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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CARI-ANNE PITMAN RODRIGUEZ, Administratrix of the Estate of DANA F. PITMAN, Plaintiff, v. ATG, Inc., a corporation, RELIANCE STANDARD LIFE INSURANCE COMPANY, a corporation, and DOES 1 through 25, Defendants.	Case No.: C 03-04189 CRB (ARB) **REPLY BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT/JUDGMENT ON THE RECORD** **[Filed concurrently with Declaration of Peter Sailor]** **DATE: April 2, 2004** **TIME: 10:00 A.M.** **CRTRM: 8 (San Francisco)**

Defendant RELIANCE STANDARD INSURANCE COMPANY ("RSL") hereby submits the following memorandum of points and authorities in reply to Plaintiff's opposition to RSL's motion for summary judgment/judgment on the record.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

Plaintiff asks this court to ignore the language in the Reliance Standard policy that is applicable to this claim. Instead, plaintiff asks this court to rely on language contained in a letter from the employer which is not part of the administrative record and is not an official plan document, therefore, it cannot be considered by this court. Moreover, contrary to plaintiff's argument, the letter does not even support the claim for benefits. Under the plain language in the policy, Mr. Pitman was not covered at the time of his death. Therefore, Reliance Standard is entitled to judgment in its favor.

II.

RESPONSE TO PLAINTIFF'S COUNTER-STATEMENT OF FACTS

Plaintiff does not dispute that ERISA applies to this claim for benefits. Nevertheless, plaintiff relies primarily on evidence that may not be considered under the law applicable to this ERISA action. Under the law of this Circuit, the Court may only consider that evidence that was before the plan at the time of the final decision to deny benefits. *See Taft v. Equitable Life Assurance Society*, 9 F.3d 1469, 1472 (9th Cir. 1993). Even when the court's review is *de novo*, the Ninth Circuit generally

will not consider evidence that is not part of the administrative record. *See Kearney v. Standard Insurance Company*, 175 F.3d 1084, 1090 (9th Cir. 1998). Here, there is no question that the court is limited to the administrative record since the policy explicitly grants discretionary authority to the defendant.

Plaintiff has attached to her brief numerous exhibits that are not part of the administrative record and cannot be considered. These include the declaration of plaintiff and the majority of the exhibits attached to it. With the exception of Exhibit 3 which was prepared by Reliance Standard and Exhibit 4 which is a letter that was sent to Reliance Standard, none of the other exhibits to plaintiff's declaration are included in the administrative record. Therefore, they are not properly before this court.

Plaintiff also questions defense counsel's competency to authenticate the policy which is attached to defendant's initial brief. Plaintiff fails to recognize the nature of this action or the documents attached to defendant's moving papers. As explained above, ERISA cases are decided on the administrative record. This record includes the policy applicable to the claim. As explained in defense counsel's affidavit, the policy and the two other exhibits, which consist of the denial and appeal denial letters, are from the administrative record. Plaintiff truly does not dispute that these are copies of the actual documents. Instead, it appears that counsel for plaintiff is attempting to make any argument he can think of in

an attempt to create an issue of fact to defeat defendant's motion. There is no merit, however, to these arguments.

Contrary to plaintiff's arguments, the policy along with the other exhibits are properly before this court. In *Stuart v. UNUM Life Ins. Co. of America*, 217 F.3d 1145 (9th Cir. 2000), the Appellate Court reversed the decision of the district court which concluded that ERISA did not apply. In arguing that ERISA applied, the defendant submitted to the court a copy of the policy. The district court refused to consider the policy, however, stating that it constituted inadmissible hearsay. The Ninth Circuit held that the district court erred when it refused to consider the policy. As explained by the Appellate Court, the policy is "excluded from the definition of hearsay and is admissible evidence because it is a legally operative document that defines the rights and liabilities of the parties in this case." *See Stuart*, 217 F.3d at 1154.

Next, in her statement of facts, plaintiff primarily argues that neither her employer nor Reliance Standard ever provided her with the insurance policy or a booklet explaining the coverage. Relying on a document that is not properly before the court, plaintiff refers to a document which states that "complete coverage information will be distributed in the form of booklets by Reliance Standard Life." See brief of plaintiff at page 2. Significantly, this document does not state that Reliance Standard would provide these documents to the decedent. Nor was Reliance Standard under any legal obligation to provide any documents to the decedent.

Under the law of ERISA, the duty to provide documents belongs to the Plan Administrator. *See* 29 U.S.C. § 1021(a); 29 U.S.C. § 1132(c). When no Plan Administrator is specifically designated, the employer is deemed to be the Plan Administrator under the Statute. *See* 29 U.S.C. § 1002(16). Here, there is no document designating Reliance Standard as the Plan Administrator. On the contrary, plaintiff's Exhibit 12 states that ATG is the plan administrator, not Reliance Standard. Thus, only ATG can be responsible if it did not provide documents.

Plaintiff does not have a valid argument based on the fact that Reliance Standard never sent to the decedent a copy of the policy or summary plan description. Nor does plaintiff have a valid complaint against the employer in this case. ATG was under no obligation to provide these plan documents to the decedent absent a request from him. *See Kleinhans v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 622 (7th Cir. 1987) (there is no liability on the part of the plan administrator for failing to provide information that was never requested); *Verkuilen v. South Shore Bldg. & Mortgage Co.*, 122 F.3d 410, 412 (7th Cir. 1997) (no liability on the part of the plan administrator absent a written request for documents by the participant); *Pane v. RCA Corp.*, 868 F.2d 631, 639 (3rd Cir. 1989) (the plaintiff's request for coverage was not a request for information under ERISA which could lead to liability); *Watson v. Deaconess Waltham Hospital*, 298 F.3d 102, 111, 115 (1st Cir. 2002) (the plan administrator has no obligation to provide an employee with a personalized benefits assessment or provide information regarding the plan

absent a specific request). Here, plaintiff does not allege that the decedent made a request for plan information nor is there any evidence to support such a suggestion. Accordingly, plaintiff cannot rely on the fact that the decedent did not receive the policy in an attempt to avoid its terms.

Contrary to plaintiff's arguments, her claim must be based on the language contained in the Reliance Standard policy and the materials in the administrative record. Since Mr. Pitman was not insured at the time of his death, Reliance Standard correctly denied the claim.

III.

ARGUMENT

1. Standard of Review

Plaintiff argues that the court's review is *de novo* since "Reliance has failed to submit admissible evidence to show that the plan gave it discretionary authority." See brief of plaintiff at page 4. This refers to plaintiff's erroneous argument that the policy is not properly before the court. Since there can be no dispute that the policy is correctly before this court and it contains an explicit grant of discretionary authority, plaintiff's argument must fail.

Plaintiff also cites to a decision from another Circuit, *Bartlett v. Martin Marietta Operations Support*, 38 F.3d 514 (10th Cir. 1994), in an attempt to avoid the arbitrary and capricious standard of review. Plaintiff has misstated the holding in that case. The court in *Bartlett* did not hold that discretionary

authority did not apply since the plan document was not produced until after the death of the employee. Instead, the court held that the plan document, which contained discretionary authority, did not apply since it was not *prepared* until after the employee's death. Those facts are not present in this case. The Reliance Standard policy which is before this court and which contains discretionary authority was prepared and delivered to the policy holder prior to the death of Mr. Pitman. Therefore, this coverage governs the claim.

Plaintiff next argues that the court's review should be *de novo* since Reliance Standard was acting under a self interest. In support of this argument, plaintiff states that "Reliance undertook to conceal, and utterly disregarded ATG's representations regarding the plan terms by denying plaintiff benefits. . ." See brief of plaintiff at page 4. The fact that a claim is denied is not evidence of self-interest. If that were true, every case involving a denial of benefits would be reviewed *de novo*. Nor did Reliance Standard conceal or disregard any representations by ATG. On the contrary, the fact that ATG never paid premiums for Mr. Pitman's coverage demonstrates that it also did not believe that he was covered at the time of his death.

In support of her claims, plaintiff is relying on the letter from the employer which is not part of the administrative record, which is improperly before the court and which simply states that Mr. Pitman would be eligible for a variety of benefits after he completed his ninety day probation period. As explained below, this is not an official plan document on which

plaintiff may rely. Moreover, the letter simply states that Mr. Pitman would be "eligible for [ATG's] standard package of benefits. . . upon completion of [the] ninety day probation period." The letter does *not* state that his coverage under the benefit plan would begin immediately after the ninety days, only that he would become eligible. This eligibility began on the first of the following month, after the death of Mr. Pitman. Therefore, no benefits are owed.

In this section of her brief, plaintiff once again argues that the declaration of counsel for plaintiff regarding the applicable policy is not competent evidence. As explained above, plaintiff's argument is contrary to the law of this Circuit. Plaintiff also should be careful making this argument. If the Reliance Standard policy does not apply to her claim, then there is no basis for Reliance Standard to be a party to this lawsuit. Reliance Standard will not advance this argument, however, since it is as absurd as plaintiff's argument.[1]

2. California Law is Preempted

Plaintiff argues that her claim must be governed by California law since the policy states so on its cover. Based on California law, plaintiff argues that Reliance Standard cannot deny coverage since it did not deliver a copy of the

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[1] Even though the policy and defendant's other exhibits are properly before the court, Reliance Standard is nevertheless providing this court with a declaration from Peter Sailor of Reliance Standard. This declaration confirms that the policy previously produced by Reliance Standard is the one that was in effect at the time of this claim. This should put to rest plaintiff's arguments regarding the applicability of that policy.

policy to the decedent. Plaintiff is wrong on both points. According to plaintiff, an employer and a benefit plan insurer can avoid ERISA regulation simply by stating that the policy is governed by the laws of a particular state. This is obviously not true. A number of plaintiffs have raised this same argument which has consistently been rejected by courts. In *Tormey v. General American Life Ins. Co.*, 973 F. Supp. 805 (N.D. Ill. 1997), the plaintiff argued that the defendant waived its right to proceed under ERISA because the policy stated that it was "delivered in Illinois and governed by its laws." The court recognized that "the policy may be governed by Illinois law in general, but that cannot prevent ERISA preemption." Even if the plan was governed by Illinois law, "that law is preempted to the extent that it is a law 'relating to' an employee benefit plan, which is superseded by ERISA's § 514." *Id.* *See also Buce v. Allianz Life Insurance Company*, 247 F.3d 1133, 1148 n.6 (11th Cir. 2001); *Dang v. UNUM Life Insurance Company of America*, 175 F.3d 1186, 1190 (10th Cir. 1999). Therefore, plaintiff's claim must be decided based on the law of ERISA and not California state law which is preempted.

The California law that plaintiff relies on in this case is clearly preempted. As explained above, the duty to provide information belongs to the plan administrator, not defendant. Since the California law conflicts with the administrative scheme of ERISA, that law is preempted. *See UNUM Life Insurance Company of America v. Ward*, 526 U.S. 358 (1999).

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3. The RSL Policy Governs the Claim

Citing to cases from other jurisdictions, plaintiff next argues that Reliance Standard may not rely on the policy terms since they were not disclosed to plaintiff. Once again, plaintiff takes out of context and misstates the holdings of these cases. For example, plaintiff cites to *Feifer v. Prudential Ins. Co. of America*, 306 F.3d 1202 (2d Cir. 2002). In *Feifer*, there was no written document as required under ERISA other than the summary plan that was provided to employees. Those facts are not present in this case. Here, the Reliance Standard policy was in place long before the decedent became employed by ATG. Moreover, as stated in the numerous cases cited above, plaintiff cannot complain that a copy of the policy was not provided to the decedent since there is no evidence at all that he ever requested the policy. It bears repeating that unlike the cases relied on by plaintiff, the Reliance Standard policy existed and was available to Mr. Pitman at all times. Accordingly, it is based on this language that his claim must be decided.

Plaintiff argues on page 9 of the brief that coverage should be based on the written offer of employment which was provided to Mr. Pitman by his employer. As explained above, this document should not be considered by the court since it is not part of the administrative record and was never provided to Reliance Standard. Second, the letter correctly states that Mr. Pitman would be "eligible" for coverage under the life insurance policy "upon completion of [the] 90 day probationary period ." While Mr. Pitman became eligible for coverage upon the

completion of his 90th day, the coverage did not become effective until the first of the following month pursuant to the terms of the Reliance Standard policy. Therefore, there are no inconsistencies between the policy and the employer's statement.

Finally with respect to the letter from Mr. Pitman's employer, even if it was properly before the court, it has no legal effect since it is not an official plan document. The letter from the employer cannot be considered a summary plan description because it contains none of the information required of such a document under ERISA. *See* 29 C.F.R. § 2520.102-3. Nor can the letter be considered the "plan" since it does not identify the method of funding, procedures for amending the plan or specify when payments are to be made under the plan. *See* 29 U.S.C. § 1102(b). Therefore, plaintiff may not rely on it in seeking benefits.

Likewise, plaintiff attempts to rely on a document titled "benefit summary" which simply identifies the amount of benefits available under the Reliance Standard policy. See plaintiff's Exhibit 3. This document contains none of the information required of an ERISA plan or a summary plan description. More important, the document specifically states that complete coverage information is contained in other booklets. Therefore, this document is also not relevant to the claim.

Neither the letter from the employer nor the benefit summary are official plan documents that may be relied on by plaintiff. In support of her contrary argument, plaintiff cites to the Tenth Circuit's decision in *Bartlett*. Plaintiff fails to state, however, that in *Bartlett*, the defendant "conceded that

Mr. Bartlett's eligibility should be determined with reference to the language stated in the plan enrollment booklet." *See Bartlett, supra.* Reliance Standard made no such concession in this case. Moreover, it is clear that the documents referenced above are not official plan documents.

Other court decisions, including one from the Tenth Circuit, confirm that benefit summaries may not be relied on in seeking benefits under an ERISA plan. *See Miller v. Coastal Corp.*, 978 F.2d 622 (10th Cir. 1992); *Sengpiel v. B.F. Goodrich Company*, 970 F.Supp. 1322, 1337 (N.D. Ohio 1997), *aff'd* 156 F.3d 660 (6th Cir. 1998); *Etherington v. Bankers Life & Casualty Co.*, 747 F.Supp. 1269, 1277 (N.D. Ill. 1990); *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310 (3d Cir.), *cert. denied*, 501 U.S. 1232 (1991).

In *Miller*, the plaintiff sought additional pension benefits based on letters he received from his employer. These letters calculated the pension benefit in a manner different than the plan. The Tenth Circuit held that the written summaries provided to the plaintiff do not satisfy the "written instrument" requirement of ERISA. The court further held that the summaries did not satisfy the requirements of a plan amendment. Accordingly, the court held that there could be no liability under ERISA for these "informal" plan summaries. *See also Sengpiel, supra.* (Highlights booklet which simply summarized other plan documents could not be relied on); *Etherington, supra.* (Benefits booklet distributed to all employees which highlighted coverage did not meet the requirements of a summary plan description and was not an

official plan document); *Gridley, supra.* ("Overview brochure" which lacked most of the information required of a summary plan description and contained only "perfunctory descriptions" was not an official plan document on which the plaintiff could rely).

There is one additional plan document referred to in plaintiff's brief and that is the summary plan description. A summary plan description *is* an official plan document that may be relied on by a claimant. Plaintiff first complains that Reliance Standard never provided this document to Mr. Pitman. As previously explained, there is no evidence that Mr. Pitman requested a copy of the summary plan description nor did the obligation to disclose documents belong to Reliance Standard since it was not the plan administrator. Counsel for plaintiff also complains that the document is dated after the death of Mr. Pitman. This is the only version that Reliance Standard has as it sent to Mr. Pitman's employer earlier copies for distribution. More important, there were no differences in the summary plan descriptions. However, if plaintiff persists in her argument that the summary plan description should not be applied to her claim, this simply means that the policy governs her claim.

Finally, with respect to the summary plan description, counsel for plaintiff has taken extreme liberties with his presentation and discussion of this document. Counsel for plaintiff admits in footnote 4 on page 10 of the brief that the summary plan description is included in a certificate booklet. However, plaintiff only produced the portion of the booklet

which included the summary plan description. Then plaintiff argues that this document does not contain information on eligibility as required under ERISA. See brief of plaintiff at page 10, n. 4. Eligibility information is included in the complete booklet which counsel conveniently redacted. A copy of the complete certificate booklet, including the summary plan description, is attached as Exhibit "B." Not surprisingly, this booklet contains the same eligibility requirements that are stated in the policy.

Plaintiff argues that Reliance Standard is bound by the representations of the employer under California law. This law is preempted under ERISA, however. Plaintiff also argues that under ERISA, benefit summaries are binding when they conflict with the policy. This statement is inaccurate. When a summary plan description conflicts with a policy, the terms of the summary plan description will govern. *See Atwood v. Newmont Gold Company, Inc.*, 45 F.3d 1317, 1321 (9th Cir. 1995). This rule does not apply to informal benefit summaries as argued by plaintiff since they are not official plan documents. As mentioned above, there is no conflict between the summary plan description and the Reliance Standard policy. Therefore, the cases cited by plaintiff have no application.

Plaintiff next argues that Reliance Standard is bound by the alleged representations of the employer since ATG was the plan administrator. The problem with this argument is that ATG made no representations regarding coverage in an official plan document. As reflected in *Atwood* and the numerous cases cited above, a beneficiary may only rely on an official plan document

such as the "written instrument" establishing the plan in (the policy) or a summary plan description. The informal documents prepared by ATG do not satisfy this requirement.

In its initial brief, Reliance Standard cited to the Supreme Court decision in *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999). In *Ward*, the Supreme Court of the United States held that California agency law which deemed the policy holder-employer to be the agent of the insurer is preempted by ERISA. Incredibly, plaintiff argues that this Supreme Court decision does not apply to this case.

Plaintiff attempts to distinguish *Ward* by arguing that unlike *Ward*, the Reliance Standard policy does not state that the employer is not considered the agent of the insurer. The Supreme Court did not need this language to reach its decision. Instead, the court recognized that California's agency law would impose duties under ERISA that were not "undertaken voluntarily." *See Ward*, 526 U.S. at 378. Moreover, contrary to plaintiff's argument, the Reliance Standard policy specifically states that no agent has the authority to change the terms in the policy. See Exhibit "A" to defendant's motion for summary judgment at page 3.0.

In this section of her brief, plaintiff repeats her erroneous argument that California law should apply to her claim. Plaintiff then argues that even if it does not apply, Reliance Standard breached its fiduciary duty by including governing law language in the policy. There was nothing improper in Reliance Standard stating that the policy is governed by California law. ERISA only applies to a claim for

benefits. In the event of a dispute between ATG and Reliance Standard, for example to recover premiums owed, ERISA would not apply. Therefore, California law would govern. However, since plaintiff is seeking benefits, the law of ERISA applies to her claim.

It is argued on page 16 of plaintiff's brief that if the employer improperly changed the eligibility requirements, Reliance Standard would still have to pay the claim but "that would be grounds for a claim by Reliance against ATG." Plaintiff has it backwards. First and foremost, there was no change by ATG. Second, if there was a change, Reliance Standard can only be compelled to pay benefits in accordance with the terms of its policy. To the extent that plaintiff seeks benefits not payable under the policy, it is she who would have to pursue a claim against the employer.

Plaintiff's attempts to distinguish the Ninth Circuit's holding in *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154 (9th Cir. 2001), also lack merit. Plaintiff admits that the court in *Grosz-Salomon* held that the integration clause in the policy, similar to the one in the Reliance Standard policy, prevented the employer from binding the insurer through promises made in extraneous documents. See brief of plaintiff at page 17. Plaintiff attempts to distinguish *Grosz-Salomon*, however, by arguing that the case "involved construction of the terms of a contract between two sophisticated corporate entities" whereas this case involves a claim related to an employee. Contrary to plaintiff's argument, *Grosz-Salomon* also involved a claim for benefits. Nor is there anything in the court's opinion which

supports plaintiff's argument that the court should rely on letters which are not official plan documents in determining plaintiff's eligibility for benefits. It bears repeating that the policy and the summary plan description in this case contain the identical terms of coverage.

4. The Policy Language Is Unambiguous

In yet another attempt to avoid the terms of the policy, plaintiff argues that the policy is ambiguous as to when coverage begins after the 90 day waiting period has been satisfied. See brief of plaintiff at page 18. Contrary to plaintiff's argument, there is no ambiguity in the policy. The policy states on page 1.0 that an individual's effective date is "the first of the Policy month coinciding with or next following completing of the Waiting Period." See Exhibit "A" to defendant's motion for summary judgment at page 1.0. There is no dispute that the waiting period for Mr. Pitman was 90 days of employment. Plaintiff argues, however, that the policy is ambiguous since coverage might begin immediately after the 90 days are satisfied. This interpretation of the policy is unreasonable. As previously stated, an individual's coverage becomes effective on the first of the policy month "coinciding or next following completion of the Waiting Period." As stated on the cover of the policy, the policy month begins *on the first of each month*. The first premium was due on the effective date which was *August 1, 1999*. The policy also states that subsequent premiums "are due monthly, in advance, *on the first day of each month*." Thus, the policy can only be read as

commencing individual coverage on the first of each month. Reliance Standard's interpretation was obviously shared by ATG as it did not pay premiums for Mr. Pitman for any portion of the month in which he satisfied the waiting period.

Plaintiff's argument with respect to the effective date of coverage is obviously flawed. Plaintiff's argument only makes sense if Mr. Pitman was the only one insured under the policy. Otherwise, there would be multiple policy months depending on when an individual satisfies the waiting period. This simply makes no sense.

In support of her arguments, plaintiff cites to a North Carolina state court decision which involves the question of when coverage terminates, not when it begins as in this case. See brief of plaintiff at page 19. Unlike the ambiguity in the case cited by plaintiff, the Reliance Standard policy contains no ambiguity. If the waiting period coincides with the first of the policy month, coverage begins on that month. If, however, the waiting period is completed after the first of the policy month, i.e., the first of the month, then the individual's coverage becomes effective on the first of the next month.

Plaintiff also erroneously asks this court to apply the doctrine of reasonable expectations. This doctrine only applies where the insurer relies on language that is ambiguous or inconspicuous. *See Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 387 (9th Cir. 1994). Here, the language is unambiguous and conspicuously located in the policy. Therefore, the doctrine has no application to this case.

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IV.

CONCLUSION

For the reasons stated above and in defendant's initial motion, Reliance Standard Life Insurance Company respectfully requests that the Court enter judgment in its favor on all claims.

DATED: March 19, 2004

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