IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

HAROLD A. SMITH and	:	**No. 3:01cv0961**
PATRICIA A. SMITH, his wife,	:	
Plaintiffs	:	**(Judge Munley)**
	:	
v.	:	
	:	
CONTINENTAL CASUALTY	:	
COMPANY,	:	
Defendant	:	

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MEMORANDUM

Before the court for disposition is the defendant's motion for summary judgment in this case involving the denial of employee disability benefits. Plaintiff Harold A. Smith, formerly practiced as an emergency room physician for Geisinger Medical Center. He brings the instant action to recover long term disability benefits he claims are owed to him. Plaintiff's employer, Geisinger, had purchased a group disability insurance policy from Defendant Continental Casualty Company. The insurance policy is an employee benefit plan as covered by the Employee Retirement Income Security Act of 1974 (hereinafter "ERISA") 29 U.S.C. § 1132.[1] Plaintiff seeks to recover disability benefits pursuant to this policy. The matter is ripe for disposition having been fully briefed and argued.

[1]Defendant argues that Plaintiff Patricia A. Smith has no legal right in the underlying action and judgment should be granted in its favor with respect to her. Plaintiffs concede that summary judgment should be granted to the defendant with regard to Plaintiff Patricia A. Smith. See Pl. Brief in Oppo. to Sum. Judg. at 24. Accordingly, summary judgment shall be granted to the defendant with regard to Patricia A. Smith.

Background

Geisinger Medical Center employed Plaintiff Harold A. Smith (hereinafter "plaintiff") as an emergency room physician. Geisinger provides disability insurance benefits to its employees through a plan that is an "employee welfare benefit plan" as that term is defined by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. ERISA governs the instant case as it arises from the denial of long term disability benefits afforded under an employee welfare benefits plan.

Plaintiff stopped working in February 1997. He could not, at that time, work for more than one or two hours at a time because of profound fatigue. He also claims to have suffered from cognitive dysfunctions, and pain in his extremities, bladder, legs and buttocks. Plaintiff asserts that he is disabled as he is unable to work in the specialized field of medicine that he practiced immediately prior to his disability, that is, an Emergency Room Department Physician. He made a claim to Continental for disability benefits. Continental denied the claim in July 1997. The terms of the policy provide for an appeal process which the plaintiff proceeded to utilize. Continental denied his appeal in January 1998. Plaintiff claims that he sought to submit new evidence, and Continental informed him in July 1999 that it would not consider the new evidence. Accordingly, plaintiff instituted the instant action to recover the disability benefits.

Jurisdiction

We have jurisdiction over the instant case pursuant to 29 U.S.C. § 1132(e)(1)

(providing United States District Courts jurisdiction over ERISA actions) and 29 U.S.C. § 1331 (providing United States District Courts with jurisdiction over "all civil actions arising under the Constitution, laws, or treaties of the United States.").

Standard of review

Granting summary judgment is proper if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. See Knabe v. Boury, 114 F.3d 407, 410 n.4 (3d Cir. 1997) (citing Fed.R.Civ.P. 56(c)). "[T]his standard provides that the mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no genuine issue of material fact." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986) (emphasis in original).

The standard of review for an action brought under section 1132(a)(1)(B) of ERISA is not set forth in the statute. The United States Supreme Court has held that courts should ordinarily apply a *de novo* standard of review in assessing a plan administrator's denial of ERISA benefits. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). However, where the ERISA plan commits discretion to the plan administrator, the reviewing court applies an arbitrary and capricious standard. Skretvedt v. E.I. DuPont de Nemours and Co., 268 F.3d 167, 173 (3d Cir. 2001). In the instant case, the parties are in agreement that the decision should be reviewed under the *de novo* standard of review. See Def's Brief in

Support of Sum. Judg. at 4; and Pl. Brief in Oppo. to Sum. Judg. at 12.

Discussion

Plaintiff claims that he is entitled to long-term disability benefits under his employer's group long-term disability insurance policy, hereinafter "the policy." Under the terms of the policy:

> "Total Disability" means that, because of injury or [s]ickness, the Insured Employee is:
>
> (1) continuously unable to perform the substantial and material duties of his regular occupation;
>
> (2) under the regular care of a licensed physician other himself [sic]; and
>
> (3) not gainfully employed in any occupation for which he is or becomes qualified by education, training or experience.
>
> . . . For Physicians . . . "regular occupation" means the specialty in the practice of medicine. . . which the insured was engaged in just prior to the date disability started."

See Def. Ex. A, Administrative Record for Plaintiff's Long Term Disability Claim at CNA 17 (hereinafter, "R. at" page number)

Defendant claims that it properly concluded that plaintiff did not suffer from total disability because the medical evidence did not illustrate that he could not perform the duties of his regular occupation as a physician. More particularly the defendant stated: "We. . . do not find objective medical evidence of limitations which would preclude you from performing the substantial and material duties of your regular occupation as a Physician." R. at 123, Correspondence of 7/16/97 (informing plaintiff of denial of benefits); see also R. at 105- 07, Correspondence of 1/06/98 (stating that the medical evidence failed to substantiate a condition of such severity as to prevent plaintiff from engaging in the substantial and

material duties of his occupation beyond December 31, 1996).

Plaintiff's position is that subsequently gathered evidence provides the objective medical evidence that establishes he is disabled under the plan. The evidence consists of two medical reports indicating that from December 1996 on the plaintiff suffered from Lyme, Borrelia and other infections from tick bites which remained undiagnosed until October of 1998.

Defendant replies that such evidence cannot be considered by this court because it is not a part of the administrative record upon which it made its determination that benefits were not appropriate. Plaintiff contends that it is proper for the court to review the evidence. We are in agreement with the plaintiff. The law provides that district courts applying *de novo* review to ERISA determinations are not limited to evidence before the plan administrator. Luby v. Teamsters Health, Welfare and Pension Trust Funds, 944 F.2d 1176, 1184-85 (3d Cir. 1991). The defendant tries to distinguish Luby by asserting that its holding applies only where no evidentiary record is available to the court. We do not read Luby so narrowly. Luby used very broad language. It stated:

> Limiting the review of an ERISA benefit decision to evidence before the administrator . . . makes little sense. . . when a plan administrator's decision is reviewed *de novo*. So limiting the scope is contrary to the concept of *de novo* review. *De novo* means here, *as it ordinarily does*, that the court's inquiry is not limited to or constricted by the record, nor is any deference due the conclusion under review.

Id. at 1184 (internal quotation marks and citations omitted, emphasis in the original).

Furthermore, district courts sitting in the Third Circuit have acknowledged that new

evidence is admissible when applying the *de novo* standard of review and have not limited the admission of such evidence to where there is no evidentiary record. See, e.g., Nave v. Fortis Benefits Ins. Co., 1999 WL 672659 * 6 (E.D. Pa. Aug. 25, 1999) (explaining that the law is "well-settled" that a court may consider additional evidence when conducting a *de novo* review of a denial of ERISA plan benefits and considering two additional medical reports in addition to the evidentiary material upon which the plan administrator relied); Sussex Auto Ctr., Inc. v. Optimum Choice, Inc., 2001 WL 822329 * 2 (D. Del. July 20, 2001) (stating that a district court exercising *de novo* review over an ERISA determination is not limited to the evidence before the fund's administrator and allowing additional evidence provided by the insurer). Hence, we find that additional evidence that the plaintiff seeks to submit can be reviewed by the court in determining whether benefits are due.

Defendant next claims that if additional evidence is to be reviewed, the matter should be remanded to it for a determination based upon the additional evidence. We are not convinced. As stated above, a *de novo* review by this court of the original evidence and the supplemental evidence is appropriate. Moreover, the defendant had the opportunity to review additional evidence in 1999, but refused to do so. In October of 1998, after being diagnosed with Lyme disease, the plaintiff notified the plan administrator that he had more medical information. He asked the Appeals Committee what steps were necessary to present it. See Plaintiff's Ex. F, Letter of October 29th, 1998. The Appeals Committee replied that the information could be submitted to them. Further, they noted that "there are no time

constraints governing second appeals." Plaintiff's Ex. G, Letter of Nov. 4, 1998. In July 1999, plaintiff again wrote to the counsel indicating that he had obtained "new medicals" that spoke to the date of disability. Plaintiff's Ex. H, Letter of July 14, 1999. Defendant wrote to the plaintiff stating that the "administrative record" had been closed since January 6, 1998. Thus, the defendant had the opportunity to examine additional medical evidence, but refused to do so. We will not now remand this case to the defendant to review what it refused to review in 1999.

The new evidence plaintiff presents creates genuine issues of material fact regarding whether plaintiff was "disabled" within the meaning of the policy. See Plaintiff's Ex. K and L, Reports of Gregory P. Bach, D.O., P.C., of October 31, 1999 and February 11, 2002 respectively (detailing his conclusions regarding plaintiff's disability). Accordingly, summary judgment is inappropriate and the defendant's motion will be denied. An appropriate order follows.

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	:	
v.	:	
	:	
CONTINENTAL CASUALTY	:	
COMPANY,	:	
Defendant	:	

::

ORDER

AND NOW, to wit, this 10th day of January 2003, the defendant's motion for summary judgment (Doc. 17) is hereby **GRANTED** in part and **DENIED** in part. Summary judgment is **GRANTED** to the defendant with regard to Plaintiff Patricia A. Smith. The motion is **DENIED** in all other respects.

BY THE COURT:

_____
JUDGE JAMES M. MUNLEY
United States District Court

Filed: January 10, 2003