* when the Court explained that the district court improperly "act[ed] as a substitute trustee," by stripping the administrator of the deference owed under the terms of the plan. *Id*. at 515 (quoting *Eaton v. Eaton,* 82 N.H. 216, 218, 132 A. 10, 11 (1926)). *See also Perry v. Simplicity Eng'g,* 900 F.2d 963, 966 (6th Cir.1990) (noting that nothing "in the legislative history suggests that Congress intended that federal district courts would function as substitute plan administrators").

Implicit in all of the decisions recognizing the importance of discretionary review is that the administrator must make an initial claim determination before a court may address a plan-related dispute. By making eligibility decisions in the first instance, the court in this case substituted itself for the administrator, contrary to the goals of ERISA.

2. The necessity of the administrator making the initial benefit decision is also reflected in the exhaustion doctrine which is widely recognized under ERISA and applies under both de novo and deferential review.[1] According to this rule, a claimant cannot seek

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[1] *See e.g. Terry v. Bayer Corp*., 145 F.3d 28, 36 (1st Cir. 1998); *Kennedy v. Empire Blue Cross & Blue Shield,* 989 F.2d 588, 594 (2d Cir. 1993); *D'Amico v. CBS Corp*., 297 F.3d 287, 291 (3d Cir. 2002); *Makar v. Health Care Corp*., 872 F.2d 80, 82 (4th Cir. 1989); *Swanson v. Hearst Corp. Long Term Disability Plan*, 586 F.3d 1016, 1018 (5th Cir. 2009); *Ravencraft v. Unum Life Ins. Co. of*

judicial review of a disputed benefit until all administrative avenues of review have been exhausted. A significant purpose behind the exhaustion requirement is to fully develop the administrative record prior to judicial review. *Kennedy*, 989 F.2d at 594; *Hall v. Nat'l Gypsum Co.*, 105 F.3d 225, 231 (5th Cir. 1997). The lack of administrative review in this case led the court to award benefits in a manner contrary to the language in the Plan.

B. Factual Background

Respondent R. Jeffrey Evans, an attorney, sought long term disability benefits under his employer's welfare benefit plan based on a "mental breakdown." App. 11. The plan is funded by a policy of insurance issued by Sun Life. App. 11. Sun Life also serves as claims administrator for benefits. The policy sets forth the eligibility requirements for receipt of benefits under the plan. To qualify for benefits a claimant must prove the existence of a total disability continuously lasting during the 180-day elimination period which begins when the claimant stops working. App. 12.

Sun Life denied the benefit claim after concluding that Mr. Evans was not totally disabled during the entire elimination period. App. 11. Mr. Evans appealed

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Am., 212 F.3d 341, 343 (6th Cir. 2000); *Schorsch v. Reliance Standard Life Ins. Co.*, 693 F.3d 734, 739 (7th Cir. 2012); *Brown v. J.B. Hunt Trans. Servs., Inc.*, 586 F.3d 1079, 1085 (8th Cir. 2009); *Diaz v. United Agric. Emp. Welfare Benefit Plan*, 50 F.3d 1478, 1483 (9th Cir. 1995); *Salisbury v. Hartford Life & Acc. Ins. Co.*, 583 F.3d 1245 (10th Cir. 2009); *Perrino v. Bell Tel & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000); *Boivin v. U.S. Airways,* 446 F.3d 148, 158 (D.C.Cir.2006).

the decision and Sun Life upheld the denial of benefits during the administrative appeal. App. 20. As such, no benefits were paid to Mr. Evans prior to the filing of the lawsuit.

C. Proceedings Below

Mr. Evans filed his lawsuit against Sun Life under 29 U.S.C. § 1132(a)(1)(B). App. 21. Section 1132(a)(1)(B) of ERISA authorizes, in part, a participant or beneficiary to file a lawsuit "to recover benefits due to him under the terms of his plan." *Id*.

After the submission of trial briefs and responsive trial briefs, a bench trial was conducted by the district court. App. 4. The trial consisted of argument addressing the contents of the record assembled during the administrative review of Mr. Evans' claim. Brief of Appellant at 9, Sun Life and Health Insurance Company (March 24, 2014) (No. 13-55601) ("Sun Life's C.A. Brief"). After reviewing the submissions, the district court decided that Sun Life abused its discretion "when it determined that Mr. Evans failed to demonstrate that he was disabled prior to being terminated from his job and continuously disabled during a 180 day 'elimination period.'" App. 11.

At the request of the district court, Mr. Evans submitted a proposed judgment in which he requested the maximum twenty-four months of benefits available under the plan for a mental illness disability claim for a total award of $217,068. App. 5. In opposing the proposed judgment, Sun Life explained that the claim needed to be remanded to it as claims administrator to gather necessary claim information. Sun Life's C.A. Brief at 12.

Before judgment was entered in the district court, Sun Life learned that Mr. Evans returned to work with a major Los Angeles law firm during a significant portion of the time he claimed to be totally disabled and for which he asked the district court to award disability benefits. App. 6. Sun Life explained to the court that this information was relevant not only to whether Mr. Evans was eligible to receive the full twenty-four months of disability benefits but also the calculation of benefits based on several plan terms. App. 6-7.

The only issue decided by Sun Life and for which there was an administrative record was whether the claimant remained disabled and satisfied the plan's 180-day elimination period. There was no administrative record on whether Mr. Evans remained totally disabled for twenty-four months following the elimination period, whether he was under the continuous care of a physician for the entire time he was claiming benefits, or the amount of benefits he would have been entitled to receive taking into consideration any salary continuation, severance or other earnings he received during the claimed benefit period, all of which are required under the plan. Sun Life's C.A. Brief at 44-45.

Determining whether a person satisfied the terms of the plan is a highly fact sensitive process uniquely within the expertise of the claim administrator, requiring extensive investigation. Because Sun Life determined that the claimant did not satisfy the plan's initial eligibility requirements, issues surrounding whether there was a continuing disability and the amount of any benefits were never investigated or decided during the administrative review process.

Therefore, there was no administrative record on any income Mr. Evans received while claiming disability, a fact essential to calculating benefits under the plan.

Further explaining the need for a remand, Sun Life pointed out that while Mr. Evans was asking for benefits through May 31, 2010, the most recent medical report in the administrative record was from December 2008. Sun Life's C.A. Brief at 44. Therefore, there was no evidence on which the district court could conclude that Mr. Evans remained totally disabled or under the continuous care of a physician for eighteen of the twenty-four months for which he claimed benefits.

Notwithstanding the lack of an administrative record or a decision by Sun Life, the district court refused to remand the claim to the administrator to investigate the extent of the claimant's employment, his earnings and whether there were any medical records supporting an award of benefits for the entire twenty-four months. App. 7. The court instead ordered Sun Life to pay the full twenty-four months of benefits without consideration of potential reductions along with a substantial fee award. App. 7, Sun Life's C.A. Brief at 15.

Sun Life timely appealed the district court decision. App. 7. In the appeal, Sun Life argued relevant to this petition that the judgment was contrary to several plan terms.[2] Sun Life's C.A. Brief at 49-50. Also, because the

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[2] In addition to the question presented in this petition, Sun Life raised numerous other arguments in its appeal before the Ninth Circuit, including the district court's failure to properly apply the law, its refusal to apply the terms of the plan and its refusal to

court made plan eligibility decisions that Sun Life never had an opportunity to address, the district court impermissibly acted as "substitute plan administrator." Sun Life's C.A. Brief at 51. In support of its position, Sun Life cited to *Lemons v. Reliance Standard Life Ins. Co*., 534 Fed.Appx. 162 (3d Cir. 2013), where the Third Circuit upheld the district court's refusal to address the amount of benefits owed because the only issue before the court was whether the denial was arbitrary and capricious. Sun Life's C.A. Brief at 51.

On April 22, 2015, in a single page decision, the Ninth Circuit affirmed the decision of the district court. Responding to the numerous arguments supporting remand of the claim to the administrator to consider the plan terms and new evidence, the Ninth Circuit merely stated that the arguments were "unsupported." App. 1.

REASONS FOR GRANTING THE WRIT

There is currently a divide among a number of the circuits on whether a court may address issues of plan eligibility that were not previously decided by the administrator. This issue is one of exceptional importance because legal rules impacting benefit plans can have a significant impact on both the coverage provided and their costs. Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 451 (2010). As explained in *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996), in enacting ERISA, Congress

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consider evidence that the claimant returned to work. Sun Life's C.A. Brief at ii-iv. The Ninth Circuit failed to address most of the arguments raised by Sun Life. App. 1-3.

sought "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place."

I. The Decision in this Case is Wrong and Conflicts with the ERISA Statute and Decisions from this Court.

The primary role of the plan in administering benefit claims instead of the courts is confirmed by the language in the ERISA statute. ERISA requires a "full and fair review by the appropriate named fiduciary" from a claim denial. 29 U.S.C. § 1133. In his concurrence in *LaRue v. DeWolff, Boberg & Assocs., Inc.,* 552 U.S. 248, 258-259 (2008), Chief Justice Roberts recognized that this provision requires claimants to "exhaust the administrative remedies mandated by ERISA § 503, 29 U.S.C. § 1133, before filing a lawsuit under § 502(a)(1)(B)" as a "safeguard" for administrators. Exhaustion of remedies allows for a fully developed factual record before an issue is presented to a court for review. *Edwards v. Briggs & Stratton Ret. Plan,* 639 F.3d 355, 359 (7th Cir. 2011).

Deference to the decisions of the designated plan fiduciary has been recognized by this Court in numerous decisions.[3] *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 117-118 (2008). In *Conkright v. Frommert*, 559 U.S. 506, 517 (2010), the Court explained that deference "promotes efficiency by

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[3] The plan in this case grants to Sun Life discretionary authority over eligibility decisions and plan interpretation. App. 21.

encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation [and] promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from *de novo* judicial review." *Id*. There is no deference to the designated fiduciary when courts make decisions on eligibility completely on their own. In those instances, as in this case, a court is improperly acting as "substitute trustee." *Conkiright*, 559 U.S. at 515.

The Court further recognized in *Conkright* that "Congress enacted ERISA to ensure that employees would receive the benefits they had earned …." This is consistent with the language in § 1132(a)(1)(B) of ERISA, which limits a court to awarding "benefits due under the terms of the plan." 29 U.S.C. § 1132 (a)(1)(B). An award of benefits without proof as was done in this case is not a benefit "earned." Nor can it be considered an "appropriate remed[y]" under ERISA. 29 U.S.C. § 1001(b).

Under ERISA the proper remedy for a court confronted with new eligibility issues is to remand the claim to the administrator to develop an administrative record and issue an eligibility determination. It is this view that is followed by the majority of circuits.

II. The Circuits are Divided on the Question Presented.

Six of the circuits have addressed when a court is required to remand a claim to the plan for a claim decision. Two circuits, including the one in this case, refused to remand claims involving new issues and

instead acted as substitute fiduciaries and awarded benefits. Four circuits recognize that remand is required under ERISA when the issue before the court was not addressed in the plan's prior decision.

Second Circuit. Reversing the decision of the district court to remand the claim to the administrator for a decision, the Second Circuit awarded benefits based on the plan's arbitrary and capricious appeals process in *Zervos v. Verizon New York, Inc.*, 277 F.3d 635 (2d Cir. 2002). One member of the panel dissented and would have affirmed the remand for the plan to obtain and consider new evidence.

Ninth Circuit. In the case which is the subject of this petition, the Ninth Circuit affirmed the district court's refusal to remand the claim for consideration of the duration of the disability and the amount of benefits owed. According to the district court, remand was not allowed because it would give the defendant a second bite at the apple even though the only issue that the plan decided was whether the claimant satisfied the elimination period in order to qualify for benefits.[4]

[4] According to the district court and affirmed by the Ninth Circuit, during litigation Sun Life had the opportunity to conduct discovery on the duration and amount of benefits. App. 6-7. As one court explained, "it is unnecessary for plans to hedge their bets on a possible reversal on appeal." *Pakovich v. Broadspire Services, Inc.*, 535 F.3d 601, 605 (7th Cir. 2008). As recognized in *Glenn,* it is improper to impose these types of "special procedural rules [that] would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress." 554 U.S. at 116-117.

In contrast to the two circuit decisions identified above, four circuits have concluded that remand to the plan is required to develop an administrative record and issue a decision under the circumstances presented in this case.

Third Circuit. When the defendant voluntary paid benefits after the lawsuit was filed in *Lemons v. Reliance Standard Life Ins. Co*., 534 Fed.Appx. 162 (3d Cir. 2013), the claimant disputed the benefit calculation of the defendant. The district court refused to address the dispute over the amount of benefits and the court of appeals affirmed. The Third Circuit recognized that the amount of benefits was "a separate and unrelated claim … the *only* issue in front of it was whether Defendants had arbitrarily *terminated* Lemon's benefits." (emphasis in original).

Seventh Circuit. The Seventh Circuit's decision in *Pakovich v. Broadspire Services* involved a plan's denial of "own occupation" disability benefits. The court of appeals agreed with the district court that the denial of "own occupation" benefits was arbitrary and capricious. The district court went further; however, and decided that the claimant was not entitled to "any occupation" benefits even though this part of the claim was never decided. The Seventh Circuit vacated that decision, stating that since the plan did not issue a decision on the claim for "any occupation" benefits, "the matter must be sent back to the plan administrator to address the issue in the first instance." 535 F.3d at 607.

Eighth Circuit. Remand to the plan rather than an award of benefits was the correct remedy according to the Eighth Circuit in *Chronister v. Baptist Health*, 442 F.3d 648 (8th Cir. 2006). The administrator denied

the claim based on the plan's self-reported symptoms limitation. The court concluded that the denial based on the limitation was an abuse of discretion. Since this was the only decision made by the plan, the court remanded the claim to the administrator "to re-open the administrative record and make a new determination of the claim exercising the discretion given to it by the plan."

Tenth Circuit. In *DeGrado v. Jefferson Pilot Financial Ins. Co*., 451 F.3d 1161 (10th Cir. 2006), the appellate court reversed the district court's award of benefits to the claimant and stated that "the proper remedy is to remand the case." According to the court, remand was the appropriate remedy for the defendant to make "adequate factual findings."

In addition to the cases cited above, courts have recognized remands to the administrator as a remedy under ERISA in other circumstances. *See Miller v. American Airlines, Inc.,* 632 F.3d 837, 867-57 (3d Cir. 2011) ("In a situation benefits are improperly denied at the outset, it is appropriate to remand to the administrator for full consideration of whether the claimant is disabled. To restore the status quo, the claimant would be entitled to have the plan administrator reevaluate the case using reasonable discretion"); *Shelby Cnty. Health Care Corp. v. Majestic Star Casino,* 581 F.3d 355, 373 (6th Cir. 2009) (remanding the claim to the administrator based on an incomplete factual record); *Hackett v. Xerox Corp. Long Term Disability Income Plan*, 315 F.3d 771, 775-776 (7th Cir. 2003) (restoring the status quo and remanding to the administrator when the initial denial involved defective procedures).

In enacting ERISA, Congress sought to put in place a uniform legal system that would promote to predictability of results. *See Conkright*, 559 U.S. at 517. Therefore, the disagreement among the circuits on the question presented is especially problematic.

The ERISA statute reflects a "'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)). The decision of the Ninth Circuit is contrary to these well-recognized goals.

III. This Case Presents an Ideal Vehicle for this Court to Address Appropriate Remedies under ERISA

This case presents an ideal vehicle for this Court to decide whether a court is permitted to make eligibility determinations under an ERISA plan on issues not previously decided by the administrator or whether it must remand the claim. This case squarely addresses the issue and provides the Court with an opportunity to bring uniformity to the circuits on this important issue.

CONCLUSION

Based on the foregoing, the Court should grant this petition.

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APPENDIX A

NOT FOR PUBLICATION

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

**No. 13-55601
D.C. No. 8:11-cv-01516-CJC-FFM**

[Filed April 22, 2015]

R. JEFFREY EVANS,

Plaintiff - Appellee,

v.

SUN LIFE & HEALTH INSURANCE COMPANY, a Connecticut corporation,

Defendant - Appellant.

MEMORANDUM[*]

Appeal from the United States District Court
for the Central District of California
Cormac J. Carney, District Judge, Presiding

Argued and Submitted April 10, 2015
Pasadena, California

[*] This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

Before: KLEINFELD, BENAVIDES[**], and CLIFTON, Circuit Judges.

Sun Life & Health Insurance Co. appeals from the district court's judgment awarding R. Jeffrey Evans past due benefits under his ERISA plan, attorneys' fees, costs, and interest. We have jurisdiction under 28 U.S.C. § 1291. We review de novo the district court's choice and application of the standard of review to decisions by fiduciaries in ERISA cases. Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 962 (9th Cir. 2006) (en banc). We affirm.

Both parties agree that the plan gives Sun Life discretion to determine eligibility for benefits. Thus, the district court correctly reviewed Sun Life's decision for abuse of discretion. Id. at 963. The review is generally limited to the administrative record. Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090–91 (9th Cir. 1999) (en banc). The district court did not abuse its discretion by not expanding the record. Sun Life's conflict of interest required more skeptical judicial review. Montour v. Hartford Life & Accident Ins. Co., 588 F.3d 623, 631 (9th Cir. 2009).

Weighing all the facts and circumstances, we conclude that the district court correctly found that Sun Life abused its discretion in denying Evans's long-term disability benefits application. The record, including the police officer's application for a 72-hour detention of Evans and Evans's medical records, shows

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[**] The Honorable Fortunato P. Benavides, Senior Circuit Judge for the U.S. Court of Appeals for the Fifth Circuit, sitting by designation.

that Evans became disabled before his employment was terminated, and that his psychiatric symptoms improved but not enough to return to work as a trial lawyer during the 180-day elimination period. Sun Life exhibited bias against Evans, including its failure to remedy the error caused by another patient's record mixed with Evans's by having another physician review the corrected record despite its acknowledgment that Evans was entitled to such review, its decision to conduct a pure paper review, its failure to grapple with treating physicians' and its own psychiatrist's earlier contrary determinations, and its purported reliance on objective evidence when none could be adduced for the particular condition. See Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666, 678 (9th Cir. 2011); Montour, 588 F.3d at 634, 635.

Sun Life's argument that the case should be remanded for determinations on the amount of past due benefits is unsupported. See Grosz-Salomon v. Paul Revere Life Ins. Co., 237 F.3d 1154, 1163 (9th Cir. 2001).

AFFIRMED.

APPENDIX B

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

Case No.: SACV 11-01516-CJC(FFMx)

[Filed January 2, 2013]

R. JEFFREY EVANS,	)
	)
Plaintiff,	)
	)
vs.	)
	)
SUN LIFE & HEALTH INSURANCE COMPANY,	)
	)
Defendant.	)
	)

ORDER REGARDING OBJECTIONS TO PROPOSED JUDGMENT

I. INTRODUCTION & BACKGROUND

Plaintiff R. Jeffrey Evans suffered a mental disability in December 2007, yet was denied long-term disability ("LTD") benefits by Defendant Sun Life & Health Insurance Company ("Sun Life"), the fiduciary of an ERISA disability plan (the "Plan") Mr. Evans received as part of his employment package. Following a trial on November 27, 2012, the Court held that Sun Life had abused its discretion in denying LTD benefits

to Mr. Evans. (Dkt. No. 28.) In the Memorandum of Decision, the Court directed Mr. Evans to submit a proposed judgment in accordance with the Court's decision. Sun Life was given the opportunity to submit objections to the proposed judgment.

On December 4, 2012, Mr. Evans filed a proposed judgment, directing Sun Life to pay him $217,068.00 for past due benefits. (Dkt. No. 29.) The amount was calculated using the maximum benefits under the terms of the Plan for a period of 24 months, the maximum period of LTD benefits allowed for mental disabilities. The award was offset by benefits Mr. Evans received from the California Employment Development Department ("CEDD") from June 1, 2008 through December 2, 2008. In the proposed order, Mr. Evans states that he was disabled from June 1, 2008 through June 1, 2010. Mr. Evans also submits that he is entitled to pre-judgment interest at the statutorily designated rate, as well as attorneys' fees and costs to be determined after submission of bills by Mr. Evans' counsel. On December 11, 2012, Sun Life filed four objections to the proposed judgment. (Dkt. No. 30.) For the following reasons, the Court overrules Sun Life's objections and orders it to pay Mr. Evans $217,068.00.

II. DISCUSSION

Sun Life's first objection to the proposed judgment is that Mr. Evans is not entitled to the full 24 months of benefits because he was not disabled throughout that period. Under the terms of the Plan, a person is considered totally disabled if "unable to perform all the material and substantial duties of [his] Regular Occupation." (Dkt. No. 20 at 0014). Sun Life asserts that Mr. Evans was working at a law firm from July

20, 2009 until March 29, 2010, and therefore was not totally disabled as of July 20, 2009. Sun Life bases this assertion on an internet search performed by Sun Life's counsel after the Court issued its decision. (Sapinski Decl. ¶¶ 5–6.) Sun Life's counsel also contacted the law firm to verify that Mr. Evans was indeed employed as of July 20, 2009. (*Id*. ¶¶ 7–8.)

Generally, in ERISA denial of benefits cases, a district court may only consider evidence found in the administrative record. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc). Here, there is absolutely no evidence in the administrative record to suggest that Mr. Evans was employed during the 24 month period. Even if the Court were not limited to the administrative record, Sun Life had the opportunity to conduct discovery on this point prior to trial, yet failed to do so. Sun Life made no attempt to either augment the administrative record, or move to have extrinsic evidence considered at trial. In fact, in its trial brief, Sun Life addressed this issue, and conceded that if the Court found in Mr. Evans' favor, he would be entitled to 24 months of benefits. Sun Life stated: "Should . . . Plaintiff be awarded benefits in this matter, Plaintiff's benefits are limited to a 24 months period as his disability would be caused by a mental illness as defined in the Policy." (Dkt. No. 23 at 23.) Sun Life repeated this argument in its response to Mr. Evans' trial brief. (Dkt. No. 25 at 21.) The Court cannot, after the fact, consider evidence that Sun Life should have discovered and presented to the Court at trial. Accordingly, its objection is overruled.

Sun Life's second objection is that Mr. Evans has not provided it with the financial information required to determine the appropriate amount of benefits. Specifically, Sun Life asks that the Court direct Mr. Evans to provide it with a complete set of his tax returns from 2008 through 2010 so that it may determine his income during that period. As with the issue of Mr. Evans' employment, Sun Life has failed to develop the administrative record on this point. Additionally, Sun Life has given no reason why it could not have discovered such information prior to trial. Accordingly, the Court overrules Sun Life's second objection.

Sun Life's third objection is that Mr. Evans is not entitled to an award of pre-judgment interest in excess of the rate for post-judgment interest set forth in 28 U.S.C. § 1961. Mr. Evans has stated that he intends to file a motion for attorneys' fees, costs, and pre-judgment interest in which he will address this issue. (Dkt. No. 31 at 9.) The Court will therefore consider this objection when Mr. Evans files that motion. Similarly, Sun Life's fourth objection, that Mr. Evans is not entitled to an award of attorneys' fees, is best considered after Mr. Evans has filed his motion for attorneys' fees.

III. CONCLUSION

For the foregoing reasons, Mr. Evans is entitled to LTD benefits from June 1, 2008 through June 1, 2010, subject to an offset for benefits Mr. Evans received from the CEDD from June 1, 2008 through December 2, 2008. Mr. Evans is therefore entitled to $217,068.00 in past due benefits. The Court will consider the issues of pre-judgment interest, attorneys' fees, and costs

after Mr. Evans has filed the appropriate papers with the Court.

DATED: January 2, 2013

/s/ ________________________________
CORMAC J. CARNEY
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

CASE NO. SACV 11-01516-CJC(FFMx)

[Filed January 2, 2013]

R. JEFFREY EVANS,
Plaintiff,
v.
SUN LIFE & HEALTH INSURANCE COMPANY,
Defendant.

JUDGMENT

The trial in the above-entitled action was held before the Court on November 27, 2012. On the same date, the Court issued its Memorandum of Decision, finding that Defendant abused its discretion in denying Plaintiff benefits under the subject ERISA plan. Having considered Plaintiff's proposed judgment and Defendant's objections, the Court issues its Judgment as follows:

1. Plaintiff is entitled to long-term disability benefits under the subject ERISA plan from June 1, 2008 to the end of the plan's 24-month limitation on benefits payable for a disability due to mental illness. In this instance, the 24-month limitation was reached on June 1, 2010.

2. The disability benefits are offset by the California Employment Development Department benefits Plaintiff received from June 1, 2008 through December 2, 2008.

3. Any claim for pre-judgement interest, costs, and/or attorneys' fees shall be presented to the Court by way of the appropriate application or motion, filed or otherwise submitted in accordance with the Local Rules of the Central District of California or other applicable authority.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED, AND DECREED that Plaintiff shall recover from Defendant the sum of $217,068.00, representing long-term disability benefits under the subject ERISA plan from June 1, 2008 to June 1, 2010.

IT IS SO ORDERED.

DATED: January 2, 2013

/s/ ______________________________
CORMAC J. CARNEY
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

Case No.: SACV 11-01516-CJC (FFMx)

[Filed November 27, 2012]

R. JEFFREY EVANS,)
)
Plaintiff,)
)
vs.)
)
SUN LIFE & HEALTH)
INSURANCE COMPANY,)
)
Defendant.)
)

MEMORANDUM OF DECISION

I. INTRODUCTION

Plaintiff R. Jeffrey Evans suffered a "mental breakdown" in December 2007. Mr. Evans applied for disability benefits under an insurance plan he received as part of his employment package. Plan fiduciary Sun Life & Health Insurance Company ("Sun Life") denied his claim for long-term disability benefits because it determined that Mr. Evans failed to demonstrate that he was disabled prior to being terminated from his job and continuously disabled during a 180-day

"elimination period." Reviewing Sun Life's decision, the Court finds that Sun Life abused its discretion in denying Mr. Evans' claim.

II. BACKGROUND

Mr. Evans' lawsuit stems from Sun Life's denial of long-term disability ("LTD") benefits under an insurance policy (the "Policy") he received as an employee of the law firm Adelson, Testan, Brundo & Jimenez ("Adelson"). The Policy provides that an employee is entitled to LTD benefits if he is "totally disabled." A person is considered "totally disabled" if he is "unable to perform all the material and substantial duties of [his] Regulation Occupation." (Dkt. No. 20 ["AR"] 0014). The total disability must "commence while . . . insured under the policy." (*Id.*) Coverage under the policy ceases when one's employment is terminated. The Policy also contains a 180 day "elimination period," measured from the date of impairment. (AR 0007). If the employee's total disability subsides during this elimination period, he is not entitled to LTD benefits. Mr. Evans contends that his date of impairment was December 2, 2007. Using this as the starting date, the elimination period would have ended on May 31, 2008.

In December 2007, Mr. Evans was a partner at Adelson, where he was employed as a worker's compensation attorney. (AR 0192.) Mr. Evans lived in Seal Beach, California. (AR 0243.) On December 1, 2007, following a partner meeting, Mr. Evans disappeared. (*Id.*) His wife filed a missing persons report on December 2, 2007. (*Id.*) The record of his whereabouts and actions during this time are somewhat contradictory. According to Mr. Evans, he

suffered a mental breakdown on either December 1 or December 2, 2007. (AR 0361.) He then took an overdose of medication in a suicide attempt. (*Id.*) He slept until December 4, and then decided to drive to Las Vegas, Laughlin, and Phoenix. (*Id.*) He does not know why he drove to those locations. (*Id.*) He maintains that the medication wore off on December 12, 2007, at which point he returned to his home in Seal Beach. (*Id.*)

The account Mr. Evans gave to a doctor on December 13, 2007 differs slightly. (AR 0361.) In this account, Mr. Evans disappeared around December 1 or 2, 2007. (*Id.*) He called his wife from Las Vegas on December 4, 2007, and informed her that he had taken twenty Flexeril pills, a muscle relaxant, in an attempt to commit suicide. (*Id.*) He contacted his wife again four days later to tell her that the suicide attempt was unsuccessful. (*Id.*) Mr. Evans returned home to Seal Beach on December 10, 2007. (*Id.*)

Mr. Evans was terminated from his position at Adelson on December 12, 2007 due to his failure to show up to work. (AR 0180.) On December 13, 2007 Mr. Evans' wife contacted the police regarding his "bizarre behavior," including disappearing for a week, incurring large gambling debts, and calling his life insurance company to inquire whether suicide was covered under the plan. (AR 0250.) Mr. Evans also wrote a suicide note. (AR 0243.) Mr. Evans was taken into custody by the Seal Beach Police, and admitted to the College Hospital in Costa Mesa pursuant to California Welfare and Institutions Code § 5150. (AR 0250.) Under this code section, a person may be involuntarily committed to a medical facility for treatment and evaluation if, as

a result of a mental disorder, he is a danger to himself or others. Cal. Welf. & Inst. Code § 5150.

Michael Schwartz, D.O., the College Hospital attending physician, believed Mr. Evans was suffering from "an acute mood disorder, either major depression or bipolar disorder." (AR 0244.) Mr. Evans was described as "mildly disheveled . . . extremely uncooperative and . . . poorly engaged with only poor eye contact." (*Id*). Additionally, "[his] concentration, insight and judgment [were] all poor," and he had "paranoid thoughts . . . which appear to be delusional." (*Id*.) Mr. Evans denied trying to kill himself, or having suicidal thoughts. (AR 0243.) He also denied symptoms of depression or mania. (*Id*.) Dr. Schwartz gave Mr. Evans a Global Assessment of Functioning ("GAF") score of 20. (AR 0245.) A GAF score of 20 indicates some danger of hurting one's self or others. DSM-IV-TR. Dr. Schwartz recommended that Mr. Evans "[r]eturn to his previous living situation and receive outpatient treatment" after receiving three to five days of treatment in the hospital. (AR 0245–46.) Against the recommendations of a registered nurse, Mr. Evans discharged himself from the hospital after four days, on December 17, 2007. (AR 0249.)

After being discharged from the hospital, Mr. Evans began out-patient treatment with Dr. Ali Redjaian, a Clinical Psychologist. (AR 0232.) Mr. Evans received treatment roughly once-a-week. Dr. Redjaian diagnosed Mr. Evans with major depressive disorder. From December 27, 2007 through January 23, 2008, the disorder was considered severe. (AR 0215–16, 0228–30.) From January 30 through March 12, 2008, the disorder was considered moderate. (AR 0222–27.)

From March 19, 2008 through June 11, 2008, the disorder was considered mild. (AR 0208–14, 0218–21.)

Additionally, from December 27, 2007 through January 9, 2008, Dr. Redjaian assessed Mr. Evans as having a GAF between 40 and 50. (AR 0215–16, 0229–30.) This range is defined as consisting of serious symptoms. DSM-IV-TR. From January 16 through February 13, 2008, Mr. Evans was assessed a GAF between 50 and 60. (AR 0226–28.) This range is defined as consisting of moderate symptoms. DSM-IV-TR. From February 28, 2008 through June 11, 2008, Mr. Evans was assessed a GAF between 60 and 65. (AR 0208–14, 0218–25.) This range is defined as consisting of mild symptoms. DSM-IV-TR.

On December 26, 2007, Dr. Redjaian submitted a Doctor's Certificate as part of Mr. Evans' claim for disability insurance benefits with the State of California. (AR 0238.) On the Certificate, Dr. Redjaian stated that he anticipated that Mr. Evans would be able to return to his regular work on March 1, 2008. (*Id.*) Over the next several months, Dr. Redjaian filed a number of Supplemental Certificates. On April 30, 2008, Dr. Redjaian wrote that he anticipated that Mr. Evans would be able to return to his regular work on June 11, 2008. (AR 0235.) On June 1, 2008, Dr. Redjaian pushed the date back to July 11, 2008. (AR 0234.) On August 20, 2008, Dr. Redjaian noted that he did not anticipate that Mr. Evans would be able to return to his regular work until January 1, 2009. (AR 0233.)

Beginning on or before January 3, 2008, Mr. Evans also received treatment from Dr. Winston, a psychiatrist. (AR 0385.) Dr. Winston diagnosed Mr.

Evans with "mixed depression with major depressive features," and stated that the date of impairment was December 2, 2007. (*Id.*) As of May 2008, Dr. Winston stated that Mr. Evans was "not able to work at [his] current job" but "may be able to work at suitable part-time or full time [sic] in next few months." (*Id.*) Dr. Winston was uncertain of when Mr. Evans could begin working, although he stated that the target was June 23, 2008. (*Id.*) Dr. Winston gave Mr. Evans a GAF of 55. (AR 0386.)

Dr. Winston prescribed Mr. Evans a number of psychiatric drugs throughout his treatment. In January 2008, he was prescribed Lexapro, but discontinued its use after suffering side effects. (AR 0104.) In February 2008, he was prescribed Xanax. (*Id.*) In April 2008, Mr. Evans began taking Prozac. (*Id.*) His dosage was increased in July 2008, but Mr. Evans decided to stop taking the medication in August 2008 because he believed it was not effective. (*Id.*) That same month, he was prescribed Wellbutrin. (*Id.*) In October 2008, his dosage of Wellbutrin was doubled. (*Id.*) As of December 17, 2008, Mr. Evans was still taking the Wellbutrin and Xanax. (*Id.*)

Mr. Evans first contacted Sun Life regarding his claims for short term disability ("STD") and LTD benefits around December 27, 2007. (AR 0073.) Sun Life initially denied Mr. Evans' STD benefits, based on the erroneous determination that he became disabled on December 19, 2007. (AR 0353.) Sun Life eventually decided to award STD benefits up until July 11, 2008, (AR 0153), based on Mr. Evans' date of impairment being "reasonably determined" as December 2, 2007. (AR 0158.)

Sun Life's decision to deny Mr. Evans LTD benefits was based on a separate process. As part of the process, on December 2, 2008, Sun Life forwarded Mr. Evans' file to Psychiatrist Dr. Victor Himber, Sun Life's psychiatric consultant. (AR 0192–93.) Sun Life asked Dr. Himber to determine whether "the documentation in the file provides support for a severe psychiatric condition or an incapacitating psychiatric disorder (IPD) impacting the Insured's ability to function including ability to work from 12/2/07 and forward." (AR 0193.)

Dr. Himber completed his assessment on December 5, 2008. Dr. Himber stated that, as part of his assessment, he reviewed Dr. Schwartz's hospital admission and discharge summaries, Dr. Winston's attending physician statement, a "form from Correction Mental Health, Central Jails Complex of Orange County, CA dated 4/17/08," and several records from Dr. Radjaian, including progress notes from December 26, 2007 through November 15, 2008, Doctor's Certificates related to Mr. Evans' claim for disability insurance benefits, and a letter dated November 5, 2008. (AR 0182.) The form from the Orange County jail appears to have belonged to another individual, and was erroneously included in Mr. Evans' record. (AR 0114.) Mr. Evans brought this to Sun Life's attention when he appealed the denial of his claims.

Dr. Himber noted that he assessed "whether the psychiatric record provides credible, objective and contemporaneous evidence of an incapacitating psychiatric disorder . . . ." (AR 0182.) He further stated that " '[o]bjective' refers, for example, to use of comprehensive mental status exams, detailed

neuropsychological testing, standardized rating scales of depression and anxiety such as Hamilton, Beck, periodic GAF scores and other observer (spouse, etc) information." (*Id.*) Dr. Himber determined that the records from Dr. Redjaian contained no objective data other than the GAF assessments. (*Id.*)

Dr. Himber concluded that he could not assess Mr. Evans' psychiatric condition as of December 2, 2007 because he was given no "contemporaneous documents" prior to December 13, 2007. (AR 0183.) Based on the GAF scores by Dr. Redjaian, Dr. Himber concluded that between December 13, 2007 and January 23, 2008, Mr. Evans' illness probably negatively impacted his ability to function, including his ability to work. (AR 0183.) However, the GAF scores from February 21, 2008 through November 5, 2008 were predominately "mild . . . with a brief period of 'moderate.' " (AR 0183–84.) Dr. Himber stated that he did not believe such GAF scores were consistent with an incapacitating psychiatric disorder ("IPD"). (*Id.*) Dr. Himber further concluded, based on the erroneous records from the Orange County jail, that Mr. Evans was likely abusing alcohol prior to his psychiatric admission. (*Id.*)

Dr. Himber also stated that in his opinion, the records did not indicate that Mr. Evans had received treatment consistent with someone suffering from an IPD. (AR 0184.) He noted that he would have expected that Mr. Evans would have participated in an Intensive Outpatient Program ("IOP") or Partial Hospital Program ("PHP"); however, Mr. Evans immediately began participating in a once-a-week out-patient treatment program after being discharged from the hospital. (*Id.*) Dr. Himber stated that the facts that in

September 2008, Mr. Evans had decreased the frequency of his out-patient therapy to once every two weeks, and that Mr. Evans discontinued psychotropic medications as of August 6, 2008, were also not consistent with someone suffering from "serious, on-going, psychiatric [symptoms]." (*Id.*) Dr. Hibber also noted the absence of evidence in the record that Mr. Evans had been attending follow-up meetings regarding his medication. (*Id.*)

Sun Life denied Mr. Evans' claim on December 22, 2008. (AR 0137.) In a letter to Mr. Evans, Sun Life provided relevant portions of Dr. Himber's assessment and gave two reasons for the denial. First, it stated that Mr. Evans had failed to satisfy the 180 day elimination period. (AR 0141.) In support, Sun Life noted that its medical consultant, Dr. Himber, had concluded "that there was in fact the presence of serious psychiatric symptoms which negatively impacted your ability to function, including your ability to work beginning December 13, 2008. However from February 21, 2008 and forward, there was no supporting medical documentation which proved you continued to have a condition or impairment which rose to the level of disabling proportions." (AR 0142.) Second, Sun Life stated that it was denying the claim because Mr. Evans was "not employed on the day the medical evidence supported a disability." (*Id.*) Sun Life noted that "the medical notes do not suggest a [sic] impairment of disabling proportions until the date of your admittance to College Hospital on December 13, 2008, the following day of your termination of your employment with Adelson . . . ." (*Id.*) Sun Life included the portion of Dr. Himber's assessment where he discussed the fact that he could not reach a decision on

this issue due to the lack of "contemporaneous" documents.

Mr. Evans appealed the decision on March 24, 2009. (AR 0166.) As part of the appeal, Sun Life requested additional documentation from Dr. Redjaian regarding his treatment of Mr. Evans. (AR 0104–07, 0120.) Dr. Redjaian provided Sun Life a psychiatric assessment form, based on a December 19, 2008 visit, in which he gave Mr. Evans a GAF of 65. (AR 0104.) He noted that Mr. Evans had seen "significant improvement," (AR 0105), however, in his assessment, Mr. Evans "would not be able to function as an attorney, especially as a full-time employee," (AR 0106). Dr. Redjaian stated that Mr. Evans might "potentially benefit from part-time, low demanding type jobs." (*Id.*) As part of the appeal, Sun Life additionally asked that Mr. Evans sign a release so that it could obtain additional records from Dr. Winston. (AR 0094.) Mr. Evans declined to sign the release, and maintained that Sun Life already had all of Dr. Winston's records. (AR 0092–93.)

On March 8, 2010, Sun Life upheld its denial of Mr. Evans' claim for LTD benefits. (AR 0085–88.) It does not appear that Sun Life relied on any additional medical consultants as part of the appeal. In a letter to Mr. Evans, Sun Life stated that it upheld the decision because the "medical information provided to us did not support the presence of an impairing disorder until 12-13-07," the day following Mr. Evans' termination of employment. (AR 0088.) Additionally, the medical records "did not support a finding that you were totally disabled, as defined in and required by the contract, during the 180-day Elimination Period . . . ." (*Id.*)

Following the denial of his appeal, Mr. Evans initiated this action.

III. ANALYSIS

Mr. Evans' action challenging Sun Life's benefit eligibility determination arises under Section 1132 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 28 U.S.C. § 1001 *et seq.* In *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court set forth the standard of review district courts must follow when reviewing denials of benefits under ERISA. The *Firestone* Court identified two separate standards of review, depending on the language of the plan at issue. The default standard for a denial of benefits challenged under Section 1132(a)(1)(b) is *de novo* review. *Firestone*, 489 U.S. at 115. However, if the "benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," the decision to deny benefits and the interpretation of the plan are reviewed for abuse of discretion. *Id*. In order for a plan to alter the standard of review from *de novo* to abuse of discretion, "the plan must unambiguously provide discretion to the administrator." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006) (en banc) (citing *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc)).

The plan at issue in this case clearly confers discretion to the plan fiduciary, Sun Life, and Mr. Evans concedes that abuse of discretion is the appropriate standard of review in this case. "Under this deferential standard, a plan administrator's decision will not be disturbed if reasonable. This

reasonableness standard requires deference to the administrator's benefits decision unless it is (1) illogical, (2) implausible, or (3) without support in inferences that may be drawn from the facts in the record." *Stephan v. Unum Life Ins. Co. of Am.*, 697 F.3d 917, 929 (9th Cir. 2012) (quotes and citations omitted).

In *Firestone*, the Supreme Court recognized that there are situations where a plan administrator or fiduciary that has discretion under the plan is operating under a conflict of interest. 489 U.S. at 115. When an insurer acts as both the plan fiduciary and the funding source for benefits, an inherent structural conflict of interest exists. *Abatie*, 458 F.3d at 965 (citing *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999)). The presence of a conflict of interest merely contributes to the district court's decision of "how much or how little to credit the plan administrator's reason for denying insurance coverage." *Id.* at 968. If a structural conflict is unaccompanied by evidence of "malice, of self-dealing, or of a parsimonious claims-granting history," its impact on the district court's analysis may be slight. *Id.* However, the district court may weigh the presence of a conflict more heavily if "the administrator provides inconsistent reasons for denial, fails adequately to investigate a claim or ask the plaintiff for necessary evidence, fails to credit a claimant's reliable evidence, or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." *Id.* at 968–69 (internal citations omitted).

Even if the plan presents these more serious conflicts, the standard of review remains abuse of

discretion. *Abatie*, 458 F.3d at 968–69. "[T]he existence of a conflict [is] a factor to be weighed, adjusting the weight given that factor based on the degree to which the conflict appears improperly to have influenced a plan administrator's decision." *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 631 (9th Cir. 2009). Additional factors to be considered in determining whether a plan administrator or fiduciary abused its discretion include "the quality and quantity of the medical evidence, whether the plan administrator subjected the claimant to an in-person medical evaluation or relied instead on a paper review of the claimant's existing medical records, whether the administrator provided its independent experts with all of the relevant evidence, and whether the administrator considered a contrary SSA disability determination, if any." *Id*. (quotes omitted).

Both parties recognize that Sun Life has a conflict of interest in this case, as Sun Life is both the plan fiduciary and funding source for the benefits. As will be discussed below, there is evidence that Sun Life failed to credit Mr. Evans' reliable evidence, failed to adequately investigate the claim, and failed to ask Mr. Evans for necessary evidence. As a result, the Court will give considerable weight to Sun Life's conflict of interest in determining whether it abused its discretion in denying Mr. Evans' claim.

In addition to the conflict of interest, the other factors, "the quality and quantity of the medical evidence, whether the plan administrator subjected the claimant to an in-person medical evaluation or relied instead on a paper review of the claimant's existing medical records, whether the administrator provided

its independent experts with all of the relevant evidence, and whether the administrator considered a contrary SSA disability determination, if any," *Montour*, 588 F.3d at 630, weigh in favor of a finding that Sun Life abused its discretion. Specifically, its decisions that Mr. Evans was not disabled until December 13, 2007 and that Mr. Evans was not disabled throughout the elimination period were illogical, implausible, and without support in inferences that could reasonably be drawn from facts in the record because: (1) every doctor who personally examined Mr. Evans concluded that he was disabled and unable to return to his regular work; (2) Sun Life did not subject Mr. Evans to an in-person medical evaluation; (3) Sun Life relied almost exclusively on the deeply flawed assessment by Dr. Himber; (4) and Sun Life failed to engage in a "meaningful dialogue" with Mr. Evans.

A. Initiation Date

Sun Life's determination that Mr. Evans did not become totally disabled until December 13, 2007 was unreasonable. The evidence in the record, including all of the medical records, overwhelmingly supports the conclusion that Mr. Evans was totally disabled as of December 2, 2007. Both Dr. Winston and Dr. Redjaian determined that Mr. Evans was disabled as of December 2, 2007. (AR 0363, 0385.) Additionally, Dr. Schwartz's account of Mr. Evans' actions between December 2 and December 13, clearly points to the presence of a disability. On December 1 or 2, Mr. Evans disappeared suddenly, without informing his wife or his employer. While he was gone, he overdosed on medication in an attempt to commit suicide. He contacted his wife at most two times, once to tell her he

was going to commit suicide, and the other time to tell her that his attempt failed. Mr. Evans was then involuntarily committed to a hospital within three days of returning home. This evidence strongly suggests that Mr. Evans was suffering from a severe mental illness beginning around December 2, 2007.

Sun Life informed Mr. Evans that it had reached the opposite conclusion because the "medical notes" did not suggest an impairment until December 13, 2007. (AR 0142.) However, this decision was not based on the opinion of any medical professional. Sun Life asked Dr. Himber to make such a determination, but Dr. Himber stated that he could not assess Mr. Evans' psychiatric condition as of December 2, 2007 because he was not given any "contemporaneous documents" prior to his admittance to the hospital on December 13, 2007. (AR 0184.) It is not clear whether Sun Life required proof in the form of "contemporaneous documents," or if this was simply a requirement Dr. Himber independently imposed on himself. Regardless, the requirement was unreasonable, and the lack of such documents does not show, or even imply, the absence of impairment. All the evidence in the record suggests that between December 1, 2007 and December 13, 2007, Mr. Evans was in the midst of a severe mental breakdown, heavily medicated, and aimlessly traveling over hundreds of miles. Under these circumstances, there simply would not be any contemporaneous documents describing Mr. Evans' condition.

Rather than broaden the scope of its inquiry to more than just "contemporaneous" documents, Sun Life appears to have ended its investigation into this issue after receiving Dr. Himber's assessment. Sun Life did

not conduct an in-person examination of Mr. Evans. Sun Life argues that it was not required to conduct such an examination. While that is certainly true, its decision was clearly misguided in light of the fact that the record was, in its view, lacking sufficient evidence to make any determination about the start of Mr. Evans' disability. Sun Life additionally failed to contact Mr. Evans' doctors in order to understand why they had determined that the date of his impairment was December 2, 2007. Sun Life also failed to contact Mr. Evans' coworkers who may have witnessed his behavior around December 1 and 2. Nor did Sun Life attempt to contact Mr. Evans' wife, who appears to be one of the few people he contacted during this period.

Additionally, Sun Life failed to engage in the sort of "meaningful dialogue" required between claims fiduciaries and beneficiaries. *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870 (9th Cir. 2008). In resolving Mr. Evans' claim, Sun Life was required to give him "[a] description of any additional material or information" that was "necessary" for him to "perfect the claim," and to do so "in a manner calculated to be understood by the claimant." 29 C.F.R. § 2560.503–1(g). Additionally, upon denial, it was required to explain "any additional information needed." *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011).

In denying his claim, Sun Life informed Mr. Evans that the "medical notes" did not suggest an impairment until December 13, 2007. (AR 0142.) Sun Life provided no explanation for this conclusion, other than to include excerpts of Dr. Himber's assessment discussing the issue. Sun Life now claims it did not rely on Dr.

Himber's assessment. Regardless, Sun Life also failed to inform Mr. Evans of any other information that it would need in order to reconsider its decision. This falls far short of the "meaningful dialogue" requirements under *Salomaa*.

As part of this litigation, Sun Life has identified a number of other facts in the record that it argues renders its decision reasonable. It should be noted that none of these facts were considered by any medical professional as part of Sun Life's decision to deny Mr. Evans' claim. Additionally, they were not disclosed to Mr. Evans as reason for his denial. Regardless, none of these facts support Sun Life's determination.

Sun Life points to the fact that Mr. Evans "did not seek or receive any treatment for any conditions prior to December 13, 2007" as evidence that his disability was not present until that date. (Def.'s Brief at 22.) However, this fact is not inconsistent with Mr. Evans' illness beginning on December 2. Although Mr. Evans received medical attention on December 13, it was not by choice. The reason Mr. Evans received treatment on that date was because he was involuntarily committed by the police. Dr. Schwartz, who was the first doctor to examine Mr. Evans, noted that he had delusional thoughts. (AR 0244.) Dr. Schwartz also noted that Mr. Evans denied symptoms or depression or mania, even though Dr. Schwartz believed he was suffering "from an acute mood disorder, either major depression or bipolar disorder." (*Id.*) It should come as no surprise, then, that Mr. Evans failed to voluntarily seek medical attention from December 2 through December 12.

Sun Life also argues that Mr. Evans was unlikely to have been disabled prior to December 13 because "on

[December 2, 2007, Mr. Evans] was able to travel to Las Vegas and after an eight day gambling spree travel home with large gambling debts." (Def.'s Brief at 22.) The fact that Mr. Evans traveled between December 2 and December 10 is not inconsistent with Mr. Evans' disability commencing on December 2. The circumstances of Mr. Evans' trip to Las Vegas (and possibly Phoenix and Laughlin) were bizarre and out of the ordinary. Mr. Evans' disappearance was sudden and unplanned. He did not alert his wife or his employer. In fact, Mr. Evans' wife filed a missing persons report. Sadly, during his time in Las Vegas, Mr. Evans even attempted to commit suicide by overdosing on medication. Mr. Evans also maintains that during this period, he slept for several days on end, and drove aimlessly for hundreds of miles. Clearly, these facts demonstrate that Mr. Evans was disabled on December 2.

Sun Life additionally notes that Mr. Evans "appeared to have lived with his family after his return from Las Vegas from December 10 to December 13, 2007 without any incident." (Def.'s Brief at 22.) The record is almost entirely void of information about this period. While Sun Life would argue that the lack of evidence shows a lack of incident, such an inference is unreasonable given Sun Life's lack of investigation into the matter. As noted earlier, Sun Life did not personally assess or question Mr. Evans, Mr. Evans' wife, or his doctors regarding his behavior during this period. Moreover, the evidence regarding Mr. Evans' behavior in the days prior to his return home suggests that he was already suffering from mental illness. The fact that Mr. Evans' wife waited several days to contact the police and have Mr. Evans involuntarily committed

is not inconsistent with Mr. Evans' illness being present prior to December 13. Even if Mr. Evans had been displaying signs of mental illness between December 10 and December 12, it is not unreasonable that his wife would wait several days to take the drastic step of contacting the police and having him involuntarily committed.

B. Elimination Period

Sun Life's determination that Mr. Evans was not totally disabled throughout the elimination period was unreasonable. The evidence in the record overwhelmingly points to the conclusion that Mr. Evans was totally disabled through at least May 31, 2008.[1] During this period, every physician to personally examine Mr. Evans determined that he was suffering from a major mental illness which prevented him from returning to his regular work. Mr. Evans was prescribed a number of different medications, including Xanax, Prozac, and Wellbutrin. He attended out-patient psychotherapy with Dr. Redjaian on a weekly basis. He also met with Dr. Winston, a psychiatrist, on a regular basis. While Mr. Evans' condition appears to have improved during the course of his treatment, at no point did either of his doctors determine that he was able to return to his regular work. As late as November 2008, Dr. Redjaian did not believe Mr. Evans could return to his regular work. (AR 0232–33.)

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[1] The Court has already determined that Mr. Evans was disabled on December 2, 2007. Therefore, the 180 day elimination period would have ended on May 31, 2008.

In determining that Mr. Evans had not satisfied the elimination period, Sun Life relied almost exclusively on the flawed assessment of Dr. Himber. Sun Life choose not to ask Mr. Evans to submit to an in-person examination, something it had the power to do under the terms of the policy. Neither did it discuss Mr. Evans' illness with either of his treating doctors, other than to request records for Dr. Himber's assessment.

There are a number of serious deficiencies with Dr. Himber's assessment. Dr. Himber erroneously limited his assessment to "objective" data. Sun Life argues that, while it might not be proper to limit an assessment of whether Mr. Evans was mentally ill to objective data, it was proper to do so with respect to Mr. Evans' ability to return to work. (Def.'s Response at 15–17.) However, it does not appear that Dr. Himber actually separated those issues.

Regardless, as a result of his reliance on "objective" data, Dr. Himber did not consider important "subjective" portions of Mr. Evans' doctors' reports in reaching his final conclusion. This includes Dr. Redjaian's and Dr. Winston's descriptions of Mr. Evans' symptoms and progress, as well as their determinations that he was incapable of returning to his regular work. To ignore this evidence was improper.

Dr. Himber's assessment is riddled with other errors. Most egregiously, Dr. Himber considered the records of a different patient. Though it is not clear how much of a role this played in his final determination, Dr. Himber did reach a conclusion based on such information. In the "Rationales/ Conclusions" section of his assessment, Dr. Himber noted, "[i]t seems likely that [Mr. Evans] had been

abusing [alcohol] prior to his psychiatric admission." (AR 0183.) There is no other evidence in the record that Mr. Evans was abusing alcohol prior to his admission. Sun Life argues that the inclusion of this information does not raise serious concerns, both because it had little effect on Dr. Himber's overall conclusions, and because the information was provided to Sun Life by Dr. Winston. However, the fact that Sun Life declined to have a second medical professional conduct an assessment after this problem was brought to its attention raises serious questions about the quality of the process Sun Life used in making its determinations.

Dr. Himber also erroneously relied on the fact that Mr. Evans discontinued his psychotropic medications on August 6, 2008 as evidence of a lack of "serious, on-going, psychiatric [symptoms]." (AR 0183). While Dr. Redjaian did indeed note on August 6, 2007 that Mr. Evans had stopped taking Prozac, the next week, August 13, 2008, Dr. Redjaian wrote that Mr. Evans had been prescribed a new psychotropic medication, Wellbutrin. (AR 0201–0202.) Mr. Evans continued taking this medication throughout the period of time under review by Dr. Himber, and his dosage actually doubled at one point during that time. (AR 0199–0200.)

After disregarding the many errors in the report, Dr. Himber's assessment is based entirely on three pieces of evidence: (1) Mr. Evans' GAF scores assessed by Dr. Redjaian, (2) Mr. Evans' choice to immediately enroll in a once-a-week outpatient program rather than an Intensive Outpatient Program ("IOP") or Partial Hospital Program ("PHP"), and (3) Mr. Evans' decision to decrease the frequency of out-patient therapy in

September 2008. For the reasons discussed below, this evidence does not form a reasonable basis for concluding that Mr. Evans was not totally disabled during the elimination period.

Dr. Himber's heavy reliance on the GAF scores appears misplaced. Mr. Evans was assessed significantly different GAF scores from Dr. Redjaian and Dr. Winston. Though Dr. Himber noted the scores given by both doctors, he entirely ignored Dr. Winston's scores in reaching his final conclusion. Based on an April 22, 2008 session, Dr. Winston assessed Mr. Evans as having a GAF score of 55. This score equates to "moderate" symptoms. (AR 0386). The next day, April 23, 2008, Dr. Redjaian assessed Mr. Evans as having a GAF of 62, which consists of mild symptoms. (AR 0214.) It is unlikely that Mr. Evans made such a significant improvement in one day. Instead, it suggests that GAF is not necessarily an accurate or objective indicator of Mr. Evans' condition. At the very least, this suggests that it should not have played as significant a role in Dr. Himber's analysis as it did. Certainly, Dr. Himber should have acknowledged the discrepancy.

Dr. Himber also relied heavily on the fact that Mr. Evans did not enroll in an IOP or PHP after being discharged from the hospital. However, Dr. Schwartz, who attended to Mr. Evans at College Hospital, recommended that he "[r]eturn to his previous living situation and receive outpatient treatment," which is what Mr. Evans did. (AR 0246.) Sun Life and Dr. Himber both concede that Mr. Evans' impairment was present when he was examined by Dr. Schwartz, and therefore, it can be assumed that Dr. Schwartz

recommended a treatment consistent with such a disability. Though there may be some dispute as to the proper course of treatment for Mr. Evans, Sun Life cannot hold it against Mr. Evans that he followed the course suggested by his examining physician. Dr. Himber did not even acknowledge this fact in his assessment.

The final fact relied on by Dr. Himber is that Mr. Evans decreased the frequency of his out-patient therapy in September 2008. It is not clear to what extent the decrease in therapy in September reflects on Mr. Evans' disability during the elimination period, which ended in May 2008. During the elimination period, Mr. Evans was receiving out-patient therapy with Dr. Redjaian at least once a week. Additionally, the decrease in the frequency of therapy sessions is explained by the fact that Mr. Evans responded very well to Wellbutrin, (AR 0232), a medication he was prescribed for the first time in August 2008. (AR 0104.)

Even if Dr. Himber's assessment is heavily discounted, as it should be, Sun Life argues that other facts in the record support its decision. However, because Dr. Himber declined to consider any "subjective" evidence, none of these facts were considered by any medical professional as part of Sun Life's decision to deny Mr. Evans' claim. Additionally, these facts were not disclosed to Mr. Evans as a reason for his denial. Regardless, none of these facts support Sun Life's determination that Mr. Evans did not satisfy the elimination period.

Sun Life points to statements in a letter written by Dr. Redjaian in November 2008, stating that Mr. Evans' condition had improved significantly. (AR 0232.)

Dr. Redjaian noted that Mr. Evans' "symptoms have markedly reduced and it has been this writer's observation that there has been an overall progress." (*Id.*) Dr. Redjaian additionally stated that Mr. Evans had "responded well to Wellbutrin, the most recent medication which was prescribed to him by his treatment psychiatrist." (*Id.*) As discussed in regard to Mr. Evans' decision to reduce the frequency of his therapy, it is not clear to what extent Dr. Redjaian's assessment of Mr. Evans' condition in November 2008 reflects on Mr. Evans' condition during the elimination period. Additionally, Sun Life fails to acknowledge the portions of the letter that support Mr. Evans' claim. For instance, Dr. Redjaian states that, in his opinion, "Mr. Evans may have difficulty engaging in employment at this time." (*Id.*) Additionally, in a certification attached to the letter, Dr. Redjaian noted that he estimated that Mr. Evans could not return to work until January 1, 2009. (AR 0233.)

Sun Life also points to the fact that as part of Mr. Evans' claim for disability insurance benefits, "[Dr. Redjaian] always indicated that Plaintiff would return to work in a few months." (Def.'s Brief at 20.) While this is true, Sun Life fails to acknowledge that at no point did Dr. Redjaian state that Mr. Evans was capable of returning to work at the present moment. Dr. Redjaian's expectations were continually adjusted, and the date Mr. Evans was expected to return to work was pushed back with each subsequent Doctor's Certificate. Sun Life never inquired of Dr. Redjaian why his opinions changed.

IV. CONCLUSION

Sun Life abused its discretion in denying Mr. Evans' claim for long-term disability benefits. The evidence in the record overwhelming shows that Mr. Evans was totally disabled prior the date of his termination and throughout the elimination period. Accordingly, Sun Life is ordered to pay long-term disability benefits to Mr. Evans in accordance with the Policy. Counsel for Mr. Evans is hereby directed to file a proposed judgment within seven (7) days. Sun Life shall have seven (7) days after service of the proposed judgment to file any objections thereto.

DATED: November 27, 2012

/s/ ________________________________

CORMAC J. CARNEY
UNITED STATES DISTRICT JUDGE