

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

STEPHEN F. SCHOLLE, M.D.,

Plaintiff,

CASE NO. 99-283-CIV-FTM-23D

v.

CONTINENTAL CASUALTY COMPANY,

Defendant.

**MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S
DISPOSITIVE MOTION FOR SUMMARY JUDGMENT**

I. Introduction

This case ensued as the result of the denial of benefits to the Plaintiff, Stephen F. Scholle, M.D., under a group benefit plan governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. (ERISA). Dr. Scholle is disabled from his former occupation due to severe, debilitating migraine headaches. Dr. Scholle was enrolled through his employer in a group disability plan administered by the Defendant, Continental Casualty Company (hereinafter "CCC"). As a result of his inability to work in his former occupation, Dr. Scholle filed a claim under the terms of the CCC policy. CCC had this information "reviewed" by a doctor who essentially deferred any conclusion regarding Dr. Scholle's disability to one of his treating physicians. CCC denied the claim without any contradictory medical evidence to dispute the conclusions of Dr. Scholle's treating physicians. In addition, CCC improperly asserted that additional requirements, that were not in the plan, needed to be complied with before it could determine that Dr. Scholle was eligible for benefits.

Dr. Scholle appealed the denial of his benefits and submitted additional information from his treating physicians certifying him to be totally disabled from his former occupation. CCC sent this information to a different doctor who stated that Dr. Scholle was unable to work when he was suffering from a migraine, but that he may be able to work with accommodations. CCC never examined Dr. Scholle and denied the appeal without any concrete medical evidence of its own, ignoring the conclusions of Dr. Scholle's treating physicians. CCC's actions were contrary to the applicable provisions of ERISA and its denial of Dr. Scholle's benefits was not only wrong, but unreasonable. Dr. Scholle is entitled to all benefits from his date of disability to the present as well as a decree ordering CCC to continue paying his benefits in accordance with the terms of the plan.

II. Facts

The Plaintiff, Stephen F. Scholle, M.D., had been a successful operating room anesthesiologist employed with Medical Anesthesia and Pain Management Consultants, P.A. for more than ten years. Through his hard work and dedication, Dr. Scholle became a partner with the medical group. Dr. Scholle was enrolled in a group disability plan through his employer which was administered through CCC. The purpose of the plan is to provide a monthly benefit check in the event Dr. Scholle is unable:

“to perform each of the material duties pertaining to your specialty in the practice of medicine (for doctors) or occupation (for other insured personnel); or
to perform all of the material duties of your regular specialty (for doctors) or occupation (for other insured personnel) on a full-time basis, but are
a. performing at least one of the material duties of your regular specialty/occupation or another occupation on a part-time or full-time basis, and
b. currently earning less than 80% per month of your pre-disability earnings due to that same injury or sickness.”

CCC Plan, p. 7 (attached as **Exhibit A**).

Beginning in March 1995, Dr. Scholle began experiencing severe migraine headaches while in the operating room theater or immediately thereafter¹. The migraines progressed in severity to the point that he would sometimes lose complete visual and/or auditory capability in addition to excruciating pain, an extreme sensitivity to lights and sounds and nausea persisting for up to twenty-four hours after an operation. The migraines also progressed in frequency from occurring on the average of once every three months to once a week. The associated hearing loss would persist for longer periods during successive episodes.

The hearing loss associated with the migraines was of particular concern to Dr. Scholle's treating physicians because his mother became permanently deaf during a similar pattern of migraines. Due to the familial history of permanent hearing loss associated with migraines, his treating physicians felt Dr. Scholle could potentially suffer the same fate as his mother and lose all auditory capability. Dr. Scholle's treating physicians were also extremely concerned with the safety of Dr. Scholle's patients. As is the case with most chronic migraine cases, a specific trigger for the onset of the migraines has not been identified by any of Dr. Scholle's treating physicians, but the migraines only appeared in the operating room environment². When Dr. Scholle would lose auditory and/or visual capability in the operating room, his patients were at risk for serious injury or even death as a result of his inability to continue. During past episodes,

¹ The attending physician statement with the onset date of symptoms is attached as **Exhibit B**.

² See, July 30, 1997 report of Jeff R. Comer, M.D. attached as **Exhibit C**; September 18, 1997 report of Douglas A. Newland, M.D., attached as **Exhibit D**; and September 29, 1997 report of David B. Sudderth, M.D., attached as **Exhibit E** who all agree that Dr. Scholle's migraines are triggered by something in the operating room and he should avoid this environment.

another anesthesiologist has been able to take over for him, but this option was not always available nor is the risk of harm to the patients acceptable.

Dr. Scholle was ordered by his treating physicians to discontinue working as an operating room anesthesiologist due to the risk of permanent injury to both himself and his patients³. Because he could no longer continue practicing in his medical specialty as an operating room anesthesiologist, Dr. Scholle filed a claim for disability benefits under the terms of the CCC plan⁴. CCC sent the medical information submitted by Dr. Scholle to Gary K. Friedman, M.D. for review⁵. Dr. Friedman's initial report came to no conclusions regarding Dr. Scholle's disability.

Dr. Friedman sent follow-up letters to Dr. Newland and Dr. Sudderth posing specific questions to them⁶. Dr. Sudderth agreed to provide the requested information if he was compensated for his time⁷, but CCC refused to pay him for his time and decided to rely on the information he had previously provided them with⁸. Dr. Newland did specifically answer all the questions posed to him and reiterated his opinion that Dr. Scholle was disabled from his former occupation as an anesthesiologist in the operating room⁹. Dr. Newland's answers seemed to satisfy Dr. Friedman's questions regarding Dr. Scholle's disability status because Dr. Friedman instructed CCC to "give due

³ See, footnote 2 and the attached exhibits referred to therein.

⁴ Dr. Scholle initially informed CCC of his intent to file a claim and requested the claim forms in a letter dated October 1, 1997 (attached as **Exhibit F**). When he received no response to this letter, a follow-up letter was sent on December 5, 1997 (attached as **Exhibit G**). The second request for claim forms was also ignored by CCC forcing Dr. Scholle to send a third letter on March 9, 1998 (attached as **Exhibit H**).

⁵ The July 7, 1998 report from Dr. Friedman is attached as **Exhibit I**.

⁶ The October 27, 1998 letters to Dr. Newland and Dr. Sudderth are respectively attached as **Exhibits J** and **K**.

⁷ The November 6, 1998 letter from Dr. Sudderth is attached as **Exhibit L**.

⁸ The November 14, 1998 letter from CCC is attached as **Exhibit M**.

⁹ The November 9, 1998 letter from Dr. Newland is attached as **Exhibit N**.

consideration to Dr. Newland's comments¹⁰” without ever giving a specific opinion of his own.

CCC, through its claims adjuster and in-house nurse consultant, ignored the conclusions of its hired physician, Dr. Friedman, as well as the conclusions of Dr. Friedman's treating physicians and determined that Dr. Scholle was not eligible for benefits¹¹. The basis for denial from CCC's non-physicians was that, in their opinion, there was no objective evidence to support a disability, the specific gases triggering his migraines were not identified and he did not attempt to work with accommodations¹². There is no requirement in the CCC plan for Dr. Scholle to provide objective evidence, a specific cause of his disability or for him to work with accommodations¹³.

The CCC plan does not contain a claims review procedure¹⁴ as required by ERISA, but Dr. Scholle appealed the denial of his claim through counsel including reference to a specific case against CCC in which a denial for similar reasons was found to be arbitrary and capricious¹⁵. In addition, Dr. Scholle attached an additional report from Dr. Newland concurring with the previous evidence submitted that Dr. Scholle was disabled from working as an anesthesiologist in the operating room¹⁶.

CCC responded to the appeal by sending Dr. Scholle's records to another physician to review¹⁷. CCC's second hired physician, Dr. Turok, specifically stated:

“While he is experiencing a headache, he should not be driving, **be in an operating room**, operating an airplane or performing any activity which

¹⁰ The November 20, 1998 letter from Dr. Friedman is attached as **Exhibit O**.

¹¹ The December 8, 1998 claim activity note is attached as **Exhibit P**.

¹² The December 11, 1998 denial letter is attached as **Exhibit Q**.

¹³ See, CCC Plan, Exhibit A.

¹⁴ *Id.*

¹⁵ The February 3, 1999 appeal letter is attached as **Exhibit R**.

¹⁶ The November 12, 1998 report from Dr. Newland is attached as **Exhibit S**.

¹⁷ The March 19, 1999 letter containing the February 19, 1999 report of David Turok, M.D. is attached as **Exhibit T**.

requires great visual activity. **If the migraines are controlled**, however, those activities could be resumed. . . . As I described above, however, Dr. Scholle certainly could continue practicing as an anesthesiologist, **with the absence of inhaled anesthesia** either in a pain clinic, or in an operating suite which does not use inhalational agents such as one devoted to outpatient monitored anesthesia care surgery without unacceptable risk of injury to patients.”

Dr. Turok’s report, Exhibit Q, p. 6.

In summary, Dr. Turok stated that Dr. Scholle could only perform anesthesia in the operating room if his migraines could be controlled or his job was changed. Since Dr. Newland and Dr. Sudderth both opined that the migraines could not be controlled¹⁸ and the CCC disability plan specifically relates to Dr. Scholle’s pre-disability occupational specialty, operating room anesthesiologist, Dr. Turok’s report supports Dr. Scholle’s eligibility for disability benefits. CCC agreed that:

“When having a migraine Dr. Newland [sic] should avoid or be restricted from the operating room.”

April 13, 1999 denial letter, p.2 (attached as **Exhibit U**).

However, CCC denied Dr. Scholle’s appeal because:

“[T]he records indicate that your client is doing well **as long as he stays away from anesthetic agents.**”;

“[T]he records do not contain sufficient documentation to support **any specific cause** for your client’s symptoms.”; and

“Your client could continue to perform his occupation **in other settings** such as a pain clinic, or in an operating suite which does not use inhalational agents.”

Id (emphasis added).

CCC never bothered to physically examine Dr. Scholle and it did not possess any medical evidence contrary to a finding of disability. Dr. Scholle’s claim was denied

¹⁸ See, Exhibits D and E, discussed, *supra*.

because non-medical, non-experts determined that because the specific cause of his disability was unknown, he should be able to practice his occupation if certain accommodations were made for him. This finding is contrary to the terms of the disability plan and violative of the applicable law. This suit was commenced to recover the benefits promised to Dr. Scholle under the terms of the CCC plan.

III. Summary Judgment Standard

A moving party is entitled to summary judgment if the pleadings, affidavits and other supporting papers show there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R.Civ.P., 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322, 91 L.Ed. 2d 265, 106 S.Ct. 2548 (1986). “The burden of establishing the absence of a genuine issue of material fact is on the party seeking summary judgment.” United of Omaha Life Ins. Co. v. Sun Life Ins. Co. of America, 894 F.2d 1555, 1557 (11th Cir. 1990)(citations omitted). Once this burden has been met, the adverse party must show there remains a genuine issue for trial. Fed.R.Civ.P., 56(e). “The court must view all evidence in the light most favorable to the non-movant and must resolve all reasonable doubts about the facts in favor of the non-movant.” United of Omaha Life Ins. Co., 894 F.2d at 1558.

A genuine issue of material fact exists when “the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” Anderson v. Liberty Lobby Inc., 477 U.S. 242, 248, 91 L.Ed. 2d 202, 106 S.Ct. 2505 (1986). “The mere existence of a scintilla of evidence in support of the [nonmoving party’s] position will be insufficient; there must be evidence on which the jury could reasonably find for the [nonmoving party].” Id at 252. “ If a review of the evidence presented reveals that the

non-movant has failed to produce evidence sufficient to support a jury verdict in his favor, then summary judgment should be granted.” United of Omaha Life Ins. Co., 994 F.2d at 1558.

IV. ERISA Standard of Review

The basis of Dr. Scholle’s claim is the wrongful denial of disability benefits pursuant to a group disability insurance plan, governed by 29 U.S.C. § 1001, et seq. (ERISA). The decision to deny benefits under an ERISA plan is evaluated under varying standards of review, depending on the express terms of the plan and factual circumstances of the case.

“Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132 (a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989); accord, Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1559 (11th Cir. 1990).

There is no language in the CCC plan granting discretionary authority to determine eligibility for benefits or to construe the terms of the plan¹⁹. The proper standard of review in this case is *de novo*. It is the Court’s function to review the evidence submitted to CCC and determine whether CCC’s decision to deny benefits was right or wrong based on this information.

V. CCC’s Failure to Conduct a Full and Fair Review

CCC has an obligation to conduct a full and fair review of every claim submitted to it²⁰. CCC is required to have certain minimum requirements in place to ensure that it

¹⁹ See, CCC Plan, Exhibit A.

²⁰ 29 U.S.C. § 1133; ERISA § 503.

conducts a full and fair review of all claims and claims denials²¹. Although CCC does have a claims procedure in place, it does not seem to adhere to it because Dr. Scholle had to write three letters before he even received the claim forms. In addition to its blatant disregard of its own claims procedures, CCC does not have any procedures in place to review claims²² in direct violation of the applicable provisions of ERISA²³. This technical violation of ERISA is reason enough to conclude that CCC's denial of Dr. Scholle's claim was improper.

The manner in which CCC conducted its review of Dr. Scholle's claim was also contrary to ERISA case law. CCC had a duty to consider the medical information "in tandem" and render a decision based on all the information. Paramore v. Delta Air Lines, Inc., 129 F.3d 1446, 1452 (11th Cir. 1997).

"[The plan administrator's] selective review of the medical evidence and its completely erroneous assertion that there was no physical cause for the subjective symptoms of pain renders its decision not only unreasonable but arbitrary and capricious."

Govindarajan v. FMC Corp., 932 F.2d 634, 637 (7th Cir. 1991).

Dr. Scholle submitted reports from three different doctors who all agreed that the operating room environment was causing his debilitating migraine headaches and he could not continue working there. CCC's own paid physicians concurred that the operating room environment could cause the migraines and Dr. Scholle should not be working when experiencing an episode. CCC did not even attempt to dispute this information.

"There is nothing in the decision itself to indicate that the Administrative Committee in fact examined the record in its entirety. No mention is made

²¹ 29 C.F.R. § 2560.503-1.

²² See, CCC Plan, Exhibit A.

²³ 29 C.F.R. § 2560.503-1 (g).

of the supplemental medical opinions, Mr. Todorowski's report, or the favorable decision of the Social Security Administration, finding Plaintiff completely disabled, within the meaning of the Social Security Act, as of June 1994. By relying only on 'the original' medical record and Dr. Deutsch's report, the Administrative Committee acted arbitrarily.

...

By failing to address this un rebutted opinion or refute it in any way, the Administrative Committee acted unreasonably."

Lozada v. Delta Family-Care Disability and Survivorship Plan, 1998 U.S. Dist. LEXIS 11290, *10-11 (M.D. Fla. 1998)(emphasis added)²⁴.

An ERISA plan administrator is required to have some medical information in its possession that supports a denial of a claim before it can actually deny the claim. CCC did not have any contrary medical evidence to support its denial. CCC failed to conduct a full and fair review and its decision cannot be upheld.

"Plainly put, we will not countenance a denial of a claim solely because an administrator suspects something may be awry. Although we owe deference to an administrator's reasoned decision, we owe no deference to the administrator's unsupported suspicions. **Without some concrete evidence in the administrative record that supports the denial of the claim, we must find the administrator abused its discretion.**"

Vega v. National Life Ins. Services, Inc., 188 F.3d 287, 1999 U.S. App. LEXIS 20894, *46 (5th Cir. September 1, 1999)(emphasis added); accord, Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Auto Ins. Co., 463 U.S. 29, 43, 103 S.Ct. 2856, 77 L.Ed. 2d 443 (1983) (a decision is arbitrary and capricious if the decision-maker "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it], or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise").

VI. The Treating Physician Rule

Part of the obligation to conduct a full and fair review is the concept of the treating physician rule. An ERISA plan administrator is required to give deference to the conclusions of a treating physician.

"Cases in this circuit distinguish among the opinions of three types of physicians: (1) those who treat the claimant (treating physicians); (2)

²⁴ The full case is attached as **Exhibit V**.

those who examine but do not treat the claimant (examining physicians); and (3) those who neither examine nor treat the claimant (nonexamining physicians). As a general rule, more weight should be given to the opinion of a treating source than to the opinion of doctors who do not treat the claimant. At least where the treating doctor's opinion is not contradicted by another doctor, it may be rejected only for 'clear and convincing' reasons. We have also held that 'clear and convincing' reasons are required to reject the treating doctor's ultimate conclusions. Even if the treating doctor's opinion is contradicted by another doctor, the Commissioner may not reject this opinion without providing 'specific and legitimate reasons' supported by substantial evidence in the record for so doing."

Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1995)(citations omitted)²⁵.

CCC did not have Dr. Scholle examined by a physician. This Circuit has held that the failure to examine a claimant is arbitrary and capricious in and of itself. Godfrey v. Bellsouth Telecommunications, Inc., 89 F.3d 755, 758-59 (11th Cir. 1996). The Eighth Circuit has held that it is arbitrary and capricious to rely on a reviewing physician's opinion over the treating physician's opinion. Donaho v. FMC Corp., 74 F.3d 894, 901 (8th Cir. 1996)("where the reviewing physician's conclusions are contradicted by an examining physician and two treating physicians, reliance on the reviewing physician's conclusions 'seems especially misplaced' and constitutes an abuse of discretion"). CCC's paid physicians provided no support for the denial. Instead, CCC based its denial on the conclusions of its claims adjuster and in-house nurse²⁶, neither of whom are doctors. Reliance on non-experts cannot provide a reasonable basis to deny a claim.

²⁵ Cases construing Social Security disability provisions should be used as guidance in ERISA cases. Helms v. Monsanto Co., Inc., 728 F.2d 1416, 1420 (11th Cir. 1984). Also see, Isabil v. Hartford Life and Accident Ins. Co., 1999 U.S. LEXIS 824, *6-7 (N.D. CA January 29, 1999)("As a general matter, the opinion of a treating physician is accorded more weight than that of a non-treating physician. . . . In addition, the opinion of a non-examining physician cannot, by itself, constitute substantial evidence to overturn the opinion of either an examining physician or a treating physician. In rejecting Dr. Neuwelt's diagnosis, neither Hartford's in-house nurse nor Dr. Kozin ever personally examined plaintiff. Further, Hartford later declined to have plaintiff looked at by a physician of its own choosing. . . . Dr. Lifshay's report thus amounts to an uncontradicted opinion which may be rejected only for 'clear and convincing' reasons.) (attached as **Exhibit W**).

Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118, 1123 (9th Cir. 1998). How could a participant or beneficiary ever submit satisfactory medical evidence if a non-physician can simply refute the information based on his own conclusions? CCC had no medical evidence to contradict the conclusions of trained physicians. This decision cannot be upheld.

“Specifically, the claim file does not contain any evidence showing that plaintiff is not disabled. Nor is there any evidence demonstrating that stress would not cause plaintiff to develop aneurysms or that stress would not prohibit plaintiff from performing his job duties.”

Durr v. Metropolitan Life Ins. Co., 15 F.Supp. 2d 205, 214 (D. Conn. 1998).

VII. CCC's Improper Plan Interpretation

In addition to the improper conduct discussed *supra*, CCC improperly interpreted the provisions of its disability plan. To determine whether an interpretation is proper, the first step is to look at the express language contained in the plan.

“A key principle guiding our resolution of the Retirees’ claim is that we must look to the plain language of the [] plan to determine whether the Trustees’ interpretation of that plan is ‘arbitrary and capricious.’ We have consistently explained that ‘trustees abuse their discretion if they . . . construe provisions of [a] plan in a way that clearly conflicts with the plain language of the plan.’”

Canseco v. Construction Laborers Pension Trust, 93 F.3d 600, 606 (9th Cir. 1996)(citations omitted); accord, Stvartak v. Eastman Kodak Co., 945 F. Supp. 1532, 1536 (M.D. Fla. 1996).

CCC improperly interpreted the disability plan by inserting three additional requirements for eligibility: 1) the requirement for Dr. Scholle to provide the specific cause or gasses that triggered his migraines; 2) the requirement that Dr. Scholle provide objective medical evidence of his disability; and 3) the requirement that Dr. Scholle must work in his own occupation with accommodations or alter his occupation by avoiding the

²⁶ See, Exhibit P, discussed, *supra*.

operating room. The insertion of any one of these additional requirements is reason for finding CCC's actions arbitrary and capricious. The insertion of all three of these additional requirements shows the bad faith manner in which CCC handled this claim.

The disability plan only requires the insured to submit "written proof of loss"²⁷. Throughout the claims process, CCC focused on Dr. Scholle's inability to provide it with the specific inhalant agents or other triggering mechanisms causing his migraines. In fact, this was one of the reasons given by CCC to deny Dr. Scholle's appeal²⁸. CCC improperly inserted an additional term by requiring Dr. Scholle to identify the cause of his disability.

"We find that defendant's denial was arbitrary and capricious because administrators and fiduciaries are prohibited from adding a term or extra requirement into an insurance policy that is not expressly part of it. This action alone would support a finding that a fiduciary has acted arbitrarily and capriciously. Here, the SPD nowhere provides that employees must submit objective medical evidence in support of their claims. Despite defendant's assertions that plaintiff bore the burden of demonstrating a link between stress and aneurysm formation and/or rupture, the SPD does not require employees to provide information on the cause of their disabling conditions. Instead, plaintiff submitted what was required of him under the SPD – proof of his disability – by providing copies of his medical records, his medical history, and three doctors' opinions stating that he is disabled. Thus, it was unreasonable for defendant to interpret the SPD as requiring plaintiff or plaintiff's treating physicians to provide MetLife with published studies, articles, or texts showing a connection between stress and plaintiff's condition."

Durr, 15 F.Supp 2d at 212 (citations omitted); accord, Mitchell v. Eastman Kodak Co., 113 F.3d 433, 443 (3rd Cir. 1997)(a claimant does not have to provide clinical evidence of the etiology of the condition that renders him disabled because it is not a requirement of the plan).

²⁷ See, CCC Plan, p.16, Exhibit A, *supra*.

²⁸ See, appeal denial letter, Exhibit U, discussed, *supra*.

The second additional requirement for eligibility CCC inserted into the disability plan was the requirement that Dr. Scholle submit objective evidence of his disability²⁹. Dr. Scholle suffers from migraine headaches. It would be impossible for him to submit objective evidence of migraine because you cannot see a headache on an x-ray, MRI or any other diagnostic test. The insertion of this additional term was an attempt to avoid payment under the terms of the plan and is improper.

“[The Defendant] cannot exclude a claim for lack of ‘objective medical evidence’ unless the ‘objective medical evidence’ standard was made ‘clear, plain and conspicuous enough [in the policy to negate layman [plaintiff’s] objectively reasonable expectations of coverage.’ The ‘objective medical evidence’ standard first appeared in correspondence between the parties and is not found in the original policy document. As such, [the Defendant] may not seek to deny [Plaintiff’s] claims based on standards not within the policy itself.”

Duncan v. Continental Casualty Co., 1997 U.S. Dist. LEXIS 1582 (N.D. Ca. February 10, 1997)³⁰.

The disability plan protected Dr. Scholle from being unable to work in his specific medical specialty, operating room anesthesiologist. CCC determined that Dr. Scholle was not disabled because he could perform his occupation with accommodations such as an “inline respirator³¹” or “in other settings³².” By stating that Dr. Scholle was only able to perform his occupation with accommodations, CCC effectively admitted that he was disabled from his occupation.

“A second interpretive principle guiding our analysis is that pension plan trustees or administrators may not construe a plan so as to impose an additional requirement for eligibility that clashes with the terms of the plan. Lower federal courts have held that where plan trustees ‘impose a

²⁹ CCC specifically listed lack of objective evidence in its initial denial letter (see, Exhibit P). CCC refrained from using the term “objective” in the appeal denial letter and replaced it with “without supporting evidence.” (see, Exhibit U). The semantics are irrelevant. CCC improperly inserted an additional requirement.

³⁰ The full case is attached as **Exhibit X**.

³¹ See, Exhibit P.

³² See, Exhibit U.

standard [of eligibility for pension plan benefits] not required by the pension plan itself,' that action 'results in an unwarranted and arbitrary construction of the plan'.

...

Recently, in Saffle, we extended this principle to disability benefits. In Saffle, a plan administrator denied an employee long-term benefits for 'total disability.' The administrator concluded that the employee did not satisfy the definition of 'total disability' because medical reports concluded the employee could return to work if her job was modified to allow her to perform exclusively sedentary work. On appeal, we rejected the administrator's interpretation of the disability plan in part because the administrator construed the plan to prohibit benefits if the employee was able to continue working with 'accommodations.' Such an interpretation, we concluded, would operate to 'impose [] a new requirement for coverage': it would require the claimant to show that accommodations were futile. We rejected this implied additional term, explaining that a '[plan] administrator lacks discretion to rewrite the plan.'"

Canseco, 93 F.3d at 608-9 (citations omitted).

VIII. Conclusion

Dr. Scholle is totally disabled from performing the duties of an anesthesiologist in the operating room. He submitted conclusive medical information from his treating physicians in support of his claim. CCC would have Dr. Scholle either risk permanent deafness or blindness or seriously injure or kill a patient before he could become eligible for disability. Public policy dictates against forcing a claimant to risk severe permanent injury of himself or others to prove a disability claim. In addition, there is no requirement for this in the disability plan. Dr. Scholle has abided by the terms of the plan and is entitled to disability benefits. CCC should be ordered to abide by the terms of its disability plan as well and pay Dr. Scholle his disability benefits up to date, plus interest, along with a decree ordering CCC to continue paying his future benefits.

Respectfully submitted,

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BY: _____
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CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was faxed
this ____ day of October, 1999 to: Russell S. Buhite, Esq., Fowler, White, Gillen, Boggs,
Villareal and Banker, P.A., Post Office Box 1438, Tampa, Florida 33601.

Respectfully submitted,

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